





HSE Winter preparedness for health & care settings

Foundations for Winter Planning 2026-2027

8th October 2026

This webinar is accredited for two CPD points

This CPD Recognition is accepted by all Irish Postgraduate Training Bodies

Thank you for joining the webinar, we will commence at 12:00 noon

We expect to address your queries during the presentation. Please use the question & answer function on Teams to post your questions during the webinar.

If your queries are not answered during the presentation or at the Q&A we will post responses on our website after the webinar. Website link : **Winter Preparedness**

#Winterready

Welcome & Introduction

HSE Winter preparedness for health & care settings



National Health Protection

Dr Augustine Pereira, Director of Public Health, Winter Resilience Lead

Conflict of Interest Declaration: *I have no conflicts of interest to declare*

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#Winterready

Presenters

Dr. Éamonn O'Moore, Director of National Health Protection

Dr. Augustine Pereira, Director of Public Health, Winter Resilience Lead

Ms. Carole King, Director of Nursing, Community Support Team, HSE West North West

Dr. Orla Cotter, Locum Consultant Public Health Medicine, National Immunisation Office

Dr Eimear Brannigan, Clinical Lead, Antimicrobial Resistance and Infection Control

Dr. Scott Walkin, AMRIC ICGP Clinical Lead, HSE/ICGP

Dr. Michael Hanrahan, Consultant in Public Health Medicine, HSE South West

CPD accreditation & Conflict of Interest Declaration

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No conflicts of interest to declare

All planners and speakers have confirmed that they have no financial relationships with ineligible companies within the past 24 months.

The educational content and faculty selection are free from commercial influence, and presentations are intended to be evidence-based and unbiased.

Winter Ready Guide 2026

for health and care settings

PAGE 1 • PLAN AND PREPARE

Plan & Prepare

- Check your facility's **Winter Preparedness Plan** is up to date and aligned with AMRIC guidance. The plan should include staffing resilience, vaccination, and isolation plan and a communication plan. As part of the preparedness, settings should ensure there are sufficient stocks to manage cases/ outbreaks, consumables including alcohol-based hand rub, etc.
- Leadership – Cast an inspiring vision through visible leadership campaigns promoting vaccines
- Resource planning (Winter leave cover / peer vaccinator programme planning etc)
- Laboratory pathways for acute respiratory infection (ARI) testing (to include Nursing home / Residential Care Facilities) in all Regional Health Areas.
- Ensure staff have read and understood the plan and are up to date with infection prevention and control guidance and resources.
- Offer recommended winter vaccines, including **influenza (flu)** and **COVID-19** vaccines, to eligible residents and staff.
- Ensure frequent use of alcohol-based hand rub (ABHR) to clean hands as per the WHO 5 Moments for Hand Hygiene.
- If hands are visibly soiled, then wash with soap and water. Ensure adequately stocked supplies of ABHR and soap to facilitate hand hygiene.
- Thorough surface and environmental cleaning and disinfection of the healthcare environment, this includes patient surrounds and frequently touched objects.
- Provide dedicated equipment where possible, if common use of equipment is unavoidable, clean and disinfect and allow it to dry before use on another person.
- Ensure appropriate waste management including increased appropriate healthcare risk waste capacity and collection healthcare risk waste capacity & collection during an outbreak.

Prepare early • Keep plans practical • Make supplies, pathways and responsibilities clear

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for health and care settings

Educate

- Reinforce education of staff in the WHO 5 Moments for Hand Hygiene, respiratory hygiene and PPE based on a point-of-care risk assessment, including correct donning and doffing procedures.
- Recognise the important role of IPC in preventing infections by familiarising teams with IPC resources and materials to include the following: NIO/ HPSC posters & leaflets and current guidance (ARI, Antiviral guidance, IPC, PPE).
- Reinforce PCR swabbing and laboratory multiplex testing for influenza A and B, SARS-CoV-2 and RSV.
- Ensure that staff are up to date with all appropriate training on **AMRIC Hub*** and HSELanD**.
- Give peer vaccinators protected training time and use HSE influenza vaccination materials for health and care workers.
- Remind staff not to work when unwell. Support residents with hand hygiene, respiratory hygiene and cough etiquette.

Vaccination



- Offer influenza(flu) and COVID-19 vaccines to eligible groups and promote vaccination at every appropriate opportunity.
- Offer influenza vaccine to all health and care workers, and COVID-19 vaccine to eligible staff and any worker who wishes to receive it.
- Make vaccination convenient for every shift, including overnight.
- Provide visible leadership and protected time for vaccination.
- Record staff vaccine uptake on the National Immunisation Information System for real-time reporting.
- Use local communication plans and facility uptake data, where available, to target action and improve uptake.

Case identification and Management

- Ensure staff know how to recognise signs and symptoms of respiratory illnesses, seek clinical assessment and start immediate management following the Point of Care Risk Assessment for IPC.
- Ensure staff know how and when to request lab testing for infection with respiratory viruses and have the correct swabs and lab request forms. It is recommended that you have an appropriate minimum of in date swabs on site.(e.g. 5-10).
- Know when and how to contact your Regional Department of Public Health: report two or more cases of flu-like-illness, single confirmed cases of flu or COVID-19, and outbreaks of diarrhoea or vomiting.

Outline for today

Welcome & introduction – Dr Augustine Pereira & Dr. Éamonn O'Moore



Plan & Prepare

Importance of vaccination – Dr Orla Cotter

Winter Ready Guide – Ms. Carole King

Infection Prevention and Control, Fundamental Principles – Dr Eimear Brannigan



Case Identification & management

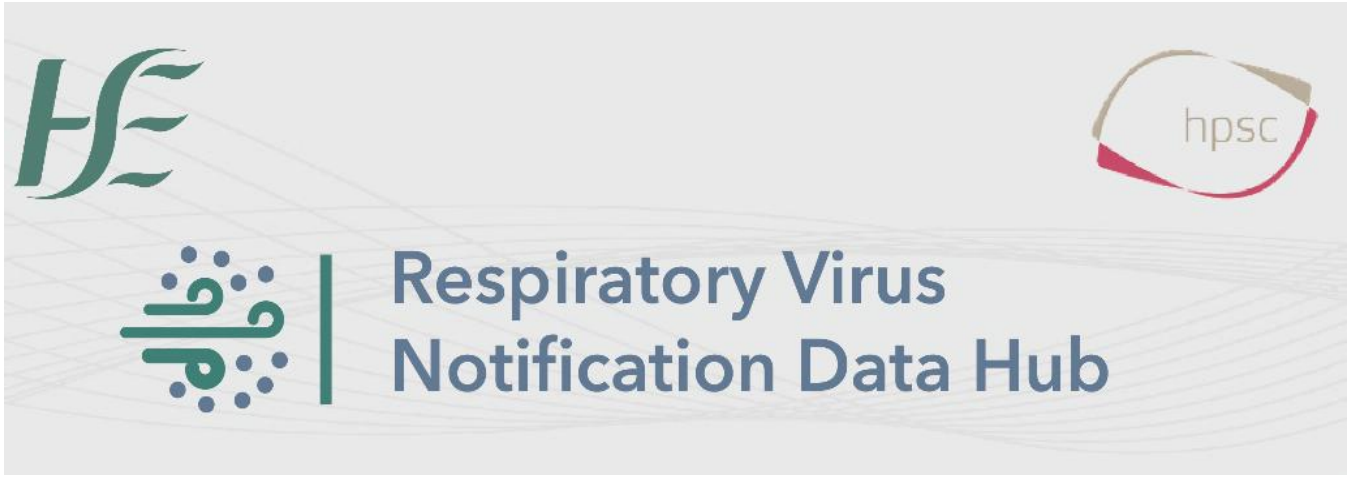
Recognising & Treating Acute Respiratory Infections – Dr. Scott Walkin

Clinical management of outbreaks – Dr Michael Hanrahan

Resources – HSE Winter Planning & Response Forum (WPRF)

Q & A session and Close

Intro slide



- https://respiratoryvirus.hpsc.ie/

- For the **latest published surveillance data on respiratory viruses** please refer to HPSC's Integrated Respiratory Virus Bulletin, published on Thursday of each week

Opening address from National Director



National Health Protection

Dr Éamonn O'Moore, Director of National Health Protection

Conflict of Interest Declaration: *I have no conflicts of interest to declare*

Importance of vaccination

HSE National Immunisation Office

Dr Orla Cotter

Locum Consultant in Public Health Medicine, HSE National Immunisation Office





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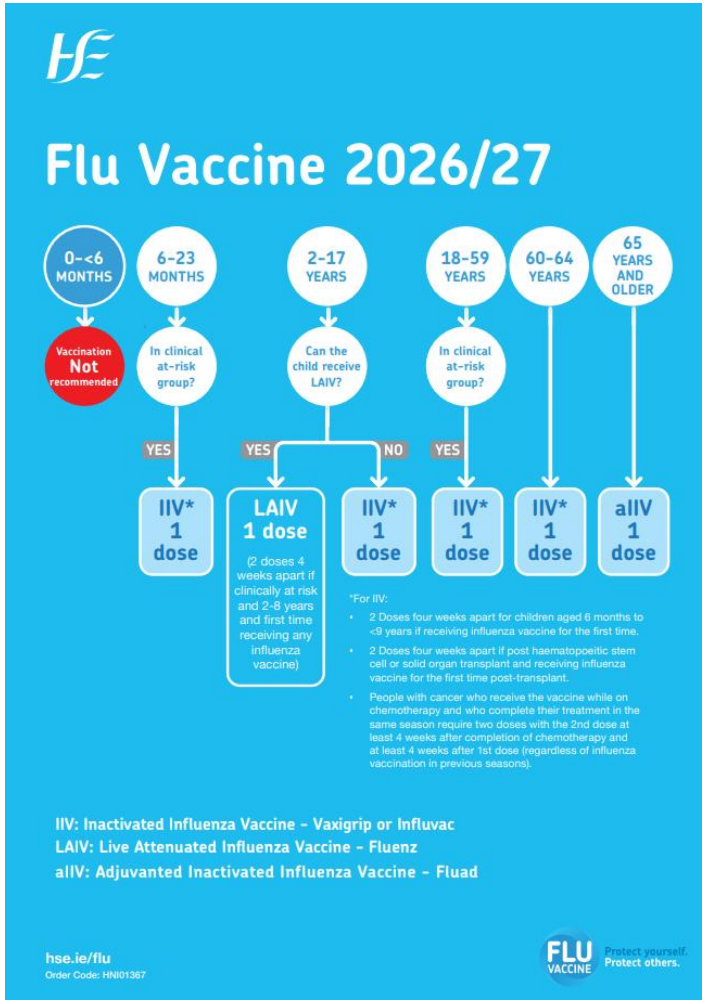
Winter Vaccination Programme overview: 2026/2027

How will the programme be delivered?

- The Winter Vaccination Programme for Influenza and COVID-19 will be launched **October 8th**
- For those in recommended groups, the vaccines will be available free via GPs, Pharmacists, HSE vaccination teams and peer vaccinators (HCWs)
- HSE vaccination teams provide vaccine clinics on-site **including RCFs**, prisons, a persons home if housebound
- **HCWs should have access to vaccines in workplace (vaccine clinics/peer vaccinators) and HCWs can also attend GP and Pharmacy**

Influenza vaccination programme







Rationale for vaccination: Influenza

- **Influenza is highly infectious**

- Illness is more severe in older people, people with immunocompromise, those with chronic heart, lung or neurological disease, in children aged 4 years or less, and in pregnancy

- **80-90% of reported deaths from influenza occur in older people**, mainly from secondary bacterial pneumonia, but also from exacerbations of underlying disease such as chronic obstructive pulmonary disease or cardiac disease

- **Influenza vaccination is the best available protection against infection and serious complications.**
- If people who are vaccinated get influenza infection, the **risk of serious illness and death from influenza is still significantly reduced by vaccination.**

Who is recommended to get an influenza vaccine in autumn/winter 2026/2027?

- **All aged 60 years and older**
  - **The enhanced (adjuvanted) influenza vaccine is supplied for those aged 65 years and older only**
- **All those aged 18 years and older living in residential care facilities for older people and other long stay facilities where rapid spread is likely to follow the introduction of infection**
- **All aged 6 months and older who is at increased risk of influenza related complications: (NIAC Chapter 11 -Table 11.1)**
  - Cancer, Chronic heart disease, Chronic kidney disease, Chronic liver disease, Chronic neurological disease, Chronic respiratory disease, Diabetes and other metabolic disorders, including inherited metabolic disorders, Haemoglobinopathies, Immunocompromise due to disease or treatment, Body mass index ≥ 40kg/m^2, Serious mental health conditions, Children and adults with Down syndrome, Children with moderate to severe neurodevelopmental disorders, Children on long term aspirin therapy
- **All children and young people aged 2 to 17 years**
- **All healthcare workers**
- **All pregnant women (at any stage of pregnancy)**
- **Carers and household contacts of people at increased risk of influenza related complications**
- **People with close, regular contact with pigs, poultry or water fowl**

FAQs: Influenza Vaccination

Why do people need to get vaccinated every year?

- The effectiveness of the influenza vaccine can vary depending on circulating strains and it can be different in different population groups
    - For a given season, the vaccine effectiveness is not known until the season is over

- **Annual vaccination recommended because immunity declines during the year after vaccination and circulating strains of influenza virus change from year to year**
    - Strains included in vaccine are based on advice from the World Health Organization (WHO)

FAQs: Influenza Vaccination

What is the enhanced (adjuvanted) influenza vaccine and why is it recommended for those aged 65 years and older?

- NIAC recommends an adjuvanted inactivated influenza vaccine (aIIV**) for all those aged 65 years and older.**
  - This year the aIIV will be supplied as Fluad (a trivalent vaccine that contains the same strains as the standard influenza vaccine IIV)

- In older adults the immune system may not respond as well to vaccines due to immunosenescence
  - aIIV is an enhanced influenza vaccine that contains an extra ingredient called an ‘adjuvant’ (MF59) to produce an enhanced immunological response
  - MF59 contains squalene a naturally occurring substance found in humans plants and animals

- The addition of an adjuvant increases the immune response in older adults compared to that of the standard vaccines

- Adjuvants have been used safely in vaccines for many years
  - A higher incidence of mild post-immunisation reactions has been reported with adjuvanted compared to non-adjuvanted influenza vaccines.

FAQs: Influenza Vaccination

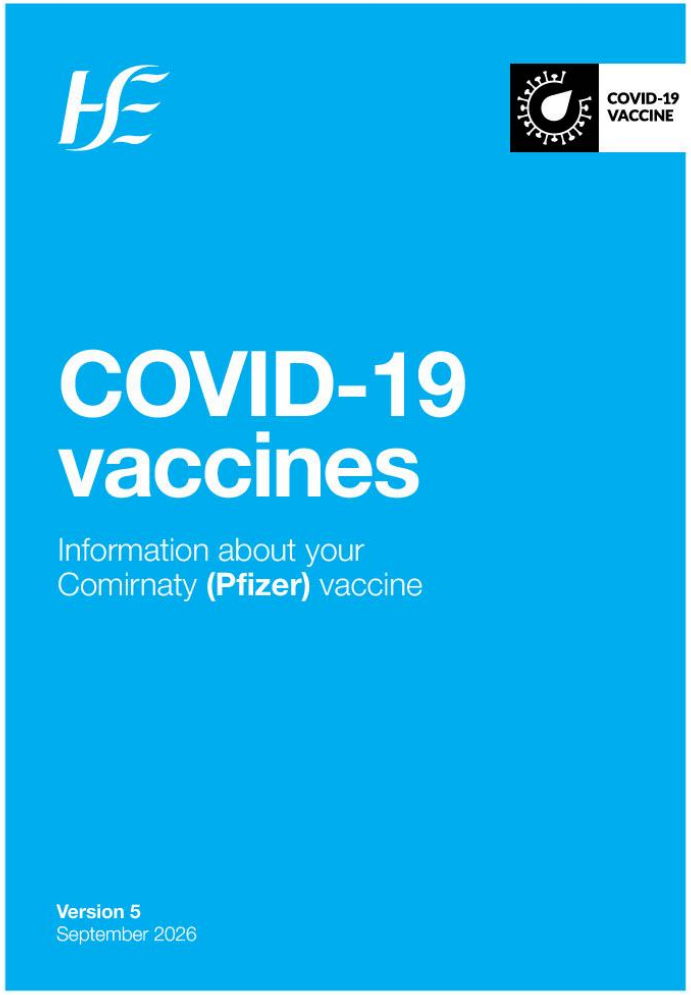
As a healthcare worker, why do I need the flu vaccine?

- As a healthcare worker you are **10 times more likely** to get the flu compared to the general public
- You can get very unwell with flu and you may get serious complications even if you have no underlying medical conditions
- Your risk of spreading flu to others, including to family members, is also much higher
- The flu vaccine is the best available protection against infection with flu and against the complications. **Patients with weak immune systems and older patients may not get sufficient protection from the flu vaccine themselves, so they rely on you to keep them safe and protect them by getting the flu vaccine**
- We know that in healthcare settings with high levels of flu vaccination there are lower rates of flu-like illness, fewer outbreaks and fewer deaths in people aged 65 years and older
- Getting the flu vaccine provides information on GPs/Pharmacies providing flu vaccine to HCWs



When you get your flu vaccine, you are playing your part in protecting yourself and your family, and in preventing the spread of flu to vulnerable patients and colleagues.

COVID-19 vaccination programme





What groups are recommended to get a COVID-19 vaccine in autumn/winter 2026/2027

- **All aged 60 years and older**
- **All aged 18 years and older living in a long term care facility for older adults**
- **All aged 6 months and older with immunocompromise associated with a suboptimal response to vaccination**
- **All aged 6 months and older with a medical condition associated with a higher risk of hospitalisation, severe disease or death due to COVID-19: (NIAC Chapter 5a - Table 5a.1)**
  - Cancer, Chronic heart disease, Chronic kidney disease, Chronic liver disease, Chronic neurological disease, Chronic respiratory disease, Diabetes and other metabolic disorders, including inherited metabolic disorders, Haemoglobinopathies, Body mass index ≥ 40kg/m^2, Serious mental health conditions, Children and adults with Down syndrome, Children with moderate to severe neurodevelopmental disorders
- **Healthcare workers who are in the groups listed above are recommended to get a COVID-19 vaccine in autumn/winter 2026/2027**
- **Anyone aged over 18 years who is not in any of the groups listed above, can get a COVID-19 vaccine in autumn/winter 2026/2027 if they choose to, following discussion with a healthcare professional**
- There should be at least a **3 month interval** between the last COVID-19 vaccine or the last COVID-19 infection before getting vaccinated
- **Outside of the autumn/winter COVID-19 vaccination programme, COVID-19 vaccines should also be available where clinically indicated, including but not limited to pregnancy, previously unvaccinated, or new period of immunosuppression**

Rationale for vaccination: COVID-19

- Older age and the presence of a medical condition significantly increases the risk of COVID-19 hospitalisation, severe disease and death

- **COVID-19 vaccines are effective in preventing hospitalisations, severe disease, death**

- **The protection that vaccines afford against infection, and mild disease wanes quickly**
- However the protection against **severe disease is more durable,** but it **wanes gradually over time**
    - Increasing the risk for those susceptible to severe disease as time from last vaccine increases

- Protection wanes more rapidly in older age groups
    - Particularly in those aged 80 years and older and in those with immunocompromise

FAQs: COVID-19

What are the key messages for HCWs regarding COVID-19 vaccination?

- While vaccine recommendations for healthcare workers have changed since the vaccine was introduced vaccination remains the **best protection we have** against the serious complications of COVID-19
- **All healthcare workers who are in a risk group (e.g. aged 60 and older, or with an underlying medical condition) should get vaccinated**
- HCWs under the age of 60 years without comorbidities (underlying medical conditions) are now at low risk of severe COVID-19
- Healthcare workers have a high exposure risk to COVID-19, **any healthcare worker who wishes to get a COVID-19 vaccine can do so**
- Vaccine recommendations for healthcare workers are constantly kept under review by NIAC and updated aligned with the latest evidence
- COVID-19 vaccines may be available in workplaces and are also available for free from GPs/Pharmacies

FAQs: COVID-19

How long do I need to wait before getting vaccinated if I have recently had COVID-19?

- For most people, COVID-19 vaccines can be given **at least 3 months** following the last SARS-CoV-2 infection or COVID-19 vaccination

Can I get both flu and COVID-19 vaccines at the same time?

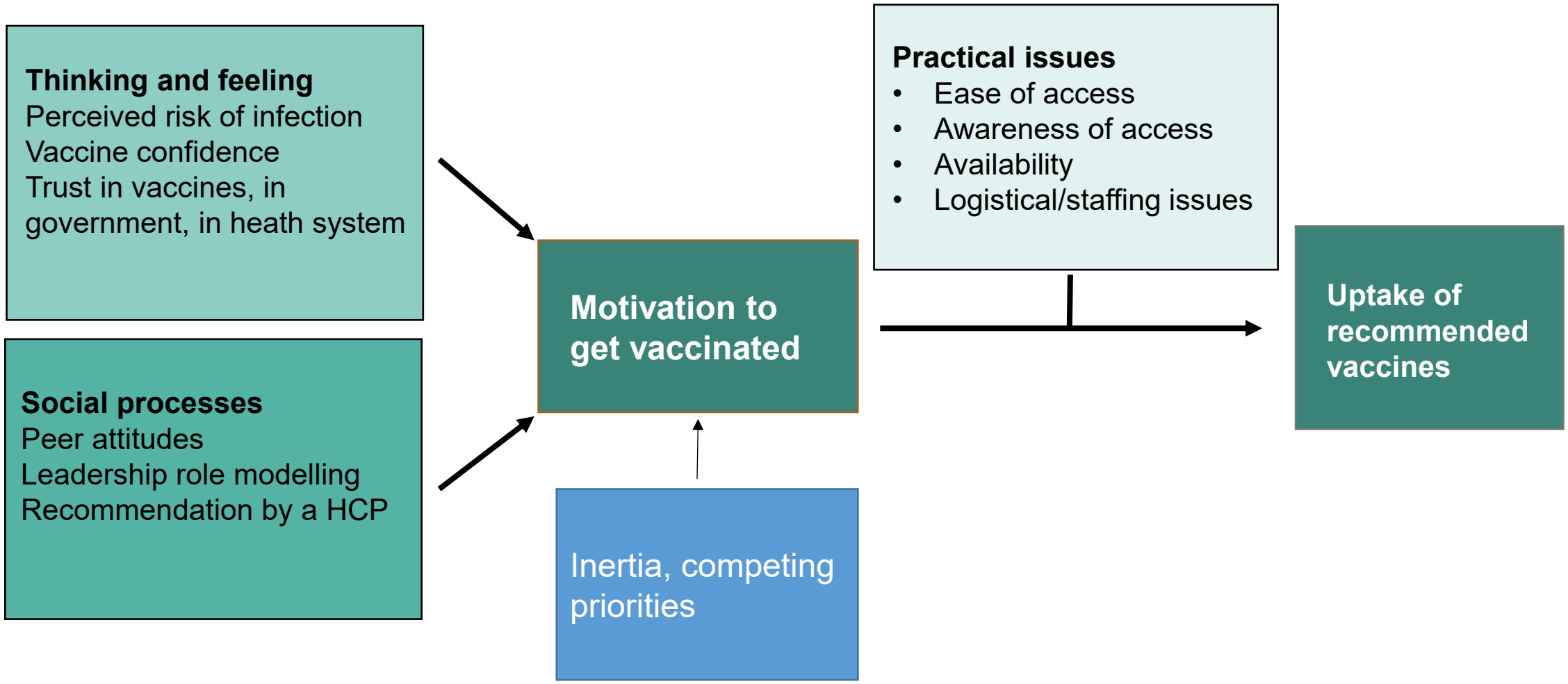
- NIAC advise that COVID-19 and adult seasonal influenza vaccines should be co-administered where practicable, to maximise uptake
- **You can get influenza and COVID-19 vaccines at the same time or at any interval**
- If you get both vaccines at the same time there may be a slight increase in short term mild adverse events after co-administration with a seasonal influenza vaccine including pain at the site of injection, fatigue, headache, and myalgia
- There are no safety or efficacy concerns with co-administration

Improving vaccine uptake in HCWs





Behavioural and social drivers of vaccination in HCWs



Adapted from WHO BeSD framework

Improving vaccine uptake in HCWs

- Literature review identified key priority areas of focus to inform the strengthening and the development of tailored multifaceted approaches to improve vaccine uptake in HCWs for winter season in Ireland
- There is a positive association between interventions and HCW vaccine uptake and **most interventions increase vaccination rates particularly by combining interventions in different areas**
- The **key priority areas** of focus to improve vaccine uptake should be:
  - Removing any and all **access** barriers to vaccination
  - Strengthening visible **clinical leadership**
  - A focus on supportive workplace strategies **that build and maintain trust** is important
  - Ensuring that there is **clear, consistent and accessible messaging** that emphasises the benefits of vaccination for HCWs
  - Offering **personalised** vaccine **invitations and reminders** for HCWs
- Multifaceted interventions to improve HCW vaccine uptake should be informed by the **priority areas identified and tailored locally** to the requirements of different professional groups in a variety of clinical settings

I am a manager, how can I increase uptake in healthcare workers?

- **Improve access**
  - Remove any and all barriers to vaccination e.g., facilitate flexible onsite access (peer to peer/mobile vaccination units)
  - Ensure there are multiple opportunities for staff to get vaccinated including extended hours for those working shifts and out of regular working hours

- **Ensure clear communication to improve awareness**
  - Ensure that all staff are informed about the multiple routes of access to vaccination for healthcare workers, including vaccine clinics on site, GP practices and community pharmacies.
  - Ensure that there is visible promotion of flu vaccine among staff, e.g., have HSE information materials like posters and leaflets on display
  - Regularly communicate updates to staff about flu and vaccination clinic times, for example, email/text reminders, by weekly newsletters or via your organisation's website and social media posts

I am a manager, how can I increase uptake in healthcare workers?

- **Have strong leadership**
  - Ensure that line managers facilitate staff to avail of any opportunity to get vaccinated
  - Ensure strong and visible leadership support, including peer leadership and support and enable peer vaccination

- **Promote and encourage vaccination**
  - Communication should promote clear factual messages about the benefits of vaccination and vaccine invitations and reminders to staff should be personalised where possible
  - Make sure healthcare workers know that the vaccine is free of charge for them, no matter where they access the vaccine
  - Acknowledge high-uptake units/wards and units with improvements
  - Consider incentives such as free coffee, raffles and prizes for vaccinated staff

Summary: Key messages for HCWs in autumn/winter 2026/2027

- Each winter, healthcare workers have a **high risk of exposure** to respiratory viruses including flu and COVID-19
- These highly infectious viruses put **staff at risk** of illness
- The **flu vaccine is strongly recommended** for all healthcare workers - **provides healthcare workers with the best available protection** against the serious complications of flu
- Getting vaccinated also protects others and reduces the chances of spreading the flu infection to family members, colleagues and patients, many of whom may be more vulnerable to serious complications
- **Healthcare workers** aged 60 years and older or healthcare workers with underlying health conditions putting them **at risk of severe COVID-19 infection** and **are recommended to get a COVID-19 vaccine** in autumn/winter 2026/2027
- **Any healthcare worker who wishes can receive a COVID-19** vaccine in autumn/winter 2026/2027
- Flu and COVID-19 vaccines are **available free of charge for all healthcare workers, and can be given at same visit**
- Vaccines will be available in staff vaccination clinics and in GP and Pharmacies

Respiratory Syncytial Virus (RSV) immunisation – Pathfinder 3.0

- Common respiratory virus that causes mild, cold-like symptoms
- RSV infection an be serious, especially for infants.
- Complications: LRTI, bronchiolitis/pneumonia, difficulty feeding
- **1 in 2 babies get RSV each season** - without immunisation, 1-3% of infected infants require hospitalisation with some requiring ICU treatment

- RSV season in Ireland usually begins in September and subsides in February
- In 2024/2025 RSV immunisation with **Nirsevimab** Pathfinder 1.0
- Monoclonal antibody - passive protection with a **duration of action of 5 months**
- Compared with 2023/2024 RSV immunisation to infants:
  - 65% decrease in cases
  - 57% decrease in ED presentations,
  - 76% decrease in hospitalisations
  - 65% decrease in ICU admissions

Respiratory Syncytial Virus (RSV) immunisation – Eligibility Criteria 2026/2027

- **Birth Cohort -** All infants born during the RSV season **- Maternity settings***
  - Infants born1st September 2026 to 28th February 2027 inclusive
- **Catch up Cohort -** All infants aged <6 months at the start of the RSV season **– GP practices**
  - Infants born 1st March 2026 to 31st August 2026 inclusive
- **High Risk Cohort – HSE Mobile Vaccination Teams** on referral from Paediatrician
  - All high risk infants (outlined NIAC Chapter 18a - Table 18a.3) aged <12 months at the start of their first RSV season.
  - All ex-preterm infants aged under 24 months of age with chronic lung disease (CLD) in their second RSV season
  - Severely immunocompromised infants under 24 months during the RSV season may also be considered for nirsevimab in consultation with their treating specialist.

- Parents of birth cohort who decline in maternity setting can avail in General Practice during the RSV season

Thank you

Thank you for protecting our population from vaccine preventable diseases



Winter Ready Guide



Community Support Team

Ms Carole King
Director of Nursing - Community Support Team, HSE West North West

Conflict of Interest Declaration: *I have no conflicts of interest to declare*

Winter Ready Guide

Winter Preparedness for Private Residential Care Facilities

Key Aim: Prepare, protect and support residents, staff and services during the winter respiratory virus season.

Focus Areas: **Plan & Prepare, Educate, Vaccinate, Monitor & Control.**

Our Winter Readiness Objectives

- Protect residents and staff
- Reduce the risk and impact of outbreaks
- Promote vaccination uptake
- Strengthen infection prevention and control practices
- Support service continuity throughout winter
- Build confidence and preparedness across all staff groups



Be Prepared Before the First Case Occurs. Preparedness plans should be reviewed now rather than during an outbreak. Ensure all staff understand their roles and responsibilities.

- Maintain an up-to-date Winter Preparedness Plan aligned with AMRIC guidance.
- Include outbreak management, isolation, staffing resilience and communication plans.
- Ensure adequate stocks of PPE, Alcohol Based Hand Rub, testing kits and other essential consumables.

Regulatory Requirements

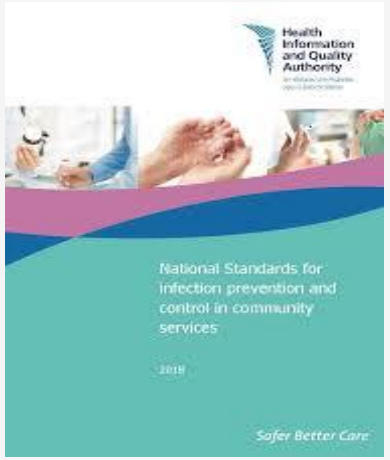
Regulation 27 of the Health Act 2007 requires residential care facilities to have effective Infection Prevention and Control (IPC) measures in place and ensure these are implemented by all staff.

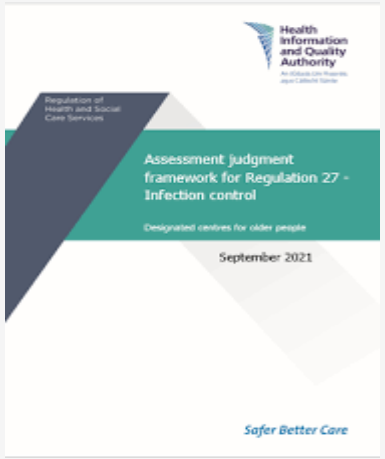
Services must comply with **HIQA standards and guidance** relating to the prevention and control of healthcare-associated infections.

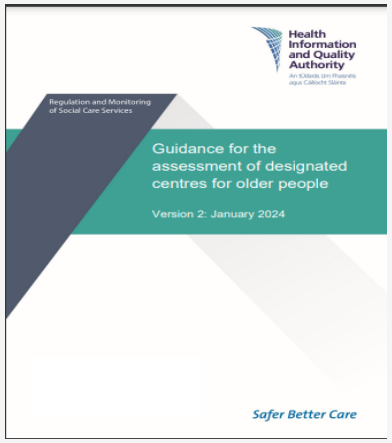
The **HIQA National Standards for IPC in Community Services (2018)** require services to identify, manage, control and document outbreaks promptly and effectively.

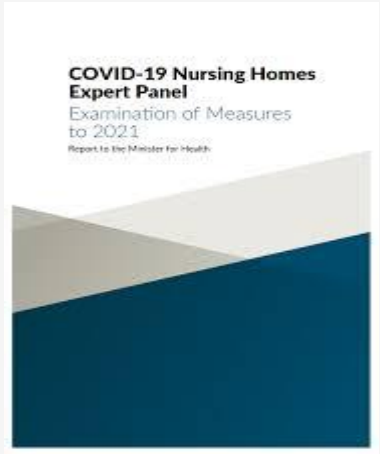
Strong governance arrangements must be in place to support safe care and effective infection prevention and control.











Winter Ready Guide

Resource Planning

Staff



- Symptom vigilance - staff are aware of who they report symptoms to and not to report to work if unwell.
- Staff replacement– agencies/staff pool/contact details
- Staff on designated floors/areas – no crossover during outbreaks
- Designated break facilities – can the staff areas be separated
- Changing and Rest rooms – cleaning protocols, staff uniforms
- Staff access to information - outbreak guidance documents from HPSC, Line listing, HSE AMRIC guidance documents, posters and relevant websites.
- Access to relevant websites and the most up-to-date Winter Preparedness in Nursing Homes (contents apply to all types of residential care facilities) https://www.hpsc.ie/a-z/winter/winterpreparednessinnursinghomes/

PPE

- Ensure that you have adequate stocks of PPE. HSE will provide for contingency and again if in outbreak.
- Ensure to restock after outbreak

Laboratory Testing



- Ensure awareness of local laboratory pathways for Acute Respiratory Infection testing.
- Maintain access to multiplex testing for Influenza, COVID-19 and RSV.
- Ensure your Nursing Home has a stock of 6-10 onsite in advance.
- Educate staff to take a swab correctly. https://www.youtube.com/watch?v=xv7PJbMFPZg&feature=emb_logo
- Arrangements for transporting the specimen to the lab
- COVID-19 Antigen testing is no longer recommended

Communication

- Ensure clear communication pathways for residents, families, staff, CST and Public Health.

Winter Ready Guide

Managing the First Case

- Isolate the resident immediately.
- Test as clinically indicated.
- Notify GP.
- Begin line listing.
- Complete outbreak risk assessment
- Escalate in accordance with local procedures.

Key Contacts

- Facilities Senior Managers/persons in charge
- Medical Officers/GPs Out of Hours GP Service/EDITH Service
- HIQA/ Mental Health Commission
- Department of Public Health
- Infection Prevention and Control Service
- Community Support Team / Covid Response Team
- Vaccination Team
- Laboratory
- Relevant Managers/Services responsible for maintenance, waste, laundry.
- Pharmacy/Supplies
- PPE Ordering
- Agencies/staff contacts

- **IPC will be covered in greater detail by Dr Eimear Brannigan**
- Hand Hygiene
- Environmental Hygiene
- Equipment
- Waste Management





Winter Ready Guide

Education & Training-Building Staff Knowledge and Confidence

Key Training Areas
- Hand hygiene
- Respiratory hygiene
- Cough etiquette
- Appropriate PPE use
- Donning and doffing procedures

Winter Education Priorities
- Multiplex PCR testing
- Current IPC guidance
- Antiviral guidance
- Outbreak management procedures

Staff Responsibilities
- Stay up to date with HSELand and AMRIC Hub training.
- Do not attend work if experiencing respiratory symptoms.

Resident Education
- Promote hand hygiene and respiratory etiquette among residents.

Regular refresher training ensures staff remain confident and prepared to respond effectively to respiratory infections.

Respiratory Viral Infection Resource Pack
- Algorithm for testing for ARI in RCF
- IPC and PH Guidance for outbreaks
- Guidance on testing for ARI in RCF
- Quick Reference Poster –guidance for Resp outbreaks
- Winter Preparedness and Outbreak Management Checklist from HPSC https:www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance/

Vaccination Strategy-Vaccination Saves Lives

Residents

Offer: Seasonal Influenza Vaccine
COVID-19 Vaccine

Healthcare Workers

- Offer: Influenza Vaccine
  COVID-19 Vaccine

Supporting Uptake

- Provide easy access to vaccination.
- Support shift and night staff attendance.
- Use peer vaccinators/HSE Vaccination Team
- Promote vaccination through leadership and education.

The Role of the IPC Champion/Link Nurse Practitioner
Named staff member, Protected time,
Ensure that current legislation, standards and guidance are followed.
IPC policies and procedures are in place and regularly reviewed.
Staff receive appropriate education and training.
Audits, monitoring and quality improvement activities are undertaken.
Contingency and preparedness plans are maintained and tested. hand hygiene training & audits, donning & doffing spot checks.
Certification & staff training database. Signage prep in advance

Community Support Team (CST)
The CST supports Residential Care Facilities by:
Building capacity for prevention, preparedness and outbreak management.
Providing advice and guidance on IPC and outbreak control.
Working collaboratively with Public Health, Infection Prevention and Control teams, and healthcare providers.
Supporting and contributing to the wider Public Health response during outbreaks

Key Take Home Messages

PREPARE
Review plans and resources.

EDUCATE
Keep staff informed and trained.

VACCINATE
Maximise uptake among residents and staff.

MONITOR
Identify risks early.

CONTROL
Act quickly to prevent transmission.

"The best managed outbreak is the one that is prevented."

Infection Prevention and Control
Fundamental principles



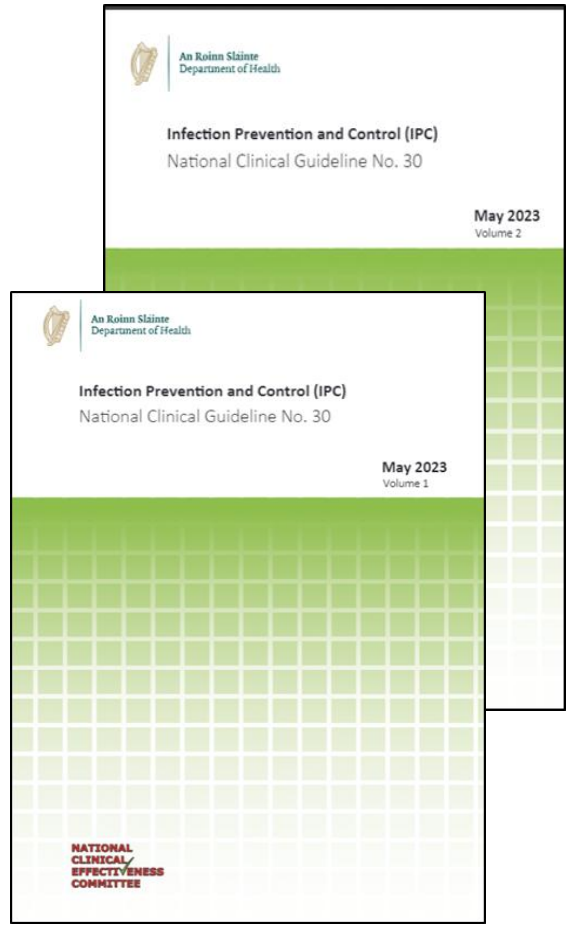
AMRIC

Dr Eimear Brannigan
Clinical Lead, Antimicrobial Resistance and Infection Control

Conflict of Interest Declaration: *I have no conflicts of interest to declare*

IPC Measures – Available Guidance

We are all familiar with the tools to protect ourselves and others from other respiratory infections



Build on knowledge & experience throughout the pandemic on how you can prevent the spread of infection

Use available resources:

- Infection Prevention and Control (IPC) National Clinical Guidelines No. 30
- AMRIC Guidance and Public Health Guidance hosted on HPSC.ie

Planning for Winter – IPC Considerations

There are 3 scenarios that we will all face over the coming months that we need to prepare for:

- Notice that respiratory viruses levels are high in the general community
- A resident or staff member displaying signs and symptoms of infection
- An outbreak of respiratory illness in your setting

Scenario 1

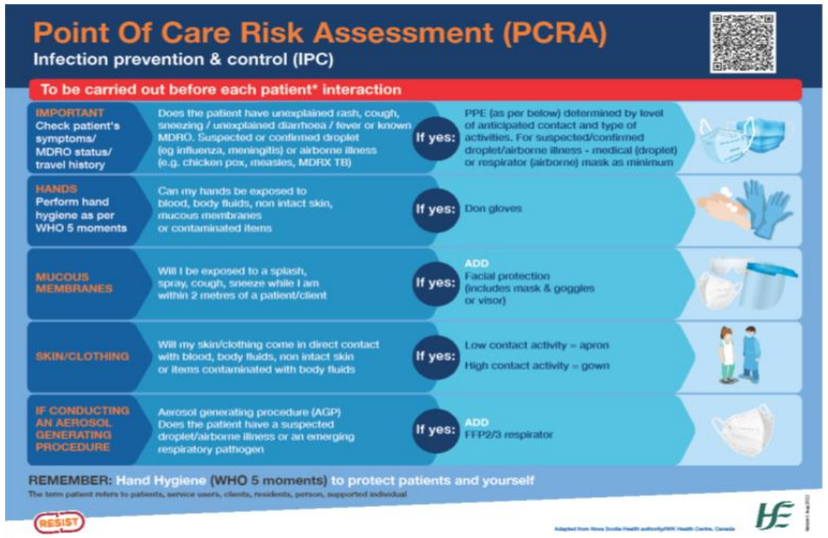
Notice that respiratory viruses levels are high in the general community



IPC Measures – Standard Precautions

Key SP Points:

- Good hand hygiene
- Promote cough and respiratory etiquette
- Consideration of patient/resident placement
- Enable natural ventilation to the greatest extent possible
- Use the Point of care risk assessment (PCRA) resources to support selection of PPE



Staff, visitors or other service providers with signs and symptoms of respiratory infection should stay away from health & care settings until symptoms have resolved – educate and inform everyone who visits your service why this is important

Surgical masks are used as part of standard precautions to keep splashes or sprays from reaching the mouth and nose of the person wearing them

Encourage staff, residents and visitors to be up to date with vaccinations

Scenario 2

A resident or staff member displaying signs and symptoms of infection



IPC Measures - Transmission Based Precautions

Key TBP Points:

- Apply transmission based precautions where required
- Patients known or suspected to have influenza virus: droplet precautions required
- Wear **surgical mask** when caring for patients who are known or suspected to have respiratory viral infection
- Wear **respirator masks (FFP2/3)** during Aerosol Generating Procedures for patients who are known or suspected to have respiratory viral infection:
  - Should be fit tested and regularly fit checked
  - Inappropriate use may lead to reduction of supply for appropriate use.







Duration of TBP

The period of isolation and application of transmission-based precautions for respiratory viruses is currently ***a minimum of 5 days from onset of symptoms or date of positive result*** (whichever first).

If the resident has no or minimal residual symptoms for two days, transmission based precautions can be discontinued not less than 5 days from date of symptom onset based on risk assessment. Extension beyond 5 days may be appropriate based on experience and an assessment of local risks and is generally appropriate in people who are immunosuppressed or following consultation with their clinical team

For patients receiving of antiviral therapy for the treatment of influenza, the period of transmission based precautions is not less than 72hrs after antiviral treatment began.

Scenario 3

An outbreak of respiratory illness in your setting



IPC Considerations - Outbreak

- Standard and Transmission Based precautions
- Zoning of areas
- Allocating staff / avoiding staff crossover
- Communication with residents/patients – limit the harm done.
- Communication with visitors – residents have a right to see their loved ones, how can this be managed in your setting?
- Staffing – have contingency plans in place
- Engagement with IPC / Public Health for advice

Additional Supports and Resources

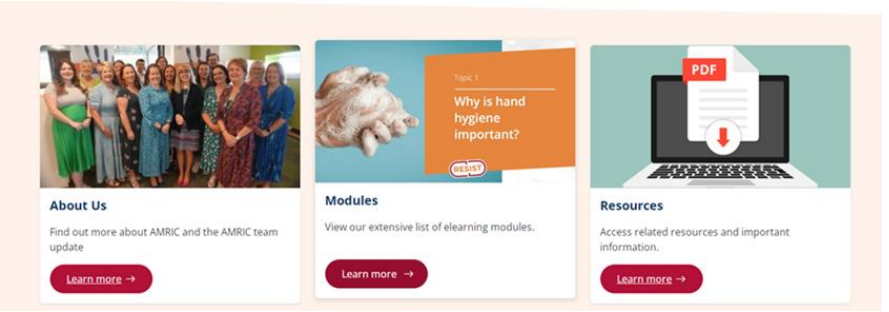


eLearning resources



Significant resources and training modules are available on the AMRIC hub of HSeLanD for staff to access







IPC Measures: Poster resources

There are a range of posters available to you on the HPSC website

Transmission based precautions posters have been added to the suite this year to standardise the message around contact, droplet and airborne precautions

Posters were developed in partnership with colleagues working in acute and community settings to ensure they are relevant in all health and social care environments



AMS key messages

AMS

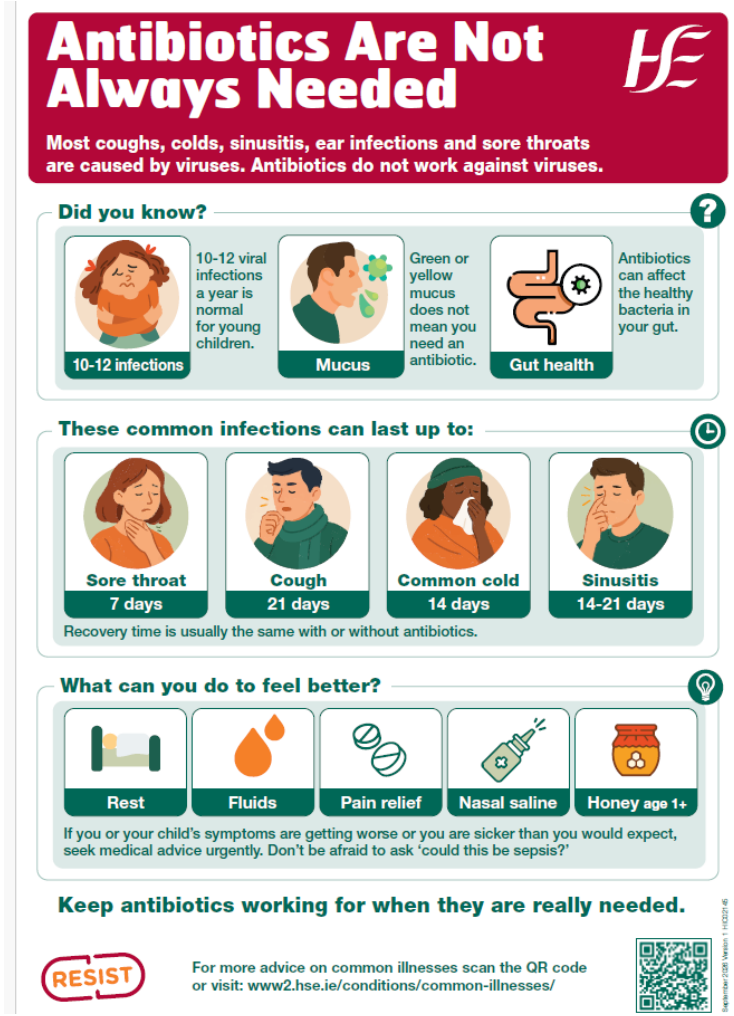
- Many RTIs are viral or self-limiting, and do not require antibiotic treatment. Most cases of otitis media, sore throat, sinusitis, and bronchitis are self-limiting and do not routinely need antibiotics.
- If an antibiotic is required the most up to date evidence suggests that for RTIs a 5 day course is as effective as 7 days. HSE national antibiotic prescribing guidance now recommend a treatment duration of 5 days for community acquired pneumonia. In addition, if antibiotics are indicated according to guidance, the treatment duration recommended for acute sinusitis, tonsillitis/pharyngitis and infective exacerbation of COPD is 5 days.

AMS key messages

AMS

- For patients in acute hospitals:
  - Oral antimicrobial therapy should be prioritised for patients over intravenous therapy whenever possible. Note: 1 in 5 patients in Route tPPS 2025 could have antibiotic stopped.
  - Position statement: Piperacillin-tazobactam is NOT indicated for treatment of community acquired pneumonia
- For patients in residential care facilities: RTI guidelines specifically for residents in RCFs on antibioticprescribing.ie. Note the ceftriaxone position statement: Ceftriaxone is NOT recommended in empiric guidelines for the treatment of infections in community settings* and should NOT form part of routine antimicrobial prescribing practice in LTCFs.

AMS resources



Antibiotics Are Not Always Needed

Most coughs, colds, sinusitis, ear infections and sore throats are caused by viruses. Antibiotics do not work against viruses.

Did you know?

- **10-12 infections** — 10-12 viral infections a year is normal for young children.
- **Mucus** — Green or yellow mucus does not mean you need an antibiotic.
- **Gut health** — Antibiotics can affect the healthy bacteria in your gut.

These common infections can last up to:

- **Sore throat** — 7 days
- **Cough** — 21 days
- **Common cold** — 14 days
- **Sinusitis** — 14-21 days

Recovery time is usually the same with or without antibiotics.

What can you do to feel better?

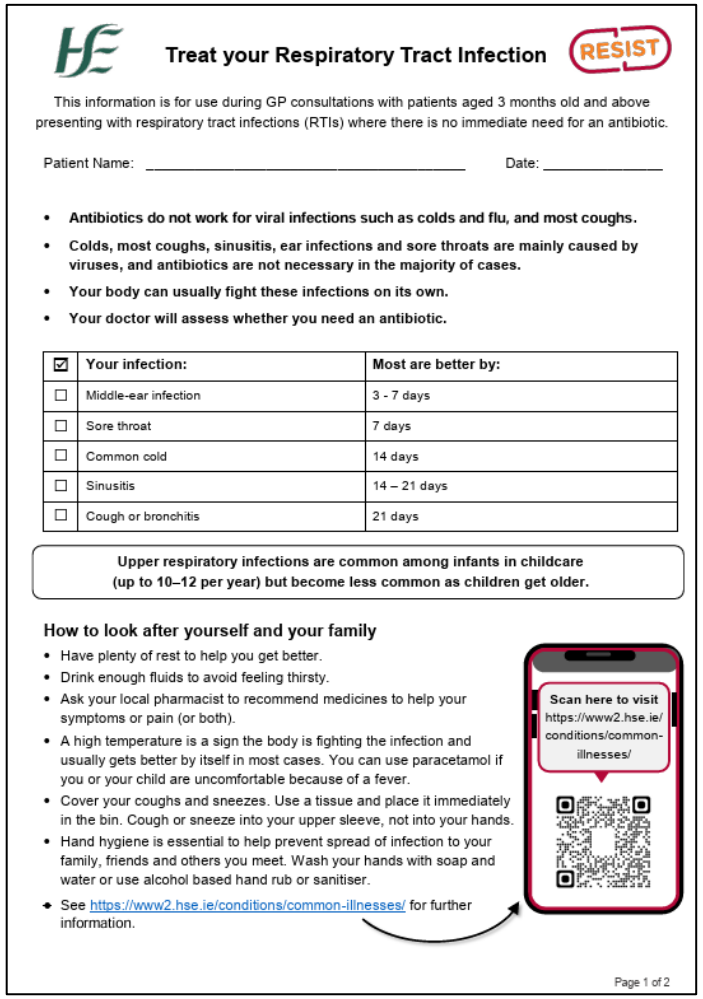
- Rest
- Fluids
- Pain relief
- Nasal saline
- Honey age 1+

If you or your child's symptoms are getting worse or you are sicker than you would expect, seek medical advice urgently. Don't be afraid to ask 'could this be sepsis?'

Keep antibiotics working for when they are really needed.

RESIST

For more advice on common illnesses scan the QR code or visit: www2.hse.ie/conditions/common-illnesses/



Treat your Respiratory Tract Infection

RESIST

This information is for use during GP consultations with patients aged 3 months old and above presenting with respiratory tract infections (RTIs) where there is no immediate need for an antibiotic.

Patient Name: _____ Date: _____

- **Antibiotics do not work for viral infections such as colds and flu, and most coughs.**
- **Colds, most coughs, sinusitis, ear infections and sore throats are mainly caused by viruses, and antibiotics are not necessary in the majority of cases.**
- **Your body can usually fight these infections on its own.**
- **Your doctor will assess whether you need an antibiotic.**

☑	Your infection:	Most are better by:
☐	Middle-ear infection	3 - 7 days
☐	Sore throat	7 days
☐	Common cold	14 days
☐	Sinusitis	14 – 21 days
☐	Cough or bronchitis	21 days

Upper respiratory infections are common among infants in childcare (up to 10–12 per year) but become less common as children get older.

How to look after yourself and your family

- Have plenty of rest to help you get better.
- Drink enough fluids to avoid feeling thirsty.
- Ask your local pharmacist to recommend medicines to help your symptoms or pain (or both).
- A high temperature is a sign the body is fighting the infection and usually gets better by itself in most cases. You can use paracetamol if you or your child are uncomfortable because of a fever.
- Cover your coughs and sneezes. Use a tissue and place it immediately in the bin. Cough or sneeze into your upper sleeve, not into your hands.
- Hand hygiene is essential to help prevent spread of infection to your family, friends and others you meet. Wash your hands with soap and water or use alcohol based hand rub or sanitiser.
- See https://www2.hse.ie/conditions/common-illnesses/ for further information.

Scan here to visit https://www2.hse.ie/conditions/common-illnesses/

Page 1 of 2

Available for order on healthpromotion.ie

Download from antibioticprescribing.ie or order by email hcai.amrteam@hse.ie

And finally International Infection Prevention Week (IIPW)

International Infection Prevention Week (IIPW) takes place from October 18–24, with the theme "*Generations of Infection Prevention* | *Past. Present. Protected*."

IIPW '26 aims to raise awareness about infection prevention, celebrate infection prevention and control teams, and promote evidence-based practices to reduce healthcare-associated infections. Infection prevention is a vital part of providing safe healthcare.



Remember:

✓ Keeping patients safe from infection is everyone's responsibility

✓ HSE 'hand hygiene' training is mandatory for all HSE staff and staff in HSE funded services

Acute respiratory infections

A practical update for health and care staff

National guidance • Autumn / Winter 2026–27



Dr. Scott Walkin

HSE/ICGP Antimicrobial Resistance & Infection Control GP Clinical Lead

Conflict of Interest Declaration: *I have no conflicts of interest to declare*

Four plus one practical learning outcomes

Irish College of GPs

Decide when respiratory virus testing will change care.

Identify who needs assessment for antiviral treatment.

Explain when influenza prophylaxis needs urgent action.

Support appropriate prescribing and self-care.

Vaccinate, vaccinate, vaccinate!

Presentation and the first assessment

Usual presentation

New cough, sore throat, breathlessness

Influenza like illness if there is also:

Sudden onset of symptoms.
Systemic symptoms: At least one of fever or feverishness, malaise, headache, or myalgia.

Older or vulnerable people

New confusion, lethargy, poor appetite
or a change from usual function.
Fever may be absent.

Acute deterioration needs prompt clinical assessment. Critical illness: emergency response / 112 or 999.

The testing decision

Irish College of GPs

What will the result change?

Treatment or prophylaxis
Infection prevention and patient placement
Outbreak response or public health action



Mild illness with no change in care usually needs no test.

National ARI testing guidance v1.0, 17 September 2026, sections 5–6

Testing depends on the setting

Setting	Practical approach
Primary care	Usually no test for mild illness. Consider testing when risk or treatment decisions justify it.
Acute hospital	Test when results guide treatment, placement or infection control.
Residential care	Test relevant symptomatic residents. Initially up to five in a suspected outbreak.
Other congregate settings	Target testing through clinical assessment and public health risk assessment.

The right test

Minimum preferred panel

Influenza A + B, SARS-CoV-2 and RSV

Laboratory multiplex PCR / NAAT is preferred.

Rapid molecular testing needs approved governance and trained staff.

Antigen tests cannot replace indicated molecular testing.

National ARI testing guidance v1.0, sections 5.2–5.4 and 6

Influenza treatment: the revised approach

Non-severe influenza

Routine antivirals are not recommended, including for high-risk patients.*

Severe influenza

Urgent clinical assessment. Early oseltamivir is usually first-line treatment.

When treatment is indicated, avoid waiting for PCR confirmation.

Severe immunocompromise, critical care and suspected resistance need the specific guidance and specialist input.

HSE influenza antiviral guidance v4.1, 29 September 2026, sections 2.1–2.3

Influenza prophylaxis after exposure

Asymptomatic contacts

Outside an outbreak: consider eligibility at extremely high risk.
Age ≥85 years, or multiple major risk factors at any age.

In health and care outbreaks: assess all exposed individuals
through the public health risk assessment, regardless of vaccination.

Oseltamivir: start promptly, normally within 48 hours of last exposure.

A care-home scenario

Two residents on the same corridor develop respiratory symptoms over three days.

What needs to happen today?

Assess each resident and introduce appropriate IPC precautions.

Notify IPC / Public Health and arrange early outbreak testing.

Assess treatment for ill residents and prophylaxis for exposed contacts.

In a GP setting – Antimicrobial Stewardship

Most acute cough / bronchitis needs no antibiotic

Explain likely recovery: cough typically lasts about 3weeks.

Offer suitable symptom relief, fluids and rest.

Consider isotonic nasal saline for upper respiratory symptoms.
Two sprays per nostril six times daily

Agree when and where to seek reassessment. Give the TYI leaflet.

Suspected pneumonia or COPD exacerbation needs its own pathway.

Applying the update in your service

For the next person with ARI…

Is there a change from baseline that needs assessment?

Which care decision would a test support?

Does the person need the treatment or contact pathway?

Who will act today, and what is the follow-up plan?

Current guidance and practical tools on the next slide

Guidance and practical tools

ARI testing guidance and setting-specific algorithms

17 September 2026

Influenza treatment and chemoprophylaxis

Version 4.1 • 29 September 2026

Influenza post-exposure prophylaxis algorithm

Version 1.0 • 17 September 2026

Pregnancy and postpartum influenza guidance

Version 7.0 • 17 September 2026

HSE prescribing guidance and TYI leaflet

Condition-specific prescribing and patient advice

NATIONAL WINTER PREPAREDNESS WEBINAR FOR HEALTH & CARE SETTINGS

Recognise, notify, manage

Practical approaches to respiratory infection outbreaks, based on current HPSC and National Health Protection Office guidance



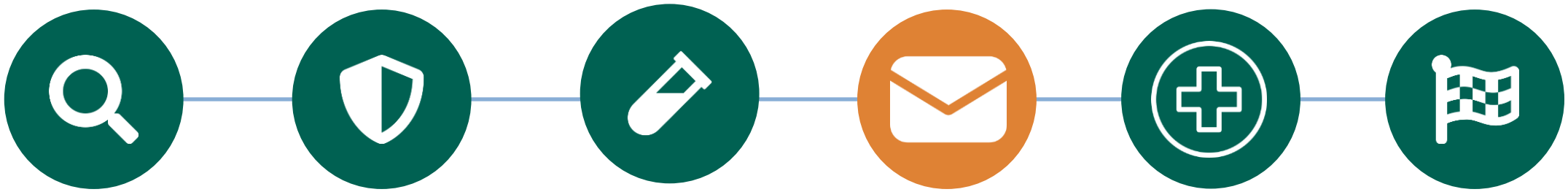
Public Health

Dr Michael Hanrahan
Consultant in Public Health Medicine, Department of Public Health, HSE South West

Conflict of Interest Declaration: *I have no conflicts of interest to declare*

Overview

What every setting should be able to do this winter



Recognise

Spot cases early, including atypical presentations

Control

Isolate, protect, cohort, protect staff and residents

Test

Swab to identify the pathogen, not every case

Notify

Contact Public Health when an outbreak is suspected

Manage

Control the outbreak

Close

Close with Public Health and review lessons

Key principle: do not wait for laboratory results before starting control measures [2]

[2] HSE AMRIC. Public Health and IPC guidance on respiratory viral infections in RCFs, V2.3, 2025

Recognise

Case of acute respiratory infection (ARI)

- Sudden onset of symptoms
- AND at least one of cough, sore throat, shortness of breath or coryza
- AND a clinician's judgement that the illness is due to infection

Outbreak trigger

2 or more

ARI cases in epidemiologically linked people within a 5-day window.

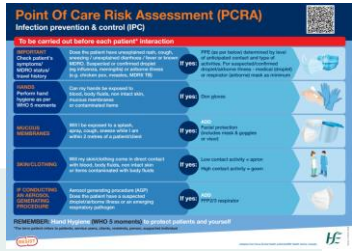
Active surveillance: check residents twice daily for new symptoms or change from baseline, and treat a rise in staff sickness absence as an early signal [2]

Older residents often present atypically

- Lethargy
- New or increased confusion
- Falls or a change from baseline
- Loss of appetite

[1] HSE NHPO. National Guidance for ARI Testing, V1.0, 2026 [2] HSE AMRIC. RCF respiratory viral infection guidance, V2.3, 2025

Control Measures



Isolate

Single room with transmission-based precautions from symptom onset; door closed where safe; improve ventilation.

Protect

PPE by point of care risk assessment: surgical mask or respirator at minimum; respirator and eye protection for longer or close care.

Organise

Hold a local incident meeting, start a line list of ill residents and staff, and agree whether an Outbreak Control Team is needed.

Cohort

Only if needed, and only by confirmed pathogen. Do not mix suspected with confirmed cases, or COVID-19 with influenza or RSV.

Staff

Staff should not work with new respiratory symptoms; start-of-shift symptom check; do not work in another facility during an outbreak; hand hygiene and respiratory etiquette.

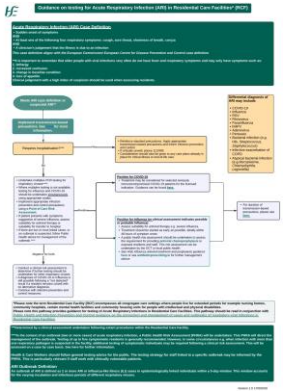
Visiting

Restrict only on documented risk assessment. Never a total withdrawal: at least one visitor at a time, end of life visits always. Inform and advise visitors of the outbreak.

Source: [2] HSE AMRIC. Public Health and IPC guidance on respiratory viral infections in RCFs, V2.3, 22 Oct 2025

Test

New national ARI testing guidance for Autumn/Winter 2026/27 [1]



Up to

5

symptomatic residents is generally enough to identify the pathogen in a suspected outbreak. After that, people meeting the case definition are probable cases.

Do

- ✔ Test when the result will change treatment, IPC or outbreak action
- ✔ Multiplex PCR covering SARS-CoV-2, influenza A and B, and RSV as a minimum
- ✔ One deep nasal or nasopharyngeal swab per resident, taken by trained staff
- ✔ Keep 5 to 10 in date viral swabs and request forms on site [5]

Avoid

- ✘ Anterior nasal swabs (not a high-quality sample)
- ✘ Rapid antigen tests in place of molecular testing
- ✘ Testing asymptomatic residents or contacts
- ✘ Testing every new case once the pathogen is known, or clearance swabs [2]

[1] NHPO National Guidance for ARI Testing, V1.0, 17 Sep 2026 [2] AMRIC RCF guidance V2.3, 2025 [5] HPSC Winter Preparedness in Nursing Homes

Notify

Regional Department of Public Health

There is a legal duty to notify the Department of Public Health of any outbreak. The Medical Officer of Health (Department of Public Health) declares the outbreak.

Infection prevention and control

Inform your IPC team or community IPC nurse at the same time and link with your Community Support Team for extra help [1,2].

Regulator

Registered providers notify the Chief Inspector (HIQA, form NF02) or the Mental Health Commission, as appropriate [2,7].

Transfers

Before transferring a resident, tell the National Ambulance Service and the receiving hospital about the suspected or confirmed outbreak [2]. Residents can return from hospital after a risk assessment, and transfers shouldn't be delayed while waiting for test results.

[1] NHPO ARI Testing, 2026 [2] AMRIC RCF guidance V2.3, 2025 [6] Infectious Diseases Regulations 1981, as amended [7] HIQA notification forms

Manage the outbreak

Assess spread

- Could onward spread have happened in the 48 hours before onset? Shared room, mobile, communal areas or group activities
- Are other residents or staff unwell, or is staff absence rising?
- Identify close contacts of influenza cases for possible prophylaxis

Coordinate

- Local incident meeting: nursing, medical, housekeeping and allied health staff
- Public Health decides if an outbreak is declared; an OCT may be convened
- Inform HIQA or the Mental Health Commission as appropriate

Monitor

- Twice-daily symptom checks for residents and staff until the outbreak is declared over
- A nominated person updates the line list for local monitoring +/- sharing with Public Health and IPC as requested
- Review whether transmission is continuing and controls are working

Communicate and support

- Regular updates for residents, families and staff
- Provide additional training/education for staff on IPC measures
- Small social groups (pods of up to 6) can continue
- Support staff and residents, especially after deaths

Source: [2] HSE AMRIC. Public Health and IPC guidance on respiratory viral infections in RCFs, V2.3, 22 Oct 2025, pages 52 to 60

Control measures: cases, contacts, cleaning

Managing cases

- Clinical assessment and treatment decisions are made by the resident's own doctor
- Single room, ideally ensuite, with transmission-based precautions; otherwise a designated commode or toilet
- Do not transfer to hospital on IPC grounds alone; transfer only when clinically needed
- Daily observations and a care plan for deterioration, including advance care preferences
- Daily access for the nominated support person

Managing contacts

- COVID-19: no contact tracing required in RCFs; PCR test contacts who develop symptoms
- Influenza: monitor contacts for symptoms; no need to isolate or cohort contacts without symptoms
- Consider influenza prophylaxis for all asymptomatic contacts
- Do not cohort contacts with suspected or confirmed cases
- A negative test or vaccination does not rule out infection if symptoms develop

Cleaning and environment

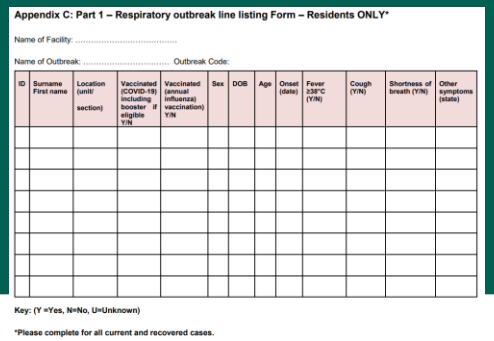
- Dedicated or single-use equipment (blood pressure cuffs, thermometers); clean shared items after every use
- Clean shared spaces with detergent and disinfectant; keep cleaning equipment for isolation areas separate
- Do not vacuum carpets in an infectious resident's room; steam clean after recovery
- Keep charts, kardexes and spare stock out of isolation rooms
- Treat all waste as healthcare risk waste while precautions apply; gentle ventilation, no recirculating fans

Source: [2] HSE AMRIC. Public Health and IPC guidance on respiratory viral infections in RCFs, V2.3, 22 Oct 2025, pages 22 to 27 and 46 to 51

The line list

Line lists

- At the start, list every ill resident and staff member
- Update it as new cases or outcomes occur, and share with Public Health and IPC as requested
- It shows whether transmission is continuing, whether controls are working, and when closure is due
- Keep separate sheets for residents and for staff, using the templates provided



Appendix C: Part 1 – Respiratory outbreak line listing Form – Residents ONLY*

Name of Facility: .....

Name of Outbreak: ..... Outbreak Code:

ID	Surname First name	Location (unit/ section)	Vaccinated (COVID-19) including booster if eligible Y/N	Vaccinated (annual influenza) vaccination) Y/N	Sex	DOB	Age	Onset (date)	Fever ≥38°C (Y/N)	Cough (Y/N)	Shortness of breath (Y/N)	Other symptoms (state)

Key: (Y =Yes, N=No, U=Unknown)

*Please complete for all current and recovered cases.

What to record for each case

Who and where: Name and ID, date of birth or age, sex, resident or staff, unit or section

Protection: COVID-19 and influenza vaccination status, including boosters where eligible

Illness: Date of onset and of notification, symptoms (fever 38°C or above, cough, shortness of breath, other), date isolation started

Testing: Samples taken with dates, test type and result

Outcome: Pneumonia, hospital admission, death, or recovery to usual health, with dates

Staff only: Role and work area, last day worked, any other facility worked in, and date excluded from work until

Source: [2] HSE AMRIC. Public Health and IPC guidance on respiratory viral infections in RCFs, V2.3, 22 Oct 2025, Appendices B and C

Influenza: antivirals are an outbreak control tool

Updated national antiviral guidance, V4.0, 17 September 2026 [3,4]

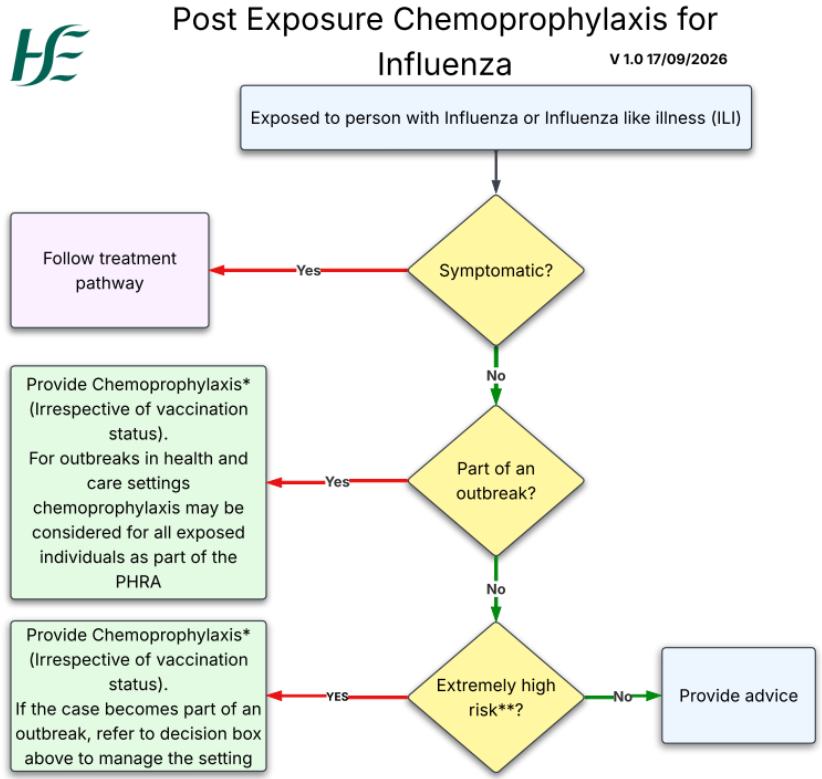
48 h

start prophylaxis within 48 hours of the most recent exposure

10 days

oseltamivir once daily after the most recent exposure (prophylaxis)

Before the season: agree with your pharmacy how you will get oseltamivir quickly, and have renal function documented for residents, so dosing is not delayed [3]



*Initiate as soon as possible after exposure due to the short incubation period of influenza.

**Patients at extremely high risk of hospitalisation are defined as:
- Age 85 years or more; or
- Any age + multiple major risk factors***

Additional risk factors that had an OR of 1.7 - 2 for hospitalisation include:
- malignancy
- pregnancy
- diabetes.

***Multiple major risk factors are those medical conditions associated with an increased risk of influenza-related complications - Cancer; Chronic heart disease; Chronic kidney disease; Chronic liver disease; Chronic neurological disease; Chronic respiratory disease; Diabetes and other metabolic disorders, including inherited metabolic disorders; Haemoglobinopathies; Immunocompromise due to disease or treatment; Body mass index ≥40kg/m^2; Serious mental health conditions; Children and adults with Down syndrome; Children with moderate to severe neurodevelopmental disorders; Children on long-term aspirin therapy. (National Immunisation Advisory Committee (NIAC). *Immunisation Guidelines for Ireland: Chapter 11 Influenza*. Dublin: Health Information and Quality Authority (HIQA); 2026)

This list is not exhaustive, and the medical practitioner should apply clinical judgment to consider the risk of influenza exacerbating any medical condition that a patient may have, as well as the risk of serious illness from influenza

[3] NHPO antiviral guidance for influenza, V4.0, 17 Sep 2026 [4] NHPO Post Exposure Chemoprophylaxis algorit

Isolation and closure

Isolation of residents

- Minimum 5 days from symptom onset or positive result, whichever is first
- End when there have been no or minimal symptoms for 2 days; a clinical decision, not an automatic one
- Influenza on treatment: not less than 72 hours after antivirals started
- Consider longer for residents who are immunosuppressed
- No clearance swabs needed

Closing the outbreak

Influenza	8 days after the last positive case linked to the outbreak
COVID-19	10 days (two incubation periods); normal operation can usually resume about 7 days after onset in the latest case
Other viruses	Case by case, discuss with Public Health and IPC

Keep heightened vigilance until Public Health confirms closure, then hold a local short debrief.

Source: [2] HSE AMRIC. Public Health and IPC guidance on respiratory viral infections in RCFs, V2.3, 22 Oct 2025

Be prepared

- Up-to-date resident and staff Influenza and COVID-19 vaccination
- Education for all staff on the early signs and symptoms of respiratory infections and who to alert if they have a concern
- 5 to 10 in date viral swabs, request forms and staff trained to swab
- Public Health and community IPC Team contact details
- Line list templates and current resident and staff lists
- A fast route to oseltamivir, agreed with your pharmacy and recent renal function results for residents

Recognise early. Act early.

Sources: [2] AMRIC RCF guidance V2.3, 2025; [3] NHPO antiviral guidance V4.0, 2026; [5] HPSC Winter Ready Guide for Nursing Homes

Supporting resources – winter resilience

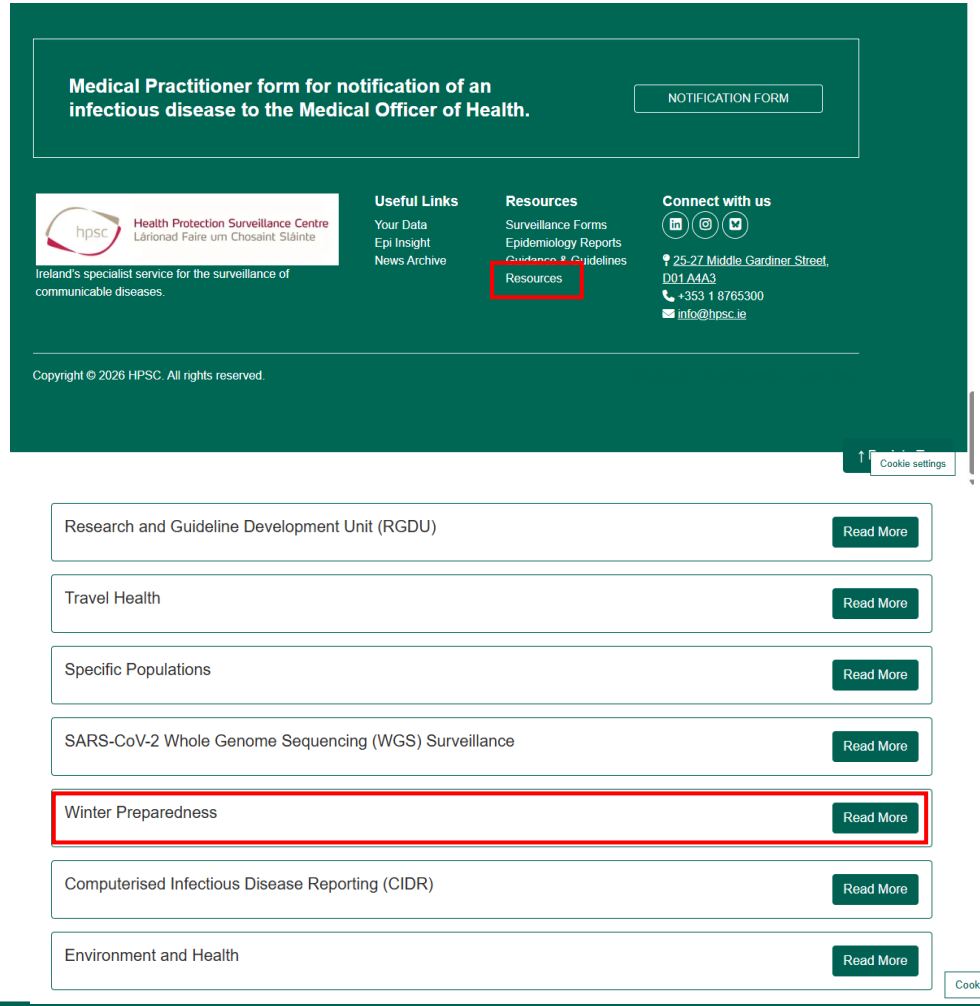


HSE Winter Planning & Response Forum (WPRF), 2026-27 winter resilience

Dr Augustine Pereira

Winter Preparedness on HPSC website

Winter Ready Guide for Health & Care Settings





Winter Preparedness (click here)

2026-27 Guidelines published

National guidance and practical algorithms for winter respiratory virus preparedness

NATIONAL GUIDELINES

1. National Guidance for Acute Respiratory Infection (ARI) Testing in Healthcare, Residential Care and Other Congregate Settings
2. Guidance on the use of antiviral agents for the treatment and chemoprophylaxis of influenza
3. Guidelines on the management of pregnant and postpartum women with suspected influenza

ALGORITHMS

1. Management of adults and children presenting with symptoms of acute respiratory infections (ARI) at Primary Care Facilities when influenza is circulating
2. Guidance on testing for Acute Respiratory Infection (ARI) in Residential Care Facilities* (RCF)
3. Post Exposure Chemoprophylaxis for Influenza

**RCF: Residential Care Facility*

https://www.hpsc.ie/a-z/respiratory/acuterespiratoryinfection/

https://www.hpsc.ie/a-z/respiratory/influenza/seasonalinfluenza/guidance

Thank you!

Any queries post the webinar can be directed to:
winter.resilience@hpsc.ie

Q & As

- Expert Panel:

- Dr. Éamonn O’Moore, Director of National Health Protection
- Dr. Augustine Pereira, Director of Public Health, Winter Resilience Lead
- Ms. Carole King, Director of Nursing, Community Support Team, HSE West North West
- Dr. Orla Cotter, Locum Consultant Public Health Medicine, National Immunisation Office
- Dr Eimear Brannigan, Clinical Lead, Antimicrobial Resistance and Infection Control
- Dr. Michael Hanrahan, Consultant in Public Health Medicine, HSE South West

Feedback form



Thank you for participating in this webinar

Any queries you have after the webinar can be directed to:
winter.resilience@hpsc.ie