

# Chapter 1: Introduction to the manual

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## Acronyms and abbreviations

ARI	Acute respiratory infection
CDNA	Communicable Diseases Network of Australia
CoP	Community of practice
HAI	Healthcare-associated infection
HW	Health worker
IPAC	Infection prevention and control
MPS	Multi-purpose services
NSW	New South Wales
OMT	Outbreak management team
PHEOC/PHRB	Public health emergency operations centre / Public health response branch
PPE	Personal protective equipment
RACF	Residential aged care facility
SHEOC	State health emergency operations centre

## 1.1 Introduction

This document provides recommendations relating to infection prevention and control (IPAC) measures for COVID-19 and other acute respiratory infections (ARIs) in acute and non-acute health-care settings. Multi-purpose services (MPS), residential aged care facilities (RACF), disability group homes, community residential care group homes and mental health services are other congregate settings that are included with specific emphasis on COVID-19 and influenza. Principles can be applied as required to respiratory syncytial virus (RSV) and other respiratory pathogens.

The manual aligns with the principles outlined in the [NSW Infection Prevention and Control Policy Directive](#) and is consistent with the principles and practices within the [Infection Prevention and Control Practice Handbook](#).

The guidance in this *Manual* also includes IPAC best practice information on COVID-19 and other ARIs, based on the known transmission characteristics, and is also responsive to the changing incidence and burden of infection in the health system. A risk assessment approach has been used to determine the level of precautions and the risk matrix is fully described and illustrated in *Chapter 3: NSW IPAC Response and escalation framework*.

For the latest information and updates on ARIs in general, health workers (HWs) should regularly check the [NSW Health](#) and the [CEC Infection Prevention and Control \(IPAC\) and Healthcare Associated Infections \(HAI\) Program](#) web pages.

The manual should be used in conjunction with the NSW IPAC policy directive, the Infection Prevention and Control Practice Handbook and local procedures. More detail can be sourced from key NSW and national sources if required:

- [NSW Cleaning of the Healthcare Environment Policy Directive](#)
- [National updates – Department of Health](#)
- [Coronavirus \(COVID-19\) - CDNA National Guidelines for Public Health Units](#)

## 1.2 Scope and purpose

The purpose of this manual is to provide guidance on IPAC requirements for patients or clients with suspected or confirmed ARIs (including COVID-19, influenza, RSV and other respiratory pathogens), the use of personal protective equipment (PPE), and transmission prevention strategies in NSW healthcare settings.

The target audience is NSW HWs, health and care staff working within acute and non-acute healthcare settings and residential care group homes including clinicians, infection control professionals, managers, and support staff.

Specific and targeted guidance for the Respiratory Protection Program is beyond the scope of this manual and is available on the CEC [website](#).

**NOTE:** Neither NSW Health or the CEC endorse or promote any products or equipment identified in this guidance document.

### 1.3 Updates to the manual

The development of the manual was led by the CEC in collaboration with CEC IPAC Community of Practice (CoP) and endorsed by the IPAC Operational Steering Committee and expert advisory committees. Refer to *Figure 1: CEC Infection Prevention and Control Safety Program Governance Structure*. The manual will continue to evolve over time with additional information added to address IPAC strategies which will be guided by new or emerging evidence and national recommendations with genuine focus to maintain currency.

Any suggestions or feedback on the manual should be communicated to the CEC via email [CEC-COVID19@health.nsw.gov.au](mailto:CEC-COVID19@health.nsw.gov.au).

### 1.4 Emergency response governance

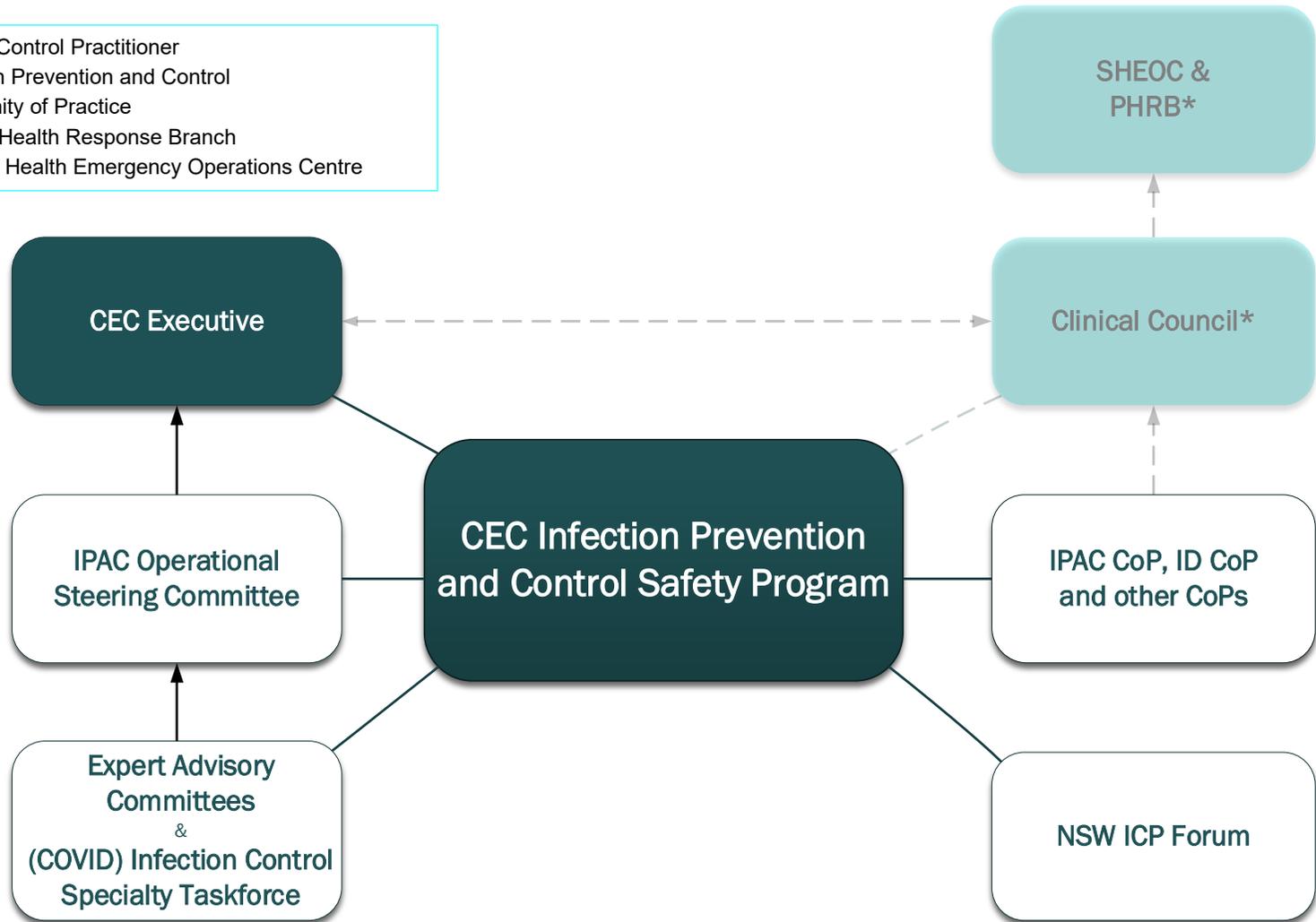
The NSW Health State Preparedness and Response Unit is responsible for 'whole of health' State-level preparedness and response to critical incidents and emergencies including infectious diseases. During an emergency response, NSW Health and partner agencies communicate regularly to determine the most effective and appropriate response. NSW Health coordinates a central, specialised response during the initial stage of a communicable disease of state or national significance management, including high consequence infectious diseases (HCID) to mitigate the risk of a public health emergency and associated healthcare system impacts. For more information refer to the NSW Health policy directive on [Early Response to High Consequence Infectious Diseases](#).

#### **Clinical Excellence Commission (CEC)**

The CEC is a board-governed statutory health corporation, responsible for leading safety and quality improvement in the NSW public health system, including residential care group homes. The role of the CEC is to promote improved clinical care, safety and quality in health services across NSW. CEC also plays a pivotal role to reduce adverse events in acute and non-acute healthcare settings, support improvements in transparency and review these events in the health system. The CEC is the lead agency for Infection Prevention and Control (IPAC) and Health care associated infection (HAI) program for NSW Health.

**FIGURE 1: CEC INFECTION PREVENTION AND CONTROL SAFETY PROGRAM GOVERNANCE STRUCTURE**

**ICP** – Infection Control Practitioner  
**IPAC** – Infection Prevention and Control  
**CoP** – Community of Practice  
**PHRB** – Public Health Response Branch  
**SHEOC** – State Health Emergency Operations Centre



\*Note: SHEOC, PHRB and Clinical Council are activated during an emergency response

## 1.5 Definitions

The following terms are used frequently in this document in the context of ARI management and prevention.

### Acute respiratory infection (ARI) definition

#### Adult:

New onset of

At least **ONE** of the following:

- Cough
- Sore throat or runny nose
- Shortness of breath or difficulty breathing

**AND**

At least **ONE** of the following systemic features:

- Fever or feverishness
- Lethargy, malaise, confusion, or decreased appetite
- Headache
- Myalgia

#### Paediatric and/or those patients who cannot mount an adequate immune response (e.g., oncology, elderly, pregnant or immunosuppressed patients):

New onset of

At least **ONE** of the following:

- Cough
- Sore throat or runny nose
- Shortness of breath or difficulty breathing

**AND**

May or may not include any of the following systemic features:

- Fever or feverishness
- Lethargy, malaise, confusion, or decreased appetite
- Headache
- Myalgia

### COVID-19

COVID-19 is a disease caused by a new strain of coronavirus. 'CO' stands for corona, 'VI' for virus, and 'D' for disease.

#### Clinical

Clinical refers to involving or related to the direct observation, examination and/or treatment of patients/clients.

#### Cluster

A cluster in relation to COVID-19 refers to two or more cases (who do not reside in the same household) that are epidemiologically related in time, place or person, that were diagnosed in the previous 14 days where a common source (such as an event or within a community) of infection is suspected but not yet established.

## Contact tracing

Contact tracing is a process of identifying individuals who have had contact with someone with a transmissible infection in order to isolate, test or treat them. Contact tracing is an essential tool for the management, prevention and control of HAIs

Key Points for COVID-19 contact tracing within healthcare settings:

- Contact tracing should be prioritised to specific high-risk groups/settings
- Contact tracing should occur for in-room contacts
- Contact tracing may be beneficial in outbreaks
- Investigations should focus on COVID-19 cases and close contacts with onsets and exposures in the previous 5 days for settings and groups at increased risk
- Universal case investigation and contact tracing are not recommended for COVID-19

## Day 0 for Isolation

The start of the isolation period is the date of the first positive test (day zero). In some circumstances, if reviewed by infectious disease specialists or their delegates, this could be backdated to the onset of symptoms if there was a delay in seeking a test.

## Declare the outbreak over

COVID-19: Outbreaks can generally be declared over 7 days after the date of isolation of the last case. The decision to declare an outbreak over should be made by the outbreak management team (OMT) in consultation with the public health unit.

Other ARIs: Outbreaks are generally declared over following completion of the infectious period of the last case.

## Healthcare-associated infection (HAI) COVID-19

Definite HAI COVID-19:

- Symptom onset on day >14 after admission.

Probable HAI COVID-19:

- Symptom onset on day 8-14 after admission, OR
- Symptom onset on day 3-7 after admission, if epidemiologically linked to a hospital exposure.

Community-associated COVID-19:

- Symptoms present on admission or with onset on day 1 or 2 after admission (unless epidemiologically linked to a hospital exposure during the last 14 days), OR
- Symptom onset on days 3-7 and a strong suspicion of community transmission.

Note: If onset of clinical features cannot be defined, a case-by-case assessment is required taking account of the date of sampling relative to the date of admission and epidemiological evidence of a link to hospital exposure.

## HAI ARI

There are no formally agreed definitions for either healthcare acquired influenza or RSV infection. However, there are a number of publications assessing the impact of HAI

influenza or RSV. HAI influenza is more common in older adults (> 65years) and has been associated with significant rates of ICU admission including the need for mechanical ventilation.

#### Suggested definitions:

##### HAI Influenza

- A positive influenza RT-PCR and symptom onset > 72 hours after admission

##### HAI RSV

- A positive RSV PCR and symptom onset  $\geq$  96 hours after admission.

#### **Outbreak**

An outbreak is a state characterised by an incidence of an infection greater than what is typically expected in a particular healthcare setting. Typically, in healthcare this has been defined as two or more cases, which should trigger an outbreak management process.

For ARI, two or more cases should trigger a management plan and may be considered an outbreak depending on surrounding circumstances and transmission pathways. For more information on outbreak management refer to [CEC Infection Prevention and Control Practice Handbook](#) and for specific guidance on residential aged care and residential homes refer to this [link](#).

#### **Resolution of symptoms**

Resolution of fever and significant improvement of ARI symptoms for at least the preceding 24 hours. Other symptoms such as headache, fatigue, anosmia, ageusia or a mild persistent cough may continue for some weeks and for HWs will not usually affect time to return to work.

#### **Zone**

A region, area, or section characterised by some distinctive feature or quality. A zone can be considered and used in the context of clinical patient and non-clinical zones, non-COVID zone, PPE zone, red, amber or green COVID zones. Functional areas for healthcare setting and zones may be interchangeable or functional areas may contain zones within these areas.

### **New variants of the virus that cause COVID-19**

All viruses, including SARS-CoV-2, change over time. This may change transmissibility, pathogenicity, escape from natural, hybrid and/or vaccine induced immunity and response to therapeutic medicines. For more information on COVID-19 variants refer to [WHO Tracking SARS-CoV-2 variants](#).

#### References

CDNA [COVID-19 Outbreaks in Residential Care Facilities](#)

ECDC [Surveillance definitions for COVID-19](#)

PD2023\_008 [Early Response to High Consequence Infectious Diseases](#)

WHO [policy brief: COVID-19 surveillance](#), 11 April 2023