This document provides a framework to assist Residential Aged Care Facilities (RACFs) determine the risk to Aged Care workers, residents (known as consumers in some facilities) and visitors when there has been contact with someone with COVID-19 at the facility. The person with COVID-19 may be a staff member working at the facility, a resident, or a visitor. It is important that appropriate actions are taken to minimise the risk of spread of COVID-19. This document supports the Commonwealth Permissions and Restrictions for Workers in Aged Care – Interim Guidance.

This document should be used to assess risk following staff, visitor, or a single resident exposure. In the context of widespread exposure of residents, or a cluster, consult with the public health unit (PHU) as risk assessment and management may differ.

Part 1 of this guidance provides a process to support safe decision making when determining whether to place work permissions/restrictions on a worker after a COVID-19 exposure. Part 2 of the guidance provides a framework to assist in determining the risk to residents and visitors.

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

For more information on infection prevention and control in aged care see below:

1. First 24 Hours: Managing an Outbreak of COVID-19 in a Residential Aged Care Facility
2. Residential aged care facility outbreak management

As a critical industry, aged care services should ensure that eligible staff and residents are vaccinated as per ATAGI recommendations (here). Access to RACFs should be in line with current Public Health advice.

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

RACF providers are responsible for conducting a risk assessment when an exposure or outbreak occurs in their setting. Aged care providers are also responsible for considering the impact on the workforce as part of the assessment outcomes and for being familiar with and able to operationalise these guidelines as part of their outbreak management plan. RACF providers should be prepared to make assessments on their own, in line with Outbreak Management Plans, in instances where PHU advice is not available.

Decisions regarding work permissions and restrictions for the worker should be accurately documented and decisions regularly reviewed by the provider in the context of the evolving local epidemiological and public health situation. If a large number of workers are affected by community transmission (as a case or contact) or an outbreak escalates, it may be necessary to review the recommended restrictions to facilitate continuation of essential care.
Registered providers of residential aged care are responsible for notifying and communicating with their local PHU of any positive cases. Where available, PHUs will consider applying a process of monitoring and evaluation locally, in line with jurisdictional requirements.

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

The ability for detailed follow up of individual cases and identification of contacts may vary with increasing levels of population exposure, high caseloads, and potential impacts on essential service delivery.

Steps for service/PHU:

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

COVID-19 contact

COVID-19 Low-risk exposure / contact

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

COVID-19 High-risk exposure / contact

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

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

Where a worker has been exposed to a COVID-19 case in a workplace setting where the risk of exposure is defined as high (see table 3) e.g.:

- Where aerosol generating behaviours or procedures have involved staff who were not wearing Contact, Droplet and Airborne precautions PPE (P2/N95 masks, eye protection, gown and gloves)

OR

- have had at least 15 minutes face to face contact where both mask and eye protection were not worn by exposed person and the case was without a mask
Management of high-risk worker contacts in the context of high impact on health service delivery

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

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

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

- More regular screening requirements (e.g., daily Rapid Antigen Test (RAT) at commencement of a shift. Routine PCR testing is not required).
- Additional PPE requirements – this should be based on the advice of Infection Prevention and Control (IPC) expertise (or PHU if IPC unavailable), in line with local requirements and may involve requirements to wear a P2/N95 respirator for the first 7 days following exposure.
- Do not use shared break areas, car-pooling, and avoidance of public transport
- Physically distancing where possible (e.g., virtual or spaced-out handovers)
- Minimising risk of exposure to vulnerable people
- Adjusting staff rosters to minimise risk to residents and/or exposure of other staff. E.g., exposed workers tending to COVID-19 cases
- Diligence with routine cleaning of high touch points (handrails, lift buttons, door handles) and shared equipment. e.g., phones and computer keyboards.

Circumstances must include the following:

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

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

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

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

<table>
<thead>
<tr>
<th>Management of low-risk exposure</th>
<th>Management of high-risk exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Low impact on services</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Management of low-risk exposure</strong></td>
<td><strong>Management of high-risk exposure</strong></td>
</tr>
<tr>
<td>Continue to work, remain vigilant for symptoms, test and isolate immediately if these occur.</td>
<td>Immediately isolate for 7 days.</td>
</tr>
<tr>
<td>Surveillance testing:</td>
<td>- Day 1-2 and 6 RAT</td>
</tr>
<tr>
<td>- Monitor for symptoms</td>
<td>- Return to work (RTW) when day 6 test result returns negative and asymptomatic</td>
</tr>
<tr>
<td>- If symptomatic immediately isolate (Test RAT or PCR) *</td>
<td>- After RTW, RAT at least every second day until day 14</td>
</tr>
<tr>
<td><strong>Additional:</strong></td>
<td>- Routine PCR testing is not required</td>
</tr>
<tr>
<td>- Work in surgical mask or P2/N95, based on IPC advice, for the first 7 days following exposure.</td>
<td>- Continue to monitor for symptoms until day 14 and immediately isolate and test if symptomatic*</td>
</tr>
<tr>
<td>- Do not use shared break areas**</td>
<td>- Apply additional requirements on RTW as below.</td>
</tr>
</tbody>
</table>

| **High impact on services**     |                                  |
|---------------------------------|                                  |
| **Critical risk to service delivery requires PHU and senior management risk assessment** | |
| Same as above                   | If symptomatic and/or unwell: Immediately isolate and perform RAT. |
|                                  | - If positive, isolate for 7 days and follow NSW Health advice. |
|                                  | If negative:                    |
|                                  | - Recommend PCR testing if symptomatic* |
|                                  | - Day 1-2 and 6 RAT (if PCR negative or unavailable) |
|                                  | - RTW if day 1-2 and 6 tests are negative. Apply additional requirements below |
|                                  | - After RTW, RAT at least every second day until day 14 |
|                                  | - Continue to monitor for symptoms until day 14. |
| **Asymptomatic:**               | Return to work with risk management plan in place: |
|                                  | - Use P2/N95 respirator for the first 7 days following exposure if at work during this period |
|                                  | - Do not use shared break areas** |
|                                  | - Limit work to a single site/area |
|                                  | - Continue to isolate in community until cleared or negative test day 6-7, travel to work via own transport or individual ride (no carpooling) following a negative RAT. |

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

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

* PCR testing is recommended if symptomatic and RAT negative

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

# If required testing unavailable, staff must not attend the workplace for 7 days after exposure
Part 2 – Exposure risk determination for Residents and Visitors

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

**Definition of aerosol-generating procedures and behaviours**

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

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

**Risk level associated with various scenarios**

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

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

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

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

**Rapid Antigen Test (RAT)**

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

If a RAT is negative for symptomatic testing, a PCR is recommended. If access to PCR is better than rapid antigen tests, then consider using PCR for testing of staff or residents.

A confirmatory PCR is recommended if a resident is RAT positive where the resident is:

- the initial case;
- at a high risk for health complications; or
- requires a PCR diagnosis for the management of clinical care.
PPE Breach Risk Assessment key principles.

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

**LOW RISK BREACH**
- Breaches in PPE that occur below the neck and managed immediately (e.g., torn glove)
- Remove from situation
- Remove item
- Perform hand hygiene

**MODERATE RISK BREACH**
- Incorrect use of PPE, incorrect PPE for task
- Contamination occurs during doffing (occurs above neck)
- Remove from situation
- Remove PPE
- Perform Hand Hygiene
- Screening/testing and continuous monitoring

**INCREASED RISK OF INFECTION**
- Exposure of mucous membranes by direct droplets from confirmed COVID positive. (e.g., spitting in HW face by confirmed COVID)
- Gross contamination during incorrect doffing
- Remove from situation
- Remove contamination
- Remove PPE
- Closely Monitor, screen/test, consider removing from clinical duties

**HIGH RISK BREACH**
- Likely risk of infection
- For more information refer to COVID-19 IPAC manual

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

**Contact Precautions PPE**
- Hand Hygiene
- Disposable Gloves
- Fluid Resistant or Isolation Gown

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

**Droplet Precautions PPE**
- Hand Hygiene
- Surgical Mask
- Eye Protection

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

**Airborne Precautions PPE**
- Hand Hygiene
- P2/N95 Respirator

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

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

<table>
<thead>
<tr>
<th>Contact type</th>
<th>Transient contact – Low Risk Scenarios</th>
<th>Medium Risk Scenarios</th>
<th>High Risk Scenarios</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Transient, limited contact that does not meet the definition of face-to-face contact</td>
<td>Face-to-face contact within 1.5 metres for less than 4 hours <strong>OR</strong> Based on agreed documented risk assessment including assessments of occupational exposures and of the physical environment</td>
<td>Face-to-face contact within 1.5 metres for 4 hours or greater <strong>OR</strong> Case with AGBs / undergoing AGP</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>PPE worn by health worker contact and case</th>
<th>Staff Contact: No PPE Case: No PPE</th>
<th>Staff Contact: Surgical mask Case: No PPE (or vice versa)</th>
<th>Staff Contact: Surgical mask Case: Surgical mask</th>
<th>Staff Contact: Surgical mask and eye protection Case: No PPE</th>
<th>Staff Contact: Surgical mask and eye protection Case: Surgical mask</th>
<th>Staff Contact: P2/N95 mask and eye protection Case: With or without PPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Contact: No PPE Case: No PPE</td>
<td>Moderate*</td>
<td>Moderate</td>
<td>High</td>
<td>High</td>
<td>High</td>
<td>High</td>
</tr>
<tr>
<td>Staff Contact: Surgical mask Case: No PPE (or vice versa)</td>
<td>Low</td>
<td>Moderate*</td>
<td>High</td>
<td>Moderate**</td>
<td>High</td>
<td>Moderate**</td>
</tr>
<tr>
<td>Staff Contact: Surgical mask Case: Surgical mask</td>
<td>Low</td>
<td>Low#</td>
<td>Moderate##</td>
<td>High</td>
<td>Moderate##</td>
<td>High</td>
</tr>
<tr>
<td>Staff Contact: Surgical mask and eye protection Case: No PPE</td>
<td>Low</td>
<td>Low#</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
</tr>
<tr>
<td>Staff Contact: Surgical mask and eye protection Case: Surgical mask</td>
<td>Low</td>
<td>Low</td>
<td>Low (if no AGB/AGP)</td>
<td>Moderate**</td>
<td>Moderate**</td>
<td>Moderate**</td>
</tr>
<tr>
<td>Staff Contact: P2/N95 mask and eye protection Case: With or without PPE</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Low</td>
<td>Moderate##</td>
<td>Moderate##</td>
</tr>
</tbody>
</table>

**LOW RISK**
- Continue to work
- HW alert to mild symptoms
- Test (rapid antigen test [RAT] or PCR) if symptomatic

**MODERATE RISK**
- Continue to attend work with risk management plan
- RAT at day 2 and 6 post exposure
- For 14 days after exposure:
  - Consider redeploying to lower patient risk area if possible
  - Mask wearing at all times – surgical or P2/N95 as per CEC guidance
  - Do not enter shared spaces such as tearooms & do not participate in any staff gatherings
  - Careful monitoring for symptoms

**HIGH RISK**
- Immediately isolate for 7 days.
- Day 1-2 and 6 RAT
- Return to work (RTW) when day 6 test result returns negative and asymptomatic
- After RTW, RAT at least every second day until day 14
- Routine PCR testing is not required
- Continue to monitor for symptoms until day 14 and immediately isolate and test if symptomatic. PCR testing is recommended if symptomatic and RAT negative
- Apply additional requirements on RTW as per Table 1
### Resident or Visitor Contact

<table>
<thead>
<tr>
<th>Contact</th>
<th>Case</th>
<th>PPE worn by resident/visitor contact and case</th>
<th>Contact type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transient contact – Low Risk Scenarios</td>
<td>Face-to-face contact within 1.5 metres for less than 4 hours</td>
<td>High Risk Scenarios</td>
<td>Face-to-face contact within 1.5 metres for 4 hours or greater OR Case with AGBs / undergoing AGP</td>
</tr>
</tbody>
</table>

| Contact: No Mask | Case: No Mask | Moderate# | Moderate# | OR | High |
| Contact: No PPE | Case: Surgical mask | Low | Moderate# |
| Contact: Surgical mask | Case: No PPE | Low | Moderate# |
| Contact: Surgical mask | Case: Surgical mask | Low | Low |
| Contact: Surgical mask | Case (HW): P2/N95 respirator | Low | Low |
| Contact: No PPE | Case: P2/N95 respirator | Low | Low |

**Note:**

- For actions based on risk classification in the matrix above are in the table on page 9. In the context of widespread exposure or an outbreak please consult with the public health unit.
- PPE not worn correctly should be considered as no PPE

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* Depending on risk assessment

** Depending on risk assessment for AGB/AGP

* Individual risk assessment to ensure fit check seal
### Actions based on risk classification

<table>
<thead>
<tr>
<th>Risk classification</th>
<th>Low Risk</th>
<th>Moderate Risk</th>
<th>High Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Requirements for residents</strong></td>
<td>Isolation not required</td>
<td>Isolate for 7 days OR If after risk assessment¹,²,³ Consideration for residents to leave their room and RAT at least every second day for 7 days and day 12 post exposure</td>
<td>Isolate for 7 days Consideration for residents to leave their room based on risk assessment¹,²,³ and RAT daily where possible OR at least every second day for 7 days Test every 48-72hrs from day 8-14 (where removed from isolation and able)</td>
</tr>
</tbody>
</table>

| Requirements for visitors | Isolation not required | Do not attend the Residential Aged Care Facility until negative day 6 swab Isolation in the community not required Test at day 2 and 6 post exposure | Isolate in community until day 7 if negative day 6 swab Test at day 2 and 6 post exposure Do not attend the Residential Aged Care Facility for the next 7 days after leaving isolation |

**Please note:** Testing in this document refers to rapid antigen test (RAT) unless otherwise specified

¹ An assessment should be made regarding the ability of residents to be isolated within the Aged Care Facility. Cohorting of residents based on level of risk may be required depending on the layout of the premises and resident factors

² Where resident cannot be effectively isolated, more frequent swabbing may be required to detect cases early, identify ongoing transmission and guide implementation of additional infection control measures.

³ Residents are part of the same exposure event and are asymptomatic and RAT at least every second day