27 Apr 2021

Dear Heads of Home / Centre Supervisors

Enhanced Precautionary Measures for Residential and Community-based Facilities Against COVID-19 (Coronavirus Disease 2019)

(This advisory summarises all relevant measures from all COVID-19-related advisories issued by MSF to date.)

A. NEW MEASURES

1. It has been three months since we transited to Phase Three. Vaccination is a key enabler to reducing this risk, together with other enablers such as safe management measures, testing and contact tracing. Singapore will be expanding our vaccination programme, and as we vaccinate more of our population, we will allow more economic and community activities to resume. Please refer to the press release issued on 24 Mar 2021 for details: https://www.moh.gov.sg/news-highlights/details/expansion-of-vaccination-programme-further-easing-of-community-measures.

2. From 28 December 2020, all Homes/Centres may resume services for all service users while ensuring compliance with safe management measures and minimal staff strength onsite. Homes/Centres should ensure that activities are conducted safely to minimise the risk of transmission, and to keep communities and vulnerable persons safe while resuming more social support services.

Safe Management of Staff

3. Homes/Centres should continue to implement a system of safe management measures that will protect staff, residents and clients and strengthen the resilience of their services to any further disruptions. These safe management measures include retaining work from home arrangements as much as possible, staggered working hours, split zone/team arrangements, avoiding physical meetings, safe distancing, regular disinfection of common touch points and equipment, and ensuring regular cleaning with disinfecting agents. To mitigate the risk of infection exposure and spread and to ensure business continuity, mandatory split zone/team arrangement will be rescinded in phases.

4. **Category 1A Facilities** should continue to implement split zones/teams (e.g. by floors). All residents and resident-facing staff (including contracted staff and vendors) should only operate within a single zone/team.

5. Split zone/team arrangements are no longer mandatory for **non-resident-facing staff in Category 1A Facilities**, and all staff in **Category 1B[1], 2 and 3 Facilities.** For these groups of staff, more staff may return to the workplace to better support in-person collaboration and business operations. Nonetheless,

[1] All clients in Cat 1B should continue their activities in fixed groups.

Homes/Centres are encouraged to support as many staff in working from home as possible.

i. Risk of transmission remains. Homes/Centres must ensure that **no more than 75% of employees who are able to work from home are at the workplace at any point in time**.[2]
ii. Homes/Centres are encouraged to support as many staff in working from home as possible. This will help to limit the number of staff exposed at the workplace at any point in time, and reduce crowding in common areas, e.g. pantries, toilets, lifts. Having more staff work from home will also help sustain business operations should a case emerge at the workplace.
iii. Work-from-home measures should enable staff to maintain work-life harmony while continuing to meet business needs[3].
iv. Homes/Centres may continue to adopt split zone/team arrangements for business continuity purposes if they so choose.

6. For staff at the workplace, Homes/Centres should **stagger start times and allow flexible workplace hours[4]**: This will spread out staff across time and place, and reduces possible congregation of staff at common spaces at or near the workplace, such as entrances, exits, lobbies, canteens, pantries. It also reduces congestion of people in public places, including public transport.

i. With more staff back in the office, Homes/Centres are encouraged to stagger the start times for all staff such that **at least half of all staff arrive at the workplace at or after 10am, as far as possible**. If physical meetings are needed, they can be scheduled after 10 am. These measures would enable more staff to avoid peak-hour travel, especially if staff require the use of public transport. Timings of lunch and other breaks should also be staggered accordingly.
ii. For staff who can work from home but who return to the workplace, **employers should also allow for flexible workplace hours**. This is not to shorten work hours, but to allow flexibility to reduce the duration spent in the workplace, while also working from home during the day.[5]
iii. If it is not feasible to implement staggered start times, flexible workplace hours, and staggered break hours due to operational reasons, Homes/Centres must implement other systemic arrangements to reduce congregation of employees at common spaces[6].

[2] For example, a company with 100 employees who can work from home can have up to 75 of these employees at the workplace at any point in time. There is no limit on the proportion of an individual employee's working time that can be spent at the workplace.
[3] The Tripartite Advisory on mental well-being at workplaces sets out practical guidance on measures that employers can adopt to support their employees' mental well-being under a variety of work arrangements.
[4] Workplace hours here refers to the hours spent at the physical workplace.
[5] To illustrate (i) and (ii), Centres could allow a proportion of their staff to work in the workplace from 10am-4pm, while fulfilling their remaining work hours from home. Centres could also allow their staff to work from home in the morning, and only return to the workplace in the afternoon (e.g. from 1-5pm); or return to the workplace only for meetings and work from home the rest of the day.
[6] E.g. arrange for different groups of employees to arrive/depart through different entrances/exits.

7. **Restrictions against cross-deployment across worksites shall continue to remain in place for all Homes/Centres**: no staff should work at more than one worksite.

8. **For Category 1A Homes, staff should avoid crowded places in the community**.

Safe Management of Residents and Clients

For Category 1 Facilities:

9. Homes/Centres should continue with existing precautions to better protect residents and reduce the likelihood of COVID-19 occurring in these facilities even as they resume more activities.

10. **Category 1B Centres** should put in place additional precautions for elderly clients and other vulnerable persons with co-morbidities being served at Centres. These measures include separating seniors from the rest of clients, limiting activities involving seniors to no more than 10 per group (staff and clients inclusive), or serving them by appointment.

For Category 2 and 3 Facilities:

11. Services should continue to be delivered remotely where possible**. Face-to-face services and intervention, such as counselling, may take place at the Centres as needed, with the necessary safe management measures in place.** These measures include serving cases by appointment and conducting interventions on an individual case basis.

12. Homes/Centres should ensure that staff strictly follow all guidelines. We seek your understanding and cooperation to comply with the measures in order to limit the risk of transmission and protect the health and well-being of our staff, residents and clients. Refer to **Table 1** for the full set of guidelines. MSF will review these guidelines from time to time to ensure they are aligned with MOH's latest advisories.

13. MSF will continue to conduct checks to ensure Homes/Centres have put in place adequate infection control measures and precautionary measures as laid out in the MSF advisories issued.

B. UPDATED PRECAUTIONARY MEASURES (FROM 27 APRIL 2021)

Table 1: Summary of precautionary measures

1	***SAFE ACCESS*** *Homes/Centres are to implement the following measures to ensure that individuals who may pose a risk to transmission are not allowed access into the premises of Homes/Centres:*
a.	**Restriction of staff, residents and enrolled clients allowed in Homes/Centres** ☑ Homes/Centres are not to allow staff, residents and enrolled clients on Quarantine Order (QO), Leave of Absence (LOA) and Stay-Home Notices (SHN) to enter premises. See Annex A on Leave of Absence and Stay-Home Notices. ☑ **Category 1A Homes:** Home leave and Day Release Scheme/work activities may be allowed for all residents from 11 Sep 2020 with precautions in place[7]. ☑ **Category 1A Homes serving elderly residents:** Residents may go on individual / small group outings of no more than eight persons with their caregivers (caregivers and residents inclusive)[8]. ☑ **Category 1 Facilities:** Face-to-face pre-admission screening may resume with safe management measures in place (e.g. safe distancing of at least 1 metre, conduct screening in a designated area). New admissions from the community into Welfare Homes, Sheltered Homes and Adult Disability Homes who (i) have passed 14 days from the date of completion of the full COVID-19 vaccination regime AND (ii) are asymptomatic for symptoms of ARIs can be exempted from isolation and COVID-19 testing measures with immediate effect.
b.	**Restriction of visitors allowed in Homes/Centres** ☑ **Category 1A Homes serving elderly residents[9]**: **Pre-designate up to four visitors per resident[10], with only two pre-designated visitor allowed to enter Homes at any one time** with precautions in place[11]. Homes may exercise discretion on the number of visitors per resident on compassionate grounds (e.g. critically ill).

[7] Category 1A Homes serving elderly residents should implement the precautions in Annex C to better protect vulnerable seniors and reduce the likelihood of COVID-19 occurring in these facilities.
[8] Caregivers should not bring out more than 1 resident (unless the residents are family members in the same split zone) to avoid mixing of residents within the Home.
[9] Homes that serve elderly residents include Senior Group Homes, Sheltered Homes, Welfare Homes, Adult Disability Homes, Disability Hostels, Community Group Homes and Transitional Shelters.
[10] The pre-designated visitors list should not be changed once designated.
[11] These precautions include:
(i) Visitors should schedule visitation appointments in advance;

	☑ **For Senior Group Homes, Community Group Homes and Transitional Shelters** located in a community-based setting, each household should limit visits to not more than eight persons at any one time, in accordance with MOH's guidelines on safe homes and community. ☑ **Other Category 1A Homes**: Allow only a maximum of four designated caregivers/ visitors per resident/ enrolled client with precautions in place[12]. ☑ **Category 1B Centres**: Only one caregiver per client allowed to accompany enrolled client with precautions in place. ☑ **Category 1 Facilities**: Face-to-face sessions with caregivers to discuss Individual Care Plans (ICP) may resume on by appointment basis. ☑ Homes/Centres are not to allow visitors, who are on QO, SHN, LOA or declared to have a close contact who is a confirmed case to enter your premises. For **Category 2 and 3** facilities, staff should arrange for services to be delivered to them remotely e.g. over the phone or online. ☑ Only visitors who are needed to support the running of facilities (e.g. contractors) and agencies who need to perform necessary functions may enter the premises. If it is necessary to have a visitor in the facility, temperature checks should be conducted. Visitors should keep a safe distance from staff, residents and clients. ☑ Identify a holding area for visitor screening before entry. It should be well-ventilated and well-separated from staff, residents and enrolled clients. Advise visitors to avoid crowding and to maintain increased spacing of at least one metre apart while seated or standing in waiting areas.
c.	**Restriction of vendors allowed in Category 1A Homes** ☑ Designate a 'drop-off point' for vendors for deliveries outside the Home. Staff can then pick up the deliveries and reduce the contact time with vendors.

(ii) Visitors should wear masks at all times during the duration of the visit and adhere to safe management measures (e.g. maintain 1 metre distance from resident, enforce hand hygiene protocols before entering and leaving the visitation area);

(iii) Visit duration should be limited to 1 hour or less:

(iv) Visits should take place at designated areas outside of living quarters and segregated from other residents. Physical barriers (e.g. glass/Perspex screens) between the resident and visitors to be set up, where possible;

(v) Number of visitors should be limited to no more than 40% of licensed bed capacity per day. Homes may impose a lower limit depending on the size of the visitation area, as they should continue to ensure there is a distance of 1 metre between residents/visitors. Homes should also ensure that residents should not come into contact with residents of other zones.

[12] These precautions include: (i)Visitors should wear masks during the duration of the visit and enforce hand hygiene protocols before and after the visit; (ii) Visit duration should be limited to one hour or less; (iii) Other measures to further mitigate risks and ensure safe distancing, taking into account the setting of the Home, e.g. use of desk shields/Plexiglass barriers between residents and visitors and other means of ensuring a safe distance of at least 1 metre; (iv) Limit to 15 persons, in groups of up to eight persons, within each visitation room. There should be no interactions between small groups.

	☑ Homes should ensure proper sanitisation and wiping down of all goods and items that are delivered to the designated 'drop-off point', before it is handled by other staff and residents. ☑ Homes may resume all maintenance work. ☑ For auxiliary personnel such as cleaners, security guards, caterers and other contractors, Homes should work with service vendors to ensure that the personnel deployed to the Homes do not reside in foreign worker dormitories with confirmed cases. ☑ **Where such contractors have to physically enter the premises, they should wear surgical masks**. Residents and care staff should not have any contact with external contractors and should not be in the same room or location where the contracted work is being done. Stricter measures should be put in place to avoid possible contamination of "high-touch" surfaces such as tables and door knobs. There should also be wiping down of the areas where works are carried out before opening up the space for residents' use. ☑ In line with prevailing MSF advisories, screen vendors for health status (temperature and respiratory symptoms), enforce hand hygiene before vendors enter the facility, record vendor contact details and movement within the Homes for contact tracing using SafeEntry and TraceTogether, and minimise the time they spend in the living quarters.
d.	**Health checks and temperature screening** ☑ <u>*On arrival*</u>: Homes/Centres are to continue with temperature screening and health checks for all staff, residents, clients and visitors. Besides health checks for visible symptoms, Homes/Centres are to explicitly ask all staff, residents and clients the following questions during health checks, and record the responses even when they do not have any symptoms: i. Have you been having a fever? ii. Do you have a cough? iii. Do you have a sore throat? iv. Do you have a runny nose? v. Do you have shortness of breath? vi. Do you have a loss of sense of smell or taste? vii. Are there household members who are unwell with fever and/or flu-like symptoms such as cough, runny nose, sore throat, shortness of breath? Homes/Centres should not admit staff, residents, clients and visitors who are unwell, and recommend that they promptly seek medical attention. For visitors/service users to **Category 2 and 3** facilities who are unwell or declared to be in close contact with a confirmed case, staff should arrange for services to be delivered remotely, e.g. over the phone or online where possible. However, if the case is assessed to

	be urgent, they can be served, but with added precautions including for the unwell person to wear a mask and to minimise close contact with others. Staff, residents, clients and visitors with household members who are unwell (with fever and/ or flu-like symptoms such as cough, runny nose, sore throat, shortness of breath) are encouraged to stay home, if possible. ☑ *During the day*: Homes/Centres should conduct the following frequency of temperature taking and health checks for residents, enrolled clients and staff. i. **Category 1** facilities – minimally twice-daily temperature screening and checking of respiratory symptoms for all residents and enrolled clients, if not already the arrangement. ii. All facilities – at least twice-daily temperature taking and checking of respiratory symptoms for all staff, including administrative and non-care staff, even if not at work. **The timing for these checks must be scheduled and not left to the discretion of individual staff.** Record temperatures and respiratory symptoms for residents, enrolled clients and staff daily. Keep declaration records of temperature taking and other indications including respiratory symptoms (e.g. cough, runny nose, sore throat, loss of smell or taste, shortness of breath) for at least 28 days for inspection purposes. **Ensure that any staff feeling unwell leave the premises immediately and seek medical treatment, and stay away until they have fully recovered**. Homes/Centres should advise staff not to clinic-hop. Where possible, Homes/Centres must ensure that each staff visits only one clinic for check-ups if unwell. Otherwise, staff should inform the clinic of all recent doctor visits over the past 14 days for any symptoms that may be related to COVID-19 (including but not limited to typical symptoms such as fever, cough and shortness of breath). For the duration of their medical certificate, the staff must not leave his or her place of accommodation and must follow the same social-distancing procedures as those on Stay Home Notices. Staff who are still unwell after the medical certificate[13] duration should not return to work and should follow up with the same medical practitioner. **Isolate residents and enrolled clients with fever and respiratory symptoms immediately.** Refer residents and enrolled clients with respiratory symptoms and/or fever to a doctor for assessment. There should be no more than one unwell resident/client in each sick bay.

[13] Reg 3(2) of the Infectious Diseases (COVID-19 Stay Orders) Regulations 2020 promulgated under the Infectious Diseases Act gazetted on 25 March 2020.

	If there is more than one unwell resident/client in the sick bay, they should be spaced 2m or more apart and be given masks to wear. If staff need to interact closely with the sick resident/client (i.e. <2m from resident/client), they should wear a mask, face shield, gown and gloves, and sanitise or wash their hands with soap after contact with the resident/client. The sick bay should be sanitised and wiped down frequently, especially after every use. **For Category 1A facilities, any staff and resident who present with ARI symptoms (e.g. cough, fever, sore throat) should go to the nearest Public Health Preparedness Clinic (PHPC)/Polyclinic immediately.** The staff/resident should inform the doctor about their symptoms and that they are working/living in communal residential settings (i.e. MSF residential homes), and request to be swabbed for Covid-19. If the doctor assesses that they do have symptoms suggestive of Covid-19 infection, the PHPC/Polyclinic will perform the Covid-19 swab at the clinic if they participate in the Swab and Send Home (SASH) initiative, or will refer the resident/staff to another PHPC clinic for the swab. They will also provide medication and issue the staff/resident with MC. The staff/resident should then take private transport back to their place of residence/the Home with windows wound down, and be isolated for the duration of the medical leave while pending swab results.
e.	**Contact tracing of staff, residents, clients and visitors** ☑ From 12 May 2020 onwards, Homes/Centres are required to use SafeEntry to collect entry and exit information of staff, residents, clients and visitors to facilitate contact tracing. Homes/Centres should ensure that they are ready to implement TraceTogether-only SafeEntry from 1 June 2021. ☑ Staff, residents, enrolled clients and vendors should download and activate the TraceTogether app to facilitate contact tracing. ☑ Homes/Centres[14] should use Trace Together (TT) tokens to help the residents/clients auto-log their close contacts for contact tracing purposes.
f.	**Travel plans and declarations** ☑ With the evolving COVID-19 situation, Homes/Centres are to continue monitoring the travel plans of staff, residents and enrolled clients to all countries closely. Homes/Centres should inform staff residents and enrolled clients to declare the following, if not already done: i. Any recent travel history; and

[14] For Homes and Centres that receive TT tokens distributed by MSF.

	ii. Intended/updated travel plans by staff, residents or enrolled clients to other countries (including the city(s) of travel) MSF will request for the above information periodically. MOH has updated its travel advisory to allow overseas travel: i. To Australia, Brunei Darussalam, New Zealand, Mainland China, and Taiwan;. ii. If they are pursuing academic studies or professional qualifications overseas, for courses or examinations which require physical presence in the foreign educational institution; iii. If they are taking on or returning to employment overseas, for employment opportunities which require physical presence overseas; iv. For essential travel for business, official and work purposes under Green/Fast Lane arrangements and the Periodic Commuting Arrangement; v. For compassionate reasons (e.g. due to death of / critically ill family member); vi. To seek medical treatment which cannot be reasonably received in Singapore; or vii. To return to country of residence to attend to, or after attending to, legal/contractual obligations. **All staff, residents and enrolled clients are advised to defer all other forms of travel overseas[15].**. You are encouraged to be judicious in approving overseas leave for staff, and also closely monitor the travel plans of staff, residents and enrolled clients in view of the SHN imposed upon return from overseas. **Inform MSF immediately if you intend to allow any of your staff to proceed with their travel plans.**
g.	**COVID-19 Preparation Information Dossier** ☑ To facilitate contact tracing and impact analysis should a staff or resident become a confirmed case, **Category 1A Homes** should ensure that the COVID-19 Preparation Information Dossier is updated daily. The list of information to be recorded can be found in Annex D.

[15] Cruises to nowhere, which depart from Singapore and do not have any ports of call, will not be considered overseas travel.

2	***SAFE BEHAVIOUR*** *Homes/Centres are to implement the following to* ***ensure that staff, residents and clients adopt safe behaviour to reduce the risk of transmission*** *and ensure a safe environment within Homes/Centres.*
a.	**Wearing of masks in Homes/Centres** ☑ All staff should wear masks within facilities[16]. Disposable/reusable masks may be used as alternatives. For staff with prolonged and close contact with residents and clients, face shields may be used in conjunction with masks for additional protection. ☑ **For Category 1A Homes, all staff should wear surgical masks[17] during the course of work.** ☑ All visitors should bring their own masks and wear a mask at all times whilst in the facility.
b.	**Practise high levels of personal hygiene** All staff, residents and clients are to maintain good personal hygiene such as: ☑ Covering their mouth and nose with a tissue when sneezing or coughing, and to throw away the tissue immediately into a foot bin. ☑ Washing their hands **at least every 2 hours** with soap, especially before eating or handling food, after toilet visits, before and after activities or when hands are dirtied by respiratory secretions after coughing or sneezing. ☑ Not sharing food/drinks, eating utensils, tooth brushes or towels with others. ☑ Avoid touching their eyes, nose and mouth. ☑ **Staff interacting with seniors should take extra care to ensure personal hygiene**. Staff should not interact with seniors when they are unwell. ☑ Encourage adjustment of social norms, e.g. avoid shaking hands and hugging. ☑ Put up signages to remind clients to be socially responsible, e.g. see a doctor and stay home if they are unwell or if they have travel history to affected countries.
c.	**Ensure high levels of environmental hygiene** ☑ Disinfect frequently touched points such as handrails and door knobs with disinfectant at least twice a day. ☑ Minimise cross-sharing of equipment and materials across split zones/teams. Equipment should be assigned individually, if

[16] For Homes, exceptions can be made outside of working hours and within living areas for staff that stay on-site in dormitories. However, these staff should continue to practise safe distancing and minimise any mingling and contact **at all times**.

[17] Surgical masks should be changed after a maximum of 6 hours of use, or if mask becomes soiled or soggy. Staff must strictly adhere to hand hygiene practices in addition to mask use to prevent cross contamination.

	reasonably practicable to do so, and to be wiped down and cleaned after each use. ☑ Step up frequency and extent of cleaning, especially for equipment/ furniture used by multiple client groups in a day. ☑ Keep public toilets clean and dry. ☑ Ensure that hand washing facilities and/ or hand sanitisers are readily available.
d.	**Appoint Safe Management Officers who are responsible for:** i. Implementation, coordination and monitoring of safe management measures; and ii. Communication and explanation of the safe management measures to staff prior to resuming work. The full requirements for Safe Management Measures can be found at mom.gov.sg/covid-19/requirements-for-safe-management-measures.
3	***SAFE FACILITIES*** *Homes/Centres are to implement the following measures to ensure **minimal interaction/ mixing between staff, residents and clients from different zones/worksites**, so as to minimise risk of cross-transmission in the event of a confirmed COVID-19 case in Homes/Centres.*
a.	**Segregate by zones/worksites** ☑ **Homes/Centres are encouraged to support as many staff in working from home as possible.** For functions where telecommuting is not feasible, such as frontline operations, employers should take the following precautions: • **There should be no physical interactions between teams working in different locations/worksites.** • **Reduce duration and proximity of physical interactions** among staff within the same worksite during their course of work, as well as during their meal and break times. • **Stagger working hours** to reduce possible congregation of staff at common spaces. • Stagger use of common areas and facilities (e.g. toilets, halls, common areas) to avoid mixing between split zones. **For Category 1A Homes:** ☑ Implement split zones/teams (e.g. by floors). All residents and resident-facing staff (including contracted staff and vendors) should only operate within a single zone/team[18]. ☑ Review staffing plans so that each zone can function autonomously. Residents and resident-facing staff within each zone should not cross into other zones or come into contact with residents and staff

[18] Crossing of zones should only be done on an exceptional basis, and staff who need to interact with residents across zones should minimise interactions with all persons who are in that zone. Staff who cross zones are not required to wear additional PPE provided no close physical body contact is anticipated. If close physical body contact is necessary, staff should don a blue gown and switch to a new gown when there is evident contamination. Used gowns should be removed before leaving a zone.

	of other zones at all times, including non-working hours. As part of this split zone arrangement, staff from different zones should not be rostered to serve the same residents on different days. Where this is not possible, the exceptions and mitigating factors should be documented. ☑ Maintain a staff movement log, which will facilitate impact analysis should a staff, client or resident become a confirmed case. Staff should also avoid social and physical interaction with other staff. This includes limiting interaction and practicing safe distancing during common times such as lunch or tea breaks, and in shared spaces such as staff pantries or common dining areas. Staff must also practise safe distancing when not on duty, including but not limited to avoiding crowds, gatherings and minimising any physical contact (e.g. handshakes). **For non-resident-facing staff in Category 1A Facilities**, and all staff in **Category 1B, 2 and 3 Facilities:** ☑ Homes/Centres must ensure that no more than 75% of employees who are able to work from home are at the workplace at any point in time. For staff at the workplace, Homes/Centres should put in place the precautions listed in Section A, para 6**.**
b.	**Safe distancing between split zones/teams during drop off/pick up times** ☑ There should be no mixing of clients from different zones/teams during arrival and departure periods. E.g. use separate routes and entrances/exits, where available. ☑ Where transport services are used: • Ensure no mixing of clients from different zones as far as possible. • Take client's temperatures prior to boarding. • Bus attendants/drivers or staff to visually screen clients for symptoms. If clients are unwell, to ask clients not to board. • Assign a specific seat to each client. • Ensure each client wears a mask and refrain from talking/interacting during the journey to and from Centres. • Alternate seating that is at least 1m apart for all clients, where reasonably practicable to do so. • Ensure that the vehicle is cleaned and sanitised before use every time.
c.	**Suspend large group activities** ☑ Suspend organised excursions, outings and participation in external events to reduce the risk of exposure of the vulnerable groups to the general public. ☑ Suspend large group communal activities and mass gatherings within the institutions (e.g. morning muster, gathering of all service users and staff). Suspend those involving large groups of external

	participants (e.g. CSR events involving volunteers). This is to reduce the risk of exposure and cross infection within an institution. ☑ Suspend communal activities across facilities, dormitories or blocks.
d.	**Small group activities** **For Category 1 Facilities** ☑ **Ensure that these activities are carried out with safe management precautions**. Homes/ Centres should stagger the activities, have more frequent sessions so that they can be carried out in smaller groups, ensure there is a distance of 1 metre between residents/ clients, and enforce hand hygiene protocols before and after the activity. Category 1A Homes should carry out activities in smaller groups of no more than 10 persons while Category 1B Centres should conduct activities in smaller groups of no more than 15 persons (up to 10 persons if seniors are involved) [19]. ☑ For Category 1A Homes, staff and residents should also strictly adhere to the split zone arrangements when participating in the group activities. ☑ **Reduce density, intensity and duration of activities.** Reduce number of participants per activity to 10 persons for Category 1A Homes/15 persons for Category 1B Centres or less to ensure sufficient space between participants, adjust the rigour of activities to minimise contact and exertion, and shorten the duration of organised activities to minimise exposure. ☑ **Category 1A Homes can allow small group outings of no more than eight persons, supervised by staff, to non-crowded areas**. ☑ Category 1A Homes serving elderly residents can allow individual outings, unaccompanied by staff, to non-crowded areas with precautions[20].**Category 1B Centres can allow small group outings of no more than eight persons (staff and clients inclusive), supervised by staff, to non-crowded areas.** **For Category 2 and 3 Facilities** ☑ **Essential interventions delivered through group work/activities should be limited to no more than eight persons with safe management precautions** e.g. ensure a safe distance of 1 metre between participants.

[19] Category 1B Centres should continue with individual activities among clients where individuals are 1m apart and do not interact or participate in shared activities or use shared materials within the small groups. Groups should also be apart from other groups with minimal physical interaction across groups.

[20] These precautions include:

(i) Residents should be advised to minimise their activities in the community (e.g. avoid going to crowded places and meeting with many different people), and inform the Home on where he/she would be going and the time of return before the individual outing is granted;

(ii) The Home should ensure that the resident understands the safe management measures to undertake in the community;

(iii) Residents are to download and activate the TraceTogether app or bring along the wearable TraceTogether token.

	For all Facilities ☑ **Space out the seats in communal areas (such as dining areas), interview rooms, service counters in Homes/Centres at least one metre apart.** • Stagger meal times with no mixing of split zones/teams. • Surfaces (e.g. tables, chairs) to be cleaned before the commencement of meals for the next split zone/team. ☑ **Use desk shields / plastic dividers / Plexiglass barriers as added precaution for service counters, dining tables and other areas should safe distancing cannot be maintained.** Ensure that these equipment are wiped down and cleaned after every use. ☑ **Everyone should keep their volume low in daily activities**. Actions such as speaking/singing loudly increase expulsion of droplets that may contain viral particles and raise the risk of transmission of diseases like COVID-19. ☑ **Keep all rooms well-ventilated.** Open windows to allow plenty of fresh air into the indoor environment, where possible. • Ensure good ventilation when conducting activities, for example conducting them outdoors, or keeping windows open and using fans when indoors.
e.	**Staff meetings, training and social gatherings** **Staff meetings and internal training** ☑ While staff meetings and training should remain online as a default, Homes/Centres may hold physical staff meetings and internal staff training (i.e. conducted for staff within one Home/Centre, by staff within the same organisation), if necessary, with SMMs in place: • No mixing of staff across Homes/Centres during the meeting and cap at 50 persons (or lower depending on venue capacity based on safe management principles). For Category 1A Homes, there should be no interaction between staff in different zones/teams or locations; • At least 1m safe distancing between individual attendees; • Meals should not be the main feature of the meeting. Homes/Centres should also avoid holding meetings over mealtimes as far as possible. Food or drinks should only be served if incidental to the meeting (e.g. the meeting or conference extends over lunchtime). In addition, the food must be served individually with the participants seated while consuming. Participants should minimise the time that they are unmasked while eating. • Masks should be worn at all times during the meeting; • Meeting venue can be within Home/Centre or at a third-party venue (subject to any additional premise owners' policies); For meeting venues within the Home/Centre, high-touch point areas in the meeting room (e.g. table) to be wiped down and disinfected after each use.

External training

☑ Homes/Centres should continue to hold external training for staff online where possible. For training areas which can only be done via in-person training (e.g. require closer monitoring to ensure the use of the right techniques, specific environments or specialised equipment to strengthen efficacy), Homes/Centres may resume face-to-face external training with the following precautions:

i. No mixing of staff from different split zones/teams and across Homes/Centres during training sessions.
ii. Use of TraceTogether App or Token. All participants entering the training premises must use the TraceTogether App on their mobile devices or the TraceTogether token[21]. This is to facilitate contact tracing should there be a confirmed case.
iii. Class Size. All external training sessions will be capped at 50 persons, including the trainer(s) [22] (or lower depending on venue capacity based on safe management principles).
iv. Seating/group arrangements.
    a. All participants must have fixed seating and grouping arrangements.
    b. Participants should be in groups aligned with prevailing group size of 8 persons, and participants within each group should keep 1 metre apart where possible.
    c. There should be no mixing across the groups and the groups should be at least 1metre apart.
v. Hygiene Matters
    a. Equipment and resources should be assigned individually within the class, if reasonably practicable to do so, and to be wiped down and cleaned after each use.
    b. When a common space is used by different classes, the tables and high touch areas must be wiped down and disinfected before and after use by each class.
vi. Breaks/Meals Arrangement
    a. Food and drinks should preferably not be served. If deemed necessary for practical reasons to serve meals, individuals must be seated and served individually and minimise contact with one another while eating. Meal durations should be kept short to minimise the period that individuals are unmasked. Homes/Centres should also avoid holding meetings over mealtimes as far as possible. Food or drinks should only be served if incidental to the meeting (e.g. the meeting or conference extends over lunchtime). In addition, the food must be served individually with the participants seated while consuming. Participants should minimise the time that they are unmasked while eating.

[21] Before TraceTogether (TT)-only SafeEntry (TOS) is mandated, those without the TT Mobile App or TT token may continue to use their QR reader app, SingPass mobile App or NRIC to check in to SafeEntry at the training premises.

[22] For SSG-funded CET programmes, SSG's prevailing guideline for a maximum class size of 40 persons, including the trainer(s), for course quality reasons remains.

	b. Break times of participants/classes should be staggered to avoid mixing between the groups and classes. vii. Masks should be worn at all times during the training. **Social gatherings between staff** ☑ Limit social gatherings to 8 persons. ☑ All social and recreational gatherings (e.g. farewell lunch, team bonding activity) within or outside the workplace must adhere to the prevailing gathering size limit of 8 persons[23]. ☑ The total gathering size must not exceed 8 persons. Gatherings involving more than a single group of 8 are not allowed. ☑ For Category 1A Homes, there should be no interaction between staff in different zones/teams or locations outside of work.
f.	**Limit home visits and outreach activities (i.e. face-to-face sustained contact with clients) to urgent or at-risk cases** ☑ Some programmes have home visits related to case work and outreach components conducted by staff or regular volunteers. In general, these activities should be limited to urgent or at-risk cases, or where the situation warrants a home visit, with precautionary measures: • For known clients and service users, conduct pre-screening over phone for known clients and service users to check for travel history, persons on SHN, LOA or Persons Under Quarantine (PUQ), and any persons who are unwell in the household. • For non-clients, before entering the residence, check for travel history, persons on SHN, LOA or PUQs, and any persons who are unwell in the household. • Check if clients/ service users are comfortable for staff and volunteers to enter their residence. • **If there are PUQs or SHN in the household**: Staff should arrange for services to be delivered remotely e.g. over the phone or online. • **If the client is unwell or there are persons on LOA in the household**: Staff should arrange for services to be delivered remotely e.g. over the phone or online. However, if the case is assessed to be urgent, they can be served, but with added precautions including for the unwell person to wear a mask and to minimise close contact with others. • **Outreach activities/ programmes (e.g. befriending, food delivery) to seniors should be delivered remotely over the phone or online utilising technology, where possible**. If engagement needs to be done face-to-face (e.g. seniors with no phone numbers), additional precautions and strict safe distancing measures should be taken e.g. limiting engagement to less than one hour, and maintaining at least one metre apart from seniors

[23] Including at common spaces such as staff canteens, pantries, water coolers / vending machines, smoking corners.

in their homes or at the gate. Staff should don surgical masks and practise hand hygiene before / after each home visit. During the home visit, residents and family members should also wear a mask as far as possible.

☑ For distribution of essential aid (e.g. food delivery), refer to MSF's Advisory on Essential Aid Distribution Against COVID-19 dated 22 December 2020.

g. Volunteer management

Volunteers may be required to support your services and your service users.

☑ Activities involving regular volunteers who perform essential and routine functions can continue. They should be regarded and managed as staff and take the necessary precautions.

☑ Activities involving **adhoc volunteers** who perform non-essential functions, or who might be in close contact with vulnerable groups, should be suspended.

☑ Category 1 facilities may resume volunteer-led activities with the following safe management precautions:

Facility	**Precautions**
Category 1A facilities serving elderly residents	• **Volunteer-led activities** may resume with safe distancing measures. • Pre-designate up to 20 volunteers, and limit to no more than eight volunteers at any one point in time. • Each volunteer-led activity should be limited to two hours or less. • In addition, the Home can have up to another eight volunteers at any one time to help with backend tasks (i.e. with no direct interaction with residents or client-facing staff).
Category 1A facilities serving non-elderly residents	• Limit to 10 volunteers within Homes at any one point in time.
Category 1B facilities	• Pre-designate up to 20 volunteers, and limit to no more than 10 volunteers at any one point in time. • Volunteers should keep to a fixed group of clients and minimise close physical contact with clients.

☑ Volunteers should not be cross-deployed to more than one Home/Centre.

14. As the COVID-19 situation may persist for a duration of time, facilities should use your resources such as surgical masks and sanitisers prudently.

15. We encourage you to check the MOH website (www.moh.gov.sg) regularly for further updates and Health Advisories. All of us have a part to play to keep our facilities clean and safe for our residents, clients and staff. We encourage Heads of Home, Centre Supervisors and Social Service Agencies serving vulnerable groups to share this information with your staff.

16. Please contact your respective MSF Division contacts if you require any assistance or clarifications on precautionary measures to be put in place. Alternatively, you may contact MSF at 6355 5000 (Monday to Friday: 8:30am to 6pm; Saturday: 8:30am to 1pm) or at www.msf.gov.sg/Pages/Contact-Us.

Annex A: Leave of Absence, Stay-Home Notice and Home Quarantine Order

Response Measure	What you should do
(i) Any staff or enrolled client who recently returned from overseas travel within the last 14 days, except for those entering Singapore from Australia, Brunei Darussalam, New Zealand, Mainland China, and Taiwan[24]	• Immigration and Checkpoints Authority (ICA) will issue SHN to all persons returning from overseas travel. • Notify MSF of SHN given to staff or enrolled client. • Monitor affected staff or enrolled client through regular telephone calls.
(ii) Any staff of all Category 1 Facilities or enrolled client of Category 1B Facilities: • living with any household members under Home Quarantine Order (HQO) • living with any household members under Stay-Home Notice (SHN) • Has a close contact who is a confirmed case	• Inform all residents/enrolled clients/staff to notify you if: o there is a household member under HQO/SHN o there is close contact who is a confirmed case • **For enrolled clients**, grant Leave of Absence, aligned to o the period of household member's HQO/SHN; or o 14 days from the last contact with the close contact who is a confirmed case • **For residents**, do not grant home leave until after household member's HQO/SHN • **For staff**, consider these precautionary measures: o Grant Leave of Absence aligned to the period of household member's HQO/SHN, or 14 days from the last contact with the close contact who is a confirmed case; or o Redeploy staff to administrative tasks • Inform MSF immediately of: o Any household member under HQO/ SHN o Any LOA given to enrolled client/ staff living with the household member under HQO/SHN, or has a close contact who is a confirmed case • Monitor health of these residents/ enrolled clients/ staff through regular telephone calls.

[24] Travellers, Singapore Citizens, Permanent Residents and Long-Term Pass holders entering Singapore and who have remained in either Australia, Brunei Darussalam, New Zealand, Mainland China or Taiwan in the last consecutive 14 days prior to their entry will not be required to serve a SHN. Instead, they will undergo a COVID-19 test upon arrival at the airport and only be allowed to go about their activities in Singapore after receiving a negative test result. Prior to receiving the test results for COVID-19, staff, residents and clients should remain in isolation at their places of residence and not come into contact with other staff, residents and clients of Homes/Centres.

Annex B: Classification of Services

Category	Nature of Service	Facility/ Programme/ Service
1	Facilities providing care and social services to vulnerable groups	**Category 1A**: Residential facilities a. Singapore Boys' Home b. Singapore Girls' Home c. Children and Young Persons Homes d. Welfare Homes* e. Sheltered Homes* f. Children's Disability Homes g. Adult Disability Homes* h. Crisis Shelters i. Transitional Shelters* j. Senior Group Homes* k. Community Group Homes* l. Disability Hostels* *Facilities serving elderly residents
		Category 1B: Disability centres and programmes a. Day Activity Centres b. Drop-In Disability Programme c. Therapy Hub d. Sheltered Workshop e. Community Based Integration Support
2	Facilities providing social services to vulnerable groups, involving sustained contact e.g. case interview, counselling session [As a guide: services involving physical contact, or within 2 metres with a contact time of ≥ 30 minutes]	Social services and programmes, including but not limited to: a. Social Service Offices b. Family Violence Specialist Centres c. Family Service Centres d. Child Protection Specialist Centres e. Integrated Services for Individual and Family Protection Specialist Centre f. Mandatory Counselling Centres g. Divorce Support Specialist Agencies h. Youth!GO Agencies

Category	Nature of Service	Facility/ Programme/ Service
		i. Integrated Service Providers
3	Facilities providing frontline services to the general public	Social services and programmes, including, but not limited to: a. Parenting Support Programme b. Early Risk Marriage Programme c. Marriage Preparation Programme
Note 1: Regular volunteers should be regarded and managed like staff in relation to this Advisory. Note 2: For Early Intervention Programme for Infants and Children, Pilot for Private Intervention Providers, Special Student Care Centres and Student Care Centres, please refer to separate Advisories issued. Note 3: Social service agencies not listed are advised to refer to the guide above to determine the application of the Advisory taking into account the nature of service.		

Annex C: Precautions on Home Leave for Category 1A Homes Serving Elderly Residents

Category 1A Homes serving elderly residents[25] should implement the following precautions when granting home leave for residents to better protect vulnerable seniors and reduce the likelihood of COVID-19 occurring in these facilities:

(i) Homes should evaluate the reasons for going on home leave and assess the medical suitability and safety of the resident before home leave is granted. In addition, providers should take a risk-managed approach based on considerations such as the proposed movement plans and activities during the home leave period, the risk of community exposure of the resident during home leave, and the ability to comply with safe management measures by the resident and those around the resident during home leave (including past observation of such compliance). If there is significant risk of exposure to COVID-19 if home leave is granted, a resident's request for home leave must be rejected.

(ii) Duration of home leave is limited to a maximum of three consecutive calendar days (72 hours).

(iii) Home leave is not permitted should the resident's caregiver/family members living in the same residence be on Quarantine Order (QO), Stay Home Notice (SHN), placed under phone surveillance for close contact with a confirmed COVID-19 case, or unwell with fever and/or symptoms of acute respiratory infection (ARI)[26] and/or infectious disease.

(iv) Before the resident goes on home leave, Homes are to brief the caregiver on the precautionary measures to undertake. Homes are to ask the caregiver to sign a letter of undertaking as an acknowledgement of the precautions needed, to safeguard the health of other residents and staff.

(v) The caregiver/resident should be advised on the following:

a. To minimise the resident's activities in the community (e.g. avoid going to crowded places and meeting with many contacts in the community, limit house visits to at most two other households per day as much as possible, adhere to prevailing safe management measures in the community strictly, a limit of 8 distinct guests visiting the resident at home in a day);

[25] Homes that serve elderly residents include Senior Group Homes, Sheltered Homes, Welfare Homes, Adult Disability Homes, Disability Hostels, Community Group Homes, and Transitional Shelters.
[26] Symptoms of ARI include cough, fever, runny nose, sore throat and anosmia.

b. To strictly disallow the resident's contact with known individuals placed under quarantine, SHN or on phone surveillance for close contact with a confirmed COVID-19 case, as well as individuals who are unwell with fever and/or symptoms of acute respiratory infection (ARI)[27] and/or diagnosed with an infectious disease;
c. For the resident to always wear a surgical mask (preferred) or reusable mask with at least 95% bacterial filtration efficiency[28] when in the community and at home if there are visitors if mask-wearing is tolerated, practise good hand washing and personal hygiene and observe all the measures put in place by the relevant authorities;
d. To download and activate the TraceTogether app or bring along the wearable TraceTogether token when in the community;
e. For the caregiver to monitor the resident for fever (38^{o}C and above) and symptoms of ARI twice a day. The caregiver is to alert the Home and bring the resident to visit a doctor immediately if the resident turns unwell whilst on home leave.
f. To submit the resident's planned movement prior to home leave and movement history to the Home at the end of the home leave.

(vi) Only one caregiver can enter the Home's premises to pick up the resident for home leave. Homes can designate a waiting area and bring the resident to the caregiver, so that the caregiver does not enter the dormitories. The caregiver should comply with the prevailing precautionary measures at the Home (e.g. SafeEntry, travel/health screening, temperature check, avoid entering the dorms and minimise contact with other staff/residents).

(vii) At the end of the resident's home leave, the caregiver should submit the following to the Home:

a. Temperature records of the resident whilst on home leave;
b. Movement history of the resident whilst on home leave; and
c. Declaration that the undertaking has been fulfilled, including that the resident did not come into contact with any individual who was on QO/SHN/under phone surveillance for close contact with a confirmed COVID-19 case, or unwell with fever and/or ARI symptoms and/or infectious disease. Should the resident come into contact with any such individual, the caregiver is to inform the Home of this immediately and update the Home on the outcome of the individual's swab test, if he/she is tested for COVID-19, as well as any other instructions or directives issued to the individual by MOH.

(viii) Should any individual who came into contact with the resident whilst on home leave develop fever and/or ARI symptoms, or be placed on QO/SHN/phone surveillance for close contact with a confirmed case, or be diagnosed with an infectious disease during the period of home leave or in the 7 days from the date the resident returns to the Home, the caregiver is to inform the Home of

[27] Symptoms of ARI include cough, fever, runny nose, sore throat and anosmia.
[28] For reference, the recent reusable masks distributed by the Government in May and June 2020 carry this specification.

this on an immediate basis and to update the Home on the outcome of the individual's swab test, if he/she is tested for COVID-19.

(ix) Residents returning from home leave will be subject to the following swabbing and/or isolation protocol:

a. For day leave (e.g. day trip of not more than 8 hours or those on Day Release Scheme (DRS)/leave the Home for work activities), Homes are to continue with prevailing precautionary measures, such as routine monitoring of residents for ARI symptoms. No isolation or COVID-19 test is required unless resident is symptomatic. Residents on DRS/leave the Home for work activities should be swabbed once in every 2 weeks, according to the Home's regular swabbing regime[29].
b. For consecutive day leave of two or more days and leave involving an overnight stay or longer (e.g. more than 8 hours), returning residents from home leave should be isolated for 7 days upon the resident's return, and tested for COVID-19 on Day 7. The resident is to remain isolated until the test results for COVID-19 returns negative. During the 14 days from the residents' return to the Home or until the test results for COVID-19 returns negative, whichever is later, the Home should closely monitor the resident for any symptoms. Homes which do not have adequate isolation capacity should not commence home leave arrangements with overnight stay. Persons who (i) have passed 14 days from the date of completion of the full COVID-19 vaccination regime AND (ii) are asymptomatic for symptoms of ARIs can be exempted from isolation and COVID-19 testing measures with immediate effect.

[29] In accordance with the surveillance testing regime for vaccinated individuals within Category 1A Homes serving elderly residents, residents on DRS/leave the Home for work activities who have completed both vaccination doses will be exempted from surveillance testing, after 14 days from the date they received the second vaccination dose.

Annex D: COVID-19 Preparation Information Dossier

Category 1A facilities should ensure that the Dossier is updated daily with the below information:

- Background of home – residents profile, physical layout, shared facilities
- Full list of all staff, contractors/vendors (e.g. cleaning staff) and residents at the Home, including contact details
- Daily records of residents (name, NRIC, ward and bed number, temperature and symptoms) with fever or respiratory symptoms for the past 30 days
- Daily records of staff reporting sick and/or on medical leave for the past 30 days
- Daily records of visitors to the Home (including which cubicle/ward they visited) for past 30 days
- Daily records of contractors to the home for the past 30 days
- Staff, residents movement on the ground e.g. if it is strictly controlled, or free mixing
- All movements of residents in and out of the Home for the past 30 days (from and to hospitals, polyclinics, home leave, outings)
- Care and medical procedures performed at the Homes, particularly those that require close contact e.g. need assistance in daily tasks like showering, medication feeding
- Additional health information of residents: Addiction issues, chronic psychiatric conditions, and/or disabilities (if any)
- Group all residents into two categories:
    - Residents that can be quarantined in Govt Quarantine Facilities (GQF) independently: Independent in Activities of Daily Living (ADL), no care needs, ambulant. This group should also include residents who may not be medication compliant, but can be served medication at the GQF by the staff
    - Residents that have to be quarantined in-situ within the Home: Have some/high care needs e.g. dialysis patients, frail, dementia, ADL dependent & behaviourally non-compliant
- MSF Home split zone arrangements (if relevant)
- Size and occupancy of Home
- Floor plans of Home

Following a confirmed case, Homes should also immediately prepare information about the confirmed case:

- Confirmed case information: name, NRIC, age, ambulatory status, health history
- Date of first onset of fever/respiratory symptoms of confirmed case
- List of staff/vendors/residents who have been in contact with the confirmed case and who entered the cubicle of the confirmed case
- Location of confirmed case’s bed and areas where the confirmed case had been from 2 days before first onset of symptoms