Health Information and Quality Authority

An tÚdarás Um Fhaisnéis agus Cáilíocht Sláinte

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

Updated on: 6 October 2021

Version history

Version	Date	Specific updates
V1.0	30 March 2020	Date of first rapid review
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.
V2.2	4 June 2020	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.
V2.3	11 June 2020	Updated guidance from Hong Kong, HPS and Australia. Included new guidance from the HPSC on visitation. Updated reopening plans for Canada and New Zealand
V2.4	18 June 2020	Updated guidance from CDC, CDNA, HPS, and PHE. Included new guidance from the Ministry of Health in New Zealand.
V2.5	25 June 2020	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.
V3.0	3 July 2020	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.
V3.1	9 July 2020	Updated guidance from the Council on the Ageing (Australia) and Hong Kong.
V3.2	16 July 2020	Updated guidance from Scotland, Northern Ireland and NSW Australia.
V3.3	23 July 2020	Updated guidance from New South Wales and Ireland. Addition of new guidance from Public Health England.
V3.4	5 August 2020	Updated guidance from Canada and Australia's Council on the Ageing.
V3.5	19 August 2020	Updated guidance from Ireland, New Zealand, NSW (Australia) and Scotland.
V3.6	2 September	Updated guidance from Ireland, New Zealand, NSW (Australia), Prince Edward Island (Canada) and US.
V3.7	17 September	Addition of new reopening guidance from Ontario (Canada). Updated guidance from Ireland and Scotland.
V4.0	06 November	Restructured to focus on guidance issued by agencies internationally that is not featured in the current guidance issued in Ireland.
V4.1	10 December	Additional guidance from: ▪ England

		▪ Scotland ▪ Prince Edward Island (Canada) ▪ New South Wales (Australia)
V4.2	14 January 21	Additional guidance from: ▪ British Columbia ▪ CDC ▪ England ▪ New South Wales ▪ Scotland ▪ Quebec
V5.1	5 February 21	New theme added: ▪ Vaccines Additional guidance from: ▪ British Columbia ▪ England ▪ New South Wales ▪ Northern Ireland ▪ Ontario ▪ Prince Edward Island ▪ Scotland
V5.2	17 February 21	Additional guidance from: ▪ CDC ▪ New South Wales ▪ Northern Ireland ▪ Scotland
V5.3	16 March 2021	Removal of Appendix A Additional guidance from: ▪ CDC ▪ CMS ▪ Ontario ▪ Scotland
V5.4	22 April 2021	Addition of a table to capture exemptions relating to vaccination status. Additional guidance from: ▪ England ▪ Ireland
V5.5	13 May 2021	Additional guidance from: ▪ CDC ▪ England ▪ Ireland ▪ New South Wales ▪ Ontario
V5.6	18 June 2021	Additional guidance from: ▪ England ▪ Ireland ▪ Ontario

		▪ Scotland
V5.7	16 July 2021	Additional guidance from: ▪ Communicable Diseases Network Australia ▪ England ▪ New South Wales ▪ Northern Ireland
V5.8	10 August 2021	Additional guidance from: ▪ British Columbia, Canada ▪ COTA Australia ▪ New South Wales ▪ Prince Edward Island, Canada
V5.9	10 September 2021	Additional guidance from: ▪ British Columbia, Canada ▪ Ireland ▪ New South Wales, Australia ▪ Ontario, Canada
V5.10	6 October 2021	New guidance from: ▪ European Centre for Disease Control (ECDC) ▪ Ireland ▪ New South Wales (Australia) ▪ Northern Ireland ▪ CDC (US).

Key points

Recommendations and measures for residential care facilities (RCFs) featured in Irish guidance are largely reflected in the recommendations of other national and international agencies. However, some variations in guidance have been observed. These variations in recommendations fall under the themes of:

- Vaccine related exceptions: The **CDC**, **England**, **Ireland** and **Prince Edward Island, Canada** have IPC guidance specific to fully vaccinated individuals. **Scotland** have stated that existing IPC guidance apply regardless of vaccination status (Table 1).
- Testing: **Northern Ireland** tests all asymptomatic care home residents on a 28 day cycle and asymptomatic staff on a 14 day cycle. US includes the use of point of care (POC) testing and routine testing as part of their testing strategy. The US **CDC** recommends performing expanded viral testing of all residents in a RCF if there is a new SARS-CoV-2 infection in any HCW or resident, if resources allow. The **CDC** has published an updated plan for testing residents and HCW recommending both vaccinated and unvaccinated asymptomatic people should receive a viral test after high-risk exposure. **Ontario** recommends immediate testing of all staff and residents in an infected area when one case of a variant of concern (VOC) is suspected or confirmed. Additionally, **Ontario** published guidance on the frequency and type of test for a range of visitors. **British Columbia** require unvaccinated staff to be tested before each shift.
- Monitoring: Residents or staff identified as other contacts (that is, not close contacts) are to be monitored for 28 days in **Hong Kong**. **England** suggests use of scoring systems (such as the RESTORE2 (Recognise Early Soft signs, Take Observations, Respond, Escalate)) as a way of monitoring residents with symptoms.
- Admissions and transfers: **Australia** does not permit admission of new residents with COVID-19 compatible symptoms to enter the facility. **Northern Ireland** has added questions relating to vaccination status in the pre-admission and admission risk assessment form. **England** no longer requires people admitted to a RCF from the community to self-isolate for 14 days on arrival after undergoing enhanced testing.
- Isolation: The **CDC and CMS (US)** provide considerations for post-vaccination for HCWs and residents relating to symptoms and testing including quarantine.
- Cohorting: **Quebec** advises RCFs to use colour coded zones to indicate units that have confirmed cases, possible cases, or no cases. **Ontario** recommends that residents can freely socialise and interact with each other outdoors within and across cohorts, including during planned or organised group activities. This recommendation also applies in indoor settings with the additional requirement of a mask and maintaining a physical distance.

- Controls to minimise risk of inadvertent introduction of virus: **Northern Ireland** and **England** ask RCFs to consider live in arrangements for staff, in situations where it can be safely done. **England** has agreed legislation, pending parliamentary approval, for a requirement of all staff including professional visitors to be fully vaccinated from October. **England** has changed the duration for which restrictions must remain in place following an outbreak, reducing care home restrictions from 28 days to 14 days after recovering tests detect no news cases. However, if a test results confirm a variant of concern in the outbreak then 28 days with no new cases is required. **NSW** (Australia) excludes visitors and staff from entering a RCF if they are on the contact tracing list or if they have been in an area identified with a cluster in the community, such as shopping centres, in the previous 14 days. **NSW** also advises RCFs when it is not possible to cease staff working across facilities or multiple settings (such as in home care and residential care), then records of staff and work locations must be maintained. **NSW** advises that staff clean their phones and place them in a new, clear zip lock bag at beginning of each shift. Multipurpose facilities that include non older person sections are recommended to prioritise and consolidate HCWs tasks in the older person section, before other areas. The **CDNA of Australia** requires RCF to maintain records of staff locations of work internal and external to the RCF. During an outbreak, staff who are working at the facility should not work in other residential facilities.
- Physical distancing: **Northern Ireland** encourages the restriction of residents to their rooms, even for mealtimes where this is practical.
- Visitations: **Quebec** requires visitors that have tested positive wait 21 days if they were admitted to ICU or 28 days if on immunosuppressing medication. **England** requires named visitors to provide a negative test result on the day for each visit (Lateral flow devices), while essential caregivers have the same PPE and testing requirements as RCF staff. Essential caregivers are able to visit residents during their isolation period. **Scotland** offers lateral flow tests to a range of visitor types including professional visitors. **Quebec** recommends RCFs provide a test, on demand, to any informal or family caregiver or visitor who so wishes. The **CMS** (US) encourages facilities in medium or high-positivity counties to test visitors, if feasible, and prioritise those visitors that regularly visit the facility for testing. **England** recommends for indoor visits the use of screens between residents and visitors, use of speakers or assisted hearing devices and that visitors enter directly from outside to the visiting area, where possible. **Scotland** recommends that all RCFs, except in the event of an active outbreak, should seek to enable indoor visits where the visitor has been tested and returned a negative result. **NSW** advises all staff (including contractors, but excluding people entering the premises in response to an emergency) and visitors to residential aged care facilities to check-in using the Service NSW QR code app. The **CDC and CMS (US)** provide considerations for post-vaccination for HCWs and residents relating to visitations and close contact. **Prince Edward Island** advise that physical distancing is not required between a resident and individuals who visit a resident primarily for social or

other supportive reasons and may include family and friends (designated visitor).

- Personal protective equipment (PPE): **Hong Kong** encourages staff to wear eye protection when escorting residents to hospitals. **Ontario** recommends patients with severe COVID-19 requiring treatment in an intensive care unit or patients with severe immunocompromised can be removed from Droplet and Contact Precautions 20 days from the onset of symptoms. **NSW** recommends the use of powder-free latex or nitrile gloves instead of vinyl gloves for the clinical care of patients in the context of COVID19 as they are less likely to be breached and cause an exposure to body fluids or COVID-19 contaminated surfaces.
- Environmental cleaning: **Hong Kong** requires cleaning staff to wear eye protection. Residents identified as other contacts (that is, not close contacts) should have their room disinfected at least once daily. **England** advises RCFs to ensure domestic staff should clean the isolation room(s) after all other unaffected areas of the facility have been cleaned.
- Immunisation: **Australia** requires all visitors including children to have had the 2020 flu vaccine. **COTA Australia** supports the mandating of COVID-19 vaccination for workers in RCFs in line with infection prevention and control measures (and with appropriate exemptions). Visitors, volunteers, regulators and service people including allied health care workers are excluded. **New South Wales** requires all visitors aged six months and over, and staff entering a residential aged care facility to provide evidence that they received a dose of the 2021 influenza vaccination. **NSW** requires all workers employed by a RCF or contracted to provide services for one or more residents to have their first dose of the COVID-19 vaccination. **British Columbia** strongly recommends that visitors age 12 and older are fully vaccinated for COVID-19 and provide proof vaccination status prior to entry.
- Caring for recently deceased: **Northern Ireland** advises that once the person has died, all visits to the deceased person must stop. This includes visits from close family and friends.
- Governance: **England** advises RCF managers to update capacity related data daily via an online portal for use by national support capacity planning and response, and locally to help localities manage discharge planning. **Scotland** recommends the use of the Safety Huddle Tool to identify factors that may impact on the health, safety and wellbeing of residents. In addition, decision making relating to care home visits policy during the pandemic is conducted at a local level by an oversight group (consisting of experts in public health, nursing, infection prevention, health protection, and social work). The Care Home Manager makes decisions about visiting for their individual home and considering the balance between safety and needs of the entire group of residents, and the safety and needs of individual residents. **Scotland** archives all guidance to facilitate the statutory duty to collect, preserve and make them publicly accessible on a permanent basis. **Northern Ireland** has published a protocol for RCFs (not experiencing an outbreak) which requires facilities to

notify PHA prior to implementing additional visiting restrictions. The **ECDC** has published an updated shorter protocol for the collection of information on the severity of breakthrough COVID-19 infections in outbreaks at RCFs, including variant and vaccine product details.

Background

Residential care facilities (RCFs) in Ireland and across the world have been affected by outbreaks of COVID-19.[1, 2] Residents of RCFs are at higher risk of acquiring COVID-19 and RCFs are vulnerable to outbreaks.[1] An analysis published on 1 February 2021 of 22 countries (Australia, Austria, Belgium, Canada, Denmark, Finland, France, Germany, Hong Kong, Hungary, Ireland, Israel, Portugal, Netherlands, Norway, Singapore, Slovenia, South Korea, Spain, Sweden, England, Wales, Northern Ireland, Scotland and the United States), where there have been more than 100 deaths from COVID-19, estimated that the number of care home resident deaths as a percentage of all deaths due to COVID-19, ranged from 8% in South Korea to 75% in Australia, with an estimated 51% for all deaths in care homes in Ireland.[3] On average, for the 22 countries in the report for which there were deaths in care homes, the share of all COVID-19 related deaths that were care home residents was estimated to be 41%.

A range of guidance has been issued by national and international agencies 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.

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. Previous versions of this review included:

- A thematic review of the areas under which infection prevention and control (IPC) guidance was issued for RCFs and a summary of the guidance issued under different themes
- A synthesis of guidance issued for reopening of RCFs (Appendix A – conducted between 3 July 2020 and 17 September 2020).

This version of the review takes a different approach and directly compares current guidance in Ireland with international guidance. The purpose of this approach is to capture any innovative or enhanced protective measures which may be in use internationally, but which are not currently featured in Irish guidance.

Methods

The review was first undertaken on 30 March 2020 with the latest update undertaken on 6 November 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.

Results

The findings of the review are summarised below under the following themes: vaccines (Table 1), 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.

Vaccines

British Columbia, Canada, the CDC, Ireland, Ontario and Prince Edward Island, have IPC guidance recommendations specific to fully vaccinated individuals. While British Columbia, England, Scotland and Wales have stated that currently existing IPC guidance applies regardless of vaccination status (see Table 1). A technical report produced by the ECDC has listed additional countries outside the scope of this report that have implemented exceptions relating to vaccination status.[6]

Table 1 Vaccination status and infection protection and control measures (updated 06.10.2021)

Country	Setting	Date implemented	Specification	Target population
Ireland	RCF	8 July 2021	No requirement for transmission-based precautions or restricted movement.	Residents
Ireland	RCF	8 July 2021	When residents are vaccinated and disease incidence is low, the requirement to restrict group activities to pods of 4 to 6 can be relaxed in stages to move towards more normal social interaction in the RCF.	Residents
Ireland	Workplace	6 April 2021	It is generally safe to return to work for	At-risk groups

			fully vaccinated people who are high risk, if it is essential, for example for certain healthcare workers. However, this may not apply if the person has problems with their immune system.	
Ireland	Community	30 March 2021	Two fully vaccinated people from different households can meet up indoors without wearing masks or staying 2 metres apart.	General public
Ireland	Community	6 April 2021	Although there is an increased risk, it is advised that it is generally safe when fully vaccinated to go into shops and use public transport if essential, and precautionary measures are maintained.	At-risk groups
Ireland	Community	6 April 2021	It is advised that it is generally safe to meet up with one other household outdoors if you are fully vaccinated although you should keep a safe distance and avoid contact.	At-risk groups
Ireland	RCFs	19 April 2021	Two vaccinated residents can meet in their own room, while wearing masks and maintaining a physical distance from each other where possible.	Residents
Ireland	RCFs	19 April 2021	If tolerated, residents should be	Residents

			encouraged to wear a mask in busy areas of the RCF or during transport to and from the facility unless fully vaccinated.	
Ireland	RCFs	12 March 2021	Derogation from restrictive movements after close contact for vaccinated HCWs, in preference over non vaccinated HCWs.	HCWs
Ireland	RCFs	22 March 2021	Greater flexibility in relation to duration of visits is appropriate if the resident and visitor are both vaccinated.	Residents, Visitors
Ireland	RCFs	22 March 2021	Frequency of visits by one person on compassionate grounds can increase to 2 per week for RCFs with a high level of vaccination in HCWs and residents* – at Level 3, 4 and 5.	Residents, Visitors
Ireland	RCFs	22 March 2021	Vaccinated residents will not be advised against individual outings for a social drive with a visitor.	Residents, Visitors
Ireland	RCFs	22 March 2021	Number of visitors received at once increases to 2 for RCFs with a high level of vaccination in HCWs and residents* – at Level 2	Residents, Visitors
Ireland	RCFs	22 March 2021	Exempt from isolation requirements when returning after >12 hours to RCF with a high level of	Resident

			vaccination in HCWs and residents*	
Ireland	RCFs	19 April 2021	Subject to individual assessment, HCWs who are fully vaccinated and who are asymptomatic generally do not need to stay out of work or are subject to testing if they are identified as contacts unless specifically advised to do so in particular circumstances.	HCWs
Canada	Community	16 July 2021	Fully vaccinated can consider getting close to others without wearing a mask, taking into account the risk level of others and the setting.	General public
Canada	Community	16 July 2021	Fully vaccinated do not need to quarantine after being exposed to a person with COVID-19.	General public
England	RCFs	17 August 2021	Fully vaccinated RCF staff do not need to self-isolation after close contact with a resident who is a confirmed or possible case of COVID-19	RCF staff
Finland	Community	9 July 2021	Fully vaccinated grandparents can meet their own unvaccinated children and grandchildren if the children and grandchildren are healthy and do not belong to an at-risk	At-risk, children

			group for severe coronavirus disease.	
Finland	Community, health and social care	19 May 2021	Quarantining following exposure is not required for those fully vaccinated or recovered.	General public, Patients, Residents, HCWs
Norway	Community	24 March 2021	Fully vaccinated people do not need to quarantine after having been in close contact with an infected person. This applies from 1 week after the last dose and lasts 6 months. If the person has only received the first vaccine dose between 3 and 15 weeks ago, quarantine is not required after a negative test result taken between 3 and 7 days after close contact with an infected person. While members of that household do not have to quarantine. If the person has only received the first vaccine dose between 3 and 12 weeks ago, quarantine is not required if a member of the same household is quarantining.	Close contacts
Norway	Community	24 March 2021	For a person who is considered protected it is recommended that they may have close social contact with unprotected	General public, At-risk groups

			people and a person at high risk of severe illness from COVID-19 if they too are protected. Protection is considered when a person has recovered from infection <6 months or 3 to 15 weeks since they received at least one dose or fully vaccinated.	
Ontario	RCF	9 June 2021	Fully immunised visitors and residents may have close physical contact, such as hand-holding.	Resident, Visitors
Sweden	Workplace	19 April 2021	For a person who has received one dose of vaccine and at least 3 weeks has passed it is recommended they do not need to self-isolate if a person they share a house with is infected.	General public
Sweden	Workplace	19 April 2021	For a person who has received one vaccine dose and at least 3 weeks has passed it is recommended they can return to the workplace.	At-risk groups
Sweden	Community	19 April 2021	For a person who has received one vaccine dose and at least 3 weeks has elapsed it is recommended they can meet healthy people from a few different households and even indoors. This relates to meeting people who	General public, At-risk groups

			are at high risk of severe COVID-19 and people who are unvaccinated.	
Switzerland	Private	18 May 2021	People who are vaccinated do not need to physical distance or wear a mask in private with others who are vaccinated.	General public
Switzerland	Workplace	7 April 2021	People who are fully vaccinated, or have had a confirmed COVID-19 infection (PCR or antigen test) and also received at least 1 dose of a vaccine and 14 days have elapsed, are not required to quarantine after close contact with someone who has tested positive.	Close contacts
Switzerland	Workplace	7 April 2021	People who are at high risk and are fully vaccinated are advised that their employer is no longer obliged to take steps to provide additional protection in the workplace. However, the general precautionary measures in the workplace still apply	Employer, Worker
Germany	Community	7 April 2021	People who have been fully vaccinated are exempt from quarantine measures after exposure to a confirmed SARS-CoV-2 case.	General public

~~Norway~~	~~Community~~	~~1 July 2021~~	~~Protected people may have close social contact with unprotected people who are not in a risk group.~~	~~General public, At-risk groups~~
~~Norway~~	~~Community~~	~~1 July 2021~~	~~Protected people can be treated as household members and do not need to be counted as visitors.~~	~~General public, At-risk groups~~
~~Norway~~	~~Community~~	~~1 July 2021~~	~~In private homes and cars, protected people can have close social contact (less than 1 metre) with other protected people, even if they are in a risk group.~~	~~General public, At-risk groups~~
~~Norway~~	~~Community~~	~~1 July 2021~~	~~Protected people are no longer advised against making unnecessary journeys in Norway.~~	~~Travel~~
Denmark	Workplace	20 April 2021	Relatives of someone at higher risk no longer need to be reassigned to other tasks (with less risk of infection) – if either the person at higher risk or the relative has been fully vaccinated.	At-risk groups, Worker
Denmark	Community	20 April 2021	Fully vaccinated people can socialise with family and close friends who are not fully vaccinated people without keeping their distance or wearing a face mask. However, this does not apply if the person they are with has not been	General public

			fully vaccinated and is at higher risk of severe illness from COVID-19	
Denmark	Community	20 April 2021	Fully vaccinated people can socialise with other fully vaccinated people without keeping their distance or wearing a face mask.	General public
Denmark	Community	20 April 2021	Fully vaccinated people are exempt from regular testing. But not testing as a result of close contact with an infected person.	General public
Denmark	Community	20 April 2021	Fully vaccinated people who are symptom free are exempt from self-isolation as a result of close contact of someone who is infected. However, you must still get tested as a result of close contact.	Close contacts
Denmark	Community	1 April 2021	People at higher risk who are fully vaccinated can have physical contact with close friends and family, participate in activities with several people, go inside shops and use public transport outside of off-peak times.	At-risk groups
Denmark	Healthcare	6 May 2021	There is no requirement for testing at admissions to public or private hospitals or for special examinations and procedures	Patients, outpatients

			(upper scopies, anaesthesia, tracheal aspiration, lung function examination, etc.) in specialist practice, general practice and dental clinic or in outpatient procedures in hospital for vaccinated or recovered. However, people with weakened immune systems to a severe degree, e.g. people in long-term immunosuppressive treatment, including organ transplants, will continue to be tested.	
CDC	Workplace	27 April 2021	Fully vaccinated workers no longer need to be restricted from work following an exposure as long as they are asymptomatic.	Close contacts
CDC	Community	27 April 2021	Immunocompromised people need to consult their healthcare provider about vaccine exemption recommendations, even if fully vaccinated	At-risk groups
CDC	Community	1 April 2021	Fully vaccinated grandparents can visit indoors with their unvaccinated family without wearing masks or physical distancing, provided none of the unvaccinated family	At-risk groups

			members are at risk of severe COVID-19.	
CDC	Community	16 March 2021	Visit with other fully vaccinated people indoors without wearing masks or physical distancing. Visit with unvaccinated people from a single household who are at low risk for severe COVID-19 disease indoors without wearing masks or physical distancing.	General public Close contacts
CDC	Wide range of settings (undefined)	19 August 2021	Fully vaccinated people who have come into close contact with someone with suspected or confirmed COVID-19 to be tested 3-5 days after exposure, and to wear a mask in public indoor settings for 14 days or until they receive a negative test result. If they subsequently develop symptoms they should self-isolate.	General public (not people in high risk settings)
~~CDC~~	Wide range of settings (undefined)	19 August 2021	Fully vaccinated person who experiences symptoms consistent with COVID-19 should isolate themselves from others.	General public (not people in high risk settings)
CDC	Wide range of settings (undefined)	19 August 2021	Fully vaccinated people can refrain from testing following a known exposure unless they	General public (not people in high risk settings)

			are residents or employees of a correctional or detention facility or a homeless shelter	
CDC	Domestic and international travel	2 April 2021	Fully vaccinated people can resume domestic travel and do not need to get tested before or after travel or self-quarantine after travel. Fully vaccinated people do not need to get tested before leaving the United States (unless required by the destination) or self-quarantine after arriving back in the United States.	Travellers
CDC	Non-healthcare congregate settings	27 April 2021	Fully vaccinated residents of non-healthcare congregate settings no longer need to quarantine following a known exposure.	Residents
CDC	Health and social care	10 March 2021	Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility if they are fully vaccinated and have not had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days.	Residents
CDC	Health and social care	10 March 2021	Asymptomatic HCPs who are fully vaccinated and have a higher-risk	HCWs

			exposure (including aerosol generating procedures) as described in the CDC guidance do not need to be restricted from work; possible exceptions	
CDC	RCFs and other healthcare settings	27 April 2021	Fully vaccinated patients/residents can participate in communal dining without use of source control or physical distancing. If unvaccinated patients/residents are dining in a communal area (e.g., dining room) all patients/residents should use source control when not eating and unvaccinated patients/residents should continue to remain at least 6 feet from others.	Residents, Patients
CDC	RCFs	10 March 2021	If the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing well-fitting source control.	Residents, Visitors
CDC	RCF	10 March 2021	Limit indoor visiting for unvaccinated residents if the RCF COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated	Residents, Visitors

CDC	RCFs	29 March 2021	Exempt from isolation for new admissions and readmissions if fully vaccinated or previous infection (<3 months)	Residents
Wales	Community	7 August 2021	Fully vaccinated adults, under 18s and vaccine trial participants will not need to self-isolate if they are a close contact of someone with coronavirus	General public
Prince Edward Island, Canada	RCF	31 March 2021	If resident vaccination rates < 85% then: Designated visitors must visit in designated areas. Residents can only leave in the company of the Partners in Care. Residents cannot attend public places unless to perform essential services (e.g., banking).	Residents, Visitors
Neutral				
Norway	Travel	20 May 2021	Being fully vaccinated or having received the first vaccine dose does not give an exemption from the travel quarantine or quarantine hotel.	Inbound travellers
Scotland	Community	14 May 2021	People who are fully vaccinated must continue to follow the general advice.	At-risk groups
Wales	Community	1 April 2021	People who are fully vaccinated must continue to follow the general advice.	At-risk groups

Canada	RCF	28 June 2021	There are currently no recommended changes to IPC practices regardless of vaccination status.	Resident, Visitors
British Columbia	RCF	5 May 2021	People who are fully vaccinated must continue to follow the general advice.	Everyone
Scotland	RCF	19 April 2021	Residents who have not been vaccinated should still be able to receive indoor visitors.	Residents, Visitors
Scotland	RCF	17 February 2021	The lateral flow testing programme, and ongoing need for other IPC and PPE measures, applies to staff who are participating in the vaccination programme.	HCWs
England	RCF	12 April 2021	Visiting a RCF is not subject to the vaccination status of the visitor or the resident.	Residents, Visitors
England	RCF	16 April 2021	No change in PPE recommendations for personal care for HCWs who have tested positive for COVID-19 or if they have had the vaccine.	HCWs

Key: HCWs –healthcare works; IPC – infection protection and control; PPE – personal protective equipment

*High level of completed vaccination is when about 80% of HCWs and residents are fully vaccinated or have had a past COVID-19 infection (<6 months)

Testing

Ireland

Residents

It is recommended all suspected cases should be tested, regardless of their testing history. RCFs should ensure that one or more staff members are trained to collect a viral swab sample for testing for SARS-CoV-2.(7) If COVID-19 is suspected a doctor should be contacted to arrange testing. Testing of close contacts for COVID-19 is recommended at day 0 and day 10, with exit from restricted movements if the day 10 test is reported as "not detected".(7) A person with a previous positive SARS-CoV-2 test, confirmed by antigen or PCR, who is currently clinically well should not be re-tested for nine months following onset of illness and does not need to restrict their movements.(8)

Repeat antigen testing should not be undertaken within two weeks after a previous positive test result.(8) It is also suggested that people who have a history of confirmed infection retested positive by an antigen test more than two weeks and within nine months, should be referred to their doctor or public health for RNA testing and sequencing and may require discussion with microbiology or infectious disease. People who were previously infected and tested positive again by antigen showing symptoms immediately within weeks, are suggested to see their doctors to assess the potential risk of impairment of their immue system caused by any medication or conditions.

A PCR result should be taken as the correct result if both the antigen and PCR are taken at the same time and the positive case should be confirmed until testing and assessment have been completed.(8)

Healthcare workers

Non hospitalised HCWs who test positive for COVID-19 may return to work 10 days (14 days for a VOC) after symptom onset (or date when test was taken if no symptoms) provided they have had no fever during the last five days and are medically well.(7) For HCWs who have required hospitalisation for treatment of COVID-19, this will be after 14 days from symptoms onset (or date when test was taken if symptom onset less clear) provided they have had no fever during the last five days and are medically well.

Where a HCW has been identified as a close contact due to a workplace exposure, testing will be carried out on Day 5 from their last exposure to the case and day 10, with exit from restricted movements if the Day 10 test is reported as 'not detected'.(7) If this testing cannot be organised for practical reasons the healthcare worker remains off duty for 14 days. Healthcare workers who are close contacts and fully vaccinated can be considered for derogation from restricted movements, in preference over other HCWs. In the case of a household contact, if the household member test result indicates COVID-19 is 'Not Detected', the HCW can return to

work even if the household contact continues to be symptomatic. If the household member test result indicates COVID-19 is 'Detected' the HCW must restrict movement and should not attend work for 14 days from their last close contact with the household member. If the household member with COVID-19 cannot be isolated at home and there is an on-going exposure risk, the HCW should restrict movements for a maximum of 17 days from the onset of index case symptoms (or date of test if asymptomatic). Contacts of contacts do not need to restrict movements. Where a HCW who tested positive, has completed self-isolation, and can return to work, if a household contact of this HCW becomes symptomatic or is confirmed COVID-19 case, the HCW can return to work and does not have to restrict movement. In addition, they should not be included in serial testing programmes in the nine months following onset of illness. This advice does not apply if the exposure to COVID-19 is to a Person Under Investigation for a VOC or to a probable or confirmed case of VOC.

In exceptional circumstances, senior management can make a decision to derogate a HCW who is a close contact, including household contacts, from exclusion from work based on a risk assessment.[8, 9] All derogated HCWs must have a negative test immediately prior to returning to the workplace. For example, if immediate return is required, then Day 0 testing must be carried out.[9] For close contacts who are derogated, testing will also be carried out on Day 0 and Day 10 as per national guidance. The derogation is no longer required following confirmation of a negative day 10 PCR test.

For the winter season, when influenza viruses are circulating in the community in Ireland (as per ECDC threshold)[10] residents or staff who present with respiratory symptoms compatible with COVID-19 should be tested for SARS-CoV-2 and may be required to be tested for influenza, based on Public Health Risk Assessment and or clinical judgement.[11] In the context of an outbreak of acute respiratory illness in a RCF, where there is any doubt as to what the testing approach should be, an appropriate public health risk assessment will be undertaken.

Other countries

CMS (US) published interim requirements which outline three routine testing regimes for staff and residents based on community transmission rates.[12] RCFs are required to test residents and staff, including individuals providing services under arrangement and volunteers, for COVID-19 based on parameters set forth by the US Department of Health and Human Services. Routine testing of asymptomatic residents is not recommended unless prompted by a change in circumstances, such as the identification of a confirmed COVID-19 case in the facility. Although it may be considered when residents are being transferred. As well as lab-based testing, rapid point-of-care diagnostic testing devices are recommended.

The CDC has published an updated plan for testing residents and HCW and suggests that both vaccinated and unvaccinated people with even mild symptoms of COVID-19 should receive a viral test.[13] Asymptomatic HCWs with a higher-risk

exposure and residents with close contact, regardless of vaccination status, should have a series of two viral tests not earlier than two days after the exposure and between five and seven days after the exposure if tested negative. It is also recommended that fully vaccinated HCWs are exempt from an expanded screening test. Unvaccinated HCWs working at a RCF with substantial to high community transmission should take a viral test twice a week. For those who work infrequently, it is suggested to take a test within three days before their shift, including the day of the shift. Unvaccinated HCWs working at RCFs with moderate community transmission should take a viral test once a week. Expanded screening testing is not recommented for asymptomatic HCWs working at facilities with low community transmission regardless of vaccination status. Resources to test vaccinated and unvaccinated symptomatic people and close contacts should be prioritised by all facilities.

Northern Ireland conducts testing of all asymptomatic residents on a 28 day cycle and asymptomatic staff on a 14 day cycle.[13]

Ontario recommends immediate testing of all staff and residents in an infected area when one case of variant of concern is suspected or confirmed.[14] Ontario has also published guidance on the frequency and type of test for a range of visitors including staff, caregivers, student placements and volunteers, support workers and general visitors.[15]

British Columbia require unvaccinated staff to be tested before each shift[16].

Screening

Ireland

RCFs should ensure that they have the means in place to identify a new case of COVID-19 and control transmission, through active monitoring of residents and staff for new symptoms of infection, rapid application of transmission-based precautions to those with suspected COVID-19, prompt testing of symptomatic residents and referral of symptomatic staff for evaluation.[7] The RCF should ensure that there is twice daily active monitoring of residents for signs and symptoms of respiratory illness or changes in their baseline condition (for example, increased confusion, falls, and loss of appetite or sudden deterioration in chronic respiratory disease). At the start of each shift, all staff should confirm with their line manager that they do not have any symptoms of respiratory illness, such as fever, cough, shortness-of-breath or myalgia.[7] Where relevant staff should be asked to confirm that they are not currently working in a facility where there is an outbreak. If a staff member develops fever or cough or shortness of breath or any kind of new respiratory symptoms then they should not attend work. Staff are required to declare that they have no symptoms before attending work. If a member of their household develops respiratory symptoms staff should report this to their manager before attending work. All staff should be temperature checked before commencing their shift and once more during the shift.

Other countries

No recommendations or measures were identified that are not already featured in Irish guidance.

Monitoring

Ireland

It is recommended that staff and residents are monitored for symptoms of COVID-19 twice-a-day.[7] Staff members who become unwell at work should immediately report to their line manager and should be sent home and advised to contact their GP by telephone. If they cannot go home immediately, they should be isolated in a separate room until they can go home. Staff members who test positive for COVID-19 may return to work 14 days after symptom onset (or date when test was taken if no symptoms) provided they have had no fever during the last five days. Repeat testing at the end of the illness is generally not appropriate. Staff members who have been identified as close contacts of a case either in the community or the occupational setting should not attend work for 14 days from the last exposure to the case and restrict their movements as much as possible. Close contacts will be offered testing for COVID-19 at day zero and day seven. Residents and staff of RCF for older people are in the first group for vaccine allocation.[7] Partially or fully vaccinated healthcare workers and residents are advised to adhere to all IPC measures in the guidelines in the same way as they did prior to vaccination, especially if they have a problem with their immune system.

Other countries

Hong Kong requires that residents or staff identified as other contacts (that is, not close contacts) are be put under medical surveillance for 28 days and must wear a mask for 28 days.[17]

England suggests the use of scoring systems, such as the RESTORE2 (Recognise Early Soft signs, Take Observations, Respond, Escalate) and NEWS2 (National Early Warning Score 2), as a way of monitoring residents with symptoms.[18]

CDC advises fully vaccinated HCP with higher-risk exposures who are asymptomatic do not need to be restricted from work for 14 days following their exposure.[19] Except perhaps when HCP has underlying immune compromising conditions (for example, organ transplantation, cancer treatment). Quarantine is no longer recommended for residents who are being admitted to a post-acute care facility if they are fully vaccinated and have not had prolonged close contact with someone with SARS-CoV-2 infection in the prior 14 days. All other IPC measures apply to resident and HCW regardless of status, except in the case of quarantine after close contact with a confirmed case, in some cases the public health and IPC officials might not require it because of strained resources.

Isolation

Ireland

Isolation, with droplet precautions, is required for 14 days for a case who is a resident of a RCF, the last 5 of which must be fever-free.[7] If the case is asymptomatic, isolation is required for 10 days from the date of the SARS-CoV-2 test. Where possible, residents with probable or confirmed COVID-19 should be isolated in single rooms with ensuite facilities. If there are multiple residents and if it is practical to do so, these single rooms should be located in close proximity to one another in one zone, for example on a particular floor or area within the facility. A test of clearance is not appropriate for COVID-19 patients. Only in exceptional circumstances, where a physician is concerned on clinical grounds that there may be an ongoing risk of transmission beyond 14 days, repeat testing may be considered in advance of ending transmission based precautions. A move to a multi-occupancy room (where this is the planned accommodation in the longer term for the resident) will be appropriate after the 14 day period, once the resident is symptom free and there is no evidence of infection in residents within the room it is proposed for the resident to move to.

Other countries

No recommendations or measures were identified that are not already featured in Irish guidance.

Admission and transfers

Ireland

New and returning residents should be tested for COVID-19 within three days of planned admission to the RCF and accommodated in a single room for 14 days after arrival, regardless of the outcome of the test and monitored for new symptoms consistent with COVID-19 during that time.[7] A person with a previous positive SARS-CoV-2 test who is currently clinically well (14 days since onset of symptoms and no fever for the last five days) should not be re-tested for nine months prior to hospital admission, scheduled procedures or transfer to the RCF. Regardless of the test result, if the resident is being admitted to the RCF from home the resident will need to be isolated for 14 days and where possible, the GP should arrange for the resident to be swabbed up to 72 hours before admission. If a pre-test cannot be arranged a resident is to be admitted as planned and will need to self-isolate for 14 days with a test arranged by the RCF or residents own GP, and tested within one day. Any resident transferred to a RCF before the 14 days have elapsed since date of onset of symptoms or date of first positive test (if symptom onset undetermined or asymptomatic), must be isolated with transmission based precautions up to day 14 on return to the RCF.[7] Provided the resident has remained afebrile for the last five of the 14 days, the resident is no longer infectious to others after day 14 has elapsed. Residents who have vaccine protection or who have had COVID-19 in the

previous nine months will not need to restrict their movements on return to their RCF if that episode of care in an acute hospital is 12 hours or more, but should be tested as above.

Residents do not require isolation on return to their RCF following hospital transfer to facilitate short investigations (for example, diagnostics, haemodialysis, radiology, outpatient appointment).[7] Residents who do not have vaccine protection and have not had COVID-19 in the previous nine months will need to restrict their movements on return to their RCF in the event that an episode of care in an acute hospital results in a longer period of time (12 hours or more) or an overnight stay. If an episode of care lasts longer than 12 hours, but less than three days there is no requirement for testing before return to the RCF unless the person has new symptoms suggestive of COVID-19. However, the resident should continue to restrict movement and be monitored closely for symptoms for 14 days after return even if the test at five to seven days is reported as not detected.

Existing residents from an RCF who require transfer to hospital from the RCF for assessment or care should be allowed to transfer back to that RCF following assessment or admission if clinically fit for discharge and risk assessment with the facility determines there is capacity for them to be cared for there with appropriate isolation and where that transfer represents the most appropriate place of care for the resident (for example, ongoing need for palliative care). If a resident has been diagnosed with COVID-19 while in hospital, it is important to assess if the resident was infected in the RCF before transfer to the hospital or if this is a hospital-acquired infection. If there are no other known cases of COVID-19 in the RCF, transfer back to the RCF should be delayed until the resident is no longer infectious to others. For a resident suspected to be infected with COVID-19 within a RCF, if the clinical condition does not require hospitalisation, the resident should not be transferred from the facility on IPC grounds.

People with COVID-19 do not require to be hospitalised for the 14 days if they are clinically fit for discharge, if infection was acquired in the RCF or if the RCF already has cases of COVID-19 and the RCF has appropriate facilities and capacity for isolation and can support care.

Other countries

Australia does not permit admission of new residents with COVID-19 compatible symptoms to enter the facility.[20]

England no longer requires people admitted to a RCF from the community to self-isolate for 14 days on arrival after undergoing enhanced testing - a PCR test before admission, a PCR test on the day of admission and a further PCR test seven days later.[21]

Cohorting

Ireland

Residents with possible or confirmed COVID-19 should be isolated in a designated zone separated from non COVID-19 zones by closed doors.[7] A zone may have multi-occupancy rooms or a series of single rooms. Single rooms with ensuite facilities is preferred for possible or confirmed COVID-19 in residents. If there are multiple residents and if it is practical to do so, these single rooms should be located in close proximity to one another in one zone. Only residents with a confirmed diagnosis of COVID-19 can be cohorted together. In multiple occupancy rooms, physical distance should be maintained as much as possible between beds. Staff should be allocated to one zone within the RCF if at all possible and staff working in COVID-19 areas should not be assigned to work in non-COVID-19 areas. Where possible, the COVID-19 cohort zone should not be used as a thoroughfare by other residents, visitors or staff from outside that cohort zone.

Other countries

Quebec advises RCFs to use colour coded containment zones for areas that are for infected residents ("hot" or "red" zone), at-risk or recently returned residents ("warm" or "yellow" zones), and all other residents ("cold" or "green" zone).[22]

Ontario recommends that residents can freely socialise and interact with each other outdoors within and across cohorts, including during planned or organised group activities. This recommendation also applies in indoor settings but with the requirement to wear a mask and maintain a physical distance.

Controls to minimise risk of inadvertent introduction of virus

Ireland

Movement of staff between facilities should be minimised and any staff working in a facility that is experiencing an outbreak should not work in any other facility.[7] Staff are required to declare that they have worked in any facility experiencing an outbreak. Where possible, each ward or floor should try to operate as a discrete unit or zone, meaning that staff and equipment are designated to a specific area and are not rotated from other areas (this includes night duty). If it is necessary for staff to move or rotate between areas within the facility it is preferable that those staff should be fully vaccinated or in the nine month period after they have had COVID-19.

All HCWs must adhere to Government guidelines on restricted movement, self-isolation and testing following travel.[23] Specific advice for HCWs who have travelled in the previous 28 days from designated states (high-risk) or countries with 'SARS-CoV-2 variants with multiple spike protein mutations observed' must be adhered to, which includes isolating for 14 days and having tests at day 0 and day 10 of arrival or close after. The current list of countries are listed online.[24]

Uniforms should be laundered separately from other household linen, in a load not more than half the machine capacity, and at the maximum temperature the fabric can tolerate.[7] In addition, HCW could consider designating a pair of comfortable, closed, cleanable shoes for wearing in a COVID-19 care area.

Other countries

Northern Ireland advises that where it can be done safely staff should consider live-in arrangements in the RCF.[13] Northern Ireland encourages staff to change clothes on arrival at work and to wash their uniform before each shift.[13]

England asks RCFs to consider how accommodation could be provided for staff who proactively choose to stay separately from their families in order to limit social interaction outside work.[18] New legislation from October – subject to Parliamentary approval and a subsequent 16-week grace period – will require anyone working in a CQC (Care Quality Commission)-registered care home in England for residents requiring nursing or personal care to have two doses of a COVID-19 vaccine unless they have a medical exemption.[25] It will apply to all workers employed directly by the RCF provider (on a full-time or part-time basis), those employed by an agency and deployed by the care home, and volunteers deployed in the care home. Those coming into care homes to do other work, for example healthcare workers, tradespeople, hairdressers and beauticians, and CQC inspectors will also have to follow the new regulations, unless they have a medical exemption. The duration for which restrictions must remain in place following an outbreak, is reduced from 28 days to 14 days after recovering tests detect no new cases.[18] However, if test results confirm a variant of concern in the outbreak, then a duration of 28 days with no new cases continues to apply.

New South Wales (Australia) excludes visitors and staff that have in the last 14 days been to a location identified with recent clusters, such as large shopping centres.[26] RCFs are directed to a government website which lists recent clusters and marks those that require consideration when subsequently visiting a RCF. Additionally, staff and visitors who are on the contact tracing list are excluded from entering the facility for 14 days.[26] If it is not possible to avoid staff working across facilities or multiple settings (such as in home care and residential care), then records of staff and work locations must be maintained.[27] Staff are advised to wipe phones clean and place in a new, clear zip lock bag at beginning of shift, wipe zip lock bag over after each use and throw zip lock bag away at the end of shift.[28] Multipurpose facilities are recommended to prioritise and consolidate HCWs tasks in the RCF section first, before other area, where the HCW cannot be solely assigned to one section.[28] All staff (including contractors, but excluding people entering the premises in response to an emergency) and visitors to residential aged care facilities will need to check-in using the Service NSW QR code app.[29]

The CDNA of Australia requires RCF to maintain records of staff locations of work internal and external to the RCF.[30] During an outbreak, staff who are working at the facility should not work in other residential facilities.

Physical distancing

Ireland

Staff are advised to physically distance when in staff areas and when in other areas, where possible.[7] For residents, it is recommended where possible to develop "pods" of about four to six residents who socialise together. Physical distancing should be maintained between residents in different pods. When residents are vaccinated and disease incidence is low, this requirement can be relaxed in stages to move towards more normal social interaction in the RCF. This is particularly the case in the context of a high level of vaccination of residents.

Residents engaged in social activity should be encouraged to maintain physical distance, with other residents and staff and practice hand hygiene and cough etiquette. Exceptions are appropriate for couples who reside in the same RCF. It remains prudent to advise social distancing when practical, frequent hand hygiene and good cough etiquette.

Other countries

Northern Ireland encourages the restriction of residents to their rooms, even for mealtimes where this is practical.[13]

Visitations

Ireland

RCFs will need to facilitate visiting and ensure that there is sufficient staff on duty at key times to support visiting. Visits are to be allowed at the discretion of the RCF and should be subject to risk assessment.[31] Testing of prospective visitors in advance of visiting is not required. Where limits on the duration of visits are required the time limit should not be less than one hour. If the resident and visitor are both vaccinated greater flexibility in relation to duration of visits is appropriate. Existing IPC measures to visitors should continue to apply in general (as vaccination roll out continues) although there is less need to emphasise avoidance of contact between visitor and the resident they have come to see when both have completed vaccination.

While the target is to allow the number and duration of visits to be in accordance with the resident's requirements, at a minimum, four visits per week by up to two people at a time should be facilitated from two weeks after the date when a high proportion (over 80%) of all residents are fully vaccinated.[32] Children, may visit, if supervised by an adult. If the proportion of residents fully vaccinated is below 80%, a minimum of two visits by one person per week should be facilitated.[31]

There is no upper limit on the frequency or duration of visiting that is acceptable where critical and compassionate grounds apply, subject to the ability of the RCF to manage the visiting safely. Compassionate grounds is not limited to circumstances when the death of a resident is imminent.

Visits should be arranged in advance and scheduled to avoid heavy footfall. A separate entrance and exit area for visitors is encouraged but is not a requirement. 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 but an RCF has flexibility to accommodate these on compassionate grounds. Visitors should be guided in performing hand hygiene when they arrive and are required to wear a surgical mask, or where not practical to wear a visor that extends from above the eyes to below the chin and from ear to ear. However, some flexibility is allowed in relation to the needs of the resident and visitor when they are together at a safe distance from others. Any necessary PPE should be provided by the RCF. 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 should be limited to one hour, with exceptions given on compassionate grounds. The number of visits per resident per week is subject to the capacity of the RCF to schedule the visits safely. Visits should take place when there is sufficient staff on duty to manage visiting and away from mealtimes. Food and refreshments are not permitted. The use of the resident's or visitors' bathroom is discouraged. The resident's right to decline a visitor shall be respected.

Outings for a drive with a visitor may be facilitated subject to risk assessment and confirming that the visitor does not have symptoms of COVID-19 and is not a COVID-19 contact. For practical reasons it may be necessary to limit the number of residents from a RCF leaving to visit elsewhere on one specific day but a visit may be possible at some time during culturally relevant occasions for example Christmas and New Year. Consideration of a visit to a private residence is based on the resident wishing to make a visit and a risk assessment that indicates that the associated risk of introduction of COVID-19 into the RCF is low. Risk assessment should take into account the ability of the host of the visit to limit the number of people the resident is exposed to on the way to and from the place, and ability to limit the number of people the resident is exposed to during the visit (generally no more than 6 other people) and an undertaking from those hosting the visit to ensure that the small group present during the visit are checked for symptoms on arrival.

If the resident is absent from the RCF for less than 12 hours and in the absence of any reported unintended exposure there is generally no requirement to restrict movement to their room on their return. If more than 12 hours (typically an overnight stay), the resident should be asked to stay in their room as much as possible for 14 days after the visit and should be offered testing on or about day 5 after their return. In the context of a RCF without a high level of completed vaccination for residents and staff and where the resident has been away for more than 12 hours (typically an overnight stay), the resident should be asked to stay in

their room as much as possible for 14 days after the visit and should be offered testing on or about day 5 after their return.

In the context of a RCF with a high level of completed vaccination (~80%) for residents and staff and where the resident has been away for more than 12 hours (typically an overnight stay), the resident need not be asked to restrict movement to their room on their return from an overnight stay unless (a) they are known to have been in contact with a person who has travelled outside of Ireland in the 14 days prior to the contact (b) are known to have been in contact with a person suspected or known to have symptoms of COVID-19.

It is important to note that flexibility is required when residents have essential business to conduct for example visit to the post office, bank or legal services or critical personal requirements for example related to death of a family member or a visit to a family grave. For those who have completed vaccination the risk of such essential business is reduced.

Service providers may be obliged to refuse entry to a prospective visitor if the person is unwilling or unable to comply with reasonable measures to protect all residents and staff or if the person has not complied with reasonable measures during a previous visit. Access for essential service providers (professional services such as healthcare, legal, financial and regulatory) cannot be denied, they should only be limited in the most exceptional circumstances and for defined periods in the context of specific public health advice. Important service providers are also permitted at level 1 and 2 but can be suspended from level 3 up. This includes those who provide services that are important to resident's sense of self and wellbeing but that are not strictly necessary, for example those who provide personal care (for example hairdressers) and entertainers. Each facility should have policies on the requirement for visitors including external contractors and those who supply services to a residential setting to wear PPE. External services should be facilitated subject to risk assessment and precautions should be adhered to.

Other countries

England advises RCF providers, when visits are taking place indoors that speakers or assisted hearing devices (both personal and environmental) should be considered to avoid the need to raise voices and therefore transmission risk. RCFs are recommended to inform family and those important to a resident when a resident is nearing the end of their life and offered the opportunity to visit.[18] RCF are asked to allow up to two named visitors per resident, twice a week and a negative test result is required by visitors on the day for each visit (Lateral flow devices). Essential caregivers have the same PPE and testing requirements as the RCF staff.[33] All RCFs – regardless of Tier – and except in the event of an active outbreak – should seek to enable indoor visits where the visitor has been tested and returned a negative result. Indoor visiting in the absence of testing (and without screens between the resident and visitor) may only happen in Tier 1 areas with visitors also from a Tier 1 area. Facilities in Tier 1 areas should still implement visitor testing as rapidly as possible.

As soon as visitor testing is available, it is by far the preferable option and should be used. Outdoor visiting and 'screened' visits can be made available to visitors who have not been tested. Any potential visitor who tests positive should immediately leave the premises and self-isolate. They should be offered a confirmatory PCR test by the RCF and their household contacts may also be required to self-isolate in line with current guidance. Essential caregivers, where a resident has one, are able to visit residents during their isolation period.[18]

The CMS (US) approves the use of Civil Money Penalty funds to purchase tents for outdoor visitation and or clear dividers to create physical barriers to reduce the risk of transmission during in-person visits. CMS encourage facilities in medium or high-positivity counties to test visitors, if feasible, and prioritise for testing visitors that regularly visit the facility.[34] The CMS and the CDC state that, in general, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation.[19, 34] This includes federal and state surveyors. Regardless of vaccination status of a resident or visitor, those who have had close contact with someone with COVID-19 infection in the prior 14 days should not be allowed visit. Outdoor visitation is preferred even when a resident and visitor are fully vaccinated against COVID-19, per the CDC's Public Health Recommendations for Vaccinated Persons. Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times and regardless of vaccination status). During a period of high risk of COVID-19 transmission, indoor visitation should only be limited for:

- Unvaccinated residents in the following scenarios if the nursing home's COVID-19 county positivity rate is >10% and <70% of residents in the facility are fully vaccinated;
- Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions;
- Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.

If the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after, with physical distancing maintained from other residents and staff.

British Columbia strongly recommends that visitors age 12 and older be fully vaccinated against COVID-19 with two doses of vaccine and provide proof vaccination status prior to entry.[35] Visitors who do not provide proof of full immunisation need to wear a medical mask at all times, including when in direct contact with the person they are visiting.

Prince Edward Island requires enhanced cleaning of spaces to take place between visits.[36] When visiting under compassionate grounds (end of life only), there is no limit on the number of visitors that may be at the bedside.[37] Physical distancing is not required between a resident and individuals who visit a resident primarily for social or other supportive reasons and may include family and friends (designated visitor).[36] However, physical distancing of 2 metres (6 feet) must be maintained from staff and other residents at the facility during the visit.

When Ontario is under a province wide COVID-19 stay-at-home order, caregivers who are not fully vaccinated are required to be tested regularly using a combination of PCR and antigen testing depending on frequency (1 to 2 times per week in areas with lower transmission and up to 3 times a week if in an area with higher transmission).[15] Visitors not fully vaccinated are advised to stay two metres apart from residents at all times, with brief hugs permitted.[38] If a long-term care home does not have enough outdoor space to accommodate visits on its property, visits can also take place in a nearby outdoor location, such as a park.

Quebec requires visitors to wear clean clothes when they go to the facility and change and wash their clothes when they return home.[22] For RCFs with no more than 10 places, a maximum of 10 informal or family caregivers and visitors from three different households are permitted to visit residents for the entire facility. Visitors are not permitted to enter equipment storerooms. They must also exit the resident's room whenever medical procedures that involve aerosols are performed and only re-enter the room once the required number of full changes of air have been completed (varies by facility). Full PPE that includes a gown, gloves and eye protection is required when a designated informal carer visits someone that either has COVID-19 or is in a unit that houses infected persons, other visitors are not allowed. The PPE must be removed before exiting the area (hot zone), except for the procedure mask. In addition to other standard requirements, visitors that have had a positive test result are required to wait 10 days since the onset of acute illness, 21 days since admission to intensive care or 28 days if immunosuppressed or on corticosteroids. Any informal or family caregiver or visitor who so wishes may be tested at the facility on request.

Scotland recommends that RCFs consider the layout of the facility in terms of minimising contact with others when deciding to allow visitations.[39] The incidence of infection in the community where the visitor has come from needs to be considered when approving their visit. Lateral flow tests are provided to care homes for designated visitors (in Level 3 areas where indoor visiting is supported), care home staff twice weekly alongside PCR testing (enhanced testing), outbreak management staff testing if advised by health protection, and a small number of professional visitors who are not covered by arrangements in place through their employer (for example, podiatrists, dentists, optometrists, essential maintenance staff, site contractors, inspectors, social workers and other non-NHS Allied Health Professionals).[40] Testing is not compulsory but is strongly recommended and is in addition to existing safety measures such as wearing PPE. Travel into and out of

Levels 3 and 4 to visit loved ones in care homes is exempt from the national restrictions.

New South Wales encourages the use of electronic check-in methods (such as QR codes) for recording visitor contact details.[26] Hand-written records (when they are collected) need to be provided to NSW Health as soon as possible, but at least within 4 hours, when needed for contact tracing. Records should be kept for a minimum of 28 days.

Northern Ireland advises in a situation when denying visiting rights, and in particular if the patient has just undergone organ transplant, that the decision must be made following a risk assessment and must be communicated clearly with the resident and their family or next of kin or carer.[41]

Scotland requires facilities to provide visitors with a fluid resistant surgical mask (FRSM) which must be worn during the visit.[42] Hand and wrist jewellery should be removed and forearms uncovered to support good hand hygiene when spending time together indoors.

Personal Protective Equipment (PPE)

Ireland

Health care workers (HCWs) should wear surgical masks when providing care to residents when within 2m of a resident and for all encounters with other HCWs in the workplace where a distance of 2m cannot be maintained and the encounter is expected to last longer than 15 minutes.[7] If a resident has suspected or confirmed COVID-19 or is a COVID-19 contact staff should have access to a respirator mask (for example FFP2) and eye protection. During an outbreak contact and droplet precautions should be taken in the cohorted area or zone.

In all other situations, a risk assessment should be undertaken by HCWs prior to performing a clinical care task, as per standard precautions. It is recommended that every effort should be made to avoid generalised use of PPE throughout the facility without considering the level of risk. Transmission-based precautions should be applied immediately for all suspected cases and can be discontinued 14 days after symptom onset, where they have been fever free for five days. However, modifications to transmission precautions may need to be made as the setting is also the resident's home. Only in exceptional circumstances, where a Physician is concerned on clinical grounds that there may be an ongoing risk of transmission beyond 14 days (but no more than 21 days), then repeat testing may be considered in advance of ending transmission-based precautions. In all other cases, testing is not recommended to end precautions. In the case of a persistent cough and if there is clinical concern then an extended period of contact and droplet precautions may be considered for up to a maximum of 28 days.

If tolerated, residents should be encouraged to wear a mask in busy areas of the RCF or during transport to and from the facility unless fully vaccinated.[7]

Other countries

Hong Kong recommends that staff escorting residents (for example, to hospital) should wear eye protection if the resident cannot wear a mask.[17] It is also recommended that when providing personal care services for residents who are not wearing masks, for example, feeding or performing oral care, staff should use eye protection such as goggles or face shield.[17] Residents or staff identified as other contacts (that is, not close contacts) will be put under medical surveillance for 28 days and must wear a mask for 28 days.

England advises HCWs to wear fluid-repellent surgical masks (FRSMs) while providing close personal care (for example, touching) or if within two metres of a resident that is coughing.[18]

New South Wales requires all staff to wear a surgical mask inside the facility.[43] NSW recommends the use of powder-free latex or nitrile gloves instead of vinyl gloves for the clinical care of patients in the context of COVID19 as they are less likely to be breached and cause an exposure to body fluids or COVID-19 contaminated surfaces.[44]

CDC recommends that HCWs should wear well-fitting source control at all times while they are in the facility, including in staff rooms or other spaces where they might encounter co-workers.[45] HCW should consider continuing to wear the same respirator or well-fitting facemask (extended use) throughout their entire work shift to reduce the number of times HCW must touch their face and potential risk for self-contamination.

Ontario recommends patients with severe COVID-19 requiring treatment in an intensive care unit or patients with severe immunocompromised can be removed from Droplet and Contact Precautions 20 days from the onset of symptoms (or from their initial test positive date if asymptomatic and immunocompromised) as long as fever has resolved and their clinical status is improving for at least 24 hours.[14]

Environmental cleaning

Ireland

Single-use equipment for the resident is recommended where possible or use designated care equipment in the resident's room or cohort area. [7] Equipment must be decontaminated immediately after use if in the COVID-19 cohort area and should not be used in non-cohort areas. If this is not possible then standard cleaning protocols must be followed. Hovering of carpet floor in a resident's room should be avoided during an outbreak and while the patient is infectious. When the resident is recovered the carpet should be steam cleaned. Equipment used in the cleaning or disinfection of the isolation area should be single-use where possible and stored separately to equipment used in other areas of the facility. All surfaces in the resident room or zone and in cohort and clinical rooms should be cleaned and disinfected at least daily and when visibly contaminated. For cohort areas and clinical

rooms a documented cleaning schedule should be available to confirm this. Terminal cleaning should always be performed after a resident has vacated the room and is not expected to return. For good practice, it is recommended that this is signed off by the cleaning supervisor before the room is reoccupied.

Other countries

Hong Kong requires cleaning staff to wear eye protection.[17] Residents identified as other contacts (that is, not close contacts) should have their room disinfected at least once daily.

England advises RCFs to ensure domestic staff should clean the isolation room after all other unaffected areas of the facility have been cleaned.[18] Ideally, isolation room cleaning should be undertaken by staff who are also providing care in the isolation room.

Immunisation

Ireland

All residents and staff should be vaccinated for influenza.External contractors should ensure that their staff who may enter clinical areas are fully vaccinated or if not fully vaccinated for COVID-19 that they are subject to a risk-assessment process equivalent to that which the HSE- applies to HSE staff [7].

Other countries

Australia requires all visitors including children to have had the 2020 flu vaccine.[20]

Following a National Cabinet decision, COTA Australia supports the mandating of COVID-19 vaccination for workers in RCFs in line with infection prevention and control measures (and with appropriate exemptions).[46] Workers that are excluded are pharmacist, allied health professionals not engaged by the Home; regular in-reach/contractors (AN-ACC/ACAT/RAS Assessors, ACQSC staff, NACAP/OPAN staff, tradespeople, delivery drivers, hairdressers, regular pastoral care workers); volunteers/visitors; or irregular in-reach/contractors (librarians, solicitors, personal pastoral care workers, on-off irregular trade delivery, trade union officials). Once Australia reaches the point that every Australian has been offered a COVID-19 vaccination, the Code will be reviewed to consider if a requirement is needed that all Visitors must have a COVID-19 vaccination to allow entry into a Home (noting there may be appropriate medical exemption from receiving the COVID-19 vaccine).

New South Wales requires all visitors aged 6 months and over, and staff entering a residential aged care facility to provide evidence that they received a dose of the 2021 influenza vaccination.[29] This is in effect from 1 June to 30 September 2021 as fewer people than usual will likely have immunity in the coming year. Currently, all workers employed by a RCF or contracted to provide services for one or more residents of the facility in NSW are required to have their first dose of the COVID-19 vaccination.[26] By 31 October 2021, this will be extended to any health practitioners

who must have at least one dose of a COVID-19 vaccination if attending a residential aged care facility under arrangement by the resident.

Providing care to residents who are not known or suspected cases

Ireland

In so far as possible, avoid the use of fans that re-circulate air.[7] Open windows for ventilation if it is safe to do so and it does not cause discomfort for the resident. It may be necessary to use mobile fans and or dehumidifiers during very warm weather to keep residents cool, in such instances these items should be cleaned regularly and maintained according to the manufacturer's instructions. Position the fans in such a manner that they do not blow air across an open door causing cross currents of air.

Residents observation charts, medication prescription and administration records and healthcare records should not be taken into the resident's room to limit the risk of contamination.

Other countries

No recommendations or measures were identified that are not already featured in Irish guidance.

Caring for recently deceased

Ireland

Any IPC precautions that have been advised before death must be continued in handling the deceased person after death.[7] In relation to COVID-19 specifically, if transmission based precautions have been discontinued before death, then they are not required after death. 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, if there is a risk of splashing. Items that can be wiped clean can be done so using hot, soapy water. Clothing should be washed at the hottest setting that the fabric can withstand. Paper materials or items that cannot be wiped should be placed in a plastic bag and left aside for 72 hours before handling. Personal belongings that family members wish to discard should be placed in a plastic bag and tied securely, then placed in a second plastic bag and set aside for 72 hours after which it can go out for collection in the appropriate general waste stream. In terms of transporting to the mortuary, an inner lining is not required for the body but may be preferred. Surgical face mask or similar should be placed over the mouth of the deceased before lifting the remains into the inner lining. Those physically handling the body and placing the body into the coffin or the inner lining should wear, at a minimum, gloves, a long sleeved gown and surgical face mask.

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. PPE is not required for transfer, once the body has been placed in the coffin.

Other countries

Northern Ireland advises that once the person has died, all visits to the deceased person must stop.[47] This includes visits from close family and friends.

Governance

Ireland

The Regional Departments of Public Health are responsible for investigating cases and outbreaks of COVID-19 and providing overall leadership and oversight for outbreak management.[7] RCF are required to identify a lead for COVID-19 preparedness and response in the RCF. The lead should be a person with sufficient authority to ensure that appropriate action is taken and may require support of a team, including an on-site IPC link-practitioner and a liaison person on each unit in the RCF. RCF settings must have COVID-19 preparedness plans in place to include planning for cohorting of residents (COVID-19 separate from non-COVID-19), enhanced IPC, staff training, establishing surge capacity and promoting resident and family communication. A care planning approach should be put in place that reflects regular monitoring of residents with COVID- 19 infection for daily observations, clinical symptoms and deterioration. Where appropriate there should be advance planning in place with residents and or advocates reflecting preference for end of life care and or transfer to hospital in event of deterioration.

Other countries

England advises RCF managers to update capacity tracker data daily via online portal.[18] Data include number of beds, number of bed vacancies, current status (for example, open or closed to admissions, including the number of COVID-19 residents), and workforce or staffing levels. These data are shared with local resilience forums via the daily national situation reports to support capacity planning and response. Local authorities will also use this information to inform their care home support plans. Where providers consider there to be imminent risks to the continuity of care, such as the potential closure of a service, they should raise this with the local authority without delay.

Scotland recommends the use of the Safety Huddle Tool to identify factors that may impact on the health, safety and wellbeing of residents.[48] For decisions relating to care home visits during the pandemic, a group of experts in each local area, called an oversight group, provide recommendations about visiting in care homes.[49] This group includes experts in public health, nursing, infection prevention, health protection, and social work. The Care Home Manager makes decisions about visiting for their individual home and while considering the balance between safety and needs of the entire group of residents, and the safety and needs of each individual

resident. Scotland now archives all guidance on National Records of Scotland Web Archive to facilitate the statutory duty to collect, preserve and make them publicly accessible on a permanent basis.[50]

Northern Ireland has published a protocol for RCFs, for implementing additional visiting restrictions to their respective healthcare settings during the COVID-19 crisis.[41] This protocol requires facilities to communicate their intentions, prior to any additional visiting restrictions being implemented, with the Public Health Agency and Department of Health. This requirement excludes the application of additional restrictions to those units experiencing active outbreaks.

The ECDC has published an updated protocol for the collection of information on the severity of breakthrough COVID-19 infections in outbreaks at RCFs and facilitates the reporting by EU/EEA Member States to ECDC.[51] This version is shorter and is aimed at obtaining timely estimates of vaccine effectiveness, by SARS-CoV-2 variant and vaccine products.

Other

Ireland

The effect on staff and residents during outbreak events should not be underestimated especially where there have been deaths in the RCF.[7] Every effort should be made to support those who are impacted by outbreak events. It is essential that the service providers engage with residents, involve them in decision making and communicate clearly with each resident and relevant others regarding visiting policy including any restrictions, the reasons for those restrictions and the expected duration of restrictions.[31] The communication should make it clear that only a very limited number of visitors can be in the RCF at one time and that to achieve this it will frequently not be possible to facilitate visitors at a specific time or date of their choosing.

Other countries

In its response to the Aged Care Royal Commission's recommendations on COVID-19, Australia is expanding access to psychiatrists, psychologists and general practitioners to enable residents of RCFs to access up to 20 individual psychological services each calendar year from 10 December 2020 to 30 June 2022.[20]

Conclusion

The advice and recommendations issued for RCFs in Ireland in the context of COVID-19 is broadly consistent with the advice and recommendations that have been issued internationally, as demonstrated in this review as well as the previous versions of this review (detailed in Appendix A). However, some variations in the advice and recommendations have been observed, specific to the following themes: vaccination, testing, monitoring, admissions and transfers, cohorting, controls to

minimise risk of inadvertent introduction of virus, physical distancing, visitations, personal protective equipment (PPE), environmental cleaning, immunisation, caring for recently deceased and governance. Additionally, as vaccine allocation continues in RCF settings across the countries included in this review, IPC guidance is being updated to include exceptions for HCWs and resident who are fully vaccinated. These include exemption from requirements relating to testing, self-isolation after close contact or for new admissions or readmissions, physical contact with visitors and less emphasis on mask wearing. However, the majority of countries reviewed have either not modified their guidance or have explicitly stated that existing IPC must be followed regardless of vaccination status. These vaccine related exceptions are similar to exceptions identified in a recent report which included additional countries outside the scope of the review.[6]

The findings from this rapid review were accurate as of 6 October 2021 13.00 GMT, however, it is important to note that the guidance identified above may change as the situation and response to COVID-19 evolves.

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Appendix A: Summary of reopening guidance for RCFs in the context of COVID-19.

Last updated 17 September 2020

Background

As the levels of community transmission decrease in countries, some countries began to ease measures that they had previously put in place and agencies began to publish guidance on when and how RCFs could 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) undertook an ongoing rapid review of guidance for RCFs in the context of COVID-19. This version of the review was first undertaken on 3 July 2020 and was updated regularly until 17 September 2020. The review summarises recommendations that have been issued internationally in the context of reopening of RCFs.

Methods

The review was undertaken, 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,[52] 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. Guidance is summarised below by country.

Results

The United States of America

The **Centers for Medicaid and Medicare Services (CMS)** have published recommendations for reopening RCFs.[53] 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 (for example, 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. 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. According to testing guidance published on 26 August, routine testing should be based on the extent of the virus in the community.[12] Ranging from once a month when the county positive rate is below 5% to twice weekly when it is over 10%. For outbreak testing, all staff and residents should be tested, and all staff and residents that tested negative should be retested every three to seven days until testing identifies no new cases of COVID-19 infection among staff or residents for a period of at least 14 days since the most recent positive result.

The **Centers for Disease Control and Prevention (CDC)**[54] 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.[55, 56] 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.[55] 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.[54] 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,[45] if a case is suspected.

As RCFs in the US begin to relax measures the CDC[54] 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 transitioned down their alert level as a nation. The country moved to alert level 1 on the 8 June 2020. At alert level 1, there is no physical distancing requirement for anyone, including those in RCFs.[57] RCFs can operate as normal with visiting policies as they were before the COVID-19 alert level system.[58] 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 2020, 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.[59] At Alert Level 1, RCFs can operate at their full scope.

New Zealand has escalated its alert level from Alert Level 1, where RCFs operate as normal, to Alert Level 2 for the rest of New Zealand.[60] At Alert Level 2, RCFs continue to operate, accepting referrals from both the community and from hospital but with additional screening restrictions according to alert level. Residents can go on outings and stay with family.[61] Visitations are allowed, including general family visits and non-essential service visits. However, providers are instructed to take precautions and manage visiting in a controlled way to minimise the risk of COVID-19 transmission to residents and staff.[62]

Canada

The **Public Health Agency of Canada** has published guidance for a strategic five step pan-Canada approach to lifting restrictive public health measures.[63] 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.

On 9 September 2020, reopening guidelines for RCFs by the Ministry of Long-Term Care, **Ontario** came into effect.[64] When a RCF is outbreak-free and a resident is not self-isolating or symptomatic, a maximum of two caregivers may be designated per resident and a maximum of two caregivers at any one time. This includes family members who provide meaningful connection, a privately hired caregiver, paid companions and translators. Any number of support workers may visit and a maximum of two general visitors per resident may visit at a time. This includes children aged under 14 years if accompanied by an adult. When a RCF is experiencing an outbreak or when a resident is self-isolating or symptomatic, visits should be limited to one caregiver per resident. This appears to not be applicable to support workers. However, visits by general visitors is not permitted in these situations. RCFs are not required to supervise visits. A visitor policy should be made visible that states that non-compliance with the RCF policies could result in a discontinuation of visits for the non-compliant visitor. Additional guidance on how RCFs should respond to non-adherence is given.

Scheduling, or restricting the length or frequency, of visits by caregivers is not required by RCFs. Whereas for general visitors, this is at the direction of the RCF and may include scheduled visits, limiting visits to 30 minutes and at least one visit per resident per week. RCFs need to consider staffing capacity and available space when determining whether indoor or outdoor is the most appropriate place for visits by general visitors.

Screening protocols must be in place. This includes RCFs attaining a verbal confirmation from visiting care workers, support workers and general visitors that they have had a negative COVID-19 test within the previous two weeks and not subsequently tested positive. In cases of emergency, this is not required for support workers. RCFs are not required to provide the testing.

RCFs are responsible for providing surgical or procedural masks, gloves, gowns and eye protection (such as face shield or goggles) for support workers and caregiver visitors. General visitors are responsible for bringing their own cloth or face covering for outdoor visits, while indoor visits are the responsibility of the RCF, who should provide a surgical or procedural mask.

Prince Edward Island remains at Level 4 (lowest regional risk level).[36] 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. Visits are limited to one hour. As of 29 July 2020, the limit on the number of designated visitors was removed. In addition, a named 'partner in care' can visit a resident's room any time during regular visiting hours to help with basic care, feeding, mobility, comfort, socialisation and companionship. Residents are also permitted to leave the RCF for a drive with their partner in care, but must not exit the vehicle during the outing.[65] An example of who may be designated as a 'partner in care' includes a husband who would normally visit his partner in care every day, or a daughter who visits her parent a few times a week. Training in PPE is provided to both 'partners in care' and visitors, who are required to wear a medical mask during indoor visits, as well as outdoor where physical distancing cannot be maintained. A further easing of restrictions was implemented on 1 September 2020 which allows for up to three 'partners in care' to be designated, while other visitors no longer need to be designated. Residents are also permitted to have an overnight stay accompanied by a 'partner in care' with precautions in place including the wearing of face coverings. As previously advised, residents may leave the facility in a vehicle with a 'partner in care' for up to one hour but can now leave the car with precautions.[36]

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.[35] A visitor who is a child may be accompanied by one parent, guardian or family member. Visits in RCFs have commenced since 1 July 2020. 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. This approach will be monitored through July with an aim to expand it in August to allow more than one designated visitor for each resident. However, there may be a limit on the number of visitors allowed at a given time. As of 17 September 2020, this guidance has not been updated.[35]

The **Government of Québec** have announced that visitation to RCFs without a COVID-19 outbreak can resume.[22] Informal carers who provide significant assistance or support can also visit while there is an outbreak at the facility.[66]

Ireland

Ireland allowed visits to RCFs to begin in a phased manner in facilities with no cases of COVID-19, from 15 June 2020.[67] The **Health Protection Surveillance Centre (HPSC)** published guidance on facilitating visits for RCFs with no ongoing COVID-19 outbreak which was last updated on 24 August 2020 (currently under review).[31] This advises that visits are at the discretion of the RCF. Each resident can have a maximum of four named visitors and generally two of those visitors can be present at any one time with flexibility as appropriate on compassionate grounds to meet the needs of residents, for example children if supervised by an adult. 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 but an RCF has flexibility to accommodate these on compassionate grounds. Visitors should be guided in performing hand hygiene when they arrive and are required to wear a cloth-face covering or a surgical mask but some flexibility is required in relation to the needs of the resident and visitor when they are together at a safe distance from others. Any necessary PPE should be provided by the RCF. 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 should be limited to one hour, with exceptions given on compassionate grounds. The number of visits per resident per week is subject to the capacity of the RCF to schedule the visits safely. Visits should take place when there is sufficient staff on duty to manage visiting and away from mealtimes. Food and refreshments are not permitted. The use of the resident's or visitors' bathroom is discouraged. The resident's right to decline a visitor shall be respected. Organised outings by bus or car should generally be facilitated with individual risk assessments. Outings for a drive with a visitor may also be facilitated subject to risk assessment and confirming that the visitor does not have symptoms of COVID-19 and is not a COVID-19 contact. During periods of high community transmission, residents may be advised against leaving the RCF based on a risk assessment. Due to a recent increase in new cases of COVID-19, HPSC advise RCFs in the Dublin area to reduce the number of visitors to one nominated visitor per resident.[68]

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.

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.[17] 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 2020, the guidance was updated to explicitly state that visitors are only allowed under compassionate grounds.[17] 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 2020, RCFs can have gatherings of residents in communal or outdoor areas while implementing physical distancing and jurisdictional requirements for gathering sizes.[20] 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.[20] Visits are limited to two visitors at any one time, per resident, and includes children of all ages. 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, has developed an industry code for visiting RCFs during COVID-19.[46] 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.

On 23 July 2020, due to a number of outbreaks in the community, temporary amendments to the code were made for the state of Victoria, including a limit on supervised visits to one visitor (who is a parent, guardian, partner, carer, or support person of the resident) for a maximum of one hour per day. Under the temporarily amended code, only one visitor is permitted at any one time (without time constraints) for essential care and necessary support care (including mental health supports). In addition, a maximum of two people at any one time may visit a resident for the purposes of end-of-life care.

New South Wales Health (NSW) has updated the guidance for RCFs on restrictions on entry into the facility and for visitation.[43, 69] 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 2020.[46]

The outbreak of COVID-19 continues in Victoria and the outbreak in NSW has now spread to some other areas. While the initial focus of cases in Victoria was in metropolitan Melbourne, there is a number of cases in other regional areas.[26] Since 7 August 2020, RCFs located in any of the latest COVID-19 case locations in NSW are not allowed visitors. Visitors performing essential caring functions may be allowed but must wear a mask. Staff who live or work in any of the latest COVID-19 case locations in NSW or the borders communities of these areas, must wear a surgical mask.[70] In all other areas it is recommended that all staff wear face masks when within 1 to 2 metres of confirmed or suspected cases. Since 25 August 2020, this advice is extended to the regions from the Gold Coast to Queensland for two weeks followed by a reassessment.[26]

NSW Health and the Department of Health published a protocol on the 10 July 2020 to support joint management of COVID-19 outbreaks in a Commonwealth funded residential aged care facility.[71] 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.

The United Kingdom

Since 19 March 2020, the UK prohibited all non-essential visits.[72] On 22 July 2020, the Department of Health and Social Care updated the visitor guidance for all RCFs in England.[33] 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.[33] 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 physical 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.[73] 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. Scotland moved from stage one on 3 July 2020, where only essential visitors were allowed, to stage two, where one designated visitor is allowed to visit outdoors. This includes visits to residents who are shielding. At stage three, multiple visitors are allowed to visit outdoors and one designated visitor to visit indoors and at stage four, a controlled programme of outdoor and indoor visits can resume. PPE must be worn by visitors and staff at all stages. From 10 August 2020, visits in outdoor areas with residents or through a window with the resident indoors were increased to allow up to three visitors from two households, with all precautions remaining in place, for example, face coverings. Indoor visits have resumed in RCFs since 24 August 2020, subject to the individual RCF receiving approval on condition of scientific advice and an agreed preparation plan. This is limited to one designated person for approximately 30 minutes once a week. Full details of restrictions at each stage are provided in the updated guidance. Since 3

September 2020, use of lounge, communal dining area and outdoors in limited numbers by residents has resumed. This includes involvement of external visitors, for example activity coordinators, musicians and exercise classes.

On 21 July 2020, the **Department of Health**, Northern Ireland updated guidance for RCFs.[74] This details different levels of visitor restrictions according the current regional surge level and the relevant RCF outbreak status and aligns with the Health and Social Board and the Public Health Agency's regional surge plan.[75] As outlined in the updated guidance, 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 environmentally 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[53] and adopted by the CDC.[54] This outlines a three phase plan with criteria for implementing and service provision guidance, including for testing (updated 26 August),[12] 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.[73] 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.[33]

Some countries are relaxing the protective measures they previously put in place. The Australian Government,[20] British Columbia, Canada[35] the CDC,[54]the CMS,[53] Hong Kong,[17] Ireland,[31, 67] New Zealand,[60] Northern Ireland,[74] NSW, [43, 69] Ontario[64] and Scotland[73] 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. New Zealand relaxed their guidance on visitation, isolation, admissions, outings and have removed the physical distancing requirement for everyone, including those in RCFs (when the country was at Alert Level 1; the country moved to Alert Level 2 on 12 August 2020 and reintroduced certain restrictions).[58] 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.[17] (On 8 July, the Centre for Health Protection Hong Kong reintroduced restrictions and now only allows visitors on compassionate grounds.[17]) Ireland has allowed visits from 15 June for RCFs with no cases of COVID-19 and, from 28 August 2020, the number of nominated visitors has increased to four, while up to two people can visit at any one time, lasting no longer than one hour. Children can also accompany adults during their visits and outings are now allowed.[20] Australia, in general, has relaxed measures for visits, communal gatherings and external excursions.[20] In addition to re-opening guidance, Ontario has published additional guidance on how RCFs should respond to non-adherence of precautionary measures by visitors.[64]

Since 8 August 2020, Scotland has eased visitor restrictions to increase the number of visitors outdoors to up to three visitors from two households. This includes visits to residents who are shielding.[73] On 3 September 2020 this was extended to resume the use of lounge, communal dining area and outdoors in limited numbers by residents. This includes involvement of external visitors, for example activity coordinators, musicians and exercise classes. Since 22 July 2020, England is allowing one nominated visitor per resident in RCFs where visits are allowed.[33] Some Canadian territories are also expanding the scope for visits and even allowing residents to leave RCFs for a drive with a designated 'partner in care'.[22, 35, 65]

In contrast, some countries have reintroduced restrictions due to an increase in outbreaks. In the state of Victoria, New South Wales (NSW) in Australia, COTA has temporarily amended its Industrial Code for the state to recommend restricting visits, for example to one visitor (who is a parent, guardian, partner, carer, or support person of the resident) for a maximum of one hour per day.[46] Since 25 August 2020, NSW Government has extended temporary restrictions to other regions from the Gold Coast to Queensland. All staff who live or work in areas affected are advised to wear face masks when providing care or support.[26] Visitations to RCFs in these areas are not allowed unless for visitors performing essential caring functions, in which case a mask must be worn.

While countries continue to update and amend their guidance to address the evolving COVID-19 pandemic, the World Health Organization (WHO) has identified a number of key policy objectives and key action points to prevent and manage

COVID-19 in RCFs in both the short and long-term. The policy brief was published on 24 July 2020 and proposes 11 key policy objectives, aimed at policy makers and authorities (national, subnational, and local) involved in the COVID-19 pandemic. WHO recommends that policy makers should, for example, include RCFs in all phases of the national response to the COVID-19 pandemic; mobilise adequate funding for RCFs to respond to and recover from the COVID-19 pandemic; ensure effective monitoring and evaluation of the impact of COVID-19 on RCFs; ensure efficient information channelling between health and residential care systems to optimise responses; and secure staff and resources, including adequate health workforce and health products, to respond to the COVID-19 pandemic and deliver quality residential care services, among other action points.[76]

The findings from this rapid review were accurate as of 17 September 2020 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

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