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<td>February 2022</td>
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<td>CEC</td>
<td>Clinical Excellence Commission</td>
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<td>IPAC</td>
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1.1 Introduction

The COVID-19 pandemic has required an unprecedented and rapidly evolving response within NSW Health to keep health workers (HWs), patients and visitors safe with the most up-to-date evidence and resources. Since January 2020, the Clinical Excellence Commission (CEC) has developed a wide range of COVID-19 guidance for healthcare and other settings. The COVID-19 Infection Prevention and Control Manual (2022) is a consolidated handbook of the guidance for acute and non-acute healthcare settings. It aims to reduce duplication of COVID-19 infection prevention and control (IPAC) information and to make it more accessible to HWs.

The COVID-19 pandemic has influenced a major change towards more practical and targeted guidance within specific settings to support principles-based policy. The manual


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:


1.2 Scope and purpose

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

The target audience is NSW Health HWs working within acute and non-acute healthcare settings including clinicians, infection control professionals, managers and support HWs.


**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

As new resources or evidence become available, they will be added to the manual. Updates to the information will be guided by new or emerging evidence and national recommendations. The manual will continue to evolve over time with additional chapters added to address IPAC in other settings if required.

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 NSW Health COVID-19 response governance

The NSW Government have brought relevant experts together to lead the State’s coordinated, emergency response to the COVID-19 pandemic. The aim is to embed health operations teams with other critical agencies to respond quickly to this evolving health crisis.

Public Health Emergency Operations Centre (PHEOC) / Public Health Response Branch (PHRB)

PHEOC leads the public health aspects of the response to COVID-19 in conjunction with Public Health Units in local health districts and NSW Pathology and is primarily involved in contact tracing, providing expert advice, issuing public health orders, epidemiology research and a range of other functions.

State Health Emergency Operations Centre (SHEOC)

SHEOC manage and oversee clinical operations in our hospitals and health facilities, support our workforce and facilitate procurement strategies.

NSW COVID-19 Clinical Council

The NSW COVID-19 Clinical Council is a multidisciplinary group that represents clinical specialties linked to the pandemic response and provides independent and impartial strategic advice on system-wide issues that affect preparedness and response to community and patient care in the COVID-19 environment.

Communities of Practice

Clinical Communities of Practice (CoP) have been established across key clinical specialities to support the response to COVID-19. The CoPs are multidisciplinary and include representation from all districts and networks. Currently there are 31 CoPs actively participating in the COVID-19 response.

Clinical Excellence Commission (CEC)

CEC is a board-governed statutory health corporation, responsible for leading safety and quality improvement in the NSW public health system. The role of the CEC is to reduce adverse events in public hospitals, support improvements in transparency and review of these events in the health system and promote improved clinical care, safety and quality in health services across NSW.

1.5 CEC governance

CEC COVID-19 guidance is based on the available evidence, expert advice and risk assessment of the current status of the pandemic in NSW.

The development of the COVID-19 IPAC manual was led by the CEC in collaboration with CEC IPAC Community of Practice and endorsed by the (COVID) Infection Prevention and Control Specialty Taskforce - refer to Figure 1: CEC Infection Prevention and Control Safety Program Governance Structure.
FIGURE 1: CEC INFECTION PREVENTION AND CONTROL SAFETY PROGRAM GOVERNANCE STRUCTURE

ICP – Infection Control Practitioner
IPAC – Infection Prevention and Control
CoP – Community of Practice
MRO – Multiple Resistant Organism
PHRB – Public Health Response Branch
SHEOC – State Health Emergency Operations Centre
1.6 Definitions

COVID-19 is a disease caused by a new strain of coronavirus. ‘CO’ stands for corona, ‘VI’ for virus, and ‘D’ for disease. The following terms are used frequently in this document in the context of COVID-19 management and prevention.

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 gathering information about the people who someone with COVID-19 has had contact with, and locations the person has been when they are infectious.

Day 0 for Isolation

The start of the isolation period is the date of the first positive test. 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

Outbreaks can generally be declared over at 7 days after the date of isolation of the last case. The decision to declare the outbreak over should be made by the Outbreak Management Team in consultation with the public health unit.

Healthcare-associated (HAI) COVID-19

Definite HAI-COVID-19:

- Symptom onset on day >14 after admission

Probable HAI-COVID-19:

- Symptoms 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, the CT value of the test result and epidemiological evidence of a link to hospital exposure.

Imported case

Imported cases are people with COVID-19 who have come from a COVID-19 epidemic area within the last 14 days.
Local case
Local cases are people with COVID-19 who have been in the locality for more than 14 days before onset of illness and have not gone to an epidemic area during this time.

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 COVID-19, one single case should trigger a management plan and may be considered an outbreak depending on surrounding circumstances and transmission pathways.

Resolution of symptoms
Resolution of fever and significant improvement of acute respiratory symptoms for the preceding 24 hours. Other symptoms such as headache, fatigue, anosmia, ageusia or a mild persistent cough may continue for some weeks and usually will not limit release from isolation including return to work.

Suspect case
A suspect case is defined as anyone who has had high-risk contact (close contact) with a confirmed COVID-19 case.

Zone
A region, area, or section characterized 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, hot, cool, red, amber or green COVID zones. Functional areas for healthcare setting and zones may be interchangeable or functional areas may contain zone within these areas.

References
CDNA COVID-19 Outbreaks in Residential Care Facilities
Contact tracing data, Victoria
ECD Surveillance definitions for COVID-19
WHO Public health surveillance for COVID-19, Interim guidance. 16 Dec 2020
Chapter 2: Infection prevention and control strategies for COVID-19

This chapter is part of the COVID-19 Infection Prevention and Control Manual, Clinical Excellence Commission, 2022.

The publication summarises current evidence about COVID-19 infection prevention and control strategies and interventions and their implementation in healthcare settings.

The publication will continue to evolve with additional chapters over time that address infection prevention and control in other settings. As new resources become available, they will be added as hyperlinks to the resources section in each chapter or to the appendices.

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Key points

- SARS-CoV-2 is mainly spread by direct contact with respiratory droplets and these droplets can be of various sizes and can be aerosolised in some specific conditions.
- Virus variants will continue to emerge and may alter the risk of transmission of the virus.
- The application of a hierarchy of controls will significantly reduce the risk of transmission.
- Understanding and application of Standard and Transmission-Based Precautions is essential in the management of COVID-19.
- The use of non-pharmaceutical interventions is required along with personal protective equipment.
- COVID-19 risk assessment should be aligned with the recommendations in Chapter 3: Response and Escalation Framework.

Acronyms and abbreviations

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<td>Air changes per hour</td>
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<td>AGB</td>
<td>Aerosol-generating behaviour</td>
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<td>AGP</td>
<td>Aerosol-generating procedure</td>
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<tr>
<td>ARI</td>
<td>Acute respiratory infection</td>
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<td>ARTG</td>
<td>Australian Register of Therapeutic Goods</td>
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<td>CDNA</td>
<td>Communicable Diseases Network of Australia</td>
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<tr>
<td>CT</td>
<td>Computerised tomography scan</td>
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<td>HVAC</td>
<td>Heating, ventilation and air conditioning</td>
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<td>Health worker</td>
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<tr>
<td>IFU</td>
<td>Instructions for use</td>
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<td>IPAC</td>
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2.1 Introduction

This chapter provides an introduction to understanding SARS-CoV-2, the virus that causes the disease COVID-19, and the worldwide pandemic that has evolved since January 2020. The principles of infection prevention and control (IPAC) describe fundamental processes to keep HW, patients and visitors safe.

2.2 How COVID-19 spreads

The primary mechanism of transmission of SARS-CoV-2 is via infected respiratory droplets. SARS-CoV-2 replicates in the respiratory tract and the highest viral load is just prior to symptom onset or in the first 5 days of symptoms. Transmission also occurs with asymptomatic infection.

Infection occurs either by direct or indirect contact with respiratory droplets. Most transmission occurs through close contact:

- People who are physically near (within 1.5 metres) a person with COVID-19, or have direct contact with that person, are at greater risk of infection compared to individuals who remain >1.5 metres from cases. Transmission studies show household members are at the highest risk.

- Infections occur mainly through exposure to respiratory droplets when in close contact with someone who has COVID-19. Respiratory droplets of various sizes are produced by breathing, talking, coughing, sneezing and behaviours such as singing and shouting.

- Respiratory droplets cause infection when they are inhaled or deposited on mucous membranes, such as those that line the inside of the nose and mouth.
Pathogens mainly transmitted by close contact can sometimes also be spread via airborne transmission through aerosols. Circumstances where airborne transmission of SARS-CoV-2 appears to have occurred include:

- **Enclosed spaces** within which an infectious person either exposed susceptible people at the same time or to which susceptible people were exposed shortly after the infectious person had left the space

- **Increased exposure to respiratory particles**, often generated with expiratory exertion (e.g., shouting, singing, exercising) that increase the concentration of suspended respiratory droplets in the air space

- **Inadequate ventilation or air handling** that didn’t adequately remove suspended small respiratory droplets and particles from the air.

Other consideration when assessing for airborne transmission risk:

- COVID-19 can be spread by exposure to the virus in small droplets and particles that can linger in the air for minutes to hours

- As respiratory droplets travel further from the person with COVID-19, the concentration of droplets decreases. Larger droplets fall out of the air due to gravity. Smaller droplets and particles spread apart in the air

- With passing time, the amount of infectious virus in respiratory droplets also decreases

- There is evidence that under certain conditions, people have been infected with SARS-CoV-2 despite being more than 1.5 metres away from someone with COVID-19. This has usually occurred within enclosed spaces with inadequate ventilation. Sometimes the infected person was breathing heavily, for example while singing or exercising

- Under these circumstances, scientists believe that the amount of infectious smaller droplets and particles produced by people with COVID-19 became concentrated enough to spread the virus to other people. The majority of spread however is via close contact rather than via airborne transmission (CDC, 2020).

**Reproductive number of coronavirus**

The reproductive number of coronavirus provides an estimate of the possible extent of disease transmission. Estimates for the basic reproductive number ($R_0$) of SARS-CoV-2 range from 2-4, with $R_0$ for confined settings, e.g., cruise ships, at the higher end of this range. The estimated $R_0$ for the Delta variant is between 2 – 4 and for Omicron 4.4 times greater than Delta variant.

Estimates of the effective reproductive number vary between settings and at different time points and are dependent on a range of factors, including public health interventions such as isolation, quarantine and physical distancing to limit close contact between people (Liu et al. 2020; Zhao et al. 2020). The recent identification of SARS-CoV-2 variants has some strains with significantly higher transmission risk, and these are associated with increased viral load.
New variants of the virus that causes COVID-19

All viruses, including SARS-CoV-2, the virus that causes COVID-19, change over time. Most changes have little to no impact on the virus’ properties. However, some changes may affect the virus’s properties, such as how easily it spreads, the associated disease severity, or the performance of vaccines, therapeutic medicines, diagnostic tools, or other public health and social measures. For more information on COVID-19 variants refer to WHO Tracking SARS-CoV-2 variants.

Incubation and infectious period

The incubation period is the duration between exposure to the virus and the onset of symptoms. The WHO currently estimates that the incubation period for COVID-19 ranges from 1 to 14 days, with a median incubation period of 5 to 6 days and only 3 days for Omicron. There are some case series which show that the incubation period may extend to 17 days. Most people become symptomatic 5 to 6 days after coming into contact with another infected person, with a range of 1 to 14 days. Around 1% of COVID-19 cases will develop symptoms more than 14 days after exposure. The advice in this guideline uses an upper range of 14 days to guide public health measures such as quarantine and isolation.

Epidemiological data to date suggests that most of the transmission occurs from symptomatic cases. COVID-19 appears to be infectious from 1-3 days prior to symptom onset with most onward transmission occurring early after infection.

Taking a precautionary approach, cases are currently considered infectious from 48 hours prior to the onset of symptoms until they meet criteria for release from isolation. More conservative periods (e.g., 72 hours prior to onset of symptoms) may be considered in high-risk settings at the discretion of the Public Health Unit. To prevent onward transmission, cases require isolation until release from isolation criteria have been met (Australian Government Department of Health, 2021a).

2.3 Deisolation and testing post COVID-19

Deisolation or release from isolation criteria consider both patient factors (presence of immunocompromise) and settings (high risk settings such as healthcare). Therefore, deisolation requirements for healthcare differ from those who remain in the community. More information on deisolation criteria for those in the community can be found here.

The following information details the circumstances under which all confirmed cases can be released from isolation. This includes confirmed cases infected with a SARS-CoV-2 variant of concern. For more information refer to Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units

Patients with COVID-19 who are discharged back to their home environment need to comply with current NSW Health advice about isolation duration and conditions.

HWs who have COVID-19 and are isolating at home are also required to comply with the current NSW Health advice about isolation duration and conditions. In some circumstances, a decision about return to work may be complex and advice from their GP, or Infectious Disease/Clinical Microbiology or other specialist is recommended. For further information refer to Appendix 2A: Deisolation criteria for COVID-19 within NSW healthcare facilities.
2.4 Safe working principles

This section outlines the principles of the hierarchy of controls and safe working principles for acute and non-acute healthcare settings.

Work-related risk is managed under the Work Health and Safety Act (2011), Regulations, and the approved code of practice ‘How to Manage Work Health and Safety Risks’. These require all Australian workplaces to assess and manage risk ‘so far as is reasonably practicable’ (Safe Work Australia, 2018). This also applies to the assessment and management of risk related to the transmission of COVID-19.

Controlling exposures to occupational hazards is the main way to protect personnel in a workplace. Usually, a hierarchy is used to achieve practical and effective controls of workplace hazards. The hierarchy lists different risk avoidance or mitigation strategies in decreasing order of effectiveness. Multiple control strategies can be implemented at the same time and/or following on from each other.

The code of practice requires workplaces to undertake a risk assessment and apply controls using the hierarchy of controls – see Figure 2: An example of a hierarchy of control for COVID-19.

2.5 Occupational Exposure to COVID-19

Protection of HW includes having appropriate risk assessment and risk mitigation strategies in place. However, there may be occupational exposures which need to be reported and investigated as soon as possible. The risk varies based on the type of work being performed, the potential for interaction with infected people, the type of PPE worn or not worn and contamination of the work environment and precautions in place. Caring for a patient in the correct PPE is not considered occupational exposure in this context.

An occupational exposure is defined as an incident which occurs during a person’s employment and involves contact with blood or other body substances. The greatest occupational exposure risk for COVID-19 is splash to eyes, nose/nares or mouth of respiratory particles.

Where such an exposure occurs, the following principles apply:

- Carry out first aid immediately:
  - Skin: wash the exposed site with soap and water
  - Eyes: rinse thoroughly while eyes are open with water/normal saline
  - Mouth: spit out and rinse with water several times
  - Clothing: Remove, shower if necessary

- Notification of the incident to immediate supervisor or manager.

Management of HWs with occupational exposure to COVID-19

Any occupational exposure assessment and management should involve Occupational Staff Health, Infection Prevention and Control, Infectious Diseases (where available) and Public Health.

Classification of contacts for the purpose of contact tracing - for close and casual contacts outside of the workplace, NSW Health definitions and requirements apply.
• Based on the risk assessment (see PPE Breach Risk assessment key principles chart below), inform HWs of their level of exposure and likely actions required, while maintaining confidentiality
• Liaise with local PHU and follow advice on:
  o Quarantine HW (home isolation or community support accommodation)
  o Testing requirements
  o Provide information on the need to monitor for symptoms and importance of consistent adherence to all recommended mitigation strategies such as hand hygiene, mask wearing, cleaning and disinfection
  o Support and encourage working from home or options to telework where possible
  o Consider using a hotline or another method for HWs to voice concerns anonymously
  o Provide follow up and support as required and plan for return to work.

Recording and reporting of a positive RAT

For all persons returning a rapid antigen test (RAT) result as positive for COVID-19, reporting of this result through Service NSW is now mandatory. This may be done through the Service NSW app, website or phone service. For more information refer to Register a positive rapid antigen test result. Also, NSW Health entities are required to report the RAT results through StaffTrakr application, developed by eHealth NSW as a web-based, mobile-friendly application that allows HWs to record and share their test results with the appropriate managers within their entity and be advised on the next steps to take. For more information refer to StaffTrakr - app for recording rapid antigen test results.
PPE Breach Risk Assessment key principles

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

- Where injury has occurred perform immediate first aid
- Where monitoring and surveillance returns a positive COVID-19 result refer to Incident Action Plan for public health responses to COVID-19 exposures in hospital settings for management of cases and contacts. For more information refer to NSW Health COVID-19 advice for health professionals.

<table>
<thead>
<tr>
<th>LOW RISK BREACH</th>
<th>Remove from situation Remove item Perform Hand Hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breaches in PPE that occur below the neck and managed immediately (e.g., torn glove)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MODERATE RISK BREACH</th>
<th>Remove from situation Remove PPE Perform Hand Hygiene</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect use of PPE, incorrect PPE for task Contamination occurs during doffing (occurs above neck)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>INCREASED RISK OF INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening/testing and continuous monitoring</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGH RISK BREACH</th>
<th>Remove from situation Remove PPE Closely Monitor, screen/test Risk assesses and likely removal from clinical duties*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure of mucous membranes by direct droplets from confirmed COVID-19 positive. (e.g., spitting in HW face by confirmed COVID-19 patient)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIKELY RISK OF INFECTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gross contamination during incorrect doffing Contamination occurs during doffing</td>
</tr>
</tbody>
</table>

* Refer Healthcare worker COVID-19 exposure risk assessment matrix for more information

Adapted and modified from work developed by AUSMAT Quarantine management and operations compendium for the Howard Springs Quarantine Facility for the Repatriation of Australians at the Centre for National Resilience. National Critical Care and Trauma Response Centre. Darwin 2021.
**FIGURE 2: AN EXAMPLE OF A HIERARCHY OF CONTROL FOR COVID-19**

### Hierarchy of Control

<table>
<thead>
<tr>
<th>Hierarchy of Control</th>
<th>Examples of control measures to prevent transmission</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elimination</td>
<td>• Vaccination</td>
</tr>
<tr>
<td></td>
<td>• Testing and quarantine at borders</td>
</tr>
<tr>
<td></td>
<td>• Travel restrictions</td>
</tr>
<tr>
<td>Substitution</td>
<td>• Physical distancing</td>
</tr>
<tr>
<td></td>
<td>• Symptomatic HW and agency group stay home and do not come to work</td>
</tr>
<tr>
<td></td>
<td>• Remote working</td>
</tr>
<tr>
<td></td>
<td>• Telehealth</td>
</tr>
<tr>
<td>Engineering Controls</td>
<td>• Ventilation and improved air changes</td>
</tr>
<tr>
<td></td>
<td>• Registration of all people entering the facility (symptom check, QR code)</td>
</tr>
<tr>
<td></td>
<td>• Negative pressure rooms</td>
</tr>
<tr>
<td></td>
<td>• Single room with ensuite</td>
</tr>
<tr>
<td></td>
<td>• Isolation of patients</td>
</tr>
<tr>
<td>Administrative controls</td>
<td>• Audit and feedback</td>
</tr>
<tr>
<td></td>
<td>• Hand hygiene</td>
</tr>
<tr>
<td></td>
<td>• Cleaning and disinfection</td>
</tr>
<tr>
<td></td>
<td>• Signs, posters, information sheets</td>
</tr>
<tr>
<td></td>
<td>• IPAC Guidance documents</td>
</tr>
<tr>
<td></td>
<td>• Training and education of HW</td>
</tr>
<tr>
<td>PPE</td>
<td>• Symptomatic patients wear surgical mask</td>
</tr>
<tr>
<td></td>
<td>• Correct transmission-based precautions, PPE worn when in contact with symptomatic patients</td>
</tr>
</tbody>
</table>

*Most effective*  
*Least effective*
For more information refer to the Australian Government Department of Health Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: the hierarchy of controls.

The adherence to hierarchy of controls including use of PPE is key in the prevention and control of any exposure to communicable diseases and pathogenic organisms. PPE requirements should be based in accordance with clinical circumstances and risk assessment.

COVID-19 vaccination reduces the risk of both infection and the risk of disease requiring hospitalisation. Vaccination information is changing rapidly and for the most up-to-date advice see COVID-19 vaccination in NSW. NSW Health workers are required to comply with the vaccination requirements of the NSW Health Public Health Order and ATAGI advice.

Risk assessment refers to utilising PPE when there is an anticipated or likely risk of contamination with splashes and/or droplets of blood or body substances. A risk assessment must be performed on the level and type of PPE required for clinical care of suspected or confirmed COVID-19 patients according to current epidemiological data, local prevalence and clinical features that might indicate elevated COVID-19 risk.

The following outlines the key elements of safe working for HWs:

- HWs are trained in the basic principles of infection prevention and control including donning and doffing of PPE; videos are available for training
- HWs know how to risk assess which PPE they should wear for their healthcare setting and clinical circumstance
- HWs have access to PPE that protects them for the appropriate setting and context
- HWs are bare below the elbows during clinical care to enable hand hygiene
- Gloves are single use as per Standard Precautions and removed after each patient contact or changed when clinically indicated
- Fluid resistant apron or gown can be worn for a session of care if the item does not come into contact with patients or their environment e.g., COVID-19 testing clinic, and are not visibly contaminated. If the apron or gown comes in contact with the patient or their environment during care, it must be doffed followed by hand hygiene
- Fluid resistant surgical masks, P2/N95 respirators and eye protection can be used for a session or extended period of work rather than a single patient contact
- Hand hygiene must be performed after removing any element of PPE.

2.6 Strategies to prevent or minimise transmission of COVID-19

To control or prevent the transmission of an infection it is essential to understand that the transmission pathway can be broken at any point in the chain of infection. Figure 3 illustrates the break in the chain of infection in the context of COVID-19.
STOP COVID-19

Break the chain of infection

- **STAY HOME**
  if you feel unwell and get tested

- **VACCINATE**
  and keep up-to-date

- **PHYSICAL DISTANCING**
  when outside your home

- **WEAR**
  a mask as recommended

- **CLEAN**
  hands frequently

- **CLEAN**
  frequently touched surfaces

- **COVER**
  coughs & sneezes with a tissue or your inner elbow and place used tissues in bin immediately

_AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTHCARE_
Standard Precautions

Standard precautions represent the minimum infection prevention measures that apply to all patient/client care, regardless of suspected or confirmed infection status of the patient/client, in any setting where healthcare is delivered.

Standard precautions apply to all settings where care is provided or where there is a risk of blood or body fluid exposure including acute and subacute care facilities, home care settings, community settings and other settings such as mortuaries. HWs must perform hand hygiene in accordance with the National Hand Hygiene Initiative. All HWs having direct contact with patients or a patient’s environment should ensure they are bare below the elbow.

During the COVID-19 pandemic there will be additional infection prevention and control practices in place to prevent or limit the transmission of COVID-19 which are described below. Before deciding on the IPAC strategies for individual patient care HWs must perform a risk assessment on the type of patient interaction, the risk of transmission of the infectious agent, and the risk of contamination of the mucous membranes by patients’ blood, body substances, secretions or excretions and how long the PPE is likely to be required to be worn, along with patient placement or cohorting.

2.6.1 Early recognition of patients with suspected or confirmed COVID-19

Early recognition of patients who have suspected or confirmed COVID-19 is essential to maintaining the health and well-being of HWs, patients/clients and the community. The symptoms of COVID-19 include:

- fever (37.5°C or higher)
- cough
- sore/scratchy throat
- shortness of breath
- runny nose
- loss of smell or
- loss of taste.

There are a number of other reported symptoms which include:

- fatigue
- muscle pain
- joint pain
- headache
- diarrhoea
- nausea/vomiting
- loss of appetite
- chest pain
- conjunctivitis.

In more severe cases, infection can cause pneumonia with severe acute respiratory distress.

**Note:** NSW Health recommends that anyone with respiratory symptoms, loss of sense of smell or taste, or unexplained fever is tested for COVID-19.
Case definition

The national case definition for COVID-19 is provided by the Communicable Diseases Network Australia (CDNA). Case definition may change over time based on variety of factors, including current epidemiology and testing capacity. Check the NSW Health website for advice on latest case definitions and testing criteria.

Surveillance Testing

Persons meeting the close contact definition should be tested for SARS-CoV-2. NSW Health COVID-19 clinics and information is available here. Refer to information from NSW Health Pathology regarding which laboratories can provide SARS-CoV-2 testing, appropriate specimen type, and specimen collection and transport.

Visit Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units for more information regarding IPAC recommendations when collecting specimens. There should be a low threshold for COVID-19 testing patients presenting to the Emergency Department or inpatients. In a setting of widespread community transmission, more extensive testing of hospital patients is expected.

2.6.2 Physical distancing and use of shared space

Where possible, physical distancing is to be practiced within healthcare facilities, between HWs and patients, and between HWs to limit the transmission of COVID-19. This includes:

- Waiting room chairs and other seating separated by greater than 1.5 metres
- Where practical, HWs and patients to remain greater than 1.5 metres apart except for clinical examinations and procedures, acknowledging that in some environments such as ambulance and transport, this may not be possible.

Additional precautions are required for workers in a shared space. Shared working space can include vehicles, small rooms, tea rooms, HW meeting rooms, conference rooms, break out rooms, HW stations or any room which workers may use to congregate. As vehicles are enclosed and are confined spaces, there is an increased risk of cross transmission.

For more information refer to the Health worker safety tab on the CEC website. The additional precautions are:

- Where possible workers to maintain physical distancing requirements in any shared areas
- Ensure signage is displayed to advise on the number of people allowed in a tearoom at any given time
- Considerations should be given to safer ways to eat and drink when designated meal rooms or eating areas are not available (e.g., not removing or pulling down mask in clinical areas to have drink). Refer to IPAC Practice Handbook section 4.10.5 Food consumption by HWs for more information.
- When entering the tearoom or other shared space mask is worn except when eating and drinking
- In an enclosed space (vehicle or small room), the situation arises where you must remove your mask (e.g., eating or drinking) make sure to do it in a safe way with only
one person at a time when removing your mask. If possible, allow external ventilation e.g., change car airflow to external exhaust not recirculate

- Use a surgical mask when sharing space with other people if physical distancing cannot be maintained (such as in a vehicle or confined tearoom space)
- Ensure safe mask use, dispose correctly and perform hand hygiene after disposal
- Use virtual meetings or gatherings where possible
- Worker’s car-pooling to and from work should be risk assessed
- Workers are to perform hand hygiene when entering and exiting shared spaces
- Ensure hand hygiene products are available at the entrance and exit
- Avoid crowding and attempt to schedule breaks in advance with flexibility
- If the room capacity is limited, consider choosing an alternative space, or if time permits wait for others to leave the area
- Where possible consider having a responsible person to perform unannounced checks of activity in these areas
- Ensure availability of neutral detergent wipes or solution for cleaning surfaces such as high touch points and equipment (e.g., taps, kettles, fridge handles and microwaves)
- Ensure shared areas are kept clean and tidy after use
- Remove items that cannot be cleaned or wiped down (including magazines and clutter)
- Laminate signs or notices posted in shared workspaces and wipe down with neutral detergent regularly
- Do not share stationary such as pens, post-it notes and writing pads
- Wipe down shared items such as computer keyboards, mouse, phone handsets, desk, keypad with neutral detergent before and after use
- Take all personal stationery and belongings when leaving a workspace and remove all personal belongings from tearooms
- Personal belongings should be stored in dedicated areas and not in shared workspaces
- Ensure ongoing enhanced cleaning of shared work environments as per the local cleaning schedule
- Designated person to ensure the cleaning has been undertaken and should maintain documentation

For further information on Non-acute healthcare settings see Chapter 7.

2.6.3 Respiratory hygiene and cough etiquette

The following measures to contain respiratory secretions are recommended for everyone. HWs are to provide education to patients/clients on:
• Covering the mouth and nose with a tissue when coughing or sneezing
• If a tissue is not available, cough or sneeze into the elbow
• Use the nearest bin to dispose of the tissue after use
• Perform hand hygiene e.g., hand washing with soap and water for 20 seconds or use alcohol-based hand rub (ABHR) after coughing or sneezing or if contaminated objects, materials, or equipment are touched.

The following should be available in waiting areas for patients and visitors:
• Relevant signage and education resources/posters
• Tissues and no-touch receptacles for used tissue disposal
• Conveniently located dispensers of ABHR; where sinks are available ensure that supplies for hand washing (i.e., soap, disposable towels) are always available.

A poster on Respiratory Hygiene for waiting areas is available on the CEC website.

2.6.4 Provide advice for patients with acute respiratory symptoms and/or suspected or confirmed COVID-19

Patients with any acute respiratory infection (ARI) symptoms must be encouraged and supported to wear a surgical face mask providing it is tolerated and not detrimental to their medical or care needs. This is to minimise the dispersal of respiratory secretions and reduce both direct transmission risk and environmental contamination.

• A surgical mask should only be worn by patients if their clinical care is not compromised for example, when receiving oxygen therapy via an oxygen mask
• The surgical mask can be worn until it is damp, moist, damaged or uncomfortable for the wearer. Provide education on appropriate use, storage and cleaning if reusable
• Once the patient is isolated in a single room, they do not need to routinely wear a mask
• Patients should be encouraged to perform hand hygiene before leaving their room.

2.6.5 Application of infection prevention and control principles

When applying infection prevention and control principles, three main levels of controls must be considered. The first level consists of administrative controls, which are measures taken to ensure that the entire system is working effectively. These controls include:

• Implementing proper procedures for triage of patients
• Detecting infections early
• Separating infectious patients from others
  o Consideration for the establishment of cohort COVID zones within the functional clinical zones to separate infectious patients from others
  o Also consider the concept of ‘ring fencing’ (e.g., identifying a designated boundary or a zone for collocating these patient groups) potential high risk non-COVID patients such as high-risk surgery and immune suppressed patients within functional areas or zones
• Transporting patients safely
• Educating patients, carers and HWs
• Designating responsibilities clearly and correctly
• Communicating with all relevant partners.

The second level is environmental and engineering controls, including cleaning of the environment, spatial separation and the ventilation of spaces.

The third level of control to further decrease the risk of transmission is personal protection, which is the provision of appropriate PPE (e.g., masks, eye protection and respirators).

When implementing infection prevention and control principles in healthcare settings, all levels of controls (administrative controls, environmental and engineering controls, and personal protection) must be given proper attention for the system to work effectively, and for the different levels to support each other.

Environmental and engineering controls

Environmental and engineering controls are an integral part of IPAC that include standards for adequate ventilation according to specific areas in healthcare facilities, adapted structural design, spatial separation, as well as adequate environmental cleaning.

Heating, Ventilation and Air-conditioning (HVAC) design in Australian healthcare facilities is regulated through the following guidelines:

- Australian Health Facility Guidelines
- State design guidelines
- AS1668.2-2012 – Section 5 – use of ventilation and air conditioning in buildings
- HB260 – 2003 Hospital acquired infections, Engineering down the risk
- GL2021_014 Engineering Services

There are three methods that may be used to ventilate spaces within healthcare facilities: natural, mechanical and hybrid (mixed mode) ventilation. Each ventilation system has advantages and disadvantages, and any modifications to healthcare ventilation need to be made carefully, taking into consideration the cost, design, maintenance and potential impact on the airflow in other parts of the healthcare facility. For more information refer to Recirculating air filtration device use in NSW hospitals – Safety Information.

Ventilation requirements for management of COVID-19

Room placement of high-risk patients should ideally be in a negative pressure room with anteroom. Where not available, a standard isolation room or a single room where there is neutral airflow with air condition or externally exhaust air handling system (refer to facility engineering service) is an acceptable alternative. Rooms with positive pressure airflow should be avoided. Other design types require additional risk assessment (Australasian Health Facility Guidelines, part D, Infection Prevention and Control).

Where single rooms are not available confirmed COVID-19 patients may be cohorted based on additional risk assessment and management using local facility procedures as guidance.

Ensure ventilation systems operate properly and provide acceptable indoor air quality for the occupancy level for each space.

• A room with ≥12 air changes per hour (ACH) [equivalent to ≥80 L/s for a 4×2×3 m³ room] and controlled direction of air flow is recommended for Airborne Precautions.
• In addition to the requirement of ≥12 ACH, in a mechanically ventilated airborne precaution room negative pressure (class N) is required to control the direction of air flow.

Other considerations when managing patients suspected or confirmed to have COVID-19

• For patient care activities, use disposable or dedicated equipment. ALL reusable equipment must be cleaned and disinfected before and after use
• Intra-hospital transfers
  o Avoid transferring patient out of room or zone unless medically necessary
  o Avoid multiple patient bed moves within ward areas
  o Prior to transporting the patient, the receiving unit/location must be notified of the transfer and should have a single room or isolation area prepared for immediate occupancy
  o Where transfer is required, patients should wear a surgical/procedural mask during transfer, perform hand hygiene and follow respiratory hygiene and cough etiquette
  o Any HW transporting the patient should wear PPE (gown, gloves, P2/N95 respirator and eye protection)
  o Patients should be transported using the most direct route to their destination
  o Clear elevator of occupants other than the patient and transport HW in appropriate PPE. Elevator rails and buttons are to be disinfected after transport
  o The chair or bed used to transport the patient must be thoroughly disinfected after use
  o Other IPAC strategies such as adequate air flow, ventilation, hand hygiene should be maintained during transport
• Allocating any necessary shared patient care equipment to the patient
• Limit the number of HW interactions by bundling the patient care activities or cohorting HWs where possible or practical.

2.6.6 Application of Standard Precautions for all patients at all times

Standard Precautions represent the minimum infection prevention measures that apply to all patient care, regardless of suspected or confirmed infection status of the patient, in any setting where healthcare is delivered. These evidence-based practices are designed to both protect individuals and prevent spread of infection among patients and HWs. Standard Precautions comprise of the following measures:

• Hand hygiene
• Respiratory hygiene (cough etiquette)
• PPE if contact with blood or body fluids is anticipated
• Aseptic technique for clinical procedures
• Occupational exposure prevention: management of needlestick/sharps injuries or blood and body fluid splashes
• Cleaning and disinfection of the healthcare environment and shared patient care equipment
- Safe handling of used linen and waste disposal.

### Health Worker Mask Use

As COVID-19 will continue to be present in the community for some time, continued use of non-pharmaceutical interventions such as mask wearing will be required. This, including screening and physical distancing, may apply through the [NSW COVID-19 Public Health Order](https://www.health.nsw.gov.au/PDF/COVID-19-Orders.pdf) (PHO) based on community transmission and epidemiological risks.

<table>
<thead>
<tr>
<th>Low Transmission (GREEN ALERT)</th>
<th>Moderate Transmission (AMBER ALERT)</th>
<th>High Transmission (RED ALERT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>HW to wear a surgical mask if within 1.5m of patients with ARI</td>
<td>HWs to wear surgical mask when in healthcare facilities, this includes clinical and non-clinical areas (e.g., on entry, corridors, office spaces)</td>
<td>Universal surgical mask use by all HWs within health facilities</td>
</tr>
<tr>
<td>All Emergency Department (ED) HWs to wear surgical masks in clinical areas during patient care and if droplet precautions required, eye protection when within 1.5m</td>
<td>In a shared office space, HWs are required to wear a mask unless they are the only person working in the office</td>
<td>Eye protection when within 1.5m of a patient</td>
</tr>
<tr>
<td></td>
<td>Eye protection when within 1.5m of a patient</td>
<td>P2/N95 respirator for suspected or confirmed COVID-19</td>
</tr>
</tbody>
</table>

**Important message regarding mask use:**

- HWs should change PPE including masks throughout the day before breaks, moving between zones, or if masks become moist or damaged
- Perform hand hygiene before and after changing a mask.

### 2.6.7 Implement Transmission-Based Precautions

Transmission-Based Precautions should be used when Standard Precautions alone are insufficient to interrupt the transmission of a microorganism based on its mode(s) of transmission.

Transmission-Based Precautions include Contact, Droplet and Airborne Precautions which are designed to limit transmission of certain communicable diseases and pathogenic or multi-resistant organisms. HWs must understand the basic principles of Contact, Droplet and Airborne Precautions as they are individually applied:
• **Contact Precautions** protect the HW by minimising the COVID-19 transmission risk from direct physical contact with patients or indirect contact from shared patient care equipment or from contaminated environmental surfaces

**Contact Precautions PPE**

- Hand Hygiene
- Disposable Gloves
- Fluid Resistant Apron or Isolation Gown

• **Droplet Precautions** protect the HWs nose, mouth and eyes from droplets produced by the patient coughing and sneezing

**Droplet Precautions PPE**

- Hand Hygiene
- Surgical Mask
- Eye Protection

• **Airborne Precautions** protect the HWs respiratory tract from very small and unseen airborne particles that become suspended in the air.

**Airborne Precautions PPE**

- Hand Hygiene
- P2/N95 Respirator

Respiratory protection devices are an important aspect of infection prevention and control, and aligning within the hierarchy of control as PPE, they should be considered as the last line of defence.

Although the predominant mode of transmission of SARS-COV-2 appears to be via close contact with respiratory particles (droplet transmission), there are well documented transmission events which implicate small particles (airborne transmission), particularly in circumstances of poor ventilation.

Airborne precautions require the use of P2/N95 respirators and eye protection whereas droplet precautions are implemented using surgical masks and eye protection. Respirators have a tight fit around the wearer face as the model and size of the respirator is specific to...
the wearer to ensure an adequate seal. Hence, respirators are recommended for HWs who provide care to COVID-19 patients.

The following recommendations are based on a critical appraisal of the existing evidence and experience from specific settings and most importantly, consensus from frontline experts. These recommendations will continue to be revised as new research evidence or identified risks emerge.

**Droplet Precautions** (surgical mask and eye protection).

- Patients negative for COVID-19 without epidemiological link, but ARI or recent onset of fever without an alternative clinical focus. (Screening and testing for other respiratory viruses are recommended).

**Contact, Droplet and Airborne Precautions** (P2/N95 respirator and eye protection)

- Confirmed COVID-19 cases
- Suspected cases (a person who meets clinical AND epidemiological criteria or a person identified as a high-risk contact by the NSW Public Health Unit, regardless of symptoms)

**Note:**

- The use of gloves is recommended as part of standard precautions to reduce the risk of contamination of HWs hands when exposure to blood and body substance is expected. COVID-19 is not transmitted via intact skin and therefore, gloves do not add a layer of protection against COVID-19
- The choice of wearing a fluid resistant apron or gown is based on a risk assessment around the level of contact to blood and body substance exposure; the approach remains the same during the COVID-19 pandemic
If the HW anticipates direct contact with the patient, then the risk assessment will direct them to an apron or gown for standard and/or transmission-based precautions.

If there is no risk of a body substance exposure on their uniform or skin, an apron is suitable. Whether an apron or a gown is worn, it should be changed between contact with patients or their environment.

Extended use of a gown or apron is only acceptable in minimal contact areas such as COVID-19 testing centres/clinics. For more information refer to **Gown or Apron: Principles for Risk Assessing**.

**For the care of confirmed or suspected COVID-19 patients:**

- P2/N95 respirator and eye protection to be worn (extended use based on risk assessment)
- Gowns or gloves are not required outside of the patient's procedure room (e.g., in the corridor or nurses’ station)
- Adhere to hand hygiene practices, cleaning of shared patient equipment in between patient care
- Gowns or aprons (risk assessment) and gloves to be applied at the entrance to the room if:
  - There is likely to be direct contact with the patient (e.g., assisting with personal care)
    - Gown and gloves are not required if you are placing a food tray on the table or talking to the patient
  - Any AGP / AGB occurring (e.g., patient is known to have a cough)
  - Transporting patient to another ward or for other investigations e.g., Medical imaging / surgery
  - Gloves are to be changed between dirty and clean tasks on the same patient with adherence to hand hygiene
  - PPE to be worn as per standard precautions e.g., handling or risk of blood or body substance exposures or as part of usual practice (e.g., dental)
- Gown and gloves to be removed before exiting the room along with hand hygiene practices

**Organisation of patient zones or cohorting**

Zoning (cohorting) refers to the grouping of patients with the same condition in the same area. The goal of zoning or cohorting patients (and the HW that attend to them) is to minimise interaction between infectious patients and non-infected patients as much as possible. For COVID-19 this would require keeping patients who are confirmed COVID-19 together in the same zone that is separate from those who are not infected. Alternatively, separating into an area of COVID-19 recovered or non-COVID patients together. If layout and staffing allow (may vary between facilities), consider the following factors before establishing zones.

The organisation of zones depends on factors such as:

- physical building space
- availability of single or shared rooms in a specific area to enable zoning
- ability of patients to be relocated
- staffing capacity
- number of suspected or confirmed COVID-19 cases
• acuity of COVID-19 positive patient
• number of contacts
• access to bathroom

The following are examples of how zoning could be applied for COVID-19:

1. **Red zone** - COVID-19 positive clients  
2. **Amber zone** - COVID-19 high risk contacts or suspected cases  
3. **Green zone** – patients that have been cleared of being COVID-19 cases or contacts  
4. **Blue zone** – areas only accessed by staff.

### 2.7 Visiting patients/clients in healthcare facilities

During the COVID-19 pandemic NSW healthcare facilities should continue to support patients to receive visits from partners, family, friends, carers and/or volunteers. This also applies to participants in care. Supporting visitor access can be achieved through additional screening or testing, vaccination, education and supervision of visitors and participants in care using the correct PPE and other IPAC strategies such as hand hygiene and physical distancing.

The advice on the requirement of PPE, visitor number and visitor restriction are based on the response to the transmission risk level within NSW and acknowledgement of individual patient needs - refer to Chapter 3: Response and Escalation Framework for more information.

### Permitting family members or carers to visit:

- Can provide support advocacy for the patient
- Can provide important context and background information to enable wholistic care
- Can significantly reduce the distress, confusion and wandering experienced by patients with cognitive impairment
- Ensure patient, families and carers are involved in decision-making during last days of life, and enable bereavement support to occur
- Enables them to identify and escalate their concerns about changes in a patient’s condition e.g., directly to a staff member or via REACH or similar patient and family activated response systems
- Not only benefits the patient and family experience of care, but also the experience of staff caring for them through a partnership that contributes to safe quality care

For more information refer to Appendix 2C: Supporting visitor access in health facilities during COVID-19 Red Alert and Table 2: Criteria for visitation and IPAC strategies.

### 2.8 Environmental cleaning

Environmental cleaning and disinfection are crucial to preventing transmission of infection in the healthcare environment. Coronavirus can persist on surfaces but can be effectively inactivated by appropriate disinfectants. It is important to clean before disinfecting as dirt and grime can affect how well a disinfectant works.
Routine cleaning and disinfection

Cleaning tasks of the COVID-19 patient care environment should be undertaken using an appropriate detergent and disinfectant solution by following Contact, Droplet and Airborne Precautions while cleaning.

High touch point cleaning is used to describe frequently touched surfaces by patients, HWs, volunteers and visitors within the healthcare environment. High touch points (such as doorknobs, bedrails, tabletops, light switches, patient handsets) in the patient’s room should be cleaned at least daily or more frequently in high intensity or high traffic areas. High touch point cleaning must be supported by good hand hygiene practices, correct use of PPE and cleaning and disinfection chemicals.

Consideration should be given to increased frequency of routine cleaning and disinfection of environmental surfaces and frequently touched surfaces in clinical areas where suspected or confirmed COVID-19 cases are being accommodated.

- Clean using an S-shaped motion from clean to dirty (see Figure 4)
- Clean general surfaces and fittings straight away when visibly dirty and after spills
- Clean often touched surfaces with detergent solution or detergent/disinfectant wipes (see Figure 5).

**FIGURE 4: S-SHAPED METHOD FOR CLEANING (IMAGE FROM GAMA HEALTHCARE)**
The preferred routine cleaning process should involve either:

- **2-step clean:**
  Physical cleaning with detergent followed by disinfection with a Therapeutic Goods Administration (TGA) listed hospital-grade disinfectant with activity against viruses (according to label/product information) or a chlorine-based product such as sodium hypochlorite

- **2-in-1 clean:**
  A physical clean using a combined detergent and TGA listed hospital-grade disinfectant with activity against viruses (according to label/product information) or a chlorine-based product such as sodium hypochlorite, where indicated for use, i.e., a combined detergent/disinfectant wipe or solution.

Disinfectant solutions should be made fresh daily, and gloves should be worn when handling and preparing solutions. Cleaning equipment, including mop heads and cloths, should be laundered in hot water, and completely dried before reuse. Cleaning equipment, such as buckets, should be emptied and cleaned with a new batch of cleaning and/or disinfectant solution and allowed to dry completely before reuse.
Terminal clean

Terminal cleaning of rooms occupied by patients or residents who have COVID-19 requires both thorough cleaning and disinfection to remove the virus.

- Terminally clean room/zone on discharge or transfer from inpatient units
- PPE for Contact, Droplet and Airborne Precautions should be used for rooms that may not have been rested prior to cleaning
- Always check with the nurse-in-charge before entering the room
- Following an aerosol generating procedure (AGP) on a COVID-19 patient, cleaners should only enter the room after 35-45 minutes depending on the air changes per hour within the room
- Following discharge or transfer of the patient, prior to cleaning the room, the patient’s personal effects should be removed, and fabric privacy curtains and window curtains, if present, should be removed for laundering
- For disposable curtains, follow local policy or follow manufacturer’s instructions including checking the expiry date
- Handle used linen and fabrics with minimum agitation to avoid contamination of air, surfaces and persons
- The room and all patient care equipment remaining in the room should be physically cleaned
- Follow or combine cleaning with a disinfectant process (see 2-step clean and 2-in-1 step clean)
- All furniture, patient equipment items, horizontal surfaces, frequently touched surfaces, e.g., light switches and call buttons, bathroom, toilet and shower area should be thoroughly cleaned and disinfected
- For procedural rooms with short patient stays (e.g., CT scan, MRI, fever clinics) clean and disinfect frequently touched surfaces between cases and terminally clean the area as per local policies e.g., at the end of the session/day.

Patient care equipment

Patient care and patient assessment devices (e.g., thermometers, sphygmomanometers, glucometers, hoists, pat slides) may transmit COVID-19 if devices are shared between patients.

To reduce the risk of transmission, disposable or patient dedicated equipment is preferred. Equipment that is unable to be dedicated should be cleaned and disinfected after use, allowed to dry, and stored clean. See above in the routine cleaning section for advice on cleaning and disinfectant solutions.

HWs involved with the cleaning and storage of shared patient care equipment should be trained in cleaning techniques and choice of chemical.

- Decisions regarding responsibility for cleaning shared patient care equipment should be documented with clear lines of accountability in each clinical area
• Cleaning shared patient care equipment must be completed by following manufacturer’s Instructions for Use (IFU) for cleaning, drying and storage

• The cleaning detergent and/or disinfectant must be compatible with the equipment and manufacturer’s IFU - see below table for type of cleaning

• Minimise equipment and items to reduce clutter in the patient areas including personal items owned by the patient.

**TABLE 1: SUMMARY OF CLEANING RECOMMENDED FOR PATIENTS/CLIENTS WITH/WITHOUT COVID-19**

<table>
<thead>
<tr>
<th>Type of cleaning</th>
<th>Cleaning for shared equipment and/or surfaces</th>
<th>Chemicals</th>
<th>Cleaning frequency</th>
<th>Cleaning method</th>
<th>Precautions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/client <em>NOT suspected or confirmed</em> COVID-19</td>
<td>Detergent and routine chemicals for equipment (recommended by the manufacturer)</td>
<td>After use</td>
<td>Routine for all equipment and/or surfaces that are required to be cleaned</td>
<td>Standard Precautions</td>
<td></td>
</tr>
<tr>
<td>Patient/client <em>WITH suspected or confirmed</em> COVID-19</td>
<td>Detergent and hospital grade disinfectant (recommended by the manufacturer or compatible with the equipment)</td>
<td>After use</td>
<td>Thorough cleaning of equipment and/or surfaces touched or used by the patient/client</td>
<td>Standard precautions. If cleaning occurs within the patient room apply Contact and Airborne Precautions Clean immediately Any disposable cleaning items into general waste</td>
<td></td>
</tr>
</tbody>
</table>


**Hand hygiene**

Use soap and water for hand hygiene at any time and especially when hands are visibly dirty. Use ABHR as an alternative to soap and water, except when hands are visibly dirty. Cleaning hands regularly also helps to reduce environmental contamination.
Information for cleaning HW

There is less risk of getting COVID-19 when performing environmental cleaning than when face-to-face with a sick person. This is because the sick person may be coughing, sneezing or producing respiratory droplets, by shouting for example.

When cleaning rooms where patients with suspected or confirmed cases of COVID-19 have been treated, cleaners should:

- Avoid touching face, mouth, nose, and eyes when cleaning
- Be trained in the use and choice of correct PPE (including doffing)
- Wear a disposable apron or gown, impermeable disposable gloves, surgical mask or P2/N95 respirator, and eye protection or a face shield while cleaning (prescription glasses are not protective eyewear)
- Perform hand hygiene, either using soap and water or ABHR before putting on and after taking off any item of PPE
- Always check with the nurse-in-charge before entering the room
- Check with nurse-in-charge on room resting time e.g., AGP
- Use a TGA registered hospital-grade disinfectant listed on the list of disinfectants for use against COVID-19 in the Australian Register of Therapeutic Goods (ARTG) for legal supply in Australia; products in this category continue to evolve; where disinfectants with specific claims are not available, use hospital grade disinfectant, with proven virucidal activity (listed on the TGA website)
- Ensure adherence to the cleaning/disinfection product manufacturer’s recommended contact time.

**NB:** Use a chlorine-based product such as sodium hypochlorite if unsure of the properties of the disinfectant provided by the facility.

### 2.9 Handling of linen

Management of linen from a suspected or confirmed COVID-19 case should be in accordance with Standard Precautions and routine procedure. Handle all used linen as per section 4.7.1 in the *Infection Prevention and Control Practice Handbook*.

- Handle soiled laundry with minimum agitation to avoid contamination of the air, surfaces and persons (e.g., roll up)
- Used, soiled or wet linen should be placed into an appropriate laundry receptacle at the point of generation
- Use clear leak-proof bags to contain linen that is heavily soiled with blood, other body substances or other fluids (including water)
- Linen bags should be securely closed and not filled completely as this will increase the risk of rupture in transit and exposure of bag handlers
- Reusable linen bags must be laundered before re-use
- Hand hygiene (using soap and water for 20 seconds or ABHR) must be performed
following the handling of used linen.

2.10 Waste management

Non-clinical waste disposal:
All waste from COVID-19 patients is general waste and should be segregated and managed according to existing waste stream definitions.

Manage waste in accordance with routine procedures:
- All non-clinical waste should be segregated where possible and disposed of with the appropriate general waste stream
- Waste (used PPE) resulting from the management of COVID-19 patients is considered general waste unless contaminated with large amounts of blood and/or body substances

Clinical waste disposal:
- Clinical waste should be disposed of with the appropriate clinical waste stream
- Sharps should be discarded into a sharps bin

Waste storage and handling
- Waste storage, handling, labelling, containment, transport and disposal should be undertaken in accordance with routine procedures for relevant waste management

Waste minimisation
- The implementation of appropriate waste minimisation strategies, that do not compromise work standards, environmental outcomes or patient or HW safety should be considered.

2.11 Curtains and bed screens

- Change bed screens and curtains (including disposable curtains/screens) that are soiled or contaminated
- Reusable curtains should be changed/replaced after positive COVID-19 patient discharge/transfer
- Disposable curtain use should be checked with the manufacturers for the efficacy against COVID-19; if unsure, dispose after transfer/discharge of suspected or confirmed COVID-19 cases.

2.12 Food service utensils

- Disposable crockery and cutlery are not required for suspected or confirmed COVID-19 patients/clients
- Kitchen utensils should be cleaned using routine cleaning cycles
- Food trolleys that have been used in any COVID-19 clinical areas should be cleaned and disinfected before reuse
• The meal ordering, delivery and collection of meal trays within a COVID-19 patient zone/ward should be led and managed by the ward/clinical area and local facility management

• Food delivery HW to wear PPE as per Transmission-Based Precautions if taking trays into a patient room or area e.g., respirator and eye protection. Gown and gloves are not required if you are placing a food tray on the table or talking to the patient.

2.13 Handling of consumer paper health records

The risk of paper health record contamination and subsequent exposure to COVID-19 in the absence of a spill (or similar) is thought to be unlikely and considered extremely low risk.

The available evidence does not support holding notes for any period prior to scanning. This is unnecessary and may increase the risk of delay in the documentation and communication of patient information.

It is acknowledged that some paper records/forms may require handling by patients during their hospital journey, but this can be mitigated by asking patients to perform hand hygiene before touching records/forms.

A local process should be implemented to manage these health records and the following steps may assist in reducing the risk of cross contamination of these items:

• Hand hygiene before/after contact with notes (patients and HWs)
• Clean pens and accessories
• Keeping desk areas clean and tidy
• Cleaning of workstations and work sites
• Attending administration areas with clean hands and no PPE
• Move to electronic notes where able
• Zone/modelling to reduce notes going directly into the patient care zone.

2.14 Handling of deceased bodies

Routine processes apply to the management of deceased bodies, with the same precautions in place after death as were in place prior to death.

HWs are unlikely to contract COVID-19 when Transmission-Based (Contact and Droplet) Precautions are used when handling the body of a deceased person. However, the following precautionary strategies should be used to minimise risks and to prevent the spread of COVID-19 when handling or transferring deceased suspected or confirmed cases:

• HWs handling deceased bodies are to wear apron/gown, gloves, masks and face shield/goggles
• Wear appropriate PPE without contaminating environmental surfaces
• Avoid unnecessary manipulation of the body that may expel air or fluid from the lungs
• Inform family members they should not kiss or touch the deceased to minimise the
risk of transmission

- If a family member does touch the body, they should wash their hands with soap and water immediately afterwards or use ABHR
- When transporting the deceased, the body must be placed and secured in a body bag or wrapping in a manner that prevents the leakage of body fluid or other substance; double bagging may be required to achieve this
- Label the outer bag ‘COVID-19: Handle with care’.

For more information refer to NSW Health [Handling of deceased bodies with suspected and confirmed COVID-19 by hospital HW (non-Coroners)](https://www.health.nsw.gov.au/handlingoffaunding/).

### 2.15 Transport

#### Inter-facility patient transport

All agencies involved in the transport of COVID-19 suspected or confirmed patients are to implement their agency specific Standard and Airborne precautions including eye protection (based on risk assessment).

If tolerated, a surgical mask should be worn by patients during the transfer.

The transferring health facility is to notify NSW Ambulance or other transport agency on the patient’s condition to ensure all HWs involved in the patient transfer are aware of the PPE requirement prior to arrival. The transporting agency is to notify the area receiving the patient where possible.

The transport vehicle is to be cleaned and disinfected after the patient is transported. Follow local cleaning and disinfection procedures.

#### Health worker transport

The number of HWs who travel together in the same motor vehicle will depend on the size of the vehicle, the outcome of a risk assessment and the seating arrangements required. The Public Health Order (PHO) must also be checked for current advice on carpooling and requirements to wear masks.

The risk assessment may include the following considerations:

- HWs are well and have no ARI symptoms, particularly those symptoms that are usually classified as mild e.g., scratchy throat, ‘bit of a snifflfe’ and have completed the HW screening symptom check and questions related to visits to areas identified for increased COVID-19 testing and COVID-19 symptoms
- Able to perform hand hygiene prior to getting into the motor vehicle
- Have completed their vaccinations as per the approved dosing schedule unless medically indicated
- Have bags that can be placed in the boot or on the floor
- Do not share drinks, snacks or other food
- Are comfortable to provide reminders to each other for face touching, hand hygiene, respiratory hygiene and high touch point cleaning of the vehicle
• Do not share mobile devices (individual HW passengers may accept work related phone calls or check emails); these mobile devices are regularly cleaned
• Transport vehicles air handling system must be set to external exhaust not recirculate
• Are in a motor vehicle that is kept clean and high touch points are cleaned between different drivers e.g., door handles, steering wheel
• Include other risks that are specific to the local team e.g., equipment that requires two people to carry, travel to a meeting/education session
• Health students should not be prevented from attending home visits if a patient/client has suspected or confirmed COVID-19 as this is a teaching opportunity.

**Patient transport**

Before transporting patients with suspected or confirmed COVID-19, perform a risk assessment on:

• the type of motor vehicle required
• physical capability of patient/client and if assistance will be required
• the ability of the patient/client to wear a surgical mask and practice respiratory etiquette (hygiene)
• no other patient transported at the same time (i.e., no multi-loading). Exemption to this approach can be applied with high community transmission and demand on the health service. Multi loading vehicles are reintroduced to transport positive COVID-19 patients from hospitals that are medically cleared for discharge back to their home.

For suspected or confirmed COVID-19 patients, before entering the motor vehicle, both the driver or clinician and passenger are to perform hand hygiene with ABHR and driver to follow Airborne Precautions. When the driver is wearing protective eyewear ensure that it does not obscure vision during the transport.

All handbags and hand luggage are to be placed on the floor and not on the seats. These can also be placed in the boot or rear of the vehicle if they are large.

Passenger to wear a surgical mask and sit in the allocated seating directed by the driver and or clinician.

If the passenger has symptoms of a respiratory illness or suspected or confirmed COVID-19, they should wear a surgical mask, perform hand hygiene and be educated regarding respiratory hygiene. They should be provided a plastic bag, tissues and alcohol hand rub.

HW to perform hand hygiene:

• before providing assistance to the passenger
• before entering the motor vehicle
• on exit from the motor vehicle
• after providing assistance to the passenger
• after dropping patient/client off and before returning to the motor vehicle.

When transporting a patient with suspected or confirmed COVID-19, the vehicle air flow should be checked to minimise recirculation by switching to non-recirculate. This setting will depend on the motor vehicle.
Cleaning of the motor vehicle is to occur at the end of the journey. Remove any visible contamination with detergent and disinfectant wipes. Clean the seat area, door handles or other areas touched by the patient or client (high touch areas) with detergent and disinfectant wipes. Do not spray any chemicals into the air conditioning vents.

Patient transfers within a health organisation should use a route that minimise contact with the general hospital population including clinicians, for example dedicated lift service, external path.

### 2.16 Outbreak management

An outbreak is a state characterised by an incidence of an infection greater than what is typically expected in a particular healthcare setting.

An outbreak for COVID-19 is a single confirmed case of COVID-19 in a patient/resident, HW or visitor of a health facility or residential care facility.

Each outbreak will differ according to the circumstances of the facility/department; therefore, the investigation and management will be applied based on identifying and understanding the features of the outbreak. For more information on outbreak response procedures refer to [CEC Infection prevention and control practice handbook](https://www.safetyandquality.gov.au/publications-and-resources/resource-library/break-chain-poster-a3), section 11.

### References


World Health Organization (WHO). Infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected Interim guidance. 2020a, March 19. Available at: https://www.who.int/publications/i/item/10665-331495


Appendix 2A: Deisolation criteria for COVID-19 within NSW healthcare facilities

This information covers advice for deisolation for HWs and their return to work and deisolation of patients in NSW Health Facilities, including those in RACF and disability group homes. It is for use by service managers and teams looking after patients with COVID-19.

Advice about deisolation is influenced by the viral kinetics and transmissibility of the predominant circulating strain/s and the likelihood of serious illness from infection. Therefore, this advice will need to be reviewed as evidence evolves. Deisolation includes both testing and non-testing strategies depending on symptoms and the time since test positivity.

Testing post-release from isolation

As an overriding principle, any testing should be done in conjunction with an assessment that includes a symptom check, vaccination status, contact status, whether they are immunocompromised and whether the person has recovered from COVID-19 in the last month.

Recovered cases should be tested for SARS-CoV-2 if they develop new symptoms of COVID-19 at least one month after release from isolation. In the absence of a re-exposure, recovered cases that are asymptomatic do not need to be retested within one month after release from isolation.

Individuals are not considered a contact if the exposed HW, patient, or visitor has recovered from COVID-19 infection, is not immunocompromised and the exposure has occurred within one month of the date of receiving their medical clearance notice/letter. These individuals do not require isolation or testing, irrespective of their risk classification. Along with release from isolation criteria immunocompromised individuals (HW or patients) may be requested to meet the below additional criteria:

- Negative RAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 7 days have passed since the first positive test: OR
- Negative RAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 14 days have passed since the first positive test

If at least one month has passed after release from isolation, and a recovered case has a re-exposure that is outside their immediate household, or there is a new case in their household, the recovered case should be managed as a contact. If there is a high-risk exposure in the workplace, this is managed as a close contact. They should, however, continue to follow community and occupational recommendations to prevent infection (e.g., physical distancing, hand hygiene and appropriate PPE), monitor for symptoms and be tested if symptoms develop (Australian Government Department of Health, 2021a).

Rapid Antigen Tests (RAT)

The use of RAT for the diagnosis and clearance of people with COVID-19 continues to evolve. The performance of a RAT does depend on the adequacy of sampling and test procedure, therefore any HW who are performing a RAT must follow the manufacturers’ instructions. For more information on Rapid Antigen Tests from NSW Health see here.
**Work restrictions: Health Worker**

- HW who are at work during their infectious period should be assessed and contact tracing undertaken.
- Return to work requires **at least 24 hours** of resolution of fever and significant improvement of acute respiratory symptoms\(^1\).
- Reinfection may occur. Symptomatic testing required and high-risk contact assessed if more than 28 days after deisolation.

<table>
<thead>
<tr>
<th>Days after positive test</th>
<th>Symptoms</th>
<th>Testing Strategy</th>
<th>RAT Results</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>Never symptomatic OR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>symptoms resolved for at least 24 hours</td>
<td>No test</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Day 6</td>
<td></td>
<td></td>
<td>Negative</td>
<td>Positive</td>
</tr>
<tr>
<td></td>
<td>Return to work at day 10</td>
<td>RAT at day 7</td>
<td>Return to work the next day</td>
<td>Excluded from work until day 11</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Earliest is day 8</td>
<td></td>
</tr>
<tr>
<td>Days 7 - 13</td>
<td>Symptoms resolved for at least 24 hours</td>
<td>Return to work after 3 additional days (after symptoms resolved)</td>
<td>RAT at least 24 hours after symptoms have resolved</td>
<td>Return to work the following day</td>
</tr>
<tr>
<td>Day 14 and later</td>
<td>Symptoms resolved for at least 24 hours</td>
<td></td>
<td>Testing not required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Symptoms continuing</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Note:** If HWs are significantly immunocompromised the isolation period may need to be extended until day 14 or longer.

\(^1\)Resolution of symptoms means at least resolution of fever and significant improvement of acute respiratory symptoms for the preceding 24 hours. Other symptoms such as headache, fatigue, anosmia, ageusia or a mild persistent cough may continue for some weeks and usually will not limit release from isolation including return to work.
### Patient Deisolation Guidance

- Patients who are not isolated or cohorted (with other COVID-19 patients) during their infectious period should be assessed and contact tracing undertaken.
- Deisolation requires at least 24 hours of symptom resolution (of fever and acute respiratory symptoms related to COVID-19 infection).
- Reinfection may occur. Symptomatic testing required and high-risk contact require assessed if more than 28 days after deisolation.

<table>
<thead>
<tr>
<th>Deisolation decisions</th>
<th>Patient returning to non-COVID ward, bed space or out of isolation if in RACF</th>
<th>Discharge to the community</th>
<th>Outpatient appointment required after discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient illness</strong></td>
<td><strong>NOT IMMUNOCOMPROMISED</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-critical</td>
<td>After day 7 AND negative RAT or PCR OR Day 10 without testing</td>
<td>Isolate at home until day 7 AND at least 24H after resolution of symptoms(^2) Avoid high risk settings until day 10</td>
<td>Requires RAT if either ongoing symptoms OR visit is between day 7 and day 10</td>
</tr>
<tr>
<td>Critical</td>
<td>After day 10 AND negative RAT or PCR OR Day 14 without testing</td>
<td>Isolate at home at least until day 7 AND at least 24 H after resolution of symptoms(^2) Avoid high risk settings until day 14</td>
<td>Requires RAT if either ongoing symptoms OR visit is between day 10 and day 14</td>
</tr>
<tr>
<td><strong>IMMUNOCOMPROMISED (See CDNA definitions)</strong></td>
<td><strong>After day 14 AND</strong> Two consecutive negative RAT 24 hours apart OR Negative PCR</td>
<td><strong>Isolate at home at least until day 7 since positive test and until at least 24 H after resolution of symptoms(^2)</strong> Avoid high risk settings until at least day 14</td>
<td><strong>Requires RAT if visit is prior to day 21(^3)</strong> See <a href="#">here</a> for NSW SoNG appendix for more information</td>
</tr>
</tbody>
</table>
| Additional assessment if still PCR positive | If PCR remains positive, consider release from isolation as follows:  
If the Ct value is high AND there is either a positive spike antibody test OR a negative RAT OR a negative culture | Isolate at home at least until day 7 since positive test and until at least 24 H after resolution of symptoms\(^2\) Avoid high risk settings until at least day 14 | Requires RAT if visit is prior to day 21\(^3\)** See [here](#) for NSW SoNG appendix for more information |

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2. Routine RAT is not required for patients being discharged to complete isolation at home. RAT may be required if entering a high-risk facility.
3. Severely immunocompromised patients may be culture positive for more than several weeks. RAT may also be required if entering a high-risk facility after 21 days. HWs to wear appropriate PPE when providing clinical care.
For HW who require a negative RAT or PCR to return to work, they must meet the following criteria

- HW’s acute respiratory symptoms have resolved, or their only symptoms are (mild) cough, fatigue, headache or anosmia/ageusia which may last for several weeks
- if the HW provides care to patients or residents who are especially vulnerable to COVID-19 (as determined by the organisation), a risk assessment should be undertaken, and consideration given to redeployment for the remainder of the isolation period
- If the negative test allowed an early return to work, then for the usual isolation period, the HW would be expected to comply with all infection prevention and control recommendations and avoid shared spaces such as tea rooms, for the remaining isolation period. For example, if they returned at day 8, they would be expected to do this until day 11

Immunocompromised

As per CDNA definitions [here](#).

Note: The CDNA definitions currently include patients on dialysis. Patients who are on dialysis but who do not meet other criteria for immunocompromise may not require extended isolation or testing for deisolation.

Significantly immunocompromised persons may include, but are not limited to, those who:

- have had an organ transplant and are on immune suppressive therapy
- have had a haematopoietic stem cell transplant in the past 2 years
- are on immune suppressive therapy for graft versus host disease
- have had an active haematological malignancy
- human immunodeficiency virus infection with CD4 T-lymphocyte count below 200 cells/per mm³ (age adjusted for children)
- are receiving dialysis (but additional risk assessment recommended)
- or other conditions specifically noted by the treating medical practitioner

Disease Severity Categories (for deisolation of some patients)

As per the National COVID-19 Evidence Taskforce see [here](#). These are replicated in this guidance.
### Disease Severity Adult

<table>
<thead>
<tr>
<th>Mild</th>
<th>An individual with no clinical features suggestive of moderate or more severe disease:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• no or mild symptoms and signs (fever, cough, sore throat, malaise, headache, muscle pain, nausea, vomiting, diarrhoea, loss of taste and smell)</td>
</tr>
<tr>
<td></td>
<td>• no new shortness of breath or difficulty breathing on exertion</td>
</tr>
<tr>
<td></td>
<td>• no evidence of lower respiratory tract disease during clinical assessment or on imaging (if performed)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moderate</th>
<th>A stable patient with evidence of lower respiratory tract disease:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• during clinical assessment, such as</td>
</tr>
<tr>
<td></td>
<td>• oxygen saturation 92-94% on room air at rest</td>
</tr>
<tr>
<td></td>
<td>• desaturation or breathlessness with mild exertion</td>
</tr>
<tr>
<td></td>
<td>OR</td>
</tr>
<tr>
<td></td>
<td>• on imaging with infiltrates consistent with COVID pneumonitis</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe</th>
<th>A patient with signs of moderate disease who is deteriorating OR</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A patient meeting any of the following criteria:</td>
</tr>
<tr>
<td></td>
<td>• respiratory rate ≥30 breaths/min</td>
</tr>
<tr>
<td></td>
<td>• oxygen saturation ≤92% on room air at rest or requiring oxygen</td>
</tr>
<tr>
<td></td>
<td>• lung infiltrates &gt;50%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical</th>
<th>A patient meeting any of the following criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Respiratory failure (defined as any of)</td>
</tr>
<tr>
<td></td>
<td>• severe respiratory failure (PaO$_2$/FiO$_2$ &lt;200)</td>
</tr>
<tr>
<td></td>
<td>• respiratory distress or acute respiratory distress syndrome (ARDS)</td>
</tr>
<tr>
<td></td>
<td>• deteriorating despite non-invasive forms of respiratory support (i.e. non-invasive ventilation (NIV), or high-flow nasal oxygen (HFNO))</td>
</tr>
<tr>
<td></td>
<td>• requiring mechanical ventilation</td>
</tr>
<tr>
<td></td>
<td>• hypotension or shock</td>
</tr>
<tr>
<td></td>
<td>• impairment of consciousness</td>
</tr>
<tr>
<td></td>
<td>• other organ failure</td>
</tr>
<tr>
<td>Clinical Disease Severity Children under 16 years</td>
<td></td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Feeding/hydration/conscious state</strong></td>
<td><strong>Respiratory/vital signs</strong></td>
</tr>
<tr>
<td><strong>Mild</strong></td>
<td>Normal or mildly reduced feeding</td>
</tr>
<tr>
<td><strong>Moderate</strong></td>
<td>Poor feeding, unable to maintain hydration without nasogastric or IV fluids AND With normal conscious state</td>
</tr>
<tr>
<td><strong>Severe</strong></td>
<td>Poor feeding, unable to maintain hydration without nasogastric or IV fluids OR Drowsy / tired but easily rousable</td>
</tr>
<tr>
<td><strong>Critical</strong></td>
<td>Poor feeding, unable to maintain hydration without nasogastric or IV fluids OR Altered conscious state / unconscious</td>
</tr>
</tbody>
</table>

Based on the National COVID-19 Evidence Taskforce see [here](#).
Appendix 2B: Recommendations for COVID-19 surveillance testing in NSW healthcare facilities

This advice applies to surveillance testing for COVID-19 in healthcare facilities only. It does not replace existing NSW Health recommendations for symptomatic testing, testing in the community, for the management of contacts of COVID-19 cases, or surveillance testing in the (non-health) workplace.

Background

With the recent Delta outbreak, the arrival of Omicron, and the move from pandemic to endemic, appropriate use of SARS-CoV-2 testing is required during this transition as well as what is likely to be a prolonged endemic phase. Testing is performed for a variety of reasons, including to inform early diagnosis and management, contact tracing, surveillance and modelling, release and deisolation, and for bed and patient management within a health facility.

The early diagnosis of COVID-19 is important for the best management of patients, particularly with availability of new antivirals, monoclonal antibodies and other therapies. Testing of patients requiring admission to hospital can also assist in appropriate placement during their hospital stay, limiting movements around the facility and the recommended use of personal protective equipment (PPE). Vaccination breakthrough infection and onward transmission is being increasingly reported; however, infection is much more likely to be either asymptomatic or mild. The advice contained in this document will continue to be reviewed as evidence and information changes.

Case numbers reported to NSW Health continue to be released each day and more comprehensive data are captured within the Risk Monitoring Dashboard for Healthcare Settings and can be found here.

General Principles

As an overriding principle, any testing should be done in conjunction with an assessment that includes a symptom check, vaccination status, contact status, whether they are immunocompromised and whether the person has recovered from COVID-19 in the last month.

Note: In the absence of the recommended test or result being available, consultation, investigation or treatment should proceed using a risk assessment and implementing Infection Prevention and Control (IPAC) and hierarchy of controls including appropriate patient placement and PPE.

Specific Settings and Recommendations

Patients Being Transferred

Patients having a planned transfer from hospitals to residential aged care facilities or disability group homes/accommodation.

1. Routine testing of patients being transferred to residential aged care or other group homes, or accommodation is not required. If done, test (PCR or RAT) results should be available prior to transfer.
2. PCR testing should be done if the patient has symptoms consistent with COVID-19, is part of a local outbreak, is identified as a contact of a COVID-19 case or if there are concerns about increasing community transmission.

3. Patients with COVID-19 who are significantly immunocompromised as per the ATAGI definition (see here) are required to have x 2 negative PCR results, collected at least 24 hrs apart after day 7 from symptom onset to be released from isolation and returned to their facility.

Children presenting to Emergency Departments

For children who present to an ED, local risk assessment is required for testing of asymptomatic unvaccinated children where vaccination is unavailable for children of their age and everyone in their immediate family who is eligible for vaccination is vaccinated.

Prior COVID-19 Diagnosis

If there has been a recent COVID-19 diagnosis, surveillance testing is not required for one month after clearance from isolation criteria have been met. If symptoms consistent with COVID-19 occur, retesting is recommended and the most recent NSW Health advice can be accessed here.

Note: In some cases, a negative test may be followed by a weakly positive test. Interpretation of weakly positive PCR results for SARS-CoV-2 in this context are complex and expert advice should be sought.

This only applies to those who have had a COVID-19 diagnosis confirmed in Australia or New Zealand.

Patients who are unable to access community testing centres

Testing for COVID-19 should be made available to those who require PCR tests and are unable to access COVID-19 testing centres. A mechanism for assisting patients with rapid antigen testing will be developed. Examples are those who are blind/vision impaired, those with other disabilities, who are frail and unable to travel to testing centres.

Some Pathology providers have limited home testing as well as providing self-collection kits where nose/throat samples are collected at home for subsequent laboratory PCR testing. Any agreement for home PCR testing should be managed by the patient’s general practitioner or the treating facility.

Guidance for health care service providers and carers on alternative approaches to COVID-19 testing for people with disability see here.

Definitions

Fully vaccinated and not immunocompromised: must have completed the approved dosing schedule for a TGA registered or recognised COVID-19 vaccine see here more than 14 days prior to presentation and must not meet criteria for immunocompromise as per the Australian Technical Advisory Group on Immunisation (ATAGI) guidance here and CDNA SoNG here.

Not fully vaccinated and/or immunocompromised: anyone whose vaccination status is unknown or not completed as per the approved dosing schedule; those who have received
vaccination with a vaccine not registered or recognised by the TGA; or those with immunocompromise irrespective of vaccination. See ATAGI guidance as above.

Explanatory Notes

- Testing of patients or staff who have compatible symptoms for COVID-19 or who have been identified as contacts of COVID-19 cases can be done by RAT. Advice on who should have a COVID-19 test as well as indications for PCR are here as per current NSW Health advice
- PCR on nose/throat samples is considered the gold standard, but sensitivity varies depending on stage of illness and collection technique.
- Owing to the short incubation period of SARS-CoV-2 infection, a screening test performed 72 hours beforehand will not exclude presence of infection.
- An essential adjunct to any screening effort is to document whether the person has been vaccinated, has had past documented COVID-19 infection and/or has had recent exposures or symptoms compatible with COVID-19 infection.
- Where the patient has arrived and not been able to source or complete a RAT and where the risk assessment deems testing a requirement, the responsibility for providing and completing falls to the LHD/SHN
- In the absence of obtaining a result patients’ consultation, investigation or treatment should proceed using a risk assessment and implementing Infection Prevention and Control (IPAC) and hierarchy of controls including appropriate patient placement and PPE
- For indeterminate rapid antigen tests, confirmatory PCR testing is strongly recommended. This must be done as soon as practicable. Proceeding with treatment should be considered based on risk assessment and implementation of appropriate risk mitigation controls and strategies – IPAC, hierarchy of controls

Testing Frequency

The utility of admission and repeated surveillance testing of asymptomatic inpatients is unclear and will vary depending on community prevalence, vaccine induced immunity and host factors such as immunocompromise. Where community prevalence is low and the patient has no risk factors for COVID-19 and is vaccinated, asymptomatic admission testing may not be required. When community prevalence is high or there is a local outbreak, universal admission and consideration for outpatient attendance testing is recommended. Repeat testing at between days 3–5 of admission is recommended where there is a local outbreak and/or where patients are in multi-bed bays. The need for universal retesting of hospital admissions is unclear but should be considered where community prevalence is extremely high.

Testing prior to elective admissions and outpatient appointments should ideally be done with within 24 hours of the appointment when PCR testing is being used for this purpose. Testing can be done 48 hours prior to admission or appointment if there are expected delays in obtaining a result.

During peak testing times where time to PCR results extend beyond 24hrs, LHDs/SHN should consider RATs on presentation to appointments/clinics. These services need to discuss COVID-19 testing with their local ID and the pathology service provider.
**TABLE A: SURVEILLANCE TESTING FOR PATIENTS (AND CARERS/PARTICIPANTS IN CARE)**

⚠️ **Note:** Symptomatic testing always applies  
⚠️ **Test type:** May be PCR standard, PCR-Rapid or RAT

**If a patient has not been able to source or complete a test and where the risk assessment deems testing is required, the responsibility for providing and completing falls to the LHD/SHN. In the absence of obtaining a result, patients’ consultation, investigation, or treatment should proceed using a risk assessment and implementing Infection Prevention and Control (IPAC) and hierarchy of controls including appropriate patient placement and PPE.**

<table>
<thead>
<tr>
<th>Alert Level</th>
<th>Green</th>
<th>Yellow</th>
<th>Amber</th>
<th>Red</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Very low transmission</td>
<td>Low transmission</td>
<td>Moderate to high transmission</td>
<td>High Transmission, outbreaks</td>
</tr>
<tr>
<td>ED presentations – Adult</td>
<td>No routine testing</td>
<td>No routine testing.</td>
<td>Recommend testing all <strong>unvaccinated</strong> patients. Consider testing all patients.</td>
<td>Recommend testing all ED presentations.</td>
</tr>
<tr>
<td>ED presentations – children</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td>Recommend testing all <strong>unvaccinated</strong> patients.</td>
<td>Recommend testing all ED presentations.</td>
</tr>
</tbody>
</table>
| Admissions (adult and paediatric) | No routine testing | No routine testing. Consider testing **unvaccinated** admissions | Test all **unvaccinated** admissions  
Consider testing all admissions. | Test all admissions and consider re-test days 3-5 |
| Adult parents/carers staying with hospitalised children | No routine testing | No routine testing | Test parents/carer when child is tested | Test parents/carer when child is tested |
| Elective admissions (adult and paediatric) | No routine testing | No routine testing. Consider testing **unvaccinated** admissions | **Unvaccinated:** Prefer PCR* 24-48 hours prior to admission.  
Consider testing all admissions. | Test all elective admissions, if using PCR*, 24-48 hours prior to admission. |
| Emergency surgery | No routine testing | No routine testing. Consider testing **unvaccinated** admissions | **Unvaccinated:** Consider PCR-rapid using for all. | Test all. Consider using PCR-rapid as primary test. |
| Outpatient appointments - including home visits (community care) | No routine testing | No routine testing | **Unvaccinated:** test 24-48 hours prior if appointments > 15 minutes and/or patients need to remove mask. | Telehealth where possible  
Recommend RAT prior if face-to-face for appointments longer than 15’ and/or if mask needs to be removed for consultation** |
| Drop-in Clinics (SH Clinics, D&A) | No routine testing | No routine testing | **Unvaccinated:** RAT on presentation | All: RAT on presentation |
| Antenatal appointments and presentations | No routine testing | No routine testing | No routine testing. | Telehealth where possible  
RAT prior if face-to-face for appointments longer than 15’ and/or if mask needs to be removed for consultation** |
<table>
<thead>
<tr>
<th>Location and Setting</th>
<th>Testing Requirements</th>
<th>Unvaccinated Test Protocols</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antenatal and postnatal wards: (only direct admissions, does not include those admitted through Birth Unit)</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td>Consider testing <strong>unvaccinated</strong> admissions.</td>
</tr>
<tr>
<td>Birthing Unit presentations</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td>Consider testing <strong>unvaccinated</strong> admissions</td>
</tr>
<tr>
<td>Participants in care including support person</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td><strong>Unvaccinated</strong>: RAT or PCR-rapid on arrival. RAT 2-3x weekly while baby is in nursery</td>
</tr>
<tr>
<td>Elective caesarean section</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td>Consider RAT or PCR-rapid testing all <strong>unvaccinated</strong> admissions</td>
</tr>
<tr>
<td>Dialysis</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td>Test 2 – 3 x week at site depending on visit schedule</td>
</tr>
<tr>
<td>Chemotherapy/radiotherapy appointments</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td>Test 2 – 3 x week at site or at community testing centre</td>
</tr>
<tr>
<td>Mental Health unit admissions</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td><strong>Unvaccinated</strong>: RAT or PCR-rapid on admission. Recommend retest days 3-5</td>
</tr>
<tr>
<td>Transfer back to RACF or Group home</td>
<td>Testing as per above guidelines for admissions, if tested, results must be available prior to transfer. See <a href="#">here</a> for more information.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*PCR testing the day prior to admission is preferential if results are reliably available within 48 hours and providing local facilities can provide the testing

**NB:** Where a positive test result is received, proceeding with the patient’s treatment should be accommodated using risk mitigation controls and ensuring delivery of safe, quality care maintaining HW safety
### TABLE B: SURVEILLANCE TESTING FOR STAFF

<table>
<thead>
<tr>
<th>Alert Level</th>
<th>Green Very low transmission</th>
<th>Yellow Low transmission</th>
<th>Amber Moderate to high transmission</th>
<th>Red High Transmission, outbreaks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff who work in high-risk areas – ICU and ED</td>
<td>No routine testing</td>
<td>No routine testing</td>
<td>Consider testing 2-3 x/week PCR or RAT</td>
<td>Consider testing 2-3 x/week PCR or RAT</td>
</tr>
<tr>
<td>Staff in COVID wards</td>
<td></td>
<td>Consider testing 2-3 x/week PCR or RAT</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Staff working in transplant units, haematology and oncology wards</td>
<td>No routine testing</td>
<td></td>
<td>Consider testing 2-3 x/week - PCR or RAT</td>
<td></td>
</tr>
</tbody>
</table>
Test information

Nucleic Acid Tests (NAT or PCR)

Sample types for NAT

- **Combined deep nasal and throat swabs**: These are the traditional sample types consisting of a single flocked swab used to collect a throat sample followed by bilateral deep nasal samples for the highest sensitivity. Combined throat and deep nasal swabs are indicated for COVID-19 diagnosis in symptomatic individuals. They may be poorly tolerated in the repeated sampling required for routine surveillance testing.

- **Rhinoswabs**: Self-collected nasal mucosa sampling using the Rhinoswab device may be better tolerated but with lower sensitivity than combined nasopharyngeal and throat swabs. Rhinoswabs may be used for routine surveillance testing in asymptomatic staff in an attempt to maintain compliance. They should not be used for diagnostic purposes in symptomatic individuals.

- **Saliva**: Saliva testing usually has lower sensitivity compared to other sample types, and so may require daily testing to overcome this. If local validation shows high sensitivity, then saliva testing could be done third daily. Saliva testing was used for surveillance in individuals with professional contact with patients with COVID-19 such as border and quarantine workers.

Test platforms used for NAT

- **Standard NAT**: Typical run times are between 2 and 6 hours, with expected turnaround times of 12 to 48 hours depending on prioritisation and transport. Sample pooling has been validated on NSWHP platforms and is used to conserve reagents and increase testing capacity when the number of positives is low. Pooled testing is NATA accredited. Pooling is not suitable when the number of positives exceeds approximately 3% because of the need for a second round of PCR testing to identify the positive in a pool (leading to delays in diagnosis and increased reagent utilisation). The reduced testing capacity when prevalence and testing volumes are high results in extended turnaround times.

- **Rapid NAT**: Rapid NAT platforms provide shorter run times (GeneXpert 45 minutes, Roche Liat 20 minutes) but are of relatively limited availability due to constraints on consumables and throughput.

Rapid Antigen Tests (RATs)

- Rapid antigen tests can be performed outside of a laboratory, with a turnaround time of 10-15 minutes. The sensitivity of rapid antigen tests is approximately 70-90% in symptomatic cohorts, but only 50% in asymptomatic cohorts. While the specificity is 99.5%, in populations with a low prevalence, many positive RATs will be false positives, and so reflex NAT testing is required to confirm positive RAT tests.

The PHLN provides useful and regularly updated guidance on laboratory testing [here](#).
Appendix 2C: Supporting visitor access in NSW healthcare facilities during COVID-19 Red Alert

To promote safety and to reduce risks to patients and HWs, there may be restrictions to visitors and/or to the number of visitors allowed into a clinical area. Restrictions should be considerate of compassionate, support and care needs of the patient. Visitors and participants in care must continue to follow infection prevention practices.

In healthcare settings, two visitors are permitted each day providing a visitor:

- Is at least 12 years of age (unless an exemption provided)
- Has received the recommended dosing schedule of a TGA approved or recognised COVID-19 vaccine
- Has evidence of their vaccination status when they enter the facility
- Wears a surgical mask while in the facility
- Is not currently isolating as a confirmed case or contact (case-by-case exemption and compliance with Public Health Order)

In situations where a visitor is not vaccinated or is partially vaccinated LHD/SHNs may apply a risk assessment to allow a local exemption on a case-by-case basis.

Special consideration for exempt visitor access

- Establish an agreed process for escalation of those visiting requests which require an exemption
- Case-by-case exceptions should be risk assessed with clear approval processes established by the facility management
- Conversations with families and carers about the risks and benefits of visiting, and alternatives such as virtual contact should occur, particularly for vulnerable patients.
### TABLE 2: CRITERIA FOR VISITATION AND IPAC STRATEGIES

<table>
<thead>
<tr>
<th>Visitor and patient category</th>
<th>Criteria for visitation</th>
<th>IPAC strategies for visitors</th>
</tr>
</thead>
<tbody>
<tr>
<td>No COVID-19 risks both patient and visitor</td>
<td>Two fully vaccinated people over the age of 12 years can visit a patient per day without an exemption. If the visitor is unvaccinated or partially vaccinated and are the only person who can visit, are permitted to enter with an exemption but must restrict movement through the facility. Where practical and available Rapid Antigen Test is recommended.</td>
<td>Delay visitation if unwell Evidence of recommended doses of a TGA approved COVID-19 vaccine Actively screened for COVID-19 risks and symptoms before entering the facility</td>
</tr>
<tr>
<td>Patient - COVID-19 Positive or close contact</td>
<td>Case-by-case exemptions should be facilitated with clear approval processes by facility management. Healthcare facilities should consult patients and their families or carers about their preferences for visiting and engage them in conversations about the risks of visiting versus not visiting, and alternatives such as virtual visiting. Assessing if visitors can maintain at least 1.5 metre physical distance from the patient and HWs. If visitors are unable to maintain that distance when visiting a patient with suspected or confirmed COVID-19, they should be provided with the appropriate PPE.</td>
<td>Check-in via a QR code (if available upon entry) It is mandatory for people over 12 years of age to always wear a face mask, however, the PHO includes several lawful reasons for not wearing a mask. Refer to <a href="#">NSW face mask rules</a> for more information. Provide education and supervision on using the correct PPE (surgical mask and eye protection) as per the advice of HW. If the visitor already wearing a respirator, they can choose to continue wearing it. There is no need for an apron/gown or gloves unless they are engaged in personal care. Comply with the advice of HW regarding putting on and taking off PPE Perform hand hygiene before and after entering the patient’s room or immediate surroundings</td>
</tr>
<tr>
<td>Visitor - COVID-19 Positive or close contact</td>
<td>Visitation by this group will not always be possible due to the risk of transmission and additional restrictions will apply. An exemption should be requested via the approval process and additional restrictions will apply. Assessing if visitors can maintain at least 1.5 metre physical distance from the patient and HWs. If visitors are unable to maintain that distance, they should be provided with the appropriate PPE.</td>
<td></td>
</tr>
<tr>
<td>Patient immunocompromised</td>
<td>Identifying patients who for clinical reasons should not have visitors (e.g., as they are deemed particularly vulnerable due to clinical condition, advanced age, co-morbidities etc.) and discussing alternative methods for meeting with their families and carers.</td>
<td></td>
</tr>
<tr>
<td>Visitation on compassionate ground</td>
<td>Visits should be facilitated on compassionate grounds such as family member seriously ill or dying, including those patients in palliative care or who are critically ill. Exemptions do not necessarily require written approval.</td>
<td></td>
</tr>
</tbody>
</table>
Visitors for patients in end-of-life/palliative care should not be restricted and visits by immediate family, support people and carers who meet the most current COVID-19 screening criteria on entry to the facility should be allowed. In circumstances where restricting visiting is necessary patients and their families, guardians and/or carers should be involved in discussions about the best ways to maintain connection (e.g., virtual visits).


<table>
<thead>
<tr>
<th>Visitors for patients</th>
<th>Maintain physical distancing, respiratory hygiene, and cough etiquette.</th>
<th>Comply with physical distancing advice.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before entering ward, patient’s room or immediate surroundings consult and follow the instructions of HWs on the ward.</td>
<td>Provide correct contact information for contact tracing.</td>
</tr>
<tr>
<td></td>
<td>Provide correct contact information for contact tracing.</td>
<td>Respect a patient’s right to say no to visitors.</td>
</tr>
<tr>
<td></td>
<td>Comply with a HWs reasonable request to leave.</td>
<td></td>
</tr>
</tbody>
</table>

**Children under 12 years as visitors**

Parents or guardians of children are to be involved in discussions about the best way to maintain support, care and connections of their child or children.

- Unvaccinated siblings under 12 years are unable to visit. An exemption is available for unvaccinated siblings of long-stay patients (more than nine days in hospital) who are welcome to visit, where appropriate, at a time pre-arranged with the wards in charge.

**Siblings**

Unvaccinated siblings under 12 years are unable to visit. An exemption is available for unvaccinated siblings of long-stay patients (more than nine days in hospital) who are welcome to visit, where appropriate, at a time pre-arranged with the wards in charge.

**Visitors with an exemption**

- Any visitor exemption process should be reasonable with clear instructions and a clear escalation process for partners, family, friends, participants in care, carers and volunteers.
- Assessing the risks and benefits of visits by young children, including visits to aged care and Multi-Purpose Services (MPS) should be considered when risk assessing and making decision on visitation.

**Participants in care (birthing partner)**

Participants in care in maternity services who have suspected or confirmed COVID-19 or who have been told they are a close contact may be supported, in specific circumstances e.g., living together in the same household with the mother, to attend during labour and birthing room/environment to provide care. There is an exemption to PHO for participants in care / birth partners.

- Processes must be in place and LHDs need to consider if this can be facilitated

IPAC strategies above apply to this group except that vaccine is not a requirement.
Visitation Conversation

Families and carers wishing to visit patients during NSW Health Red Alert Status should be engaged by the LHD/SHN in a conversation to consider the risks, benefits, and alternatives for visitation. This is particularly important when the admitted patient is considered vulnerable. A patient’s vulnerability could be related to wellbeing, mental, clinical, or social needs including immunocompromised or receiving end of life care. This should be determined locally according to the LHD/SHN local processes. The following information should be considered in this conversation:

Risks

- Transmission of COVID-19 between individuals (carers, patients, healthcare workers). This can be mitigated by appropriate use of PPE as per hospital policies, hand hygiene, distancing >1.5m where able and reducing visitation time.

Benefits

- Provide support and advocacy for the patient
- Provide important context and background information to facilitate holistic care
- Ensure that families, carers, and support people are involved in decision-making throughout the patient’s hospital journey
- Ensure that families, carers, and support people can provide support, participate in decision making and receive bereavement support in the last days of life
- Empower families and carers to identify and escalate concerns about their loved ones
- Can significantly reduce the distress, confusion and wandering experienced by patients with cognitive impairment
- Not only benefits the patient and family experience of care, but also the experience of staff caring for them through a partnership that contributes to safe quality care.

Alternatives to face-to-face visitation

- Virtual communication can be facilitated between family/carers and HCWs caring for patients such a telephone call or video-call via mobile devices
- Additional or specialised staffing where possible and appropriate (for example, 1:1 health care assistant support for wandering patients)
- Facilitating caregiving in other ways, such as sending letters or food.
Flowchart for visitation

Is the patient COVID-19 positive or a close contact?

Case-by-case exemptions should be considered
Follow local exemption process

Yes

Is the visitor COVID-19 positive or a close contact?

Yes

Visitation not always possible
Case-by-case exemptions should be considered
Follow local exemption process

No

Is the visitor fully vaccinated with the appropriate dosing schedule of a TGA approved or registered COVID-19 vaccine?

No

Is the visitor the only person who is able to visit?

Yes

2x visitors over the age of 12 years can visit a patient per day
No exemption required
No movement restrictions

No – either unvaccinated or only partially vaccinated

2x visitors over the age of 12 years can visit a patient per day
No exemption required
Once in the hospital, movement must be restricted
RAT test recommended

Visitation not permitted
Flowchart on special considerations for visitation

Do any of the following special considerations apply?

- **Patient immunocompromised**
  - A clinical assessment should be completed to determine the suitability of visitation.
  - If patient is deemed particularly vulnerable and therefore unsuitable, alternative methods such as virtual visitation should be explored.

- **Visitation on compassionate grounds**
  - For example:
    - patient seriously ill or dying
    - patients in palliative care who are critically ill
  - Visitation should not be restricted, regardless of COVID-19 status of both patients and visitors.
  - Written exemption not required.

- **Patients in care of maternity services**
  - Visitors providing care for patients in maternity services who are COVID-19 positive or a close contact should have visitation supported in appropriate circumstances.
  - For example, the visitor lives in the same household as mother.

- **Visitors under the age of 12 years**
  - Children under 12 years are not permitted to visit.
  - Case-by-case exemptions should be considered via local processes where suitable.
  - For example, siblings of long stay paediatric patients.
Chapter 3: Response and escalation framework

This chapter is part of COVID-19 Infection Prevention and Control Manual, Clinical Excellence Commission, 2022.

The publication summarises current evidence about COVID-19 infection prevention and control strategies and interventions, and their implementation in healthcare settings.

The publication will continue to evolve with additional chapters over time that address infection prevention and control in other settings. As new resources become available, they will be added as hyperlinks of the resources section in each chapter or to the appendices.

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Key points

- NSW provides a risk assessment for the health system as a whole
- The COVID-19 Risk Monitoring Dashboard brings together data on cases, clusters, the public health response and the impact of COVID-19 on the workforce
- An expert panel reviews the dashboard and assigns a risk rating which influences infection prevention and control practices.
### Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACFs</td>
<td>Aged Care Facilities</td>
</tr>
<tr>
<td>ACI</td>
<td>Agency for Clinical Innovation</td>
</tr>
<tr>
<td>AGP</td>
<td>Aerosol-generating procedure</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute respiratory infection</td>
</tr>
<tr>
<td>CEC</td>
<td>Clinical Excellence Commission</td>
</tr>
<tr>
<td>CHO</td>
<td>Chief Health Officer</td>
</tr>
<tr>
<td>DCF</td>
<td>Disability Care Facility</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>FAQs</td>
<td>Frequently asked questions</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HW</td>
<td>Health worker</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>IPAC</td>
<td>Infection prevention and control</td>
</tr>
<tr>
<td>LHD</td>
<td>Local Health District</td>
</tr>
<tr>
<td>MoH</td>
<td>NSW Ministry of Health</td>
</tr>
<tr>
<td>MPS</td>
<td>Multi-Purpose Service</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>NSWA</td>
<td>New South Wales Ambulance</td>
</tr>
<tr>
<td>PHEOC</td>
<td>Public Health Emergency Operations Centre</td>
</tr>
<tr>
<td>PHO</td>
<td>Public Health Order</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
</tr>
<tr>
<td>RACF</td>
<td>Residential aged care facility</td>
</tr>
<tr>
<td>RERP</td>
<td>Risk Escalation Review Panel</td>
</tr>
<tr>
<td>SHN</td>
<td>Specialty Health Network</td>
</tr>
</tbody>
</table>
3.1 Introduction

This COVID-19 Infection Prevention and Control Response and Escalation Framework (risk matrix) has been developed to provide guidance to NSW health facilities on the various levels of COVID-19 transmission risk. The development of this framework has been informed by NSW, national and international experience and evidence. The intent is that any changes to risk level are state-wide, an approach informed by consultation with the Ministry of Health (MoH) and Local Health Districts (LHDs)/Speciality Health Networks (SHNs) and other health organisations such as NSW Ambulance.

3.2 Escalation principles

During situations of increased risk, it is important to be able to escalate and provide a proportionate response with specific infection prevention and control precautions to align with the level of community transmission and onward spread.

The level of risk and escalation or de-escalation is assessed and provided by the Risk Escalation Review Panel (RERP) which meets weekly and has the following members: MOH Deputy Secretary (Chair), the COVID-19 Public Health Response Branch (PHRB), the Agency for Clinical Innovation (ACI), MoH Workforce, HealthShare and the CEC.

The RERP reviews a variety of data sets which includes the following:

1. Geographic clusters within LHDs/SHNs, Local Government Areas or State-wide
2. Level of community transmission and the Public Health Response
3. Number of COVID-19 tests/percentage of tests that are positive
4. Number of patients requiring hospitalisation and changes in the burden of COVID-19 within health facilities
5. Outbreaks in facilities e.g., residential aged care facilities, multi-purpose services and community residential care homes
6. Number of health worker infections and health worker furlough
7. Community vaccination numbers and rates

This information is summarised in the COVID-19 Risk Monitoring Dashboard available here.

Transition between risk levels

Although the risk of community transmission and consequent impact on health services varies across LHDs/SHNs, the agreed approach is to have a state-wide decision-making process. The criteria used to transition between risk levels of green, amber, red and the system impact are a composite of community transmission, the public health response and the burden of infection in the health system. Data supporting these is reviewed weekly by the RERP as above. Where an LHD/SHN local community risk warrants additional assessment,
this should be escalated by the Chief Executive of the LHD/SHN to the Chief Health Officer (CHO) who will call an extraordinary meeting of the RERP to agree on an NSW Health response.

As information about the COVID-19 pandemic is continuing to evolve there may be additional advice provided by the CHO or other agencies which may result in enhancement of existing risk levels.

Escalating to higher transmission risk levels requires LHDs and SHNs to rapidly respond and implement the key controls aligning with each risk level. De-escalation may require additional communication and implementation of changes may take longer.

Additional precautions may apply through the COVID-19 Public Health Order (PHO) based on community transmission and epidemiological risks.

Private and independent health care providers may refer to CEC advice for guidance and to inform their own local risk assessments.

3.2.1 System Impact

The addition of system impact to an alert is the acknowledgement of pressures of positive case numbers in addition to high staff impact. The system impact alert level will be applied in addition to the risk level as allocated by the panel and the risk escalation framework and may cover impacts outside of IPAC. The development of this additional level has been informed by NSW, national and international experience and evidence. The intent is that any changes to risk level are state-wide, an approach informed by consultation with the MoH, LHD/SHNs and other health organisations such as NSW Ambulance and HealthShare NSW.

The system impact level considerations are added to the current risk alert level to provide a complete set of guidance for Healthcare. Examples of triggers for system impact is in the table below.

<table>
<thead>
<tr>
<th>System Impact Alert Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
</tr>
<tr>
<td>ICU Capacity</td>
</tr>
<tr>
<td>Hospital capacity</td>
</tr>
<tr>
<td>ED Capacity</td>
</tr>
<tr>
<td>Transport Capacity: NSW Ambulance &amp; HealthShare NSW</td>
</tr>
<tr>
<td>PPE Availability</td>
</tr>
</tbody>
</table>
| Surgery | Emergency surgery only.  
  - Risk assessment for day procedures to continue  
  - Emergency day procedures where capacity and pressure on system continues to rise |
3.2.2 Alert level plus

Where there are additional requirements required for a risk alert level that does not warrant a complete move to another level, the risk escalation panel may apply the alert level PLUS.

The details of additional requirements will be described in the risk escalation dashboard and could include elements such as Public Health Order (PHO); IPAC strategies such as additional PPE requirements.

3.3 General principles for all settings and all scenarios

The following principles provide a robust framework for LHD/SHNs and other healthcare organisations to manage risk and apply to all settings and all scenarios. A key focus during escalation is to ensure that the hierarchy of controls are in place and to look at the use of PPE in response to the level of community transmission.

The fundamental principles of infection prevention and control must always be applied across all settings. These principles apply across all scenarios and are not outlined in detail in the tables below but are listed here:

1. Administrative and engineering controls
   (refer to Chapter 2 - section 2.6.7 Implement Transmission-Based Precautions)
2. Physical distancing
3. Standard Precautions for all healthcare interactions
   (refer to Chapter 2 - section 2.6.6 Application of Standard Precautions for all patients at all times)
4. Hand hygiene
5. Enhanced cleaning of high touch surfaces
   (refer to Chapter 2 - section 2.8 Environmental Cleaning)
6. Ensure relevant HW have completed donning and doffing of PPE training
7. Ensure there is on-site, readily available COVID-19 testing for HW
8. Health workers (Hw) stay at home if they are unwell
9. Entry screening for visitors and HW as per NSW Health guidelines.
3.4 NSW Risk Matrix

<table>
<thead>
<tr>
<th>LOW TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Precautions</strong></td>
</tr>
<tr>
<td>All Emergency Department (ED) staff to wear surgical masks in clinical areas during patient care and if Droplet Precautions required, eye protection when within 1.5m of a patient</td>
</tr>
<tr>
<td>All patients with an ARI to wear a mask on presentation and transit</td>
</tr>
<tr>
<td>Aged Care Facilities (ACFs), Disability Care Facilities (DCFs) and home care services should take extra precautions including the use of masks where there are areas for increased testing*</td>
</tr>
<tr>
<td>Risk assessment of cases and community transmission will be determined by the Risk Escalation Review Panel</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MODERATE TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard Precautions</strong></td>
</tr>
<tr>
<td>Escalate PPE controls</td>
</tr>
<tr>
<td>HWs to wear surgical mask when in healthcare facilities, this includes clinical and non-clinical areas (e.g., on entry, corridors, office spaces)</td>
</tr>
<tr>
<td>In a shared office space, HWs are required to wear a mask unless they are the only person working in the office.</td>
</tr>
<tr>
<td><strong>Eye protection when within 1.5m of a patient</strong></td>
</tr>
<tr>
<td>Patients presenting directly from the community, inter- and intra-hospital transfers wear a mask</td>
</tr>
<tr>
<td>Visitors must wear a mask before entering facilities</td>
</tr>
<tr>
<td>Risk assessment of cases and community transmission will be determined by the Risk Escalation Review Panel</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>HIGH TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Escalate PPE controls</strong></td>
</tr>
<tr>
<td>Universal surgical mask use by HWs and P2/N95 respirators for suspected or confirmed COVID-19</td>
</tr>
<tr>
<td>Eye protection when within 1.5m of a patient</td>
</tr>
<tr>
<td>Patients presenting directly from the community, inter- and intra-hospital transfers wear a mask</td>
</tr>
<tr>
<td>Risk assessment of cases and community transmission will be determined by the Risk Escalation Review Panel</td>
</tr>
<tr>
<td>Visitors by risk assessment and to wear mask</td>
</tr>
<tr>
<td>Participants in care to be risk assessed to be able to continue providing care and support. A participant in care can be described as someone actively providing care, physical and/or emotional support</td>
</tr>
</tbody>
</table>


Ensure screening and triage processes are in place to manage patients with suspected or confirmed COVID-19
<table>
<thead>
<tr>
<th>Patients</th>
<th>LOW (GREEN ALERT) TRANSMISSION</th>
<th>MODERATE (AMBER ALERT) TRANSMISSION</th>
<th>HIGH (RED ALERT) TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>All patients in hospital</td>
<td>Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene Exclude outpatients if suspected or confirmed COVID-19 unless urgent</td>
<td>All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible</td>
<td>All patients to wear a surgical mask on presentation and during transit if possible Manage suspected or confirmed COVID-19 patients in a single room where possible Prioritise single rooms based on patient’s clinical condition and risk of transmission level or cohort confirmed cases if no single rooms available Minimise patient movement where safe to do</td>
</tr>
<tr>
<td>Presenting directly to Emergency Department (ED)</td>
<td>Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene All patients with an ARI to wear a mask on presentation and transit</td>
<td>All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible</td>
<td>All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible</td>
</tr>
<tr>
<td>Patient presenting directly to Birth Suite, medical imaging, outpatients, rehabilitation groups and community health services</td>
<td>Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene Patients to wear a mask if ARI suspected or confirmed</td>
<td>All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible</td>
<td>All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible</td>
</tr>
<tr>
<td>Maternity &amp; paediatric patients</td>
<td>Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene</td>
<td>Mother and baby to stay together Children 12 years and under are not required to wear a mask#</td>
<td>Mother and baby to stay together All adult patients to wear a mask during presentation and transit if possible Children 12 years and under are not required to wear a mask#</td>
</tr>
<tr>
<td>Home based care (patients seen in their own home)</td>
<td>Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene</td>
<td>Standard Precautions (as per Green Alert level) and mask (surgical or own approved cloth mask) should be worn by patients at their discretion</td>
<td>All patients to wear a mask (surgical or own approved cloth mask) when receiving care if possible</td>
</tr>
<tr>
<td>Risk Matrix</td>
<td>LOW (GREEN ALERT) TRANSMISSION</td>
<td>MODERATE (AMBER ALERT) TRANSMISSION</td>
<td>HIGH (RED ALERT) TRANSMISSION</td>
</tr>
<tr>
<td>-------------</td>
<td>---------------------------------</td>
<td>-------------------------------------</td>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Patients</strong></td>
<td>Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene. ACFs, DCFs and home care services should take extra precautions including the use of masks where there are areas for increased testing <a href="#">NSW Health advice for RACFs</a></td>
<td>Standard Precautions (as per Green Alert level) or local decision based on case locations risk level see <a href="#">NSW Health advice for RACFs</a></td>
<td>Patient mask use should be based on facility risk assessment and NSW Health PHO recommendation</td>
</tr>
<tr>
<td>Residents of residential aged care facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health workers</strong></td>
<td>Standard Precautions Physical distancing to apply at all HW breaks/meetings where possible If Droplet Precautions required a surgical mask and eye protection if within 1.5m of patients Contact and Airborne Precautions (P2/N95 respirator) and eye protection are required when providing direct care for:</td>
<td>Universal surgical mask use by all HWs when in the facility Eye protection if within 1.5m of a patient Physical distancing to apply at all HW breaks where possible Contact and Airborne Precautions (P2/N95 respirator) and eye protection are required when providing direct care for:</td>
<td></td>
</tr>
<tr>
<td>Standard Precautions and physical distancing apply at all times</td>
<td>Healthcare facility (see next section for HW working in ED)</td>
<td>patients with suspected or confirmed COVID-19 close contact of a COVID-19 case</td>
<td>patients with suspected or confirmed COVID-19 close contact of a COVID-19 case</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>patients with suspected or confirmed COVID-19 close contact of a COVID-19 case</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>patients with suspected or confirmed COVID-19 close contact of a COVID-19 case</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Risk Matrix</th>
<th>LOW (GREEN ALERT) TRANSMISSION</th>
<th>MODERATE (AMBER ALERT) TRANSMISSION</th>
<th>HIGH (RED ALERT) TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health workers</strong></td>
<td>HWs working in ED</td>
<td>As above PLUS All ED HWs to wear surgical masks in clinical areas during any patient care</td>
<td>As above</td>
</tr>
<tr>
<td>Standard Precautions and physical distancing apply at all times</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Home based care (patients seen in their own home)</td>
<td>Standard Precautions HWs who work in DCFs and home care services should take extra precautions including the use of masks where there are areas for increased testing see NSW Health advice for RACFs</td>
<td>Surgical mask within 1.5m of patient/client</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Residential aged care facility (RACF)</td>
<td>HWs who work in RACFs should take extra precautions including the use of masks where there are areas for increased testing see NSW Health advice for RACFs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Visitors</td>
<td>Standard Precautions No restrictions if meets the COVID-19 screening criteria on entry Visitor numbers as per local policy</td>
<td>Visitors must wear a mask before entering the facility and whilst inside the facility (surgical or own approved cloth mask) Children 12 years and under are not required to wear a mask Consider limiting number of visitors (acknowledgement of individual patient needs)</td>
</tr>
</tbody>
</table>

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### Risk Matrix

<table>
<thead>
<tr>
<th>Visitors</th>
<th>LOW (GREEN ALERT) TRANSMISSION</th>
<th>MODERATE (AMBER ALERT) TRANSMISSION</th>
<th>HIGH (RED ALERT) TRANSMISSION</th>
</tr>
</thead>
<tbody>
<tr>
<td>A participant in care can be described as someone actively providing care, physical and/or emotional support</td>
<td>Standard Precautions No restrictions if meets the COVID-19 screening criteria on entry</td>
<td>Carers and support person(s) must wear a mask before entering the facility (surgical or own approved cloth mask) Participants in care to be risk assessed to be able to continue providing care and support</td>
<td>Surgical masks (universal mask use) Participants in care to be risk assessed to be able to continue providing care and support</td>
</tr>
<tr>
<td>Visitors to RACF</td>
<td>Visitation should be based on the latest advice from COVID-19 Public Health Response Branch, refer to <a href="https://www.nsw.gov.au/health">NSW Health advice for RACFs</a></td>
<td>Visitation should be based on the latest advice from COVID-19 Public Health Response Branch see <a href="https://www.nsw.gov.au/health">NSW Health advice for RACFs</a></td>
<td>Visitors, including any children will require an exemption to visit</td>
</tr>
</tbody>
</table>

**Note:** Although these principles apply across healthcare environments, when caring for vulnerable patients/residents, individual circumstances should be considered.

The evidence shows that SARS-CoV-2 can spread from hand-to-hand contact from inanimate objects and highly touched fomites, including medical equipment. There is also growing evidence on the transmission of COVID-19 in common areas when masks are off, in tea rooms, changing rooms, and crowded transport to and from the hospital where physical distancing cannot be maintained. The importance of hand hygiene, physical distancing, enhanced cleaning for shared equipment and environment remains critical to ensure the safety of HWs.

# Children 12 years and under are not required to wear a mask. This is based on the safety and overall interest of the child and the capacity to appropriately use a mask with minimal assistance.
### Summary Table: COVID-19 risk assessment guide for PPE selection for direct care of patients

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Precautions Required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequent hand hygiene</td>
</tr>
<tr>
<td>No acute respiratory infection (ARI) symptoms AND no recognised COVID-19 epidemiological risk&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Subject to current NSW Risk Level and/or Public Health Order</td>
</tr>
<tr>
<td>ARI without COVID19 epidemiological risk&lt;sup&gt;2&lt;/sup&gt; (important to test for other respiratory viruses)</td>
<td>CONTACT + DROPLET</td>
</tr>
<tr>
<td>Patients with suspected&lt;sup&gt;2&lt;/sup&gt; or confirmed COVID-19 OR as identified as a close contact&lt;sup&gt;5&lt;/sup&gt;</td>
<td>CONTACT + DROPLET + AIRBORNE&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Notes:

1. Standard precautions always include a risk assessment for the need for PPE. All health workers require COVID-19 vaccination
2. COVID-19 close contact as specified by CDNA COVID-19 SoNG
3. For extended use, masks or respirators can be worn for up to 4-8 hours respectively. Eye protection can also remain on between patients. Masks/respirators and eye protection should be discarded (or reprocessed in the case of reusable eye protection) if they are moist or contaminated with blood or bodily fluids and after removal
4. Health workers required to wear P2/N95 respirators should be trained in the correct use including fit checking, donning and doffing. This also applies to the use of reusable respirators

Adapted from Personal Protective Equipment (PPE) for patient care with symptoms of acute respiratory illness including COVID-19 HNELHD
3.5 Green Alert poster

Mask use **NOT** required on entry

**STANDARD PRECAUTIONS ALWAYS APPLY**

Ensure screening and triage processes are in place to manage patients with suspected COVID-19

---

**Patients**

Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene

Unless urgent, exclude outpatients with suspected or confirmed COVID-19

All patients with an acute respiratory infection to wear a mask on presentation and transit

---

**Health workers (HW)**

Standard Precautions

Contact and Airborne Precautions (P2/N95 respirator) and eye protection are required when providing direct care for:

- patients with suspected or confirmed COVID-19
- close contact of a COVID-19 case

All ED HWs to wear surgical masks in clinical areas and if droplet precautions required, eye protection when within 1.5m of a patient

Physical distancing to apply for all HW breaks

---

**Visitors**

No restrictions if approved during the COVID-19 entry screening criteria

Promote hand hygiene and physical distancing at entry to health facility and patient rooms

---
### 3.6 Green Alert frequently asked questions

The frequently asked questions (FAQs) provide an explanation of when masks need to be worn by HWs, patients, visitors, carers and other people coming into NSW Health facilities.

<table>
<thead>
<tr>
<th>HEALTH WORKERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When should I wear a mask?</strong></td>
<td>A decision about using a mask for patient care should be considered as part of the risk assessment for Standard Precautions (see <a href="#">Risk Assessment</a> in the Infection Prevention and Control Practice Handbook). Part of the risk assessment is the anticipated exposure risk of blood or body fluid to eyes/mouth/nose. Surgical masks and eye protection should still be worn when assessing or providing care to any patient with acute respiratory symptoms. Respirators (P2/N95) and eye protection is required when caring for patients with suspected or confirmed COVID-19.</td>
</tr>
<tr>
<td><strong>Why do I need to wear a mask when working in the ED?</strong></td>
<td>Although the risk of COVID-19 infection is very low in the community, the emergency departments are thought to be a higher risk environment and a surgical mask is required. If droplet precautions required, eye protection when within 1.5m of a patient. Respirators (P2/N95) and eye protection are required when caring for patients with suspected or confirmed COVID-19.</td>
</tr>
<tr>
<td><strong>When in crowded areas of the hospital e.g., eating areas/cafeteria, do HWs need to wear a surgical mask?</strong></td>
<td>This will be at the HW's discretion. Physical distancing, cough etiquette, respiratory hygiene and hand hygiene is always to be practiced.</td>
</tr>
<tr>
<td><strong>During this Green Alert, should HWs with conditions that place them in a ‘vulnerable’ group be redeployed?</strong></td>
<td>Vulnerable HWs should be individually risk assessed to determine their suitability for clinical areas. Vulnerable HWs may choose to wear a surgical mask when within 1.5 metres of any patient to reduce this risk and this should be considered in the risk assessment.</td>
</tr>
<tr>
<td><strong>If a HW is in a non-clinical area or office, should they wear a surgical mask?</strong></td>
<td>No, masks do not need to be worn in these settings. Physical distancing, cough etiquette, respiratory hygiene and hand hygiene are always to be practiced.</td>
</tr>
<tr>
<td><strong>If a visitor asks why a HW is not wearing a surgical mask, how should the HW respond?</strong></td>
<td>Masks are not required for routine patient care. Information about the risk levels should be placed in public spaces for patients and the relatives and carers.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If a HW travels in a shared health vehicle with another HW, do they need to wear a surgical mask?</td>
<td>If a HW travels in a shared health vehicle with another HW, do they need to wear a surgical mask? Masks are unlikely to be required. Please refer to Chapter 2: section 2.15 Transport.</td>
</tr>
<tr>
<td>Should HWs entering a school for the provision of a service wear a mask? (e.g., immunisation or school within a health facility)</td>
<td>Should HWs entering a school for the provision of a service wear a mask? For school-based programs, masks are not routinely recommended. However, a risk assessment must always be performed and there may be situations where a mask is worn. For schools located within health facilities, HWs can wear a mask and eye protection if they are required to provide direct care for high-risk person/client (ARI) within 1.5 metres.</td>
</tr>
<tr>
<td>PATIENTS</td>
<td></td>
</tr>
<tr>
<td>When should a patient wear a mask? (see also questions regarding approved cloth masks below)</td>
<td>A mask should be worn if the patient is attending a health facility and has acute respiratory symptoms (whether they have had a COVID-19 test or not). e.g., Emergency Department, Outpatient Clinic, Birth Suite, Medical Imaging, Pathology Collection.</td>
</tr>
<tr>
<td>Once a patient is admitted to a clinical area, are they required to wear a surgical mask while they are an inpatient?</td>
<td>Once a patient is admitted to a clinical area, are they required to wear a surgical mask while they are an inpatient? Patients will not usually be required to wear a mask. If they have acute respiratory symptoms or are suspected or confirmed COVID-19, they are required to wear a surgical mask if they are leaving their room (for example going to the medical imaging department). Remember: Some patients will not be able to tolerate wearing a mask.</td>
</tr>
<tr>
<td>Why don’t children 12 years and under need to wear a mask if they have respiratory symptoms?</td>
<td>Why don’t children 12 years and under need to wear a mask if they have respiratory symptoms? In general, it is not practical for children to be fitted with a mask. There appears to be limited transmission of COVID-19 from children to adults. If a child is wearing a mask, then this can continue while the child is inside a health facility. Masks can be choking hazards for children under two and are not suitable for this age group. This advice is consistent with other jurisdictions.</td>
</tr>
<tr>
<td>Can a patient with suspected or confirmed COVID-19 wear a P2/N95 respirator?</td>
<td>Patients should not wear a P2/N95 respirator but may be asked to wear a surgical mask when in a shared space.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>APPROVED CLOTH MASKS</strong></td>
<td></td>
</tr>
<tr>
<td>Can a HW wear an approved cloth mask at work?</td>
<td>No, approved cloth masks vary in quality and effectiveness and they are not fluid resistant. This means they will not prevent blood, body fluids and respiratory droplets penetrating the mask. An approved cloth mask can be worn by HWs outside the health facility e.g., travelling to and from work.</td>
</tr>
<tr>
<td>If a visitor comes in wearing an approved cloth mask, should it be changed to a surgical mask?</td>
<td>No, visitors are not required to wear masks. Reminders regarding hand hygiene, physical distancing, avoiding touching their mask and cough etiquette, respiratory hygiene are to be provided. If the visitor has acute respiratory symptoms or fever, they should not be allowed entry as per screening criteria.</td>
</tr>
<tr>
<td>If a patient/client, without any COVID-19 symptoms, comes in wearing an approved cloth mask, should it be changed to a surgical mask?</td>
<td>No, they are not required to wear a mask but may continue to wear based on personal choice. Reminders regarding hand hygiene, physical distancing, avoiding touching their mask, cough etiquette and respiratory hygiene are to be provided.</td>
</tr>
<tr>
<td>If a patient/client, with ARI or COVID-19 symptoms, comes in wearing an approved cloth mask, should it be changed to a surgical mask?</td>
<td>Yes, an approved cloth mask will become damp very quickly when someone has an acute respiratory symptom, fever or COVID-19 symptoms. The mask will be much less effective when damp and may be touched frequently by the patient. A surgical mask should be provided for the patient and usual admission/discharge processes for suspected or confirmed COVID-19 patients are to be followed. Reminders regarding hand hygiene, physical distancing, avoiding touching their mask, cough etiquette and respiratory hygiene are to be provided. Access to tissues, ABHR and a bin is to be provided.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
</tr>
<tr>
<td>If a member of the community wears a towel, scarf, tea towel etc. into the health facility, is this classified as an approved cloth mask?</td>
<td>No, these are not classified as approved cloth masks. NSW Health has released general guidance for approved cloth masks. This information should be followed.</td>
</tr>
<tr>
<td>HOME VISITS</td>
<td></td>
</tr>
<tr>
<td>Do HWs need to wear a surgical mask when they are visiting a patient in their home to provide healthcare?</td>
<td>A surgical mask and eye protection is recommended only if the patient has respiratory symptoms or is in self-isolation. A P2/N95 respirator is recommended if in an area of increased testing. HWs should maintain physical distancing whenever possible. Patients are not required to wear a mask if they are not showing ARI symptoms but may choose to wear one.</td>
</tr>
<tr>
<td>CARER IN A HEALTHCARE SETTING</td>
<td></td>
</tr>
<tr>
<td>Should carers wear a surgical face mask if within 1.5 metres of a patient?</td>
<td>Yes, if the person has an ARI and COVID-19 has not been ruled out by testing.</td>
</tr>
<tr>
<td>VISITORS</td>
<td></td>
</tr>
<tr>
<td>Are visitors required to wear a mask if they come to a health facility?</td>
<td>No, they are not required to wear a mask. If they have ARI symptoms, they need to defer their visit. If they are already wearing a cloth or surgical mask, they can continue to wear this. See section on approved cloth masks.</td>
</tr>
<tr>
<td>What should be done if a visitor appears to have ARI symptoms?</td>
<td>Offer an alternative such as a virtual visit. The visitor should be asked to defer their visit if possible. They must be referred for COVID-19 testing and told to isolate until negative test result is obtained.</td>
</tr>
<tr>
<td>AGED CARE FACILITIES/MULTI-PURPOSE SERVICE (MPS)</td>
<td></td>
</tr>
<tr>
<td>Does a resident in an ACF or MPS need to wear a surgical mask?</td>
<td>No, this is classified as their home.</td>
</tr>
</tbody>
</table>
### PATIENTS WITH A DISABILITY, COGNITIVE IMPAIRMENT, BEHAVIOURAL ISSUES AND/OR MENTAL HEALTH CONDITIONS

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should a HW/carer/visitor wear a surgical mask if within 1.5 metres of a patient?</td>
<td>A HW/carer/visitor in a DCF should take extra precautions including the use of masks where there are areas for increased testing see <a href="#">NSW Health advice for RACFs</a>. A surgical mask and eye protection is recommended only if the patient has respiratory symptoms. HWs should maintain physical distancing whenever possible. HWs, visitors and/or carers wearing a respirator or a surgical mask may cause some patients distress or trigger changes to their behaviour or mental health condition. This will require a risk assessment and ongoing monitoring to determine the best way to manage the risk of transmission of COVID-19 when providing care within 1.5 metres of the patient. If a risk assessment determines that a mask will pose a physical risk to the patient, alternatives such as physical distancing and full-face shield should be considered. The risk assessment should determine the appropriate PPE for the HW. All decisions regarding the risk assessment should be documented in the patients’ healthcare record.</td>
</tr>
</tbody>
</table>

### VOLUNTEERS IN A HEALTHCARE SETTING

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are volunteers required to wear a mask?</td>
<td>Volunteers are not required to wear a mask. If they are in a vulnerable group, they may choose to wear a mask while in the healthcare setting. If volunteering in ED a mask should be worn within 1.5 metres of a patient. Reminders regarding hand hygiene, physical distancing, cough etiquette, respiratory hygiene and not coming to the facility if unwell are to be provided. Volunteers should not be interacting with patients with an ARI or suspected or confirmed COVID-19</td>
</tr>
<tr>
<td>CONTRACTORS</td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td><strong>When should a contractor wear a mask?</strong></td>
<td></td>
</tr>
<tr>
<td>They are not required to wear a mask while in the facility unless they require one for dust/gas/environmental exposures.</td>
<td></td>
</tr>
<tr>
<td>If working within ED a mask should be worn within 1.5 metres of patients.</td>
<td></td>
</tr>
<tr>
<td>Reminders regarding hand hygiene, physical distancing, cough etiquette and respiratory hygiene are to be provided.</td>
<td></td>
</tr>
<tr>
<td>It is expected that contractors maintain adequate supplies of PPE and ABHR as part of their work, health and safety (WHS) obligations.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>STOCK DELIVERY TO CLINICAL AREAS – EXTERNAL DELIVERY/COURIER COMPANIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do delivery/courier driver need to wear a mask (surgical or own cloth) if they are making a delivery to clinical areas?</strong></td>
</tr>
<tr>
<td>No, masks are not routinely required unless within 1.5 metres of patients in the ED setting.</td>
</tr>
<tr>
<td>Reminders regarding hand hygiene, physical distancing, cough etiquette, respiratory hygiene and not being onsite if they have ARI symptoms or fever.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VALVE MASKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If a patient or a visitor is wearing a mask with a valve, do we need to change it to a surgical mask?</strong></td>
</tr>
<tr>
<td>Yes, if the patient/visitor is wearing a mask because of respiratory symptoms, this should be changed.</td>
</tr>
<tr>
<td>These masks should not be worn as the exhalation valve is generally not filtered and particles are able to be exhaled via the valve.</td>
</tr>
</tbody>
</table>
3.7 Amber Alert poster

Targeted surgical mask use for all health workers caring/working within all clinical areas

<table>
<thead>
<tr>
<th>Health workers</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>STANDARD PRECAUTIONS ALWAYS APPLY</strong></td>
<td>Ensure screening and triage processes are in place to manage patients with suspected COVID-19</td>
</tr>
<tr>
<td>- Patients presenting directly from the community, inter and intra hospital transfers are <strong>required to wear a mask</strong> where able to do so</td>
<td></td>
</tr>
<tr>
<td>- Children 12 years and under are not required to wear a mask</td>
<td></td>
</tr>
<tr>
<td>- <strong>Note</strong>: Although these principles apply across healthcare environments when caring for vulnerable patients/residents, individual circumstances should be considered</td>
<td></td>
</tr>
<tr>
<td>- <strong>HWs to wear surgical mask when in healthcare facilities, this includes clinical and non-clinical areas (e.g., on entry, corridors, office spaces)</strong></td>
<td></td>
</tr>
<tr>
<td>- <strong>In a shared office space, HWs are required to wear a mask unless they are the only person working in the office</strong></td>
<td></td>
</tr>
<tr>
<td>- <strong>Eye protection when within 1.5m of a patient</strong></td>
<td></td>
</tr>
<tr>
<td>- Contact and Airborne Precautions (<strong>P2/N95 respirator</strong>) and eye protection are required when providing direct care for:</td>
<td></td>
</tr>
<tr>
<td>- patients with suspected or confirmed COVID-19</td>
<td></td>
</tr>
<tr>
<td>- close contact of a COVID-19 case</td>
<td></td>
</tr>
<tr>
<td>- Physical distancing, hand hygiene and regular cleaning are also important</td>
<td></td>
</tr>
</tbody>
</table>

| Visitors | |
| - **Consider limiting number of visitors (acknowledgement of individual patient needs)** | |
| - Visitors must wear a mask before entering the facility (own mask or provided by the facility) | |
## 3.8 Amber Alert frequently asked questions

The FAQs provide an explanation of when masks need to be worn by HWs, patients, visitors, carers and other people coming into NSW Health facilities.

### HEALTH WORKERS

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| What does our clinical area do if we have a limited number of surgical masks for a short period of time? | All issues related to PPE should be escalated immediately through usual organisational structures. This should be addressed at LHD/SHN PPE Governance Committees.  
*Chapter 4: Personal Protective Equipment* provides guidance on extended or sessional use of PPE. HWs are not expected to complete a task if the PPE required is unavailable. See question below. |
| Can a HW wear the same surgical mask for multiple patient interactions?   | Yes, this is called extended or sessional use of PPE.  
If a surgical mask can be worn without pulling it down or removing it, for example to speak, it can be worn for up to four hours. If it is pulled down or removed, it must be discarded immediately, and hand hygiene performed.  
If the mask is touched, hand hygiene should be performed immediately. The mask should be removed if it becomes damp or loose.  
Extended or sessional use of a mask or respirator and eye protection can be used across different clinical areas if it is not contaminated. Contamination is likely when providing care for patients with COVID-19 or other infections transmitted via the respiratory route and must be changed prior to entering a different clinical area.  
Patient transport or NSW Ambulance (NSWA) HWs who move patients between facilities can wear the same mask for the duration of the transport but must discard and change their mask before the next patient transport. Ensure a comfortable fit if driving a vehicle.  
Safe mask use must always be considered. |
| When in crowded areas of the hospital e.g., eating areas/cafeteria, do HWs need to wear a surgical mask? | Yes, when in communal areas.  
Physical distancing, cough etiquette, respiratory hygiene and hand hygiene is always to be practiced.  
Masks should be worn if distancing is not possible. |
| When should HWs wear a P2/N95 respirator?                               | P2/N95 respirators including eye protection are worn when:  
- Providing care for suspected or confirmed COVID-19 patients  
- Providing care for close contact of COVID-19 cases  
- Providing care or treatment to a patient with a communicable disease that is spread by the airborne route e.g., Tuberculosis (TB), measles |
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should HWs be wearing masks in safety huddles, meetings, family</td>
<td>Yes, if mask wearing is mandated (refer to <a href="https://www.health.nsw.gov.au/infection-prevention-and-control">PHO</a>). HWs to wear surgical mask within clinical area and any communal (patient/visitor) area, on entry to hospitals and in corridors including shared spaces when with any other person. This includes spaces where there is no patient or visitor contact.</td>
</tr>
<tr>
<td>conferences etc. on the ward/other designated area?</td>
<td></td>
</tr>
<tr>
<td>What should be done if a HW declines to wear a surgical mask when</td>
<td>This is a WHS risk and should be managed within this legislation. Surgical masks, like other PPE are provided to protect HWs, patients and visitors. Where masks are prescribed for use, they must be consistently used by HWs and as such are not optional.</td>
</tr>
<tr>
<td>within 1.5 metres of a patient?</td>
<td></td>
</tr>
<tr>
<td>Should a HW wear a surgical mask when they are talking to a patient</td>
<td>Yes, a surgical mask is required within clinical areas and when providing direct care to patients.</td>
</tr>
<tr>
<td>and can maintain a 1.5 metre physical distance?</td>
<td></td>
</tr>
<tr>
<td>During this Amber Alert, should HWs with conditions that place them</td>
<td>Vulnerable HWs should be individually risk assessed to determine their suitability for clinical areas. Wearing a surgical mask when within 1.5 metres of any patient will reduce this risk and should be considered in the risk assessment.</td>
</tr>
<tr>
<td>in a ‘vulnerable’ group be redeployed?</td>
<td></td>
</tr>
<tr>
<td>If a HW is in a non-clinical area or office, should they wear a</td>
<td>Yes, if mask wearing is mandated (refer to <a href="https://www.health.nsw.gov.au/infection-prevention-and-control">PHO</a>). HWs to wear surgical mask when in healthcare facilities, this includes clinical and non-clinical areas (e.g., on entry, corridors, office spaces). In a shared office space and the office is co-located or part of a health facility, HWs are required to wear a mask unless they are the only person working in the office.</td>
</tr>
<tr>
<td>surgical mask?</td>
<td></td>
</tr>
<tr>
<td>need to wear a surgical mask?</td>
<td></td>
</tr>
<tr>
<td>Should a HW wear a surgical mask when they are examining a baby or</td>
<td>Yes, a baby or toddler will always be accompanied by a parent or guardian. Our protection is for everyone. HWs providing direct care within 1.5 metres of any patient must wear a surgical mask.</td>
</tr>
<tr>
<td>toddler?</td>
<td></td>
</tr>
</tbody>
</table>
| **Should HWs entering a school for the provision of a service wear a mask?** (e.g., immunisation or school within a health facility) | For school-based programs, the decision to wear a mask should be based on a risk assessment considering the proximity, intensity and duration of contact with children in the school.

For schools located within health facilities, HWs are to wear a mask if they are required to provide direct care within 1.5 metres. |

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**PATIENTS**

| When should a patient wear a mask? (see also questions regarding approved cloth masks below) | On arrival to a health facility e.g., Emergency Department, Outpatient Clinic, Birth Suite, Medical Imaging, Pathology.

After they are admitted as an inpatient, patients are required to wear a surgical mask if they leave their room for any reason.

Refer to the scenario table under the heading ‘Patients’. |

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| Once a patient is admitted to a clinical area, are they required to wear a surgical mask while they are an inpatient? | Patients will not usually be required to wear a mask once in their room.

If they have acute respiratory symptoms, fever or are suspected or confirmed COVID-19, they are required to wear a surgical mask if they are leaving their room (for example going to the medical imaging department).

If patients are to leave the room and physical distancing is not possible, then they will be asked to wear a surgical mask (not a respirator).

Remember: some patients will not be able to tolerate wearing a mask. |

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| When a patient is discharged from a health facility (Emergency Department or as an inpatient) are they required to wear a mask? | Yes, while in the health facility (surgical or approved own approved cloth mask). |

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| What should be done when a patient does not want to wear a mask on arrival (and is not confused or have cognitive impairment or other conditions that might cause difficulty with mask wearing)? | Check the reasons for declining to wear a mask and determine if there are alternatives that may be suitable for this patient.

If they continue to decline the alternative, the patient should be placed 1.5 metres away from other patients and informed that they are not to walk around the clinical area until they are either discharged from the ED or admitted to their clinical area.

Be mindful of the practicalities of wearing a mask for certain patient groups e.g., those with behavioural disorders or mental health conditions, cognitive impairment.

Women in labour may find mask wearing difficult and may be unable to comply. |
Where there are no obvious barriers to mask-wearing, the patient should be informed of the current Amber Alert recommendations and their risk for COVID-19.

| Why don’t children 12 years and under need to wear a mask? | In general, it is not practical for children to be fitted with a mask. There appears to be limited transmission of COVID-19 from children to adults. Parents/guardians are expected to wear a mask and to assist children in this age group with hand hygiene. If a child is wearing a mask, then this can continue while the child is inside a health facility. Masks can be choking hazards for children under two years; therefore, masks are not suitable for this age group. This advice is consistent with other jurisdictions. |
| Can a patient with suspected or confirmed COVID-19 wear a P2/N95 respirator? | Patients should not wear a P2/N95 respirator but may be asked to wear a surgical mask when in a shared space. |

**APPROVED CLOTH MASKS**

| Can a HW wear an approved cloth mask at work? | No, approved cloth masks vary in quality and effectiveness and may not be fluid resistant. This means they will not prevent blood, body fluids and respiratory droplets penetrating the mask. An approved cloth mask can be worn by HWs outside the health facility e.g., travelling to and from work. |
| If a visitor comes in wearing an approved cloth mask, should it be changed to a surgical mask? | No, a visitor can wear an approved cloth mask while visiting the health facility. If the visitor can wear the approved cloth mask without discomfort, they should continue to wear it. Reminders regarding hand hygiene, physical distancing, avoiding touching their mask and cough etiquette, respiratory hygiene are to be provided. If the visitor has acute respiratory symptoms or fever, they need to defer their visit and have COVID-19 testing. They should be asked to change to a surgical mask. |
| If a patient/client, without any COVID-19 symptoms, comes in wearing an approved cloth mask, should it be changed to a surgical mask? | No, if the patient/client can wear the approved cloth mask without discomfort, they should continue to wear it. Reminders regarding hand hygiene, physical distancing, avoiding touching their mask, cough etiquette and respiratory hygiene are to be provided. |
| If a patient/client, with an ARI or COVID-19 symptoms, comes in wearing an approved cloth mask, should it be changed to a surgical mask? | Yes, an approved cloth mask will become damp very quickly when someone has an ARI, fever or COVID-19 symptoms.  
The mask will be much less effective when damp and may be touched frequently by the patient.  
A surgical mask should be placed on the patient and usual admission/discharge processes for suspected or confirmed COVID-19 patients are to be followed.  
Reminders regarding hand hygiene, physical distancing, avoiding touching their mask, cough etiquette and respiratory hygiene are to be provided.  
Access to tissues, ABHR and a bin is to be provided. |
|---|---|
| If a member of the community wears a towel, scarf, tea towel etc. into the health facility, is this classified as a ‘approved cloth mask’? | No, these are not classified as approved cloth masks.  
NSW Health has released [general guidance for approved cloth masks](https://www.nsw.gov.au), this information should be followed. |
| HOME VISITS | HOME VISITS |
| Do HWs need to wear a surgical mask when they are visiting a patient in their home to provide healthcare? | Yes, a surgical mask **and eye protection** should be worn if providing care within 1.5 metres.  
Wear a P2/N95 respirator and eye protection if the patient suspected or confirmed COVID-19.  
If physical distancing can be maintained during the visit, a surgical mask is not required.  
Patients are not required to wear a mask but may choose to wear one. |
| CARER IN A HEALTHCARE SETTING | CARER IN A HEALTHCARE SETTING |
| Should a carer wear a surgical face mask if within 1.5 metres of a patient? | Yes, they can also wear an approved cloth mask.  
If a carer is accompanying a patient/client into a healthcare facility they should wear a mask (surgical or approved cloth mask). |
## VISITORS

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are visitors required to wear a mask if they come to a health facility?</td>
<td>Yes, visitors are required to wear a mask if they are coming into a health facility for any reason. If they are already wearing an approved cloth or surgical mask, they can continue to wear this. See section above on approved cloth masks.</td>
</tr>
<tr>
<td>Birthing room If a partner or family member from the same household is supporting the woman during labour, do they need to wear a mask when they are in the room?</td>
<td>If the patient is in a single room, a mask is not required. When the visitor leaves the room, they are to wear a mask until they leave the hospital as per the current risk framework. During labour the partner would carry the same risk as the patient and therefore would not be required to routinely wear a mask. However, in the event of participants in care is COVID-19 positive or a close contact they will need to wear a mask at all times.</td>
</tr>
<tr>
<td>What should be done if a visitor declines to wear a mask?</td>
<td>The visitor should be informed of the current Amber Alert recommendations and the risk to the patient, themselves and others in the facility they are visiting. If they continue to decline to wear a mask, they should be risk assessed to determine the location of their visit and the patient they are visiting. Offer an alternative such as a virtual visit. They should only be asked to leave the health facility if it is determined that there will be a COVID-19 risk for the patient, themselves or to the clinical area they will be visiting.</td>
</tr>
<tr>
<td>Who will teach visitors how to wear a mask?</td>
<td>As visitors are screened at entry areas, HWs who are responsible for these areas should provide assistance on the correct mask use. Posters and information on mask use are available.</td>
</tr>
</tbody>
</table>

## AGED CARE FACILITIES/MULTI-PURPOSE SERVICE (MPS)

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>In a NSW Health operated RACF/MPS, do these rules for mask wearing apply to HWs?</td>
<td>Yes, HWs who work in RACFs should take extra precautions including the use of masks where there are areas for increased testing see NSW Health advice for RACFs for more detailed information. This includes aged care areas within an MPS. An ACF can recommend the wearing of surgical masks by HWs within 1.5 metres of residents. Approved cloth masks are not recommended for HWs. Refer to ACFs/MPS in the scenario table below.</td>
</tr>
<tr>
<td>Does a resident in an ACF or MPS need to wear a surgical mask?</td>
<td>No, this is classified as their home.</td>
</tr>
</tbody>
</table>
**PATIENTS WITH A DISABILITY, COGNITIVE IMPAIRMENT, BEHAVIOURAL ISSUES AND/OR MENTAL HEALTH CONDITIONS**

| Should a HW/carer/visitor wear a surgical mask if within 1.5 metres of a patient? | If possible.  
| | P2/N95 respirator is recommended for HWs when providing care for patients with suspected or confirmed COVID-19.  
| | HWs, visitors and/or carers wearing a respirator or a surgical mask may cause some patients distress or trigger changes to their behaviour or mental health condition. This will require a risk assessment and ongoing monitoring to determine the best way to manage the risk of transmission of COVID-19 when providing care within 1.5 metres of the patient. If a risk assessment determines that a mask will pose a physical risk to the patient, alternatives such as physical distancing and full-face shield should be considered. The risk assessment should determine the appropriate PPE for the HW.  
| | All decisions regarding the risk assessment should be documented in the patients’ healthcare record. |

**VOLUNTEERS IN A HEALTHCARE SETTING**

| Are volunteers required to wear a mask? | Yes, volunteers are required to wear a mask if they are coming into a health facility.  
| | Volunteers should not be within 1.5 metres of patients suspected or confirmed COVID-19.  
| | Reminders regarding hand hygiene, physical distancing, cough etiquette, respiratory hygiene and not coming to the facility if unwell are to be provided.  
| | A risk assessment of vulnerable volunteers should be conducted based on community transmission case locations.  
<p>| | Volunteers should not be interacting with patients with an ARI or suspected or confirmed COVID-19 |</p>
<table>
<thead>
<tr>
<th><strong>CONTRACTORS</strong></th>
</tr>
</thead>
</table>
| **When should a contractor wear a surgical mask?** | Yes, contractors are required to wear a mask if they are coming into a health facility.  
Also check latest [PHO](https://www.health.nsw.gov.au/AlcoholDrugUse-CDC/Coronavirus/COVID-19upport.aspx)  
Reminders regarding hand hygiene, physical distancing, cough etiquette and respiratory hygiene are to be provided.  
It is expected that contractors maintain adequate supplies of PPE and ABHR as part of their WHS obligations.  
Refer to ‘Contractors’ in the scenario table below |
| **If a cafeteria is located within a health facility (contracted by the LHD/SHN), should the HW wear a mask when interacting with patients, HWs and visitors?** | Yes, mask is required when interacting with patients, HWs and visitors.  
Also check latest [PHO](https://www.health.nsw.gov.au/AlcoholDrugUse-CDC/Coronavirus/COVID-19upport.aspx)  
Reminders regarding hand hygiene, physical distancing, cough etiquette and respiratory hygiene are to be provided. |

<table>
<thead>
<tr>
<th><strong>STOCK DELIVERY TO CLINICAL AREAS – EXTERNAL DELIVERY/COURIER COMPANIES</strong></th>
</tr>
</thead>
</table>
| **Do delivery/courier driver need to wear a mask (surgical or cloth) if they are making a delivery to clinical areas?** | Yes, masks and ABHR should be made available to delivery/courier driver, if they do not have their own approved cloth mask.  
Reminders regarding hand hygiene, physical distancing, cough etiquette, respiratory hygiene and not being onsite if they have acute respiratory symptoms or fever. |

<table>
<thead>
<tr>
<th><strong>VALVE MASKS</strong></th>
</tr>
</thead>
</table>
| **If a patient or a visitor is wearing a mask with a valve, do we need to change it to a surgical mask?** | Yes, these masks should be changed.  
These masks should not be worn as the exhalation valve is generally not filtered and particles are able to be exhaled via the valve. |
### 3.9 Amber Alert scenarios

#### AMBER ALERT SCENARIOS

<table>
<thead>
<tr>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PATIENTS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Patient transferring from the ward to the operating theatre. Patient to wear a surgical mask from the ward to the operating theatre or until anaesthetic given. A surgical mask should be put on the patient before leaving the recovery room and removed when returning to their bed.</td>
<td>A patient attending a community health centre. Patient to wear a mask on presentation. If accompanied by any children aged 12 years and under, they do not need to wear a mask unless specified by the parent or guardian.</td>
<td>Home visit by a community HW. Wear P2/N95 respirator and eye protection for patients with suspected or confirmed COVID-19. HW to wear a surgical mask and eye protection when within 1.5 metres of the patient/client. Patient/client can wear a mask (surgical or approved cloth mask) where able</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>AGED CARE FACILITIES/MULTI-PURPOSE SERVICE (MPS)</strong></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Scenario 1</td>
<td>Scenario 2</td>
<td>Scenario 3</td>
</tr>
<tr>
<td>A Registered Nurse works at an MPS that has acute, aged care and the 24-hour drop in/urgent care service. They are asked to see a patient in the 24-hour drop in/urgent care service with suspected COVID-19 and they are currently providing wound care in the aged care area. The P2/N95 respirator and eye protection must be worn to see the suspected or confirmed COVID-19 patient but must be removed and discarded after the completion of the consultation before moving to another area. A surgical mask and eye protection to be worn when providing wound care in the aged care area.</td>
<td>A General Practitioner (GP) has been asked to see patients/residents in both the acute care and aged care areas. No one has suspected or confirmed COVID-19. The GP can implement extended use of the surgical mask and keep it on to see all patients/residents. Safe use of the mask must be applied. Standard Precautions must be adhered to.</td>
<td>Patient transport/NSWA have been requested to transport a patient between a hospital facility and MPS. HW should wear a P2/N95 respirator and eye protection if the patient is suspected or confirmed COVID-19. If not, then a surgical mask should be worn for the duration of the transport and the patient should be offered a mask before leaving to be transported. Standard Precautions must be adhered to.</td>
</tr>
</tbody>
</table>
Standard Precautions must be adhered to.

<table>
<thead>
<tr>
<th>CONTRACTORS</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Scenario 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>A contractor is</td>
<td>coming into the facility to perform work on the air handling unit located</td>
<td>coming into the facility to perform work on the air handling unit located</td>
<td>A contractor enters through the main hospital entry and is visiting the</td>
</tr>
<tr>
<td>presenting to</td>
<td>in the roof space. They present to the Engineering Department which is</td>
<td>in the roof space. They present to the Engineering Department which is</td>
<td>Environmental Cleaning Services Manager. They will be providing a</td>
</tr>
<tr>
<td>the Engineering</td>
<td>located away from clinical and patient areas. A mask is required if they</td>
<td>located within the main hospital building and entry will be through the</td>
<td>demonstration on new equipment.</td>
</tr>
<tr>
<td>Department</td>
<td>need to enter into the facility. Usual sign on procedures to be completed.</td>
<td>main door.</td>
<td>A mask is required as they are in the main hospital building, which is</td>
</tr>
<tr>
<td>which is</td>
<td>Reminders regarding hand hygiene, physical distancing, cough etiquette</td>
<td>A mask is required as they are in the main hospital building, which is</td>
<td>accessed by HWs, patients and visitors.</td>
</tr>
<tr>
<td>located within</td>
<td>and respiratory hygiene are to be provided.</td>
<td>is accessed by HWs, patients and visitors.</td>
<td>Reminders regarding hand hygiene, physical distancing, cough etiquette</td>
</tr>
<tr>
<td>the main hospital</td>
<td></td>
<td>Reminders regarding hand hygiene, physical distancing, cough etiquette</td>
<td>and respiratory hygiene are to be provided.</td>
</tr>
<tr>
<td>building</td>
<td></td>
<td>and respiratory hygiene are to be provided.</td>
<td></td>
</tr>
</tbody>
</table>
### 3.10 Red Alert poster

#### Mask use for everyone entering a health facility

| Patients | Patients presenting directly from the community, inter and intra-hospital transfers, and in waiting areas to wear a mask when able  
|          | Minimise patient movement where safe to do  
|          | Community Health Centre – patient/client to wear a mask  
|          | Home visit – patient/client to wear a mask |
| Health workers (HW) | Universal surgical mask use by all HWs when in the facility  
|          | Eye protection when within 1.5m of a patient  
|          | Contact and Airborne Precautions (P2/N95 respirator) and eye protection are required when providing direct care for:  
|          | • patients with suspected or confirmed COVID-19  
|          | • close contact of a COVID-19 case |
| Visitors | Visitors based on risk assessment  
|          | Participants in care to be risk assessed to be able to continue providing care and support  
|          | All family members, carers and support services to wear a mask when entering and remaining in the health facility |
### 3.11 Red Alert frequently asked questions

The FAQs provide an explanation of when masks need to be worn by HWs, patients, visitors, carers and other people coming into NSW Health facilities.

<table>
<thead>
<tr>
<th>HEALTH WORKERS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What does our clinical area do if we have a limited number of surgical masks or P2/N95 respirators for a short period of time?</strong></td>
<td>All issues related to PPE should be escalated immediately through usual organisational structures. This should be addressed at LHD/SHN PPE Governance Committees. <em>Chapter 4: Personal Protective Equipment</em> provides guidance on extended or sessional use of PPE. HW are not expected to complete a task if the PPE required is unavailable. See question below.</td>
</tr>
<tr>
<td><strong>Can a HW wear the same mask or P2/N95 respirator for multiple patient interactions?</strong></td>
<td>Yes, this is called extended or sessional use of PPE. If a P2/N95 respirator can be worn without pulling it down or removing it for example, to speak, drink or eat, it can be worn for up to 8 hours continuously; 4 hours for a surgical mask. If it is pulled down or removed, it must be discarded immediately, and hand hygiene performed. HWs need to be allowed to take breaks so 4 hours is the maximum period of continuous wear that is recommended. If the mask/respirator is touched, hand hygiene should be performed immediately. The mask/respirator should be removed if it becomes damp or loose. Extended or sessional use of a mask or respirator can be used across different clinical areas if it is not contaminated. Contamination is likely when providing care for patients with COVID-19 or other infections transmitted via the respiratory route and must be changed prior to entering a different clinical area. Patient transport or NSWA HWs who move patients between facilities can wear the same mask/respirator for the duration of the transport but must discard and change their mask before the next patient transport. Ensure a comfortable fit if driving a vehicle. Safe mask/respirator use must always be considered.</td>
</tr>
<tr>
<td><strong>When in crowded areas of the hospital e.g., eating areas/cafeteria, do HWs need to wear a surgical mask?</strong></td>
<td>Yes, Universal mask use applies during Red Alert. Physical distancing, cough etiquette, respiratory hygiene and hand hygiene is always to be practiced.</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Can HWs wear a P2/N95 respirator for routine care of the patient?       | Yes, P2/N95 respirators and eye protection are indicated for routine care of patients during Red Alert as per Airborne Precautions. Airborne Precautions (includes the use of a P2/N95 respirator and eye protection) are required when caring for:  
  - Suspected or confirmed COVID-19 patients  
  - Close contact of a COVID-19 case  
  - Patient with a communicable disease that is spread by the airborne route e.g., Tuberculosis (TB), Measles |
| Should HWs be wearing masks in safety huddles, meetings, family conferences etc. on the ward/other designated area? | Yes, universal mask use applies during Red Alert. Physical distancing also applies.                                                                                                                  |
| What should be done if a HW declines to wear a surgical mask/respirator during Red Alert? | This is a WHS risk and should be managed within this legislation. Surgical masks/respirators, like other PPE are provided to protect HWs, patients and visitors. Where masks/respirators are prescribed for use and risk assessed as required, they must be consistently used by HWs and as such are not optional. |
| Should a HW wear a surgical mask when they are talking to a patient and can maintain a 1.5 metre physical distance? | Yes, All HWs are required to wear a surgical mask for all patient/client care during Red Alert. Airborne Precautions (includes the use of a P2/N95 respirator and eye protection) are required when caring for:  
  - suspected or confirmed COVID-19 patients  
  - close contact of a COVID-19 case  
  - patient with a communicable disease that is spread by the airborne route e.g., Tuberculosis (TB), Measles |
<p>| During Red Alert, should HWs with conditions that place them in a ‘vulnerable’ group be redeployed? | Vulnerable HWs should be individually risk assessed to determine their suitability for clinical areas. Wearing a surgical mask or P2/N95 respirator as required during patient care will reduce this risk and should be considered in the risk assessment. |
| If a HW is in a non-clinical area or office, should they wear a surgical mask? | Yes, universal surgical mask use is required during Red Alert. Physical distancing, cough etiquette, respiratory hygiene and hand hygiene are always to be practiced. |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If a HW travels in a shared health vehicle with another HW, do they need to wear a surgical mask?</td>
<td>Yes, universal surgical mask use is required during Red Alert. Please refer to Chapter 2: Section 2.15 Transport.</td>
</tr>
<tr>
<td>Should a HW wear a surgical mask when they are examining a baby or toddler?</td>
<td>Yes, a baby or toddler will always be accompanied by a parent or guardian. Our protection is for everyone. HWs providing direct care of any patient must wear a surgical mask.</td>
</tr>
<tr>
<td>Should HWs entering a school for the provision of a service wear a mask? (e.g., immunisation or school within a health facility)</td>
<td>Yes. Restrictions for attending may apply based on risk assessment. For school-based programs, the decision to attend even when wearing a mask should be based on a risk assessment considering the proximity, intensity and duration of contact with children in the school. For schools located within health facilities, HWs are to wear a mask.</td>
</tr>
<tr>
<td><strong>PATIENTS</strong></td>
<td></td>
</tr>
<tr>
<td>When should a patient wear a mask? (see also questions regarding approved cloth masks below)</td>
<td>On arrival to a health facility e.g., Emergency Department, Outpatient Clinic, Birth Suite, Medical Imaging, Pathology. After they are admitted as an inpatient, patients are required to wear a surgical mask when in shared rooms or if they leave their room for any reason and does not affect their clinical care.</td>
</tr>
<tr>
<td>Once a patient is admitted to a clinical area, are they required to wear a surgical mask while they are an inpatient?</td>
<td>Patients will not usually be required to wear a mask once in their room. If they have acute respiratory symptoms, fever or are suspected or confirmed COVID-19, they are required to wear a surgical mask if they are leaving their room (for example going to the medical imaging department). If patients are to leave the room and physical distancing is not possible, then they will be asked to wear a surgical mask (not a respirator). Patients that are cohorted in open spaces (avoid where able) may be recommended to wear a surgical mask while in this area. Remember: Some patients will not be able to tolerate wearing a mask.</td>
</tr>
<tr>
<td>When a patient is discharged from a health facility (ED or as an inpatient) are they required to wear a mask?</td>
<td>Yes, while transiting through the health facility (surgical mask).</td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| What should be done when a patient does not want to wear a mask on arrival (and is not confused or have cognitive impairment or other conditions that might cause difficulty with mask wearing)? | Check the reasons for declining to wear a mask and determine if there are alternatives that may be suitable for this patient.  
If they continue to decline the alternative, the patient should be placed 1.5 metres away from other patients/clients and informed that they are not to walk around the clinical area until they are either discharged from the ED or admitted to their clinical area.  
Be mindful of the practicalities of wearing a mask for certain patient groups e.g., those with behavioural disorders or mental health conditions, cognitive impairment.  
Women in labour may find mask wearing difficult and may be unable to comply but it is strongly recommended during Red Alert.  
Where there are no obvious barriers to mask-wearing, the patient should be informed of the current Red Alert recommendations and their risk for COVID-19 and the risk to others. |
| Why don’t children 12 years and under need to wear a mask?              | In general, it is not practical for children to be fitted with a mask. There appears to be limited transmission of COVID-19 from children to adults.  
Parents/guardians are expected to wear a mask and to assist children in this age group with hand hygiene.  
If a child is wearing a mask, then this can continue while the child is inside a health facility.  
Masks can be choking hazards for children under two years; therefore, masks are not suitable for this age group.  
This advice is consistent with other jurisdictions. |
| Can a patient with suspected or confirmed COVID-19 wear a P2/N95 respirator? | Patients should not wear a P2/N95 respirator but may be asked to wear a surgical mask when in a shared space.  
Surgical masks provide source control by the patient when wearing. |
| APPROVED CLOTH MASKS                                                   |                                                                                                                                  |
| Can a HW wear an approved cloth mask at work?                          | No, approved cloth masks vary in quality and effectiveness and they are not fluid resistant. This means they will not prevent blood, body fluids and respiratory droplets penetrating the mask.  
An approved cloth mask can be worn by HWs outside the health facility e.g., travelling to and from work. |
<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| If a visitor comes in wearing an approved cloth mask, should it be changed to a surgical mask? | No, a visitor can wear an approved cloth mask while visiting the health facility.  
If the visitor can wear the approved cloth mask without discomfort, they should continue to wear it.  
Reminders regarding hand hygiene, physical distancing, avoiding touching their mask and cough etiquette, respiratory hygiene are to be provided.  
If the visitor has acute respiratory symptoms or fever, they need to defer their visit and have COVID-19 testing. They should be asked to change to a surgical mask. |
| If a patient/client, without any COVID-19 symptoms, comes in wearing an approved cloth mask, should it be changed to a surgical mask? | No, if the patient/client can wear an approved cloth mask without discomfort, they should continue to wear it.  
Reminders regarding hand hygiene, physical distancing, avoiding touching their mask and cough etiquette, respiratory hygiene are to be provided. |
| If a patient/client, with an ARI or COVID-19 symptoms, comes in wearing an approved cloth mask, should it be changed to a surgical mask? | Yes, an approved cloth mask will become damp very quickly when someone has an ARI, fever or COVID-19 symptoms.  
The approved cloth mask will be much less effective when damp and may be touched frequently by the patient.  
A surgical mask should be placed on the patient and usual admission/discharge processes for suspected or confirmed COVID-19 patients are to be followed.  
Reminders regarding hand hygiene, physical distancing, avoiding touching their mask, cough etiquette and respiratory hygiene are to be provided.  
Access to tissues, ABHR and a bin is to be provided. |
| If a member of the community wears a towel, scarf, tea towel etc. into the health facility, is this classified as an ‘approved cloth mask’? | No, these are not classified as approved cloth masks.  
NSW Health has released general guidance for approved cloth masks. This information should be followed. |

**HOME VISITS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
</table>
| Do HWs need to wear a surgical mask when they are visiting a patient in their home to provide healthcare? | Yes, a surgical mask should be worn if providing care in the home.  
Wear a P2/N95 respirator and eye protection when providing care to patients with suspected or confirmed COVID-19.  
Patients are also recommended to wear a mask during visit where able. |
### CARER IN A HEALTHCARE SETTING

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Should a carer wear a surgical face mask?</td>
<td>Yes, they can also wear an approved cloth mask. If a carer is accompanying a patient/client into a health facility, they should wear a mask (surgical or approved cloth mask).</td>
</tr>
</tbody>
</table>

### VISITORS – ALSO REFER TO CHAPTER 2- SUPPORTING VISITOR ACCESS IN HEALTH FACILITIES DURING COVID-19 RED ALERT

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are visitors required to wear a mask if they come to a health facility?</td>
<td>Yes, visitors are required to wear a mask if they are coming into a health facility for any reason. If they are already wearing an approved cloth mask (as per NSW Health criteria) or surgical mask, they can continue to wear this. See section above on approved cloth masks. Reduce visitors to essential only and follow local procedures.</td>
</tr>
<tr>
<td>Birthing room If a partner or family member from the same household is supporting the women during labour, do they need to wear a mask when they are in the patient’s room?</td>
<td>A mask is recommended for the mother and any support person(s). When the visitor leaves the room, they are to wear a mask until they leave the hospital as per the Red Alert risk level. Also refer to Chapter 2 Supporting visitor access in health facilities during COVID-19 Red Alert</td>
</tr>
<tr>
<td>What should be done if a visitor declines to wear a mask?</td>
<td>The visitor should be informed of the current Red Alert recommendations and the risk to the patient, themselves and others in the facility they are visiting. If they continue to decline to wear a mask, they should be risk assessed to determine the location of their visit and the patient they are visiting. Offer an alternative such as a virtual visit.</td>
</tr>
<tr>
<td>Who will teach visitors how to wear a mask?</td>
<td>As visitors are screened at entry areas, HWs who are responsible for these areas should provide assistance on correct mask use. Posters and information on mask use are available <a href="#">here</a>.</td>
</tr>
</tbody>
</table>
### AGED CARE FACILITIES/MULTI-PURPOSE SERVICE (MPS)

**In a NSW Health operated RACF/MPS, do these rules for mask wearing apply to HWs?**

Yes, HWs who work in RACFs should take extra precautions including the use of masks where there are areas for increased testing see [NSW Health advice for RACFs](https://www.health.nsw.gov.au) for more detailed information. This includes aged care areas within an MPS.

P2/N95 respirator and eye protection is recommended for HWs when providing care for patients with suspected or confirmed COVID-19.

Visitors, including any children may require an exemption to visit.

**Does a resident in an ACF or MPS need to wear a surgical mask?**

Risk assess.

Focus should be on separation, segregation, and isolation. All HWs to wear appropriate PPE.

### PATIENTS WITH A DISABILITY, COGNITIVE IMPAIRMENT, BEHAVIOURAL ISSUES AND/OR MENTAL HEALTH CONDITIONS

**Should a HW/carer/visitor wear a surgical mask if within 1.5 metres of a patient?**

Yes.

P2/N95 respirator and eye protection is recommended for HWs when providing care for patients with suspected or confirmed COVID-19.

HWs, visitors and/or carers wearing a P2/N95 respirator or a surgical mask (and eye protection) may cause some patients distress or trigger changes to their behaviour or mental health condition. This will require a risk assessment and ongoing monitoring to determine the best way to manage the risk of transmission of COVID-19 when providing care during Red Alert. If a risk assessment determines that a mask will pose a physical risk to the patient, alternatives such as physical distancing and full-face shield should be considered. The risk assessment should determine the appropriate PPE for the HW.

All decisions regarding the risk assessment should be documented in the patients’ healthcare record.

### VOLUNTEERS IN A HEALTHCARE SETTING

**Are volunteers required to wear a mask?**

Volunteers may be restricted during Red Alert.

If a volunteer provides support or assistance in the facility, they are required to wear a surgical mask (this includes administrative areas).

Reminders regarding hand hygiene, physical distancing, cough etiquette, respiratory hygiene and not coming to the facility if unwell are to be provided.

A risk assessment of vulnerable volunteers should be conducted based on community transmission case locations.

Volunteers should not be interacting with patients with an ARI or suspected or confirmed COVID-19
<table>
<thead>
<tr>
<th>CONTRACTORS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When should a contractor wear a surgical mask?</strong></td>
</tr>
<tr>
<td>They are required to wear a mask when they enter the facility. Universal surgical mask use will be in place during Red Alert. Reminders regarding hand hygiene, physical distancing, cough etiquette and respiratory hygiene are to be provided. It is expected that contractors maintain adequate supplies of PPE and ABHR as part of their WHS obligations.</td>
</tr>
</tbody>
</table>

| **If a cafeteria is located within a health facility (contracted by the LHD/SHN), should the HW wear a mask when interacting with patients, HWs and visitors?** |
| Yes. Universal mask use (surgical or **approved cloth mask**) is required. |

<table>
<thead>
<tr>
<th>STOCK DELIVERY TO CLINICAL AREAS – EXTERNAL DELIVERY/COURIER COMPANIES</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Do delivery/courier driver need to wear a mask (surgical or own cloth) if they are making a delivery to clinical areas?</strong></td>
</tr>
<tr>
<td>Yes, masks and ABHR should be made available to delivery/courier driver, if they do not have their own approved cloth mask. Reminders regarding hand hygiene, physical distancing, cough etiquette, respiratory hygiene and not being onsite if they have acute respiratory symptoms or fever.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VALVE MASKS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If a patient or a visitor is wearing a mask with a valve, do we need to change it to a surgical mask?</strong></td>
</tr>
<tr>
<td>Yes, these masks should be changed. These masks should not be worn as the exhalation valve is generally not filtered and particles are able to be exhaled via the valve.</td>
</tr>
</tbody>
</table>
Chapter 4: Personal protective equipment

This chapter is part of the COVID-19 Infection Prevention and Control Manual, Clinical Excellence Commission, 2022.

The publication summarises current evidence about COVID-19 infection prevention and control strategies and interventions, and their implementation in healthcare settings.

The publication will continue to evolve with additional chapters over time that address infection prevention and control in other settings. As new resources become available, they will be added as hyperlinks of the resources section in each chapter or to the appendices.

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Key points

- Personal protective equipment (PPE) is essential when caring for patients with suspected or confirmed COVID-19
- PPE forms part of Standard, Contact, Droplet and Airborne Precautions
- Understanding how to choose the appropriate PPE and how to put it on (don) and remove it (doff) safely is essential for health worker (HW) safety
- Hand hygiene is a key part of donning and doffing PPE
- PPE training modules are available at HETI My Health Learning
- The use of P2/N95 respirators (masks) is accompanied by fit checking (at each point of use) and fit testing
- COVID-19 risk assessment and application of PPE should be aligned with the recommendations in Chapter 3: Response and Escalation Framework.

Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAMI</td>
<td>Association for the Advancement of Medical Instrumentation</td>
</tr>
<tr>
<td>ABHR</td>
<td>Alcohol-based hand rub</td>
</tr>
<tr>
<td>ACORN</td>
<td>Australian College of Perioperative Nurses</td>
</tr>
<tr>
<td>AGP</td>
<td>Aerosol-generating procedure</td>
</tr>
<tr>
<td>ANZCA</td>
<td>Australian and New Zealand Collage of Anaesthetists</td>
</tr>
<tr>
<td>APF</td>
<td>Assigned protection factor</td>
</tr>
<tr>
<td>ARTG</td>
<td>Australian Register of Therapeutic Goods</td>
</tr>
<tr>
<td>ASTM</td>
<td>American Society for Testing and Materials</td>
</tr>
<tr>
<td>Acronym</td>
<td>Definition</td>
</tr>
<tr>
<td>---------</td>
<td>------------------------------------------------</td>
</tr>
<tr>
<td>BFE</td>
<td>Bacterial filtration efficiency</td>
</tr>
<tr>
<td>BiPAP</td>
<td>Bilevel Positive Airway Pressure</td>
</tr>
<tr>
<td>CDC</td>
<td>U.S. Centres for Disease Control and Prevention</td>
</tr>
<tr>
<td>CDNA</td>
<td>Communicable Diseases Network Australia</td>
</tr>
<tr>
<td>CPAP</td>
<td>Continuous positive airway pressure</td>
</tr>
<tr>
<td>ED</td>
<td>Emergency Department</td>
</tr>
<tr>
<td>ESLI</td>
<td>End of service life indicator</td>
</tr>
<tr>
<td>FDA</td>
<td>U.S Food and Drug Administration</td>
</tr>
<tr>
<td>HME</td>
<td>Heat and moisture exchanger</td>
</tr>
<tr>
<td>HW</td>
<td>Health worker</td>
</tr>
<tr>
<td>IFU</td>
<td>Instructions for use</td>
</tr>
<tr>
<td>IPAC</td>
<td>Infection prevention and control</td>
</tr>
<tr>
<td>NIOSH</td>
<td>U.S. National Institute for Occupational Health and Safety</td>
</tr>
<tr>
<td>ONS</td>
<td>Oncological Nursing Society</td>
</tr>
<tr>
<td>PAPR</td>
<td>Powered air purifying respirator</td>
</tr>
<tr>
<td>PEEP</td>
<td>Positive end expiratory pressure</td>
</tr>
<tr>
<td>PEL</td>
<td>Permissible exposure limit</td>
</tr>
<tr>
<td>PFE</td>
<td>Particle filtration efficiency</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
</tr>
<tr>
<td>RPD</td>
<td>Respiratory protection device</td>
</tr>
<tr>
<td>RPP</td>
<td>Respiratory protection program</td>
</tr>
<tr>
<td>SHPA</td>
<td>Society of Hospital Pharmacists of Australia</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
4.1 Introduction

PPE protects the wearer from pathogenic microorganisms. Proper use helps to keep HWs safe and reduce the spread of COVID-19. PPE for care of patients/clients with suspected or confirmed COVID-19 includes surgical masks, particulate filter respirators (such as P2 or N95), eye protection, gloves and gowns or aprons. The terms P2 and N95 are used interchangeably in this manual.

This chapter provides guidance on the use of PPE in acute healthcare settings during the COVID-19 pandemic. The guidance in the chapter should be considered as the minimum. This advice is continually reviewed as new evidence about COVID-19 transmission risks becomes available.

4.2 General principles when using PPE

Using PPE optimally is important for HW safety. This means selecting appropriate PPE at the right time, in the right setting, for the right patient and then applying (donning) and removing (doffing) PPE in line with evidence-based practice and current COVID-19 guidance.

General principles when using PPE include:

- HWs caring for patients with COVID-19 should be trained in the correct use of PPE including donning and doffing. Training should include when hand hygiene and glove changes are required during different procedures or tasks on the same patient/client
- Only PPE labelled as reusable should be cleaned, disinfected, and reused according to the manufacturer’s reprocessing instructions; all other PPE must be disposed of after use
- Extended or sessional use of a mask and eye protection is currently only recommended when caring for patients with suspected or confirmed COVID-19
- Isolation aprons/gowns (Levels 1, 2, 3 and 4) which are impervious or fluid resistant are suitable for Contact, Droplet and Airborne Precautions
- Sterile surgical gowns (Levels 1, 2, 3 and 4) should only be used in surgical environments and for sterile procedures
- When caring for patients with Droplet and Airborne Precautions, eye protection is required along with a surgical mask or P2/N95 respirator
- Fluid resistant surgical masks (Levels 1, 2 and 3) are all suitable for Contact and Droplet Precautions
- P2/N95 respirators are used when providing care to patients with suspected or confirmed COVID-19 or for close contact of a COVID-19 case
- P2/N95 respirators should be fit tested before first use and fit checked at every use
- Incorrect removal of PPE is associated with an increased risk of contamination

For further information on recommended PPE refer to:
4.3 PPE training

Training on the appropriate selection, use and disposal of PPE is required to ensure safe use of PPE. Some of the potential issues to consider are:

- How to minimise unnecessary contact with a mask
- Importance of adherence to hand hygiene before donning PPE, during doffing and following cleaning/disinfection of reusable protective eyewear or face shields
- When and how to change gloves between different procedures or tasks
- Correct removal and cleaning/disinfection of reusable protective eyewear
- How to ensure adherence to proper PPE donning and doffing technique to reduce self-contamination.

Refer to HETI My Health Learning training modules in Table 3 below.

**TABLE 3: MY HEALTH LEARNING MODULES RELEVANT TO COVID-19 PPE**

<table>
<thead>
<tr>
<th>Title</th>
<th>Course code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step-by-step guidance on PPE donning and doffing</td>
<td>294450660</td>
</tr>
<tr>
<td>Donning and fit checking of P2/N95 respirators in NSW healthcare settings video series</td>
<td>319438161</td>
</tr>
<tr>
<td>Personal protective equipment for combined Transmission-Based Precautions</td>
<td>294450660</td>
</tr>
<tr>
<td>Infection Prevention – Transmission-Based Precautions</td>
<td>253093581</td>
</tr>
<tr>
<td>Infection Prevention – Enhanced Precautions for Pandemic Flu</td>
<td>289888589</td>
</tr>
</tbody>
</table>
4.4 PPE risk assessment

Over the course of the pandemic, risk assessment for PPE has become critical on three different levels:

1. **Standard Precautions** - use PPE when there is an anticipated or likely risk of contamination with splashes of blood or body substances and based on the nature of care or the task being undertaken

2. **Transmission-Based Precautions** - consider the need for Contact, Droplet and Airborne Precautions based on the mode of transmission when caring for patients with epidemiologically important or transmissible pathogens with high-risk consequences that can transmit or cause infection

3. **Response and Escalation Framework** - the level and type of PPE for clinical care of suspected or confirmed COVID-19 patients should be based on the risk assessment (see Chapter 3: Response and Escalation Framework).

4.5 Types of PPE

The type of PPE used will vary based on the level of precautions required, such as Standard Precautions and Contact, Droplet or Airborne Precautions. The procedure for putting on and removing PPE should be tailored to the specific type of PPE.

Appropriate PPE should be selected to prevent contamination of skin, mucous membranes and/or clothing. Selection should be guided by the anticipated type and amount of exposure to blood and body substances and the likely transmission route of microorganisms.

The CEC Competency Assessment for Combined Precautions provides guidance on assessing HW competency in application of Combined Precautions.

**Aprons and gowns**

Disposable fluid resistant aprons or gowns are designed to protect uniforms or clothing from moisture or soiling from blood, body substances and/or transmissible microorganisms during direct patient care. They also protect the patient during direct contact.

Disposable, fluid resistant aprons are recommended for general clinical use where the risk of contamination from blood of body substance is low e.g., when providing routine care for a patient who is not coughing, sneezing or vomiting. Apron use can be considered based on anticipated contact or exposure to droplets while caring for symptomatic COVID-19 patients. For guidance see Appendix 4A: Recommended PPE for health workers in clinical settings.

There are two main types of gowns available: isolation gowns and surgical gowns.

**Isolation gowns** offer varying resistance to blood and other bodily substances depending on the type of the material, permeability and wear and tear. Isolation gowns may be classified as ‘disposable/single-use’ or ‘reusable/multi-use’.

Disposable/single use isolation gowns are designed to be discarded after a single use and are typically constructed of nonwoven materials alone or in combination with plastic films or other materials that offer increased protection from liquid penetration. These gowns should offer an impervious or fluid resistance barrier.
The need for, and type of gown selected, is based on the nature of the patient interaction, including the anticipated degree of contact with infectious material and potential for blood and body substance penetration of the barrier. A gown provides an increased coverage compared with an apron.

**Single use surgical gowns** are sterile, fluid-resistant, disposable garments made of natural and/or synthetic materials worn over a scrub suit during surgical and aseptic procedures, to help protect both the patient and operating room personnel from the transfer of microorganisms, body substances and particulate material.

A correctly fitted surgical gown covers the wearer from the neck to the knees with sleeves finishing at the wrists with cuffs. The gown should have enough overlap at the back that it does not separate when the person is sitting.

The Association for the Advancement of Medical Instrumentation (AAMI) is a recognised and collaborative organisation that develops international standards, information and guidance to achieve safe use of medical devices (ACORN, 2018; CDC, 2015). The AAMI has established a classification system for minimum requirements for healthcare protective apparel and drapes based on their liquid barrier performance in their standard (ACORN, 2018; CDC, 2015). According to AAMI classification a surgical gown with a Level 1 classification provide the lowest level of protection and Level 4 provide the highest level of protection (CDC, 2015). For more information refer to Appendix 4G: AAMI Level Standards for Gowns.

**Risk assessment and gown selection in procedural areas and operating suites**

Penetration of a sterile gown by any fluid places both the HW and patient at risk of microbial exposure (ACORN, 2018; CDC, 2015). Risk assessment considers the anticipated risk of exposure to blood, body fluids/substances and irrigation fluid, the procedure itself, and the patient. Regardless of gown level, once fluid has penetrated the gown, the integrity of the protective barrier and sterility is compromised. It is recommended the gown is then changed (ACORN, 2018). Some common procedures are provided as examples in the tables below, to guide sterile gown selection based on the AAMI standard.

When selecting the most suitable sterile gown, consider:

- Does the surgery/aseptic procedure require a sterile gown?
- What level of exposure to HW is anticipated during the procedure? Note, not all clinicians will have the same level of exposure and therefore may not require the same level of gown.
- What is the anticipated risk of exposure and estimated level of blood, body substances and irrigation fluid?
- How much fluid will be used during the procedure for irrigation?
- Are there measures in place to control blood, body substances and irrigation fluid exposure e.g., a collection pouch, tourniquet?

The examples provided are not inclusive of all procedures or specialties and this guide is not a substitute for clinical judgement.
**TABLE 4: STERILE SURGICAL GOWN SELECTION FOR ROUTINE SURGERY (CARDINAL HEALTH, 2021; CDC, 2015; ASTM INTERNATIONAL 2017)**

<table>
<thead>
<tr>
<th>Examples of procedures drawn from industry supplier</th>
<th>Barrier performance</th>
<th>Risk of exposure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>This list is not exhaustive</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Regional anaesthesia (epidural/spinal)</td>
<td>Level 1</td>
<td>Minimal fluid</td>
<td>Used for situations where risk of exposure to blood, body fluids/substances or irrigation fluids is MINIMAL. Provides a barrier to small volumes of fluid. Single test of water impacting the surface of the gown material is conducted to assess barrier protection performance.</td>
</tr>
<tr>
<td>• Biopsies, excision of superficial lesions</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minor gynaecological procedures (e.g., dilatation and curettage)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minor orthopaedic surgery (e.g., carpal tunnel, wedge resection toenails)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Ophthalmic surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Insertion of central venous access devices</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minor ear, nose and throat surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Scalp leads – foetal monitoring</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Lumbar puncture</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Minimally invasive surgery (e.g., laparoscopic, endoscopic)</td>
<td>Level 2</td>
<td>Low fluid</td>
<td>Used for situations where risk of exposure to blood, body substances or irrigation fluids is LOW. Provides a barrier to larger amounts of fluid penetration through splatter and some fluid exposure through soaking. Two tests are conducted to assess barrier protection performance:</td>
</tr>
<tr>
<td>• Hernia repair</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Breast reduction, plastic/cosmetic surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Orthopaedic arthroscopy (ankle)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Open reduction internal fixation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Dental surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Chest drain insertion</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Interventional radiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Cardiac catheterisation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Maxillofacial surgery</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Examples of procedures drawn from industry supplier

*This list is not exhaustive*

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Barrier performance</th>
<th>Risk of exposure</th>
<th>Description</th>
</tr>
</thead>
</table>
| Mastectomy                                                                | Level 3             | Moderate fluid                 | Used for situations where risk of exposure to blood, body substances or irrigation fluids is MODERATE. Provides a barrier to larger amounts of fluid penetration through splatter and more fluid exposure through soaking than Level 2.  
Two tests are conducted to test barrier protection performance:  
• Water impacting the surface of the gown material  
• Pressurising the material                                                                                              |
| Urological procedures and hysteroscopy                                    |                     |                                |                                                                                                                                                                                                             |
| Laparoscopic assisted hysterectomy/bowel resection                       |                     |                                |                                                                                                                                                                                                             |
| Joint replacement surgery                                                 |                     |                                |                                                                                                                                                                                                             |
| Neurosurgery & vascular surgery                                           |                     |                                |                                                                                                                                                                                                             |
| Orthopaedic arthroscopy (shoulder/knees)                                  |                     |                                |                                                                                                                                                                                                             |
| Burns                                                                     |                     |                                |                                                                                                                                                                                                             |
| Spinal surgery                                                            |                     |                                |                                                                                                                                                                                                             |
| Suturing vaginal tears                                                    |                     |                                |                                                                                                                                                                                                             |
| Major trauma                                                              | Level 4             | Highest fluid and microbial barrier | Used for situations where risk of exposure to blood, body substances or irrigation fluids is HIGH. Provides a barrier to large volumes of fluid penetration and greater resistance to fluid soaking than Level 3.  
In addition to the other tests conducted under Levels 1-3, barrier level performance is tested with a simulated blood containing a virus – if no virus is found at the end of the test, the gown passes |
| Knee/shoulder reconstruction                                              |                     |                                |                                                                                                                                                                                                             |
| Lower segment caesarean section                                           |                     |                                |                                                                                                                                                                                                             |
| Cardiac/thoracic – open procedures where the surgeon's hands/arms are in a body cavity throughout the procedure |                     |                                |                                                                                                                                                                                                             |

**Gloves**

HWs wear gloves as a barrier to protect their hands from contamination or to prevent the transfer of microorganisms on their hands to patients or the environment. Key points for glove use include:

- Intact gloves must be worn on both hands and used where the HW is potentially exposed to blood or body substances or has direct or indirect contact with communicable diseases or multidrug-resistant organisms.
• Double gloving is only recommended in theatre settings and/or on a risk-based approach for specifically determined procedures

• Double gloving is usually implemented to allow a seamless transition during a procedure from ‘dirty’ to ‘clean(er)’ steps or reduce the impact of sharps injuries for the surgeon

• Double gloving is not recommended as a protective measure against COVID-19 acquisition due to the increased incidence of dermatologic side effects including overhydration, irritant dermatitis and eczema, excessive skin soaking with sweat and skin chapping

• The use of ABHR on gloves must be avoided as the effects of hand sanitisers are tested on the skin and application on gloved hands may affect gloves’ mechanical properties. In addition, alcohol is inactivated in the presence of organic matter, which can easily remain on used gloves, thus potentially driving viral transmission. Use of ABHR on the outside of gloves can affect the porosity of gloves, causing them to become more porous, create pinholes or cause the gloves to rupture after a short period of time

• Gloves are single use items and at present no standardised and validated procedure exists for reprocessing of single use gloves

• If a glove manufacturer states that ABHR can be used on gloves, evidence must be provided, and HW educated on how and when it can be used safely

• Gloves should always be put on immediately before:
  o a procedure
  o cleaning shared patient care equipment
  o contact with blood or body fluids
  o when cleaning the patient care environment

• Gloves should not be worn in non-patient zones unless directly handling blood or body substance such as pathology specimens or cleaning up a blood or body substance spill or when in contact with cleaning chemicals.

**Wearing gloves is not a substitute for hand hygiene.** Hand hygiene must be performed immediately:

• before putting on gloves to avoid contamination of the outer surface of the gloves AND

• after removing gloves to avoid transfer of microorganisms to another person, the environment, clinical equipment or the HW.

Inappropriate glove use can result in transmission of pathogenic organisms:

• between different surfaces

• between the wearer and their face (eyes, nose, mouth)

• from the patient to biomedical or other equipment and furnishings.
Eye protection

Evidence shows that the mucous membranes including conjunctivae of HWs can be exposed to infective droplets and aerosols from patients with suspected or confirmed COVID-19 during close contact. Eye protection must be worn when there is risk of body substances splashing or spraying into the conjunctiva. Personal or prescription glasses are not a substitute for eye protection unless they are specified as safety glasses.

Eye protection such as safety glasses, mask visor, goggles or a face shield is required for close contact within 1.5 metres of a suspected or confirmed COVID-19 patient.

Visors are transparent personal protective devices intended to shield the face and eyes of a HW and are suitable for use with prescription glasses and masks.

Use a mask visor or a face shield if there is exposure to an excessive amount of splash or spray. If reusable eye protection is used, it should be cleaned and disinfected in accordance with the manufacturer’s instructions for use.

HWs should note the following:

- Single use eye protection can be worn for an extended period unless moist, wet or contaminated, and disposed of at the end of the session
- Reusable eye protection requires cleaning and disinfection between use
- There must be a clearly described procedure in place for the cleaning, disinfection, drying and storage of reusable eye protection to reduce the risk of a HW donning an item that has not been effectively reprocessed since its last use.

Respiratory and facial protective equipment

A Respiratory Protective Device (RPD) is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer’s risk of inhaling hazardous particles (including dust particles and infectious agents), gases or vapors. There is a range of RPDs available that provide facial and respiratory protection, and this includes either a surgical mask or a respirator, with or without eye protection.

Respiratory and facial protection is required for those organisms that are usually transmitted via the droplet or airborne route, including when aerosols have been artificially created, such as during AGPs.

Surgical masks

Surgical face masks provide a barrier to splashes and droplets impacting on the wearer’s nose, mouth and respiratory tract. They do not provide protection against airborne particles (aerosols) and are not classed as RPD. They are loose-fitting protection devices that create a physical barrier for the mouth and nose of the wearer. Some surgical masks have an integrated eye protection shield (mask visor). Surgical face masks used by HWs for protection against microorganisms must be fluid repellent and disposable.

Surgical masks are for use in clinical care, dental settings and surgery as per Standard Precautions. Surgical masks should be worn for the duration of the relevant exposure, task or procedure.
Masks have different properties and colours depending on the manufacturer. Each mask barrier level will provide varying levels of fluid penetration resistance and protection against droplets from a patient with COVID-19.

See Appendix 4H: AS 4381:2015 Single use surgical face mask standard for more details on mask barrier levels and properties.

When wearing a mask, it is important to remember the following:

**Do not:**
- Touch the mask or face as this may contaminate the wearer
- Pull the mask below the nose or chin
- Hang the mask around the neck or top of the head.

**Do:**
- Change the mask if it becomes moist
- Change the mask if it is sprayed or splashed on
- Change the mask if contaminated with blood or body fluids
- Immediately perform hand hygiene if the mask is accidentally touched
- Perform hand hygiene after removing a mask
- Place the mask into a general waste bin, perform hand hygiene and replace with a new mask
- Report mask pressure injuries to the supervisor or manager, following local reporting processes and usual WHS processes
- Remove a mask outside of patient care areas or patients requiring other precautions (e.g., between rooms or patient zones, break room, reception area) and before proceeding to care for patients that are not isolated for COVID-19.

**Respirators**

A respirator is used by an individual to provide respiratory protection. There are many types of respirators available which include:

- Air-purifying respirators which protect the wearer by filtering inhaled air. These types of respirators can be disposable or reusable and are either:
  - non-powered – uses inhalation to draw air through a filter
  - powered – uses a fan to draw air through a filter
- Supplied-air respirators which protect the wearer by supplying clean breathing air from an independent source such as an air compressor or compressed air cylinder.

In the healthcare setting, an air-purifying respirator (or particulate filtering respirator) most commonly relates to the disposable filtering half face respirator also known as a **P2 or N95 mask**.

There are a variety of respirators available, and these may differ between healthcare facilities.
For more information refer to Appendix 4I: Properties of P2 and N95 respirators and Appendix 4J: P2/N95 Respirator Range within NSW Health.

The category of particulate filtering respirators can be further divided into:

- **Disposable particulate filtering respirators**, where the entire respirator is discarded at the end of a session of care, or when it becomes unsuitable for further use due to excessive resistance, sorbent exhaustion, or physical damage.

- **Reusable particulate filtering respirators**, also called elastomeric respirators, may take the form of a reusable full-face or half-face respirator and harness fitted with particulate P2 or P3 filters that are activated passively by inhalation.

- **Powered Air Purifying Respirators (PAPRs)** supply filtered air to the wearer and deliver positive air pressure via a battery-operated blower unit.

Reusable respirator facepieces are cleaned and reused but the filter cartridges are discarded and replaced when they become unsuitable for further use. All reusable items must be cleaned and disinfected in accordance with the manufacturer’s recommendations and AS/NZS 4187:2014 Reprocessing of reusable medical devices in health service organisations.

For more information refer to Appendix 4K: Difference between Elastomeric Respirators and PAPRs.

**Filter efficiency**

Disposable P2/N95 face masks or respirators can filter out very fine particles (less than 0.5 micron) from the air when worn correctly.

**AS/NZS1716:2012 Respiratory protective devices** uses a classification system to identify the different types of particulate filters which are P1, P2 and P3. The ‘P’ refers to the particle size of the particulate matter that the respirator is designed to protect against.

Particulate filters are classified and marked as P1, P2 or P3, with P3 providing the highest level of protection. However, P3 protection can only be achieved if the P3 filter is used in a full-face respirator. P3 filters are currently not part of the Standards or readily available for use in Australian healthcare.
• P1 = 80% Filter efficiency
• P2 = 94% Filter efficiency
• P3 = 99% Filter efficiency.

**Assigned protection factor**

A respiratory protective device is considered adequate if it has the capacity to reduce the wearer’s exposure to a hazardous substance to acceptable levels. Assigned protection factor (APF) refers to the level of respiratory protection that a respirator or class of respirators is expected to provide to users. The APF is the ratio of the airborne concentration of the substance outside the device to that inside the device (Table 5).

**TABLE 5: FILTER TYPES AND ASSIGNED PROTECTION FACTORS**

<table>
<thead>
<tr>
<th>Conformité Européen Marked Particle Filter Type</th>
<th>Assigned Protection Factor (what is likely to be attained in practice)</th>
</tr>
</thead>
<tbody>
<tr>
<td>P1</td>
<td>4</td>
</tr>
<tr>
<td>P2</td>
<td>10</td>
</tr>
<tr>
<td>P3</td>
<td>20</td>
</tr>
</tbody>
</table>

Elastomeric masks and PAPRs are regarded as having high levels of APF, particularly when used with full-face protection. The typical APF for a disposable N95 mask and a half facepiece elastomeric is 10 and full facepiece elastomeric is 50. An APF of 10 means that the respirator (if used properly) can be safely used in an atmosphere that has a hazardous concentration of up to 10 times the Permissible Exposure Limit (PEL) or other exposure limit for that hazard.

N95 respirators (masks) and P2 respirators (masks) are similar and applied interchangeably to the same conditions. There are, however, differences in testing and certification practices between Australia and the USA (Table 6).

**TABLE 6: DIFFERENCE BETWEEN TESTING OF P2 AND N95 RESPIRATORS**

<table>
<thead>
<tr>
<th></th>
<th>P2 masks (Australian &amp; New Zealand Standard)</th>
<th>N95 respirator (USA NIOSH Standard)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Filter efficiency</td>
<td>at least 94%</td>
<td>at least 95%</td>
</tr>
<tr>
<td>Testing substance</td>
<td>Sodium Chloride Aerosol</td>
<td>Sodium Chloride Aerosol</td>
</tr>
<tr>
<td>Aerosol flow rate</td>
<td>95 litres per minute</td>
<td>85 litres per minute</td>
</tr>
<tr>
<td>Aerosol particle size</td>
<td>0.3 to 0.6 microns</td>
<td>0.3 microns</td>
</tr>
</tbody>
</table>

**Surgical and standard P2/N95 respirators**

There are two types of P2/N95 respirators: surgical and standard.

- **Surgical** P2/N95 respirators are fluid resistant
- **Standard** or **non-surgical** P2/N95 respirators are not fluid resistant.
Use a surgical P2/N95 respirator when:

- performing tasks such as surgery, that may expose HWs to high pressure streams that produce aerosols of blood or body fluid
- providing care for suspected or confirmed COVID-19 patients

Standard P2/N95 respirators can be used for dry airborne situations where minimal exposure to droplets is expected such as caring for patients with suspected or confirmed tuberculosis, measles or chickenpox. Standard P2/N95 respirators can be used together with a face shield, surgical mask or a visor if fluid resistance is required.

For more information refer to Appendix 4I: Properties of P2 and N95 Masks and Appendix 4J: P2/N95 Respirator Range within NSW Health.

Considerations before selecting respiratory protection devices

Before selecting RPD, the following should be considered:

- Identify hazards (e.g., the respiratory hazards to which HWs will be potentially exposed during routine and emergency situations)
- Proper donning, doffing and use of respirators
- Mandatory fit check (user seal check) to provide maximum protection, training and competency assessment
- Fit testing of respirators
- Fit check (user seal check) at point of use every time a respirator is used. Refer to the donning and fit checking of P2/N95 respirators in NSW healthcare settings video series available through HETI My Health Learning (Course code 319438161) for more information
- HWs are to ensure that they have the physiological ability to wear a respirator.

A respiratory protection program (RPP) including fit testing should be in place and consideration for fit testing should occur only after fit (seal) checking is fully implemented. Fit testing may provide additional information to determine the suitable type(s) of P2/N95 respirators for an individual. In situations where fit testing has not yet been carried out, and a P2/N95 respirator is recommended for use, a fit-checked P2/N95 respirator is preferred over a surgical mask.

At all times when a HW is required to use a respirator; the HW must not have any facial hair present. This includes at the time of fit testing.

Australian and New Zealand Standards and P2/N95 respirator manufacturers’ instructions for use (IFU) require the wearer to have no facial hair to achieve a good facial seal. No member of HW is required or expected to undertake any work requiring a P2/N95 respirator unless an adequate facial seal can be achieved. Ensure a risk assessment is conducted on the possibility of removing facial hair, redeployment or alternative respiratory protective device provision where the HW cannot achieve an adequate facial seal. For more information refer to CEC Respiratory Protection Program. Also refer to Figure 8: Flowchart for Respiratory Protection Fit Checking and Fit Testing Process.
Optimal use of P2/N95 respirators

Contact and Airborne Precautions (P2/N95 respirator and eye protection) are required when providing care for

- patients with suspected or confirmed COVID-19
- close contact of a COVID-19 case

For the optimal use of a P2/N95 respirator, healthcare facilities should consider the following:

- Minimise the number of individuals who need to use respiratory protection through the preferential use of engineering and administrative controls, such as:
  - minimising the number of HWs in the room
  - ensuring well-ventilated isolation rooms
  - air-handling systems (with appropriate directionality, filtration, exchange rate, etc.) that are properly installed and maintained
  - appropriate triage and placement of patients
  - patients over 12 years of age with acute respiratory symptoms wearing a surgical mask
  - patient education regarding respiratory and hand hygiene
  - HW training in donning and doffing PPE and fit checking

- P2/N95 respirator alternatives e.g., other classes of filtering face piece respirators or powered air purifying respirators, must be risk assessed and fit for use in healthcare, and specific use is to be endorsed by the LHD/SHN Clinical Governance and IPAC/Infectious Diseases services

- Implement practices allowing extended or sessional use when acceptable or possible within COVID-19 areas/zones

- P2/N95 respirator should not be sealed with tape. It should be fit checked and if unable to form a seal, a different respirator should be used.
FIGURE 8: FLOWCHART - RESPIRATORY PROTECTION-FIT CHECKING AND FIT TESTING PROCESS

Disposable P2/N95

Fit Check

Pass

Fit test based on HWs risk category

Pass

Fail

Fail

Fit test different size/brand

Re-check and re-test with different fit test assessor AND
Continue to explore alternative and suitable disposable P2/N95 respirators, until options exhausted AND
Consider risk assessment and redeployment

Loose fitting PAPR (No fit test required)

Fit Check

Fail

Pass

Tight fitting PAPR (some models to be fit tested)

Reusable Elastomeric Respirator

Notes:

A Fit check must be performed each time a respirator is donned.

A Pass equals optimal fit & can proceed with use of respirator.

A Fail equals optimal fit is not achieved (fit fail)

Tight fitting PAPR - with an exhalation valve, wear a surgical mask or filter over the exhalation valve

Loose fitting PAPR - with exhalation valve, wear a surgical mask underneath respirator
Discarding P2/N95 respirators after use

A P2/N95 respirator should be:

- **Discarded and replaced** if it becomes contaminated with blood, respiratory or nasal secretions, or other bodily fluids
- **Discarded and replaced** if it becomes hard to breathe through or if the mask no longer conforms to the face or loses its shape or fit
- **Removed** outside of patient care areas or before caring for patients requiring other precautions (e.g., between rooms or patient zones, or before entering break rooms or reception areas) and before proceeding to care for patients that are not isolated for COVID-19
- **Discarded** following an AGP.

Alternatives to disposable P2/N95 respirators

There are a variety of masks used by HWs when caring for patients with infections such as COVID-19. In situations where there is a risk of airborne spread the recommended RPD is a particulate filter mask or respirator. For some HWs and in some conditions, the available disposable P2N/95 respirators may not provide optimal fit.

The reusable respirator should be considered for HWs who are unable to achieve a facial seal (fit check) with available disposable P2/N95 respirators and/or have not passed a fit test and cannot be re-deployed to a lower risk clinical area due to their specialist skills. In this situation, alternatives to consider include reusable elastomeric respirators and PAPR.

Considering the complexities and challenges surrounding the use of reusable respirators in healthcare, the decisions on the selection and purchase of elastomeric respirators or PAPRs for use in healthcare facilities must involve specialists in infection prevention and control, work health and safety, biomedical engineering, reprocessing and the procurement or product evaluation committee.

**Elastomeric respirators**

Elastomeric respirators have historically had limited use in healthcare and their design may not comply with requirements of the healthcare environment. Their use during COVID may provide an additional PPE possibility. These devices are not recommended for routine use in healthcare. The illustrations in figure 9 is not an endorsement but illustrating different types for consideration. Decisions on the selection and purchase of these respirators for use in healthcare should follow process for procurement including certification where required on ARTG.

For more information refer to [CEC Respiratory protection manual](#)

**Powered Air-Purifying Respirators**

A PAPR is a battery-powered device that provides filtered air under positive pressure into either a loose-fitting hood or helmet or a tight-fitting facepiece. Because the filtered air is delivered under positive pressure, the device can compensate for an imperfect seal. For this reason, a PAPR is regarded as potentially providing a higher level of protection than other RPD but is more complex to use and maintain.
In industrial settings, filtered air may be provided to the user directly from a cylinder or pipeline supply, rather than using a battery-powered motor and cartridge filter. For more information refer to CEC Respiratory Protection Program resources.

**FIGURE 9: EXAMPLES OF DIFFERENT TYPES OF RESPIRATORS**

<table>
<thead>
<tr>
<th>Half-Face Disposable</th>
<th>Half-Face Reusable</th>
<th>Full-Face Reusable</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Image" /></td>
<td><img src="image2.png" alt="Image" /></td>
<td><img src="image3.png" alt="Image" /></td>
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<td><img src="image4.png" alt="Image" /></td>
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<td><img src="image8.png" alt="Image" /></td>
<td><img src="image9.png" alt="Image" /></td>
</tr>
</tbody>
</table>

**Difference between disposable P2/N95 respirators, reusable elastomeric respirators and PAPRs**

The most significant difference between disposable respirators, reusable elastomeric respirators and PAPRs is that reusable respirators must be maintained and inspected after each use, including cleaning and disinfection of the reusable components such as facepiece valves, valve covers and straps. Refer to Appendix 4K: Difference between elastomeric respirators and PAPRs.

**Reusable respirators with exhalation valves**

Respirators with exhalation valves protect the wearer from COVID-19 but may not prevent the virus spreading from the wearer to others because some models do not have filters on the exhalation valve. The exhalation valve is designed to open during exhalation to allow exhaled air to exit the respirator and then it closes tightly during inhalation.

Reusable respirators with no filter on the exhalation valve should not be used due to the risk of unfiltered air or SARS-CoV-2 (from an infected wearer) expelled from the exhalation valve contaminating the surrounding environment and potentially exposing other individuals. When a PAPR with an exhalation valve is being worn in the operating theatre, an exhalation valve filter or a surgical mask should be worn over the exhalation valve. A surgical mask or a...
A disposable respirator can be worn under a loose fitting PAPR. This is not necessary with some hooded models.

Until data is available to describe how effective respirators with exhalation valves are in preventing the spread of COVID-19 from the wearer to others:

- HWs are to wear a respirator without an exhalation valve
- If the only respirator available has an exhalation valve, cover the exhalation valve with a surgical mask that does not interfere with the respirator fit.

4.6 PPE donning and doffing

HWs should understand PPE requirements, when to wear PPE and how to remove and dispose of PPE safely.

HW should not use PPE other than those prescribed in NSW Ministry of Health policy directives, CEC COVID-19 guidance and local policy or procedures.

PPE ‘creep’ has been identified during the pandemic as a risk to HWs who add or choose PPE that is not recommended for Transmission-Based Precautions e.g., a cloth or disposable surgical scrub cap and overshoes, an apron over a long-sleeved disposable gown or other PPE adornments. This potentially increases the risk of self-contamination, particularly on PPE removal. If the PPE is uncomfortable, does not fit properly, or the HW has an adverse reaction using it, they should consult their manager or supervisor.

PPE donning

For most contact between HWs and patients, the following PPE is safe and effective and should be donned before entering the patient’s room or zone.

HWs should be bare below the elbows and tie long hair back when providing care and donning PPE. The sequence of donning is:

- Perform hand hygiene
- Apron* or fluid resistant long-sleeved or isolation gown
- Surgical mask or P2/N95 respirator
- Eye protection
- Perform hand hygiene** and don disposable nonsterile gloves upon entering the room before contact with the patient.

*Apron use can be considered when it is based on the anticipated contact/exposure to droplets while caring for COVID-19 patients.

**Do not apply ABHR to the outside of a glove once the glove is on the hand – ABHR can create pinholes unless the glove is designed to be sanitised.

While wearing PPE avoid self-contamination and the spread of microorganisms by:

- Keeping hands away from face
- Limiting surfaces touched
- Changing gloves when torn or visibly contaminated
- Performing hand hygiene after PPE is removed.
PPE for Contact, Droplet and Airborne Precautions should be applied as per a risk assessment. Risk assessed use refers to using PPE when there is an anticipated/likely risk of contamination with splashes or droplets of blood or body fluids.

When providing direct care or performing an AGP on a suspected or confirmed case of COVID-19, the main modification to PPE (for the addition of Airborne Precautions), is the use of a P2/N95 mask or equivalent instead of a surgical mask.

Respirator fit checking and fit testing

**Fit checking** or user seal check is a process to ensure that the P2/N95 respirator fits the wearer’s face snugly (i.e., creates a seal) to minimise the number of particles that bypass the filter through gaps between the wearer’s skin and the mask seal. Fit checking involves a **check each time the mask is put on** to ensure that the respirator is properly applied and is the appropriate minimum standard at the point of use for HWs using respirators.

**Fit testing** is performed to determine whether a specific type, model and size of respirator is a suitable fit for the wearer and that it is worn correctly to achieve a facial seal and comfort.

Healthcare settings are to ensure that a range of models and sizes of P2/N95 respirators are available for HWs so that users can have access to respirators that achieve a seal against their face.

Detailed Fit Checking and Fit Testing Processes are explained in the [CEC Respiratory Protection Program Manual](#). Also refer to [Principles of Fit Checking](#) and [CEC PPE donning and doffing training videos](#) for more information.

PPE NOT required when in contact with a patient/client with suspected or confirmed COVID-19:

- **Use of boots or shoe covers** is not recommended as part of COVID-19 PPE. These are only required in the operating theatre or a trauma room.
- **A head covering** is not required. Head coverings are part of operating theatre attire or when performing a sterile/aseptic procedure (e.g., central line insertion) to prevent contact between a HWs hair and patient/equipment and to reduce shedding of skin squames/hair and associated bacteria into the sterile/aseptic field.
- **PPE adornments** or extra equipment such as cloth caps are not to be used. If HWs have WHS safety concerns regarding their skin integrity around their hair area they should be raised via their normal reporting processes.
- **The use of a mask loop holder** should only be used if all other avenues to secure masks have been trialed. Their use can increase the risk of contamination and contribute to issues with both donning and doffing. If a mask loop holder is used, the following need consideration:
  - Whether to use a single use or a reusable item?
  - Are there any additional steps for donning and doffing that is required to be added to the procedure e.g., additional hand hygiene, cleaning/disinfection of the mask loop holder?
  - Do they interfere with the seal (for P2/N95 respirators)?
• **Coveralls** are NOT recommended for use in NSW health facilities based on evidence regarding COVID-19 modes of transmission. There is an increased risk of contamination on removal as they are not used routinely or frequently to become proficient. Currently there are no guidelines from the World Health Organization (WHO), the U.S. Centers for Disease Control and Prevention (CDC), the U.S. Occupational Safety and Health Administration (OSHA) or Communicable Diseases Network of Australia (CDNA) regarding use of coveralls for protection from COVID-19 during patient care. If a determination is made to use protective coveralls, then the selection of appropriate protective coveralls should be based upon a site-specific risk assessment conducted by qualified individuals such as those working in infection prevention and control and infectious diseases roles.

**PPE removal**

There are a variety of ways to safely remove PPE without contaminating clothing, skin, or mucous membranes with potentially infectious materials. Remove all PPE upon exiting the patient zone/room, removing mask and protective eyewear last after leaving room or zone and closing the door.

**Always perform hand hygiene if there is risk of contamination between steps, immediately after removing gloves and when the sequence of PPE doffing has been completed.**

**Example 1: Suggested doffing sequence**

1. Gloves
2. Hand hygiene
3. Apron or gown
4. Hand hygiene
5. Eye protection or face shield (if reusable, clean immediately)
6. Hand hygiene (if cleaned reusable protective eyewear)
7. Mask or respirator
8. Hand hygiene

**Example 2: Suggested doffing sequence**

1. Gloves and gown (as one step)
2. Perform hand hygiene
3. Goggles or face shield
4. Mask or respirator
5. Perform hand hygiene

**Note:**

- Dispose of removed PPE into the general waste unless visibly soiled or contaminated with blood or body substance
- Gown and gloves can be removed as one step
• Avoid touching the face while wearing PPE and during removal
• Facilities can adopt other safe ways of PPE removal according to local guidelines and procedures.


### 4.7 Extended or sessional use of PPE

Extended use of PPE refers to wearing the same PPE for repeated close contact episodes with more than one patient, without removing them between patient care based on risk assessment and contamination risk, e.g., on a ward round or providing ongoing care for multiple inpatients in a cohort area with suspected or confirmed COVID-19. Hand hygiene must be performed in between patients and care episodes.

Extended or sessional use of PPE is only recommended when caring for patients during a pandemic with suspected or confirmed COVID-19. This is not recommended for any infectious conditions outside of COVID-19 (e.g., Multidrug resistant organisms). Evidence continues to evolve on the issue of increased healthcare associated infection when gown and gloves are not changed in between patients.

The following points should be considered when deciding on an extended or session use:

- Extended use of above neck PPE (mask/respirator and eye protection) is well suited to situations where multiple patients are confirmed with COVID-19 and patients are cohorted together in a dedicated waiting room or hospital inpatient clinical area
- The decision on extended or sessional use of PPE must be based on a risk assessment, clinical situation, local facility needs and consultation with the facility infection prevention and control team
- A single session refers to a period where a HW is undertaking duties in a specific clinical care setting or exposure environment. A session ends when the health worker leaves the care setting/exposure environment, PPE becomes contaminated or the HW requires food or drink
- Both surgical mask and P2/N95 respirator can be safely and comfortably worn for up to 4 hours continuously without removing the mask unless damaged, soiled or contaminated
- Gown and gloves must not be used in between patients and to be removed on exit or before exiting the room along with hand hygiene. The exception for gown or apron extended use will be COVID-19 testing clinics or similar settings where there is limited contact with patients or low risk of gown/apron contamination e.g., meal tray collection. Gloves must always be changed, and hand hygiene performed in between patients.
- The duration of use of PPE items should not exceed the manufacturer’s instructions

For guidance on appropriate use of PPE in community and home visits refer to [Chapter 7](#) and [Chapter 8](#).
4.8 Bringing your own PPE

Clinicians must not bring any PPE (reusable or disposable) into a health facility unless it has been approved for use by the local facility, LHD/SHN, and/or NSW Health. Considerations include:

- Checking with HealthShare if the PPE is available
- All PPE must conform to AS/NZS standards and Australian Register of Therapeutic Goods (ARTG) registration and certificate; this information is required from the PPE manufacturer
- Approval for use by the relevant clinical department, the hospital and LHD/SHN Executive (PPE Strategic Committee) following HealthShare procurement processes
- The full approval process of the equipment and the circumstances it is to be used in must be documented following:
  - PPE assessment and acceptance for use within the facility by Infection Prevention and Control, Work Health and Safety, biomedical engineering, Unit Manager and the facility sterilizing service manager, who will undertake service compatibility and risk assessment for reprocessing between uses within the capacity of their sterilizing facility
  - Manufacturer’s IFU on reprocessing, filter management and maintenance, and a supply of replaceable components including straps, inhalation and exhalation valves, valve covers, filters, cartridges and canisters
  - Insurance coverage for privately owned PPE that requires reprocessing within the health facility
  - Appropriate training required for the safe use of the PPE. Training and education should be clearly documented; the manufacturer may be obligated to provide training in the proper use of the PPE
  - Decision on who will provide and take responsibility for the training and assessment of the HW wearing or using their own PPE
  - Donning and doffing procedures may need to be altered to accommodate non-standard equipment and this will need assessment by Infection Prevention and Control
  - The financial and resource implications, including the capacity to accommodate the volume, complexity, storage and resources required for reprocessing.

For more details on the management of reusable RPD refer to Refer to CEC Respiratory Protection Program Manual.

4.9 Patient transfer / transport

All agencies involved in the transfer/transport of patients suspected or confirmed COVID-19 are to implement their agency specific Standard, Contact and Airborne Precautions. If tolerated, a surgical mask should be placed on patients during the transfer. Refer to Section 2.15 Transport for more information on patient and HW transport.
The transferring health facility is to notify NSW ambulance or other transport agency on the patient’s condition to ensure all HWs involved in the patient transfer are aware of the PPE requirements prior to arrival. The transporting agency is to notify the area receiving the patient where possible.

### 4.10 Mask use and skin sensitivity

Prolonged wearing of masks and eye protection can cause adverse skin reactions such as acne, contact dermatitis and skin injuries from pressure effects, as well as exacerbating any underlying skin conditions. This guidance relates solely to considerations to reduce skin irritation for disposable P2/N95 respirator or surgical mask use.

#### Facial skin care to reduce adverse effects of wearing masks

Advice for facial skin care to reduce adverse effects of wearing masks includes:

- Use a mild skin cleanser, soap substitute or micellar water at the beginning and end of the day. Standard soap is alkaline and has been shown to change skin pH and can damage the skin barrier function
- Moisturise regularly with simple formulations and avoid fragranced products
- Start with a less greasy lotion before progressing to a greasier cream if tolerated
- Avoid greasy creams if acne prone
- Anti-ageing skin care products containing glycolic acids or retinoids can be very irritating, especially when the skin barrier is damaged or compromised; these products may also exacerbate skin sensitivity
- Moisturise face before going to bed.

#### Mask fitting and skin sensitivity

To reduce the risk of skin sensitivity when fitting a mask:

- Perform hand hygiene before putting on the mask and after taking it off
- Find the best fitting mask and take time to fit the mask
- Do not overtighten the mask.

#### Wearing a mask if experiencing skin sensitivity

To help prevent or minimise skin problems while wearing a mask:

- Before going to work or 1 to 2 hours before donning a surgical mask
  - Wash face and hands well, dry thoroughly
  - Apply moisturiser to face and hands and let the skin dry
- At work, before donning a surgical mask
  - Apply skin barrier to dry face including forehead, nose, cheeks and ears
  - Let the skin dry
Don the surgical mask

- Try to minimise the time wearing a mask as much as possible and give skin regular breaks for at least 5 minutes, preferably every few hours
- Find the best fitting mask
- Remain hydrated for general skin health.

**If friction is a problem, consider the following actions:**

- Apply moisturising lotion at least 30 minutes before wearing a mask to lubricate the skin and reduce friction between the skin and surgical mask
- Apply silicone protectors such as a no-sting barrier film wipe which will protect the skin and prevent friction
- Barrier creams can also be used when wearing masks for an extended length of time, however these products tend to be greasy which may aggravate acne in which case a lighter silicone-based product is recommended.

**Allergic reactions**

There are very few chemicals used in masks, and reactions are most likely irritation rather than allergy. Allergic reactions rarely occur.

Monitor areas that may contribute to a reaction including:

- The glue strip along the nose
- The nose bridge that contains a metal wire for moulding
- Where the mask is in contact with cheeks.

**Skin irritation**

Irritant contact dermatitis is nearly always the cause of mild redness and dryness from masks. The following actions are suggested:

- Change the brand or type of a mask to a softer variety if available
- Put a soft dressing or a thin silicone pad or a barrier wipe under the surgical mask where irritation occurs (not indicated when using a tight-fitting respirator)
- Increase moisturiser use, particularly at night and consider using a greasier variety
- If significant dermatitis persists, low-strength topical steroids available over the pharmacy counter can be used.

If the irritation worsens, consider consulting a dermatologist and report the worsening condition to the HW line manager or supervisor for risk assessment.

**Pressure injuries**

Pressure from the mask can cause skin indentation and minor injuries. Most indentation will resolve spontaneously. Consider the following actions for pressure injuries from masks:
• Apply compresses with three to four layers of gauze soaked in cold water/normal saline to the skin for around 20 minutes every 2 to 3 hours
• Moisturisers can be applied to intact skin before and after wearing a surgical mask
• Use a silicone dressing (e.g., tape, thin pad) under the surgical mask, and behind the ears for skin protection; the pad redistributes pressure, and the dressings conform to the face to reduce pain, shear and friction and are gentle on removal
• Hydrocolloids may also protect the skin but are not indicated when wearing tight fitting respirators; care should be taken when removing the hydrocolloid to reduce trauma and monitor moisture build up
• Avoid using hot water or ethanol or other irritants to clean the skin
• If pressure from goggles is the main problem, switch to a visor
• If there is skin breakdown secondary to pressure, use a medical grade silicone-based cream cloth to moisturise, protect and restore the skin when a dressing can’t be applied
• Consult a doctor or dermatologist if there is further aggravation of the skin condition
• Do not wear a mask whilst skin is broken and redeployment away from clinical care may be required until skin has recovered.

Use of prophylactic dressings to prevent facial skin injury due to tight fitting respirators

Prolonged wear of tight-fitting respirators may cause unintended skin injuries, despite taking steps to protect skin integrity. To prevent loss of skin integrity, the wearing of a prophylactic dressing may be appropriate. For more information refer to CEC Respiratory Protection Manual, Appendix 1B: Instructions for use of prophylactic dressings under tight fitting respirators.

Reporting incidents

HWs should notify a No person incident in ims+ when PPE has contributed to harm or near misses, such as masks with defective strings or ear loops.

HWs should notify a Worker incident case when PPE has caused a skin rash, allergic reaction or other adverse effect.

For health services that do not use ims+, HWs should use their usual local process (e.g., IIMS) for reporting incidents with or harm caused by PPE.

Mask wearing exemptions in healthcare facilities

During Red Alert risk level HWs risk of exposure may increase when inadequate PPE is worn. HWs who are unable to wear mask at all should not come to work when PHO advises mandatory mask wearing. There may be HWs who can wear masks for shorter periods and should have a process to risk assess whether they could be accommodated doing suitable duties.
4.11 Uniforms and scrubs

The following information is provided to clarify the use of uniforms, scrubs, aprons and gowns in healthcare settings.

Uniform ‘scrubs’ are supplied by NSW Health to meet uniform requirements and are referred to as ‘uniform’ in this guidance.

Surgical scrubs are theatre attire worn by HWs in theatre or other specialities. They are supplied by NSW linen service and are referred to as ‘surgical scrubs’ in this guidance.

NSW Health stipulates when scrubs and uniforms should be worn, as outlined in the NSW Health Policy Directive Uniforms Policy (PD2019_012). Employees who are required to wear a uniform are required to comply with the policy, LHD/SHN Uniform and Dress Code requirements and the NSW Code of Conduct.

Perioperative attire (surgical scrubs) should not be worn outside of the perioperative area as per local procedures, with the exception of emergency attendance of patients within the hospital building. An outer gown should cover the front of the attire when leaving the perioperative environment (ACORN, 2020).

The NSW Health Code of Conduct (PD2015_049) states that HW must:

“4.3.4 Dress in a way that is appropriate for the work they do and complies with any local dress requirements.”

A range of frequently asked questions are addressed below.

Is there specific advice in relation to scrubs or uniforms and PPE for clinical HWs?

Specific reference is made in relation to HW clothing in the Infection Prevention and Control Practice Handbook.

At any time, if a HWs clothing becomes contaminated with blood or body fluid, the clothing should be removed as soon as practical and before the HW attends to other patients.

If skin is contaminated with blood or body fluid, the HW must remove contaminated clothing/uniform or PPE and wash any affected skin, then perform hand hygiene.

PPE must not be worn outside the hospital setting unless it is specific for clinical service e.g., during a home visit, resuscitation/first aid on campus grounds, COVID-19 screening clinics.

How long can the COVID-19 virus live on the parts of the uniform not covered by an apron?

There have been no documented cases of transmission of the novel coronavirus via clothing at this point of the pandemic.

Chin et al. (2020) found no viable virus on clothing 2 days after exposure with coronavirus. There is no data that supports transmission of coronavirus via clothing.
Can I wear my uniform outside of the hospital setting?

HWs can wear a uniform outside the hospital and for community visits and use PPE when they are in contact with blood and body fluid. The PPE protects their uniforms when worn.

Standard and Transmission-Based Precautions are both a requirement of NSW Health Infection Prevention and Control Policy (PD2017_013) and NSW Health Practitioner Regulation 2016: Schedule 3. These precautions protect clinical HW uniforms.

In acute healthcare settings HWs are required to use appropriate PPE for any close contact with a person who has suspected or confirmed COVID-19 and are within 1.5 metres. The risk of uniform contamination from wearing appropriate PPE is unlikely or extremely low.

In community settings the same principles apply, and the recommendations are the same as for acute healthcare settings. That is, if they anticipate close contact or exposure to blood and body fluid, PPE must be worn which includes wearing a fluid resistant apron or a gown.

If a uniform becomes contaminated during community care, the usual local procedures should be applied to remove, or spot clean any contamination.

The choice to change out of a uniform before leaving work is a personal one. Surgical scrubs are not to be worn outside the hospital setting.

Should HWs wear an apron or a gown for Standard and Contact Precautions?

The choice of an apron or gown is based on a risk assessment and is documented in the Australian Guidelines for the Prevention and Control of Infection in Healthcare and also supported by the ICEG Guidance on the use of personal protective equipment (PPE) for health care workers in the context of COVID-19.

The risk assessment approach to choosing an apron or a gown for Standard and Contact Precautions remains an option during the pandemic period.

The risk assessment will include:

- patient factors such as their ability to practice respiratory and hand hygiene;
- the time spent or anticipated within 1.5 metres; and
- what tasks or procedures they will be doing with the patient.

During the risk assessment, if the HW anticipates exposure to blood and body fluid on an uncovered part of their uniform, then the risk assessment will direct them to a gown for contact precautions.

During a shift, if there are periods of time where there will be direct care provided within the 1.5 metres and no risk of exposure to blood and body fluid on an uncovered part of their uniform. The risk assessment will direct the HW to wear an apron for Contact Precautions.
References


Bibliography


Guo ZD, Wang ZY, Zhang SF, Li X, Li L, Li C, Cui Y, Fu RB, Dong YZ, Chi XY, Zhang MY. Aerosol and Surface Distribution of Severe Acute Respiratory Syndrome Coronavirus 2 in Hospital Wards, Wuhan, China, 2020. Emerging infectious diseases. 2020 Apr 10;26(7)


Appendix 4A: COVID-19 risk assessment guide for PPE selection for direct care of patients

<table>
<thead>
<tr>
<th>Patient Characteristics</th>
<th>Precautions Required</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Frequent hand hygiene</td>
</tr>
<tr>
<td>No acute respiratory infection (ARI) symptoms AND no recognised COVID-19 epidemiological risk&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Subject to current NSW Risk Level and/or Public Health Order</td>
</tr>
<tr>
<td>ARI without COVID-19 epidemiological risk&lt;sup&gt;2&lt;/sup&gt; (important to test for other respiratory viruses)</td>
<td>CONTACT + DROPLET</td>
</tr>
<tr>
<td>Patients with suspected&lt;sup&gt;2&lt;/sup&gt; or confirmed COVID-19 OR as identified as a close contact&lt;sup&gt;5&lt;/sup&gt;</td>
<td>CONTACT + DROPLET + AIRBORNE&lt;sup&gt;4&lt;/sup&gt;</td>
</tr>
</tbody>
</table>
Notes:

1. Standard precautions always include a risk assessment of the need for PPE. All health workers require COVID-19 vaccination


3. For extended use, masks or respirators can be worn for up to 4-8 hours respectively. Eye protection can also remain on between patients. Masks/respirators and eye protection should be discarded (or reprocessed in the case of reusable eye protection) if they are moist or contaminated with blood or bodily fluids and after removal.

4. HWs required to wear P2/N95 respirators should be trained in the correct use including fit checking, donning and doffing. This also applies to the use of reusable respirators.


Adapted from Personal Protective Equipment (PPE) for patient care with symptoms of acute respiratory illness including COVID-19 HNELHD
Appendix 4B: Visual guide to application of PPE

- Gloves should be changed, and hand hygiene performed between patients; change or remove gloves when clinically indicated, if contaminated, moving from dirty to clean site on the same patient or when torn or damaged
- Perform hand hygiene immediately after removing gloves and other PPE if there is risk of contamination between steps
- Gown/apron should be removed and discarded appropriately upon completion of care (session) and/or on leaving the room/zone
- Reusable eye protection should be cleaned/disinfected between use
- Clean and disinfect reusable shared patient equipment and high touch points.
Appendix 4C: Aerosol-generating procedures

Aerosol-generating procedures (AGPs) may need to be performed during the care of patients suspected or confirmed to have COVID-19. AGPs produce droplet nuclei (< 5 micrometres in size) or airborne particles (aerosols) due to air or gas flowing rapidly over a moist or wet surface (World Health Organization, 2014). There are many procedures that may be ‘aerosol-generating’ and these are considered to increase the risk of transmission of SARS-CoV-2.

The purpose of this appendix is to provide guidance about risks associated with transmission of SARS-CoV-2 when conducting respiratory AGPs on patients with suspected or confirmed COVID-19, and application of appropriate Transmission-Based Precautions to reduce this risk. This section should be read in conjunction with ACI Clinical practice guide for respiratory support in adults with COVID-19.

As the highest viral load is seen in respiratory tract secretions, respiratory AGPs are those associated with production of respiratory tract-generated aerosols. The procedure should be conducted in a negative pressure room or if unavailable, a single room (that is not positive pressure) with the door closed.

Note that other procedures that may cause aerosolisation of fluid or tissues that are not from the respiratory tract or lungs are not considered high risk AGPs for transmission of COVID-19.

Some considerations include:

- AGPs on suspected or confirmed COVID-19 should be performed with a minimum number of HW present and where possible, the most qualified person should carry out the procedure. In circumstances where there may be an ongoing need for the AGP (e.g., non-invasive ventilation), it is recommended that a plan for review and discontinuation of the AGP is put in place.
- Nebulisers are not recommended and alternative means of delivering medication (such as pressurised metered-dose inhaler or a spacer) should be used. If the use of a nebuliser cannot be avoided in a patient with suspected or confirmed COVID-19 then:
  - Isolate the patient
  - Use a negative-pressure room if available, otherwise use a single room with the door closed
  - HWs administering nebulisers should wear Airborne Precaution PPE, including an impervious gown and gloves, P2/N95 respirator and eye protection
  - If staying in the room, depending on the air changes per hour, continue these precautions for at least 30 minutes after the nebuliser treatment. See link: CDC Air Changes.

For guidance regarding other specialised procedures related to Allied Health procedures, refer to Appendix 4D. For guidance to dental procedures, refer to CEC guidance which can be found here.

Cardiopulmonary resuscitation

Cardiopulmonary resuscitation (CPR) is complex in terms of assessing AGP risk. While many procedures (e.g., intubation) undertaken during the course of CPR are considered high risk AGPs, there is no consensus and a paucity of data about whether chest compressions result in aerosol generation or transmission of COVID-19 (Tran et al. 2012; Couper et al, 2020). In many reports, it appears likely that there was simultaneous exposure to airway manoeuvres, such that the isolated
effect of chest compressions could not be reliably identified. In contrast there is consensus that defibrillation is not an AGP, and it is known that early chest compressions and defibrillation may improve survival. This uncertainty has led to variations in national and international guidelines about the use of PPE particularly for first responders.

Given the uncertainty of transmission of SARS-CoV-2 via chest compression and the need to provide clear and unambiguous advice ensuring that HWs are protected, and patients receive timely resuscitation, we recommend that for patients with suspected or confirmed COVID-19, Airborne (in addition to Contact and Droplet) Precautions are used when doing cardiac compressions or airway manipulation. If a first responder enters the room using Droplet and Contact Precautions, then oxygen via a mask can be placed on the patient and defibrillation can be performed. It is critical that all HWs who are responders for cardiac arrests have practiced the safe, effective and rapid donning of PPE required for Contact, Droplet and Airborne Precautions.

Airborne precautions including P2/N95 respirator should be used for

- patients suspected or confirmed to have COVID-19
- close contact of a COVID-19 case.
References for Appendix 4C


Bibliography


Appendix 4D: PPE in Allied Health procedures

The following advice is intended to support Allied Health decision making for the recommended use of PPE in hospitals, community health centres and other facilities. It was prepared by speech pathologists and physiotherapists and in collaboration with the NSW Health Chief Allied Health Officer and the CEC. Broad consultation with NSW Health physiotherapists, speech pathologists and the CEC Infection Prevention and Control Community of Practice and Expert Reference Committee was also undertaken during the development.

The presence and risks related to SARS-CoV-2 vary between locations and therefore this information should be used in collaboration with individualised advice received from LHD/SHNs and services according to Chapter 3: Response and Escalation Framework.

Where it is considered that particular risks apply to a service, specialist advice should be sought from local specialist infectious disease experts and infection prevention and control before deviating from the advice included in Figure 10.

Clinicians should refer to ACI Clinical practice guide for respiratory support in adults with COVID-19 and all other documents that are relevant to their specific clinical practice.

Underpinning this advice is the need for all Allied Health professionals to use a risk-based approach prior to undertaking clinical assessment, procedures and treatments to ensure that the appropriate PPE is always used, not only related to COVID-19.
**FIGURE 10: DECISION ALGORITHM FOR RECOMMENDED PPE IN ALLIED HEALTH PROCEDURES**

Does the patient have suspected or confirmed COVID-19, influenza, or another acute respiratory viral infection? *

- **NO**
  - Is the Allied Health procedure an aerosol-generating procedure?
    - **NO**
      - Is there a risk of exposure to droplets?
        - **NO**
          - Use Standard + Contact Precautions dependent on risk (1)
        - **YES**
          - Use Standard + Contact or Droplet Precautions dependent on risk (2)
    - **YES**
      - Use Contact + Droplet Airborne Precautions (3)

- **YES**
  - Is the Allied Health procedure an aerosol-generating procedure?
    - **NO**
      - Use Contact + Droplet + Airborne Precautions (3)
    - **YES**
      - Use Contact + Droplet Airborne Precautions (3)

*Definition will depend on the service location and should be based on national case definitions and guided by local infectious disease and public health advice.

Algorithm is based on:

- National guidance in the use of personal protective equipment PPE in hospitals during the COVID-19 outbreak (Australian Government Department of Health, 2020)
- Australian and New Zealand College of Anaesthetists (ANZCA) Statement on personal protective equipment during the SARS-CoV-2 pandemic (15/05/2020)
• ANZCA Recommendations for PPE according to SARS-CoV-2 risk screening flowchart Version 4, October 2020 (Australian and New Zealand College of Anaesthetists, 2020).

General considerations
Where possible maintain more than 1.5 metres distance between clinician and patient during assessment and treatment and if there are any other risk factors Droplet Precautions may be required.

Risk factors
Risk factors to be considered:
• Cognition and cooperation of patient
• Secretion control/volume
• Cough etiquette and respiratory hygiene
• The position of the clinician during the procedure (e.g., behind or beside patient) and ability to maintain greater than 1.5 metres distance
• The cumulative length of time spent with an individual patient (2 hours >1.5 metres over a 48-hour period is considered low risk). If this is longer or distance can't be maintained, additional PPE may be required.

If these circumstances put the clinician at risk of infection, Droplet Precautions should be considered.

1. Allied Health procedures with no risk of droplet exposure
Standard Precautions should always be adhered to, ensuring ongoing risk assessment approach during patient contact
Examples of procedures (not exclusive):
• General mobilisation of patients
• Outpatient orthopaedics / hydrotherapy / musculoskeletal / lymphoedema / women’s health / cardiac and pulmonary rehabilitation
• Videofluoroscopic Swallow Assessment / Modified Barium Swallow
• Clinical dysphagia assessment
• The presence of dysphonia, dysphasia or dyspraxia.

2. Allied Health procedures with risk of exposure to droplets or body fluids
Standard Precautions, plus Contact and Droplet Precautions
Examples of procedures (not exclusive):
• Airway clearance techniques including, closed suction, sputum collection procedure, positioning / gravity assisted drainage techniques, active cycle of breathing technique (ACBT) and manual techniques (excluding where open suction is required)
• Manual assisted cough i.e., abdominal cough or cough with pressure
• Use of breathing devices with viral filter (positive end expiratory pressure (PEEP) devices, excluding non-invasive ventilation)
• Inspiratory and expiratory muscle strength training on non-ventilated patients
• Non-AGP assessment, weaning and treatment of tracheostomy patient (e.g., deflating cuff, changing inner cannula or placement of speaking value in non-ventilated patients)
• Assessment and treatment of laryngectomy patient including change of voice prosthesis / Heat Moisture Exchanger (HME) management where there is direct manipulation of stoma or treatment in close proximity
• Neonatal / paediatric feeding assessment where 1.5 metre distance cannot be maintained
• Treatment of head and neck cancer patient where 1.5 metre distance cannot be maintained
• Spirometry or peak flow meter device (to avoid contamination of the device consider using viral filter).

3. Allied Health aerosol-generating procedures

Examples of procedures (not exclusive):

• Use of positive pressure breathing devices, mechanical insufflation-exsufflation devices, intra/extra pulmonary high frequency oscillation devices
• Open suctioning of nasopharynx, oropharynx, tracheostomy, endotracheal tube or laryngectomy stoma
• Assessments where a patient is receiving non-invasive ventilation, high-flow nasal prongs, inhalation therapy or a nebuliser
• Manual hyperinflation and inspiratory muscle training device on ventilated patient
• Procedures that have risk of ventilator disconnection e.g., manual assisted cough, manual techniques, mobilising
• Induced sputum via ultrasonic jet nebuliser
• Fibreoptic endoscopic evaluation of swallowing assessment (Co-phenylcaine spray should not be used at present as aerosolises. It is recommended that this procedure should NOT be conducted on COVID-19 suspected/confirmed cases).

Explanatory Notes

Evidence regarding droplets versus aerosols in coughing

• There is good evidence that COVID-19, like most respiratory viral infections, is predominantly transmitted by droplets
• Clinical and epidemiological evidence suggest that airborne transmission is rare but appears to be potentiated when air circulation or air exchanges are poor
• Coughing, sneezing and shouting are known to increase the number and size range of particles (droplets/aerosols) produced. Some of these will be in the aerosol range for size. Generally, the larger the droplet, the more virus it contains
• By definition respiratory AGPs aerosolise respiratory droplets hence the increased risk for transmission.

References for Appendix 4D

Australian and New Zealand College of Anaesthetists (ANZCA) Recommendations for PPE according to SARS-CoV-2 risk screening flowchart (28/04/2020)

Appendix 4E: Managing PPE for the administration of hazardous drugs

Background

Occupational Health and Safety and Worker Compensation authorities (SafeWork 2017, 2017; Worksafe Queensland, 2017) as well as various Professional Practice Standards (SHPA Committee of Specialty Practice in Oncology, 2005; International Society of Oncology Pharmacy Practitioners Standards Committee, 2007; ONS, 2018) uniformly mandate the use of PPE by HWs who handle hazardous drugs and related waste.

The Cancer Institute NSW and eviQ support the use of PPE for safe handling and administration of hazardous cancer drugs for those drugs listed on the NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016 (Centers for Disease Control and Prevention, 2016).

In the event of a PPE shortage for safe handling and administration of hazardous drugs, it is anticipated that facilities who deliver systemic anti-cancer treatments and other hazardous drugs across NSW may, at times, have difficulty accessing the required PPE, especially gowns and seek alternative ways to provide patient care and/or optimise current supply.

Personal protective equipment

All PPE should comply with the Australian Standard or equivalent. Selection criteria for chemotherapy gowns includes:

- Disposable, lint free, and rated to resist chemotherapy
- Long sleeves and elastic or knit cuffs, fasten in the back (no open front), and be without seams or closures that could allow hazardous drug exposure
- Polyethylene-coated polypropylene or other laminate is recommended.

Do not use cloth laboratory coats, scrubs, or isolation gowns.

Optimisation strategies and recommendations

Strategies to optimise the current stock of gowns are necessary to support decision making for HW and patient safety in clinical cancer care during the COVID-19 pandemic.

Procurement of gowns during this time may result in the brand or colour varying from the standard supply, however ALL PPE must comply with Australian Standards and provide the same protection and be disposed of as cytotoxic waste.
Strategies to preserve supply include:

1. Reserving chemotherapy gowns for when handling and administering hazardous cytotoxic drugs and related waste i.e., those on Table 1 of the NIOSH list of hazardous drugs
   - The use of gowns is not warranted for either dose preparation or administration of monoclonal antibodies (Cancer Institute, 2019), except those conjugated to a cytotoxic agent, fusion protein or a radioisotope

2. In the event of critical PPE shortages, the use of chemotherapy gowns for handling patients body waste for at least 48 hours (ONS, 2018) after completion of cytotoxic drug administration the following should be taken into consideration:
   - Check the excretion time of each drug in the treatment protocol. Timeframes and routes for excretion of cytotoxic drugs in the patient’s body waste following administration can be found in Appendix 10 in Safe Work NSW Guide (Safe Work NSW, 2017)

3. In the event of a chemotherapy rated gown being unavailable, a long-sleeved fluid repellent disposable gown may be considered (ONS, 2018)

4. Consideration around the allocation of tasks rather than individual patient care e.g., one nurse hangs bags or performs all takedowns of chemotherapy. Note that patient assessment does not require the use of a chemotherapy approved gown.

Healthcare facilities should use standard practices (including the use of gloves, goggles/face shield, mask) whenever possible.

For more information refer to eviQ Education’s rapid learning around COVID-19 and Personal Protective Equipment.

Disclaimer: This guidance is for when the availability of gowns for the administration and handling of hazardous drugs is in short supply. Otherwise, PPE for the safe handling and waste management of hazardous drugs should not deviate from current practice, which is based on current evidence and best practice.

References for Appendix 4E


Centers for Disease Control and Prevention. NIOSH List of Antineoplastic and Other Hazardous Drugs in Healthcare Settings, 2016


SHPA Committee of Specialty Practice in Oncology, Standards of Practice for the Safe Handling of Cytotoxic Drugs in Pharmacy Departments. Journal of Pharmacy Practice and Research 2005; 35(1); 44-52

Appendix 4F: PPE guidance for NSW Health security HWs

In managing COVID-19 risks, security HWs are advised to seek to eliminate the risk first, as far as is reasonably practicable. If it can't be eliminated, the security HW must minimise the risk as far as is reasonably practicable.

Apply the hierarchy of controls (see Chapter 2: Section 2.5) using the highest level of control that is reasonably practicable, a combination of controls may be required. Eliminating the risk is the best option, followed by substitution, then isolation and engineering controls. If the above can't be achieved, then reduce the risk through administrative controls. Reducing the risk by using PPE is the lowest level of control.

Frequently asked questions

1. What PPE is to be worn when:
   a. in close proximity with an individual outside the hospital but on hospital grounds (e.g., when restraining or escorting off the premises or when enforcing smoking by-laws)?
   b. touching surfaces (e.g., as part of lock up / lock down)?
   c. managing hospital access points?
   d. conducting general patrols within a health campus?

No specific PPE is required for any of these situations unless in contact with blood or body fluids.

It is recommended that frequent hand hygiene is performed using ABHR or washing with soap and water for 20 seconds at a hand wash basin.

Care should be taken to avoid touching the face.

Physical distancing (>1.5 metres) should be utilised where practical. Shared keys should be cleaned with a disposable cleaning cloth. This should occur before the start of the shift and at the end of each shift.

Standard Precautions apply to all patient care and comprise of hand hygiene, respiratory hygiene (cough etiquette), PPE if in contact with blood or body substances, occupational exposures prevention, cleaning and disinfection of the healthcare environment and shared equipment, and appropriate waste disposal.

2. What PPE is to be worn routinely while in attendance in a COVID clinic?

COVID clinics are attended by people who are symptomatic for COVID-19 or are being tested if they have a known exposure.

Physical distancing should be utilised where practical.

It is recommended that Contact, Droplet and Airborne Precautions are applied if in direct contact with patients. This includes P2/N95 respirator, eye protection, plastic apron/gown and gloves.

Gloves should be worn during direct contact with patients.

HWs wearing PPE must complete the My Health Learning training for donning and removal of PPE (Course Code 294450660, PPE for combined Transmission-Based Precautions).

It is recommended frequent hand hygiene is performed using alcohol-based hand rub or washing with soap and water for 20 seconds at a hand wash basin.

Care should be taken to avoid touching the face.
3. **What PPE is to be worn when restraint of a patient is required?**

Patients with suspected or confirmed COVID-19 in hospital will be known. It is important to maintain security HW safety against respiratory droplets by putting on the correct PPE prior to contact with the patient.

If called to a clinical area and restraint is required, the HW will inform the security HW what PPE is required which will include:

- P2/N95 respirator for suspected or confirmed COVID-19
- Protective eyewear
- Gloves
- Apron/gown for close contact
## Appendix 4G: AAMI Level Standards for gowns


<table>
<thead>
<tr>
<th>Barrier Performance</th>
<th>Barrier Protection</th>
<th>Resistance Measure</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Level 1**         | Minimal            | Liquid penetration | • Used for MINIMAL risk situations  
                      |                    |                     | • Provides a slight barrier to small amounts of fluid penetration  
                      |                    |                     | • Single test of water impacting the surface of the gown material is conducted to assess barrier protection performance |
| **Level 2**         | Low                | Liquid penetration | • Used in LOW-risk situations  
                      |                    |                     | • Provides a barrier to larger amounts of fluid penetration through splatter and some fluid exposure through soaking  
                      |                    |                     | • Two tests are conducted to assess barrier protection performance:  
                      |                    |                     |   • Water impacting the surface of the gown material  
                      |                    |                     |   • Pressurising the material |
| **Level 3**         | Moderate           | Liquid penetration | • Used in MODERATE risk situations  
                      |                    |                     | • Provides a barrier to larger amounts of fluid penetration through splatter and more fluid exposure through soaking than Level 2  
                      |                    |                     | • Two tests are conducted to test barrier protection performance:  
                      |                    |                     |   • Water impacting the surface of the gown material  
                      |                    |                     |   • Pressurising the material |
| **Level 4**         | High               | Liquid and viral penetration | • Used in HIGH risk situations  
                      |                    |                     | • Prevents all fluid penetration for up to 1 hour  
                      |                    |                     | • May prevent VIRUS penetration for up to 1 hour  
                      |                    |                     | • In addition to the other tests conducted under Levels 1-3, barrier level performance is tested with a simulated blood containing a virus – if no virus is found at the end of the test, the gown passes |
Appendix 4H: AS 4381:2015 Single-use surgical face mask use in healthcare


<table>
<thead>
<tr>
<th>Testing</th>
<th>Barrier Performance</th>
<th>Bacterial Filtration Efficiency (BFE) %</th>
<th>Differential pressure (ΔP), mm H₂O/cm²</th>
<th>Resistance to penetration by synthetic blood (fluid resistance) minimum pressure in mmHg for pass result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mask materials are evaluated for resistance to penetration by synthetic blood, bacterial filtration efficiency and differential pressure</td>
<td>Level 1</td>
<td>≥ 95%</td>
<td>&lt; 4.0</td>
<td>80mm Hg</td>
</tr>
<tr>
<td></td>
<td>Level 2</td>
<td>≥ 98%</td>
<td>&lt; 5.0</td>
<td>120mm Hg</td>
</tr>
<tr>
<td></td>
<td>Level 3</td>
<td>≥ 98%</td>
<td>&lt; 5.0</td>
<td>160mm Hg</td>
</tr>
<tr>
<td></td>
<td>Test method</td>
<td>ASTM F2101-14 or EN 14683:2014</td>
<td>EN 14683:2014</td>
<td>ASTM F1862 /F1862M-13 or ISO 22609</td>
</tr>
</tbody>
</table>
Appendix 4I: Properties of P2 and N95 respirators

<table>
<thead>
<tr>
<th>Properties</th>
<th>P2 Respirator</th>
<th>N95 Respirator</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other names</td>
<td>N95 masks, respiratory protection device, particulate respirator</td>
<td>P2 respirator, respiratory protection device, particulate respirator</td>
</tr>
<tr>
<td>Characteristics</td>
<td>P2 particulate filtering respirators/masks must have a filter efficiency of at least 94% when tested with sodium chloride aerosol at a flow rate of 95 litres/minute. Under the European Norms system, aerosol testing is similar to Standard AS/NZS 1716: 2012 but has additional filter efficiency testing with paraffin oil aerosol that must also meet the minimum 94% filter efficiency to be classified as P2. The particle size of this aerosol has a median diameter of 0.3 to 0.6 microns with a range of particles in the 0.02 to 2-micron size range.</td>
<td>NIOSH classified N95 particulate filtering respirators/masks must have a filter efficiency of at least 95% when tested with sodium chloride aerosol at a flow rate of 85 litres/minute.</td>
</tr>
<tr>
<td></td>
<td>• Raised dome or duckbill</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• 4–5 layers (outer polypropylene, central layers electret [charged polypropylene])</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Filtration through mechanical impaction and electrostatic capture</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Designed to provide a good facial fit to minimise aerosol contamination of the mucous membranes of the nose and mouth</td>
<td></td>
</tr>
<tr>
<td>Sealing</td>
<td>• Ties or straps at crown and bottom of head, pliable metal nose bridge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Recommend Fit checking all respirators, Fit testing based on risk category</td>
<td></td>
</tr>
<tr>
<td>Australian Standards</td>
<td>Standard AS/NZS 1715: 2009</td>
<td>Set by the US NIOSH classification (NIOSH Guidelines – Procedure No. TEB-APR-STP-0059)</td>
</tr>
<tr>
<td>Intended use</td>
<td>• Routine care of patients on Airborne Precautions</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• High-risk procedures (or AGPs) such as bronchoscopy when the patient’s infectious status is unknown, or the patient has suspected or confirmed COVID-19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Procedures that involve aerosolisation of particles that may contain specific known pathogens (AGPs)</td>
<td></td>
</tr>
</tbody>
</table>

Source: Australian Guidelines for the Prevention and Control of Infection in Healthcare, 2019
Appendix 4J: P2 and N95 respirator range within NSW Health

This table is not exhaustive and additional products will be added on to the Respiratory protection program fit testing algorithm

<table>
<thead>
<tr>
<th>Respirator</th>
<th>Description</th>
<th>P2/N95</th>
<th>Fluid resistant</th>
<th>Standard</th>
<th>Precautions suited to</th>
<th>Specifications and additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>BYD</td>
<td>N95 respirator</td>
<td>N95</td>
<td>16kPa</td>
<td>NIOSH</td>
<td>Airborne / AGP</td>
<td>• Meets CDC guidelines for <em>Mycobacterium tuberculosis</em> exposure control</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• FDA cleared for use as a surgical mask</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 99% BFE (Bacterial Filtration Efficiency) according to ASTM F2101</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Fluid resistant according to ASTM F1862</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Respirator contains no components made from natural rubber latex</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Collapse resistant cup shape design</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Braided headbands, cushioning nose foam, and light weight construction for comfortable wear</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• &gt;95% filtration efficiency against solid and liquid aerosols free of oil</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• 4-ply Protection, Particulate Filtration Efficiency (PFE) 95%, Splash Resistance Pressure 16kPa</td>
</tr>
<tr>
<td>BSN Medical (Aust) Pty Ltd</td>
<td>P2/N95 Filter, Medium, Pleated, Double Strap (Proshield)</td>
<td>P2/ N95</td>
<td>160mmHg</td>
<td>AS/NZS 1716:2012 NIOSH</td>
<td>Airborne / AGP</td>
<td>• BFE greater than 99% for particles greater than 3 microns</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• The super high PFE material filters more than 99% of particles greater than 0.1 microns</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• The N95 mask is NIOSH approved as an N95 particulate filter respirator. It meets or exceeds the standard performance criteria demanded by the US National Institute for Occupational Safety and Health</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Respirator</th>
<th>Description</th>
<th>P2/N95</th>
<th>Fluid resistant</th>
<th>Standard</th>
<th>Precautions suited to</th>
<th>Specifications and additional information</th>
</tr>
</thead>
</table>
| BSN Medical (Aust) Pty Ltd     | P2/N95 Filter, Small, Pleated, Double Strap (Proshield) | P2/ N95    | 160mmHg         | AS/NZS 1716:2012                  | Airborne / AGP                                                                         | (NIOSH) for the management of tuberculosis  
• The fluid resistant qualities of the mask provide protection against fluid strikethrough |
| 3M Australia Pty Ltd           | P2 masks 1860                                     | P2/ N95    | 120mmHg         | AS/NZS 1716:2012                  | Airborne / AGP                                                                         | • NIOSH certified N95  
• Meets CDC guidelines for *Mycobacterium tuberculosis* exposure control  
• FDA cleared for use as a surgical mask  
• BFE more than 99% according to ASTM F2101  
• Fluid resistant according to ASTM F1862 at 120 mmHg  
• Mould nose clip to wearer’s nose shape to help reduce eyewear fogging and ensure a better seal/fit  
• Respirator contains no components made from natural rubber latex |
| 3M Australia Pty Ltd           | Cupped N95 Respirator 1860S                       | N95        | 80mmHg          | AS/NZS 1716:2012                  | Airborne/ Level 1 Fluid Resistance For AGPs wear with face shield or a surgical mask on top of P2 | • NIOSH certified N95  
• Meets CDC guidelines for *Mycobacterium tuberculosis* exposure control  
• FDA cleared for use as a surgical mask  
• BFE > 99% and PFE >95 according to ASTM F2101  
• Fluid resistant according to ASTM F1862 at 80 mmHg  
• Mould nose clip to wearer’s nose shape to help reduce eyewear fogging and ensure a better seal/fit |
<table>
<thead>
<tr>
<th>Respirator</th>
<th>Description</th>
<th>P2/N95</th>
<th>Fluid resistant</th>
<th>Standard</th>
<th>Precautions suited to</th>
<th>Specifications and additional information</th>
</tr>
</thead>
</table>
| 3M Australia Pty Ltd          | P2 masks 1870                | P2/N95 | 160mmHg         | AS/NZS 1716:2012          | Airborne / AGP                                                                        | • NIOSH certified N95                                                                                          • Meets CDC guidelines for *Mycobacterium tuberculosis* exposure control  
• FDA cleared for use as a surgical mask  
• BFE more than 99% according to ASTM F2101  
• Fluid resistant according to ASTM F1862 at 160 mm Hg  
• Respirator contains no components made from natural rubber latex  
• Red coloured head straps for health care use  
• Mould nose clip to wearer’s nose shape to help reduce eyewear fogging and ensure a better seal/fit                                                                                                                                |
| 3M Australia Pty Ltd          | P2 respirator 8110S          | P2     | N/A             | AS/NZS 1716: 2012         | Dry airborne*                                                                          | For AGPs wear with face shield or a surgical mask on top of P2                                                                                 • Lightweight construction for added comfort that may increase wearer time  
• Mould nose clip to the wearer’s nose shape to help reduce eyewear fogging and for a better seal and fit  
• Made from 3M™ Advanced Electret Filter Material for effective filtration with low breathing resistance  
• Does not contain components made from natural rubber latex  
• Fluid Resistant (ASTM F1862) - not applicable  
• N95 (similar to Class P2) rated filtration efficiency  
• Protects against hazards such as dusts, mists, smoke and fume                                                                                                                                                                          |
<table>
<thead>
<tr>
<th>Respirator</th>
<th>Description</th>
<th>P2/N95</th>
<th>Fluid resistant</th>
<th>Standard</th>
<th>Precautions suited to</th>
<th>Specifications and additional information</th>
</tr>
</thead>
<tbody>
<tr>
<td>KN95*</td>
<td>N95 respirator</td>
<td>N95</td>
<td>N/A</td>
<td>GB2626-2006</td>
<td>Dry airborne*</td>
<td>• Meets performance requirements of AS/NZS 1716 (P2) and complies with NIOSH N95</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>For AGPs wear with face shield or a surgical mask on top of P2</td>
<td>• Material: Non-woven fabric</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Standard: KN95</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Protection Class: KN95/FFP2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Filtering Rate: ≥95% (0.075μm particles)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Applications: hospitals, outpatient clinics</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Fluid Resistant (ASTM F1862) - not applicable</td>
</tr>
</tbody>
</table>

Respirator with an exhalation valve • Not recommended

*Standard P2/N95 respirator can be used for dry airborne situations such as tuberculosis, measles or Chickenpox where minimal exposure to droplets are expected.

*KN95 respirators/masks are the Chinese standards for respirators. N95 masks are the USA standards for respirators. There are requirements that the USA National Institute for Occupational Safety and Health requires manufacturers to meet in order to label their masks as N95s. Mask standards for Europe (FFP2), Australia (P2), Korea (KMOEL), and Japan (DS) are also highly similar. There are different brands and levels of KN95 respirators available; when selecting a KN95 respirator ensure that the particulate filtration level and fluid resistance aligns with the requirements of P2/N95 respirators. Some P2/N95 respirators are not fluid resistant, if fluid resistance status is unknown, wear the respirator with a face shield or surgical mask while performing AGPs.
## Appendix 4K: Difference between elastomeric respirators & PAPRS

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Elastomeric respirators</th>
<th>Loose-fitting PAPR</th>
<th>Tight-fitting PAPR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Description</td>
<td>Non-powered</td>
<td>Powered</td>
<td>Powered</td>
</tr>
<tr>
<td>Figure</td>
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</tr>
<tr>
<td>Specifications</td>
<td>An elastomeric respirator is a reusable device with exchangeable cartridge filters. They are tight-fitting respirators that are generally either a half facepiece or full facepiece where the facepieces are made of synthetic or natural rubber material with a removable filter</td>
<td>Most models are a battery powered blower that pulls air through attached filters or cartridge. The blower forces the ambient air through air-purifying elements [a filter cartridge] to the inlet covering [a hood, helmet or facepiece]. The blower then pushes the filtered air into the facepiece. This process creates an air flow inside either a tight-fitting facepiece or loose-fitting hood or helmet, providing an assigned protection factor (APF) between 10-100</td>
<td></td>
</tr>
<tr>
<td>Facepiece</td>
<td>A tight-fitting half or full facepiece</td>
<td>A loose-fitting facepiece, hood, or helmet</td>
<td>A tight-fitting half or full facepiece</td>
</tr>
<tr>
<td>Limitations</td>
<td>More commonly used in industrial and mining settings, but some models may be assessed for use in healthcare. Currently there are no standardised procedures for cleaning and disinfection of these items within healthcare</td>
<td>The safe levels of contaminant concentrations may have been established for industries but have not been determined for healthcare settings. Only provide protection if the correct type of filters and/or cartridge(s) is/are used for the contaminant(s) of concern. PAPR batteries must be recharged or replaced, respirators require significant amount of storage space between</td>
<td></td>
</tr>
<tr>
<td>Criteria</td>
<td>Elastomeric respirators</td>
<td>Loose-fitting PAPR</td>
<td>Tight-fitting PAPR</td>
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<tr>
<td><strong>Description</strong></td>
<td>Non-powered</td>
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<td></td>
<td>environments. Caution must be taken regarding the use and reuse of elastomeric respirators to decrease contamination of the inside of the respirator and thus increasing the risk of infecting health workers between use</td>
<td>shifts and a robust maintenance program for replacing or repairing components that have become damaged during use or during cleaning and disinfection is required Competent HWs are required to support the PAPR maintenance program and HWs must be competent and trained on appropriate use, cleaning and disinfection of the item. PAPRs also require ongoing or at least adequate supply of various parts e.g., for the Halo mask: extra neck supports, harnesses etc.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>The nosepiece can affect the ability to achieve satisfactory fit for safety or prescription spectacles, operating microscopes or other technical equipment</td>
<td>The HWs ability to hear may be reduced because of the blower noise, and noise induced by the movement of a loose head covering. In case of battery or fan failure there is a risk of build-up of carbon dioxide exhaled by the wearer, and breathlessness</td>
<td>Performance can be markedly reduced by facial hair between the facepiece and the face and by the arms of spectacles. May cause discomfort and or heat build-up during hard work or in hot environments</td>
</tr>
<tr>
<td><strong>Assigned protection factor (APF)</strong></td>
<td>Half face elastomeric APF = 10 Full facepiece elastomeric APF = 50</td>
<td>Loose-fitting hoods and helmets APF = 25</td>
<td>Tight-fitting half masks APF = 50 Tight-fitting full facepiece APF = 1000</td>
</tr>
<tr>
<td><strong>Face to respirator seal</strong></td>
<td>Require an excellent face-to-facepiece seal</td>
<td>Do not require a close face-to-facepiece seal</td>
<td>Require a good face-to-facepiece seal</td>
</tr>
<tr>
<td><strong>Fit test required</strong></td>
<td>As the facepiece of the elastomeric respirator should form a tight seal against the user’s face, fit testing may be required</td>
<td>A fit test is not required for PAPRs with loose-fitting headgear such as hoods and helmets</td>
<td>Some models require fit testing, in the event of blower failure</td>
</tr>
<tr>
<td><strong>Comfort to the wearer</strong></td>
<td>Some faces may achieve better seal, although some users may experience discomfort due to physiological responses,</td>
<td>Due to the use of highly efficient filters and utilisation of positive pressure, the constant airflow provides a cooling effect on the user.</td>
<td></td>
</tr>
<tr>
<td>Criteria</td>
<td>Elastomeric respirators</td>
<td>Loose-fitting PAPR</td>
<td>Tight-fitting PAPR</td>
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<tr>
<td><strong>Description</strong></td>
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<tr>
<td></td>
<td>Non-powered</td>
<td>Powered</td>
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</tr>
<tr>
<td></td>
<td>such as perceived increased temperature under the facepiece or skin irritation</td>
<td>A PAPR may be less taxing from a physiological/breathing resistance perspective than other respirators</td>
<td></td>
</tr>
<tr>
<td><strong>Facial hair</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Facial hair will interfere with face and respirator seal</td>
<td>Compatibility with facial hair and various facial structures</td>
<td>Facial hair will interfere with face and respirator seal</td>
</tr>
<tr>
<td><strong>Integrated eye protection</strong></td>
<td>Only for full-face models</td>
<td>Yes</td>
<td>Only for full-face models</td>
</tr>
<tr>
<td><strong>Fluid resistance</strong></td>
<td>Some models are fluid resistant</td>
<td>Fluid resistant</td>
<td>Fluid resistant</td>
</tr>
<tr>
<td><strong>Level of protection</strong></td>
<td>Under testing conditions, the protection provided by reusable elastomeric respirators varies by filter type and model and they provide less protection than PAPR or supplied-air types of respirators</td>
<td>Over breathing of a loose fitting PAPR would result in some measurable volume of ambient air entering the breathing vicinity of the wearer. Therefore, over breathing could potentially expose the wearer to contaminant risks while wearing a loose fitting facepiece</td>
<td>Generally, very low risk of contaminated air leaking into the respirator</td>
</tr>
<tr>
<td><strong>Integrated PPE from the neck up</strong></td>
<td>Half facepiece provides no coverage of head or neck</td>
<td>Only a hooded model provides neck and head protection</td>
<td></td>
</tr>
<tr>
<td><strong>Visualisation</strong></td>
<td>Line of sight may impede with some models e.g., when intubating or insertion of intravascular access devices. Full face piece will allow patients to see HWs face. May interfere with the visual field while looking downwards</td>
<td>The clear face shield will allow patients to see the HWs face</td>
<td>Full face piece will allow patients to see HWs face</td>
</tr>
<tr>
<td></td>
<td>May interfere with the HW’s visual field because of the limited downward vertical field of view</td>
<td></td>
<td>May interfere with the HW’s visual field because of the limited downward vertical field of view</td>
</tr>
<tr>
<td><strong>Clinical care</strong></td>
<td>Does not interfere with the use of some medical equipment such as a stethoscope</td>
<td>The use of a stethoscope may be limited.</td>
<td>Full facepiece may limit the use of a stethoscope</td>
</tr>
<tr>
<td>Criteria</td>
<td>Elastomeric respirators</td>
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<tr>
<td>Description</td>
<td>Non-powered</td>
<td>Powered</td>
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<tr>
<td></td>
<td></td>
<td>Allow other equipment to be used concurrently such as headlights, loupes, mask underneath the unit</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>The facepiece can affect the intelligibility of the wearer's speech</td>
<td>Interference with hearing and mobility. The HW's ability to hear or be heard may be reduced because of the blower noise, and noise induced by the movement of a loose head covering</td>
<td></td>
</tr>
<tr>
<td>Exhalation valves</td>
<td>Has a separate exhale vent, but this is not filtered. Exhaled air may be contaminated. Recommend that an expiratory filter or a surgical mask is worn to cover the exhalation valve for source control</td>
<td>There is no filter on the exhalation valve. When a PAPR is being worn in the operating theatre, it is recommended that a surgical mask be worn under a PAPR or over a facemask respirator. This is not necessary with some hooded models</td>
<td>There is no filter on the exhalation valve. It is recommended that a surgical mask be worn on top of exhalation valves to reduce the microbial dispersal from the wearer. Filters for expiratory ports are under development</td>
</tr>
<tr>
<td>Cleaning and disinfection</td>
<td>Specific procedures for cleaning and disinfection (reprocessing) within healthcare environments must be established for the environment where elastomeric may be used. To ensure reliability, it is recommended that reprocessing be undertaken in a central sterilising department. The filter material itself typically cannot be cleaned or disinfected for reuse. Specific safe working procedures must be in place to manage the filters. Filter components should be discarded when they become damaged, soiled, or clogged</td>
<td>Most PAPRs have components that are disposable. Reusable components must be cleaned and disinfected between use as per the manufacturer instructions. Any reprocessing will be required to be undertaken in a central sterilising department. The outside of the filter cartridge can have surface cleaning and decontamination while the rest of the unit is being serviced. Viruses and bacteria causing ARI can survive on respirator components for variable periods of time, from hours to weeks. Consequently, contaminated respirators must be handled, cleaned, and disinfected properly to reduce the possibility of the device serving as a fomite and contributing to disease transmission. Any procedure that is used to clean and disinfect the PAPR and its components must be recommended or approved by the manufacturer. Cleaning and disinfection must be done by competent, trained individuals. Centralising this activity can ensure it is properly done</td>
<td></td>
</tr>
<tr>
<td>Criteria</td>
<td>Elastomeric respirators</td>
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</tr>
<tr>
<td>Description</td>
<td>Non-powered</td>
<td>Powered</td>
<td>Powered</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Require maintenance and a supply of replaceable components including straps, inhalation and exhalation valves, valve covers, and filters, cartridges, or canisters</td>
<td>PAPR batteries must be recharged or replaced and ongoing maintenance is required. Change cartridges as needed and inspect equipment for problems. Involve biomedical engineers in the maintenance process</td>
<td></td>
</tr>
<tr>
<td>Cartridge and filter replacement</td>
<td>Each manufacturer has instructions regarding cartridge and filter replacement</td>
<td>The correct combination of filters and cartridges must be used. Cartridges and filters have a limited life and should ideally be equipped with end-of-service-life indicators (ESLI). In the absence of an ESLI, the manufacturer's recommended change schedule must be observed</td>
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</tr>
<tr>
<td>Education and training</td>
<td>Training shall be provided by a competent person and it should cover donning, fit checking, fit testing, appropriate use, doffing, cleaning and disinfection, maintenance, filter change and storage</td>
<td></td>
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</tr>
</tbody>
</table>
Chapter 5: Reprocessing reusable devices

This chapter is part of the COVID-19 Infection Prevention and Control Manual, Clinical Excellence Commission, 2022.

The publication summarises current evidence about COVID-19 infection prevention and control strategies and interventions, and their implementation in healthcare settings.

The publication will continue to evolve with additional chapters over time that address infection prevention and control in other settings. As new resources become available, they will be added as hyperlinks of the resources section in each chapter or to the appendices.

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5.5 Cleaning and disinfection of virtual reality equipment 172

Key Points

- Reusable medical devices need to be safe for each use which includes being free from contamination of microorganisms
- These must be reprocessed according to the manufacturer instructions for use and do not require additional reprocessing
- Single use personal protective equipment (including respirators) is not suitable for reprocessing
- Reusable personal protective equipment devices such as elastomeric respirators and powered air purifying respirators must be reprocessed according to the manufacturer instructions for use.
5.1 Introduction

Reprocessing refers to the activities required to ensure that a reusable medical device (RMD) is free from microorganisms, so it is safe for its intended use. Reprocessing includes cleaning, disinfection and sterilization of reusable equipment, instruments and devices used in healthcare facilities. Reprocessing of RMDs, equipment and instruments must be in accordance with AS/NZ Standard 4187:2014 Reprocessing of reusable medical devices in health service organisations and the manufacturer instructions for each device.

5.2 Reprocessing reusable medical devices

Routine procedures for cleaning and disinfection for reprocessing RMDs such as surgical instruments, flexible endoscopes, ultrasound probes should be followed. No additional
processing or procedures are required for RMDs used on COVID-19 suspected or confirmed cases. Used RMDs should not be labelled as ‘COVID-19 CASE’.

Any shared non-critical patient equipment such as a stethoscope, bladder scanner or sphygmomanometer should be cleaned and disinfected according to manufacturer instructions for use (IFU) after use. Standard precautions should be applied while cleaning these items. If cleaning occurs within the patient room apply precautions based on risk assessment.

For additional information refer to GESA and GENCA Recommendations For Endoscope Reprocessing During the COVID-19 Pandemic.

5.3 Reprocessing personal protective equipment

The CEC does not recommend or endorse any strategies for single use personal protective equipment (PPE) reuse that differ from standard infection prevention and control practices. In times of a pandemic and global supply shortages, temporary emergency strategies can be considered.

If the manufacturer IFU specifies the reprocessing of reusable PPE, then manufacturer IFU for reprocessing including cleaning and disinfecting should be followed and HWs must be trained to ensure that equipment is reprocessed after each use.

Reusable PPE devices such as elastomeric respirators and powered air purifying respirator (PAPR) must be reprocessed according to the manufacturer IFU.

It is important that facilities considering reprocessing of PPE medical supplies intended for single use understand the following:

- Reprocessing (cleaning and disinfection and/or sterilization) may have a deleterious effect on the safety and performance of single-use masks and gowns that may not be obvious to the end user
- Any individual or entity reprocessing PPE for reuse meets the legislative definition of a manufacturer under the Therapeutic Goods legislation and will need to meet all legislative obligations and responsibilities for manufacturers
- The manufacturer has provided validated reprocessing IFUs for the PPE
- These responsibilities include ensuring that reprocessing activities (such as repeated cleaning and disinfection or sterilization) do not affect the material properties or effectiveness of the device
- Some PPE, such as P2/N95 respirators, may not be compatible with reprocessing activities, including gamma and ionizing radiation, as these may damage or impair the respirator
- Reprocessing of single use PPE must not affect the function of the PPE or cause adverse skin reactions from chemicals used
- The reprocessing of single-use PPE is considered as ‘off-label’ use and the healthcare setting is responsible for all risks and associated liabilities with off-label use of medical devices
• When a single use item is reprocessed for reuse, the healthcare facility responsible for carrying out reprocessing activities meets the legislative definition of a manufacturer as per the Australian Register of Therapeutic Goods ARTG Therapeutic Goods Act 1989, as they have:
  o changed the intended purpose of the PPE
  o certified the device is suitable for reuse
  o assumed legal liability for the quality, safety and performance of the device.

Factors to consider when reprocessing single-use medical devices for reuse include the following:

• Reprocessing single-use PPE must not be undertaken without prior written approval from the NSW Ministry of Health
• Requires approval by an LHD/SHN PPE Governance Committee
• Procedures and safeguards must be implemented to prevent inadvertent environmental contamination with hazardous microorganisms (including from the point of collection environment through to the reprocessing environment)
• Procedures and safeguards must be implemented to prevent inadvertent exposure to hazardous microorganisms
• Processes should be established for reprocessed items to enable traceability and tracking during reprocessing and reuse.

5.4 Reprocessing respirators

Clean and disinfect reusable respirators as per the manufacturer's IFU and AS/NZS 4187: 2014 Reprocessing of reusable medical devices in health service organisations.

Always consult with the manufacturer concerning the effectiveness and compatibility of any alternative cleaning and disinfection methods such as disinfectant solutions used to clean and disinfect the facepiece, straps and filter components. The reprocessing procedures must be effective for disinfection (thermal or chemical) and not damage the respirator, including the filter media, which usually is discarded or cause harm to the HW such as skin irritation from wearing a respirator.

Prolonged or repeated use of disinfectants may damage or degrade some of the respirator components (facepiece, valves, valve covers, straps) causing components to discolor, swell, harden or crack. This can be assessed by visual inspection prior to, and at the end of reprocessing.

Facilities require a process with the following steps for each device based on manufacturer IFU:

• Cleaning
• Chemical or thermal disinfection
• Drying and storage
• Inspection
• Particulate filter replacement
• Respirator storage
Training for reprocessing.

For more information on reprocessing of reusable respirators refer to individual manufacturer IFU and CEC Respiratory Protection Program Manual.

5.5 Cleaning and disinfection of virtual reality equipment

COVID-19 has increased the need to explore innovative training methods to complement existing face to face training. Virtual care provides an effective platform to engage and provide safe and efficient care to patients during the COVID-19 pandemic. Virtual reality (VR) is used in many other industries as a method of education and training.

The objective of this advice is to provide information on how to clean VR equipment to minimise the risk of transmitting pathogenic microorganisms between users.

Different types of VR equipment have different cleaning options. Each manufacturer of VR equipment offers options on how to clean their products. General tips are provided that could be applied to most VR equipment.

VR Head Mounted Displays (HMD) are non-critical devices used for VR based education. The HMD comes into contact with the user’s face and hair and the controls come into contact with the user’s hands. The headsets are shared between different users and may be used in either a home or healthcare setting.

**FIGURE 11: EXAMPLE OF HMD (LEFT) AND HANDHELD CONTROLLERS (RIGHT)**

When using HMDs, the following need to be addressed:

- Velcro elements of the HMD cannot be cleaned or disinfected and should be replaced with a fastening system such as buckle clip that is cleanable

**FIGURE 12: EXAMPLE OF VELCRO COVERING ON HMD**
• Ensure the facial interface is wipeable and replaceable. If not use a disposable impervious barrier layer between the user and the facial interface.

**FIGURE 13: WIPEABLE FACIAL INTERFACE (LEFT) AND DISPOSABLE FACE INTERFACE (RIGHT)**

![Wipeable Facial Interface](image1.png) ![Disposable Face Interface](image2.png)

• Distribute only the required equipment in a cleanable case or disposable bag with label ‘CLEAN’ ready for use or ‘DIRTY’ to be cleaned depending on the situation.

**FIGURE 14: EXAMPLE OF SAFE COVERINGS**

![Example of Safe Coverings](image3.png)

• VR devices are not to be used if HW have any cold or flu symptoms or any open cuts/sores on the face or hands.

**How to clean and disinfect the virtual reality headset**

• Remove disposable face pads (interface) and discard
• Clean reusable face pads with a detergent solution or wipe
• Clean hands with alcohol-based hand rub or soap and water
• Use a new wipe to clean the inner surface of HMD
• Using a new wipe, clean the outer surface
• Clean the handheld devices with a new detergent wipe
• Disinfect the reusable components with a TGA and manufacturer approved disinfectant
• Allow to dry in a clean area
• Once the items are dry, store in a clean sealable and disposable bag
• Perform hand hygiene after completion.
At home user instructions

- Only the designated HW who borrowed the HMD should use the device
- Perform hand hygiene prior use of the HMD
- The HMD should be thoroughly wiped down with neutral detergent (solution or wipe) prior to returning the unit to the hospital or educational facility
- The controllers should be wiped down with neutral detergent (solution or wipe) prior to returning the unit
- The whole device should be cleaned with a neutral detergent, once the item is dry, place in a clean bag prior to return of the device to the hospital or educational facility
- The disposable facial interface should be removed and replaced by the designated coordinating educator or HW wearing appropriate PPE
- The reusable facial interface should be cleaned with a neutral detergent and left to dry.

In hospital use

- Perform hand hygiene prior to use of the HMD
- The facial interface should be disposed of and changed or cleaned by the designated coordinating educator or HW between users
- The HMD and controllers should be wiped down with neutral detergent (solution or wipe) and allowed to adequately dry by the designated coordinating educator or HW between users.

The advice in this Chapter was informed by resources developed by Nathan Moore, Lead for Educational Innovation and Technology, Research and Education Network – WSLHD.

Chapter 6: Specific healthcare settings

This chapter is part of the COVID-19 Infection Prevention and Control Manual, Clinical Excellence Commission, 2022.

The publication summarises current evidence about COVID-19 infection prevention and control strategies and interventions, and their implementation in healthcare settings. The publication will continue to evolve with additional chapters over time that address infection prevention and control in other settings. As new resources become available, they will be added as hyperlinks of the resources section in each chapter or to the appendices.

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Key points

- Infection prevention and control is required when managing patients through a surgical pathway to ensure the safety of HW and patients
- COVID-19 risk assessment should be aligned with the recommendations in Chapter 3: Response and Escalation Framework

Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGB</td>
<td>Aerosol-generating behaviour</td>
</tr>
<tr>
<td>AGP</td>
<td>Aerosol-generating procedure</td>
</tr>
<tr>
<td>CEC</td>
<td>Clinical Excellence Commission</td>
</tr>
<tr>
<td>CO</td>
<td>Carbon monoxide</td>
</tr>
<tr>
<td>COHb</td>
<td>Carboxyhaemoglobin</td>
</tr>
<tr>
<td>CO ppm</td>
<td>Carbon monoxide parts per million</td>
</tr>
</tbody>
</table>
6.1 Introduction
This chapter provides advice on specific acute healthcare settings. Content will evolve over time and be added as updates.

6.2 Maternity and neonatal services
Specific guidance relating to maternity and newborn services is available on the NSW Health website: [Guidance for maternity and newborn care](https://www.nswhealth.gov.au). 

Carbon monoxide testing in pregnancy
Smoking in pregnancy is one of the single most important avoidable causes of stillbirth and other adverse pregnancy outcomes. Carbon monoxide (CO) monitoring can be a very useful tool for smoking cessation.

NSW Health supports carbon monoxide monitoring for pregnant women as per LHD guidance, however this is dependent upon the transmission risk levels (refer to Chapter 3 – Response and Escalation Framework).

During high and medium transmission risk levels this testing is not recommended to enable women to maintain mask wearing during their antenatal appointments.

The purpose of this guidance is to provide infection prevention and control advice for LHDs that elect to undertake CO monitoring in their maternity services.

NOTE: Neither NSW Health nor the CEC endorses or promotes any products or equipment identified in this guidance.

Infection prevention and control measures for carbon monoxide measurement
NSW Health Maternity services use a handheld expired CO monitor to measure CO levels in the pregnant woman’s breath. The monitor has a single-use mouthpiece for each user and
the filters are changed when visibly soiled and according to the manufacturer’s instructions for use.

Adhere to the following advice on infection prevention and control principles when using an expired CO monitor:

- Do not provide CO monitoring for a woman who answers ‘yes’ to any COVID-19 screening questions - refer to Chapter 7: Section 7.2 Community Primary and Outpatient Settings or local LHD guidelines
- Maintain physical distance > 1.5 metres whenever possible
- Both the HW and pregnant woman must perform hand hygiene prior to testing
- The HW should don non-sterile gloves if there is a risk of contact with blood or body fluid/respiratory droplets
- The HW should wear a surgical mask during the procedure; refer to Chapter 3: Response and Escalation Framework.

Procedure

1. The HW provides an explanation and offers the pregnant woman CO testing
2. Use a single-use mouthpiece (straw) for each woman
3. The HW inserts the mouthpiece into the expired CO monitor prior to handing the monitor to the woman
4. The woman holds the monitor while the test is being performed
5. The HW should maintain physical distance of > 1.5 metres where possible. Whilst the woman is exhaling, the HW should avoid positioning themselves in front of the exhaust port of the monitor
6. To start, press the symbol on the front of the monitor
7. Ask the woman to breathe in and hold when she sees the clock come up on the screen; ask the woman to keep holding her breath for the 15 second countdown
8. Two short beeps will sound during the last three seconds of the countdown
9. At the commencement of a long beep, ask the woman to blow slowly into the mouthpiece aiming to empty her lungs completely (over at least 5 seconds)
10. The CO parts per million (ppm) and equivalent % COHb levels appear on the screen
11. Refer to the NSW Health Fact Sheet on using an expired CO monitor for interpretation of the levels and additional information
12. Ask the woman to remove the single-use mouthpiece and dispose in the general waste on completion of the assessment
13. Hand hygiene to be performed following use of the monitor by both the HW and the woman.

Cleaning and storage

- Wipe the monitor and D-Piece external surfaces with neutral detergent wipes after each use
- Do not use cleaning solutions/wipes that contain alcohol or other organic solutions and refer to the manufacture’s information for use
- Inspect the D-piece after each use and discard and replace if the filter is visibly soiled or contaminated
- Allow the monitor to be air dried prior to storage
- The monitor must be stored away from direct patient contact when not in use.
Additional information on CO monitoring

NSW Health Maternity Services currently use the Bedfont Smokerlyzer®. The manufacturer has a statement supporting the use of the device during COVID-19. The D-piece filter has been tested to filter viruses as small as 24 nanometres in diameter and the COVID-19 virus particle has a diameter of approximately 125 nanometres. Bedfont have concluded that bacterial and viral pathogens (including COVID-19) will effectively be removed by the D-piece filter at an efficiency rate of > 99% (bacteria) and > 97% (viruses).

**FIGURE 15: EXAMPLE OF CARBON MONOXIDE MEASUREMENT EQUIPMENT**

Information on the Bedfont Smokerlyzer®

Manufacturer information including user manual, infection control and maintenance guidelines are available on the Bedfont Smokerlyzer® website.

6.3 Access to surgery

Access to surgery may vary depending on the level of community transmission of COVID-19 and therefore it is important to check for up to date information at NSW Health Updated guidance for the management of surgery during COVID-19.

Surgery / Procedure

If the patient is suspected or confirmed to have COVID-19 and the decision is to proceed with surgery, then follow Transmission Based precautions for Contact, Droplet and Airborne Precautions including eye protection.

The decision to operate on a patient confirmed to have COVID-19 will be influenced by the level of transmission risk at a state level and the surgical need for each patient. The pathway for a patient from the emergency department (ED) or a ward bed to the operating theatre and return to the ward involves a number of interactions between HWs and the patient. Standard Precautions always apply.

The following table outlines these steps and the actions needed to reduce the risk of transmission of SARS-CoV-2.
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Booking of surgery/procedure</td>
<td>Medical Officer making booking to inform the Senior Nurse Manager/Patient Flow Coordinator, Anaesthetic Team and Procedural Charge Nurse of patient’s COVID-19 status</td>
</tr>
<tr>
<td>Intubated patients for transfer</td>
<td>Contact, Droplet and Airborne Precautions apply Isolate and contain resuscitaire for post-operative transfer if remaining intubated post procedure</td>
</tr>
<tr>
<td>Non-intubated patients with oxygen <em>in situ</em> transfer</td>
<td>Contact, Droplet and Airborne Precautions apply Where possible consider using nasal prongs with a maximum O₂ flow of 4L under a surgical mask instead of a simple oxygen mask where possible</td>
</tr>
<tr>
<td>Arrival in procedural area</td>
<td>Identify the correct patient and procedure. Transfer the patient directly to the operating / procedural room then continue completion of the pre-operative checklist. Bypass holding and anaesthetic bays where these exist</td>
</tr>
<tr>
<td>Anaesthesia induction - AGP</td>
<td>Wear PPE for Contact, Droplet and Airborne Precautions also follow COVID-19 airway management advice and resources</td>
</tr>
<tr>
<td>Anaesthesia - regional/sedation - non AGP</td>
<td>Wear Contact, Droplet and Airborne Precautions Refer above to “Non-intubated patients with oxygen <em>in situ</em> transfer”. If the patient is unable to tolerate or it is not appropriate for the patient to wear a surgical mask, anaesthetic, scout and scrubbed HW’s will need to don Contact, Droplet and Airborne Precautions</td>
</tr>
</tbody>
</table>
| Procedural room                                                        | Minimise equipment and items in the room prior to the patient arrival where possible Avoid unnecessary entry and exiting of the procedural room following the patient’s arrival. Consider:  
  - Limiting the number of HWs in the room  
  - HWs who are involved in the procedure (scrub/scout) within 1.5 metres to wear PPE for Contact, Droplet and Airborne Precautions and follow local procedures for correct sequence of donning and doffing |
<table>
<thead>
<tr>
<th>Criteria</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extubation – AGP</td>
<td>HW to wear PPE for Contact, Droplet and Airborne Precautions when they extubate [including laryngeal mask airway (LMA) removal] in the procedural room</td>
</tr>
</tbody>
</table>
| PACU (Recovery) – assess the risk| Depending on workload and resources recover the patient in the operating or procedure room. If this is not possible use a negative pressure or isolation room in the PACU if available or single room with door closed  
Wear PPE for Contact, Droplet and Airborne Precautions  
If additional airway support is required, follow routine procedures. For airway resources see COVID-19 airway management  
Senior Nurse Manager/Patient Flow Coordinator to communicate to the post procedural receiving area |
| Bypassing PACU (assuming patient is intubated) | Contact, Droplet and Airborne Precautions apply |
| Transfer to receiving department from procedural area | Sending department to inform receiving area and HW responsible for transferring the patient of patient’s COVID-19 status  
Contact, Droplet and Airborne Precautions apply  
Patient to wear a surgical/procedural mask where possible |
| Family/carers                     | Close contacts of COVID-19 should be in home isolation, and limit visitors.  
For participants in care or birth partner as they may an exemption means they are not required to be at home for the birth if in theatre and the hospital can facilitate appropriate IPAC strategies |
| Environmental cleaning            | Apply routine procedures for PPE  
Follow advice for cleaning in Chapter 2  
Dispose of all single use items and reprocess reusable items as per local procedure  
Following patient discharge, the procedural and PACU isolation room (where used) should be left vacant and allow for air exchange, based on the air change per hour (ACH/hour) as per CDC Air changes/hour (ACH) and time required for airborne-contaminant removal by efficiency. Confirm air exchange rates for the procedure room for maximum room vacancy times with:  
• engineering department  
• local IPAC |
| Reprocessing of reusable medical devices (RMDs) | Follow routine procedures. DO NOT LABEL USED RMDs as COVID-19 CASE |
### Criteria

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Handling of linen</td>
<td>Handle all used linen as per Standard Precautions</td>
</tr>
<tr>
<td>Waste management</td>
<td>Manage in accordance with routine procedures: Clinical waste should be disposed of in clinical waste streams. All non-clinical waste should be disposed of into general waste stream (PPE is considered general waste unless contaminated with bulk blood and or body substances).</td>
</tr>
<tr>
<td>Education</td>
<td>Ensure HWs understand how to choose, don and doff PPE safely</td>
</tr>
</tbody>
</table>

Further information is available at:
- Surgical Services Taskforce; NSW Health: [Emergency Surgery Guidelines](#)
- NSW Health elective surgery table [Waiting Time and Elective Surgery Policy](#).

### 6.4 Blood transfusions

The CEC Blood Watch team developed this information for clinicians in consultation with the CEC Infection Prevention and Control team and NSW Health Pathology due to concerns raised about the safety of blood and blood products during the COVID-19 pandemic.

In order to maintain supply and prevent wastage of blood products, the principles of Patient Blood Management (particularly single unit policy) should be adhered to in conjunction with Standard Precautions.

**Principles for clinical areas**

- Do not request blood products until both the clinical area and patient are ready for transfusion
- Blood components should only be taken to potentially contaminated clinical areas or COVID-19 restricted areas immediately prior to transfusion
- Blood components should be kept on surfaces that have been cleaned and are not at risk of respiratory droplet contamination (including satellite refrigerators, platelet incubators/agitators, transport containers or other cleaned surfaces)
- All blood products should continue to be handled with Standard Precautions i.e., using gloves as routinely required along with hand hygiene
- Blood component use for patients with confirmed COVID-19 who are acutely unwell is generally low, except for those receiving extracorporeal membrane oxygenation (ECMO) who may also have an increased need for platelets/plasma (NHS, 2020).

**Frequently Asked Questions**

1. What is the risk of contamination if a blood pack is taken to potentially contaminated bedsides or clinical areas and not used?
There is no evidence that the virus causing COVID-19 can permeate a blood pack (NHS 2020).

2. Is there any way of wiping a blood bag to clean or disinfect it?

No. Lifeblood have advised they are unable to recommend any product to clean or disinfect blood component bags. There is no validated or approved product or method for this purpose (Australian Red Cross Lifeblood, 2020).

3. Where a blood product enters a COVID-19 specific area can it be accepted back into laboratory inventory?

Where Standard Precautions have been applied, blood products should not pose a risk to HWs upon return to the laboratory. Single use plastic transport bags may be used.

4. Should blood products from any clinical area be accepted back into the inventory?

Blood components should only go to the clinical area and the patient bedside when the transfusion is ready to commence.

If a blood component has been out of controlled storage, has breached the cold chain requirements and is no longer required, the laboratory should be contacted.

If a blood component has been correctly stored and is no longer required, it can be returned safely from clinical areas containing patients infected with COVID-19 with no special precautions. Local infection prevention and control teams can confirm local policy.

Ensure Standard Precautions are used when blood components are returned and follow guidance about personal protection.

5. Should there be a quarantine box to keep in cases where particular groups or product stock levels are low?

A quarantine box should not be needed if the blood bag is taken to the patient bedside or into a COVID-19 restricted area when it is ready to transfuse.

References


Chapter 7: Non-acute healthcare settings

This chapter is part of the COVID-19 Infection Prevention and Control Manual, Clinical Excellence Commission, 2022.

The publication summarises current evidence about COVID-19 infection prevention and control strategies and interventions, and their implementation in healthcare settings.

The publication will continue to evolve with additional chapters over time that address infection prevention and control in other settings. As new resources become available, they will be added as hyperlinks of the resources section in each chapter or to the appendices.

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Key points

- Providers of care in these settings should continue to ensure there is minimal impact on patient/client care activities and models of care during the pandemic
- The components of COVID-19 recognition and prevention must not impede routine care and necessary patient/client safety and quality programs
- COVID-19 risk screening prior to entry should be aligned with the recommendations in Chapter 3: Response and Escalation Framework
- A risk assessment should be undertaken, and a risk management plan developed to enable a COVID-19 safe environment for group community sessions/meetings in various types of venues
- When establishing drive-through, pop-up or mobile van COVID-19 testing clinics, it is important to consult with the local infection prevention and control team and to consider a range of practices.
7.1 Introduction

The purpose of this chapter is to provide specific infection prevention and control (IPAC) guidance for non-acute healthcare settings such as community health centres, primary care services, community services and outpatient settings. Providers of care in these settings should continue to ensure there is minimal impact on patient/client care activities and models of care during the pandemic. The components of COVID-19 recognition and prevention must not impede routine care and necessary patient/client safety and quality programs.

This guidance is not intended for the NSW Ambulance Service as they have specific procedures and guidance available.

7.2 Community, primary care and outpatient services

Community, primary care and outpatient services provide a diverse range of programs and health promotion activities to local populations or communities. The COVID-19 pandemic has highlighted the importance of maintaining services with risk mitigation strategies to ensure the safety and well-being of HWs and patients/clients.

The following table summarises the IPAC preparation recommended for patient visits in a range of settings.
<table>
<thead>
<tr>
<th>ACTIVITY</th>
<th>RECOMMENDATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Telehealth</strong></td>
<td>• Consider if telehealth options may be employed to connect separate rooms within the same facility to ensure that appropriate physical distancing occurs. Guidance in relation to telehealth is available at ACI-Telehealth</td>
</tr>
<tr>
<td><strong>Screening</strong></td>
<td>• Screening of patients for symptoms prior to attendance as part of routine clinical assessment</td>
</tr>
<tr>
<td><strong>Waiting room signage (with language translations)</strong></td>
<td>• Post signs at entrances and in waiting areas about infection prevention actions such as hand hygiene, respiratory hygiene, physical distancing and reporting to reception if unwell • If the number of people who can sit in a waiting area has been defined, this should be displayed at the entrance</td>
</tr>
<tr>
<td><strong>Limiting the number of people/family members accompanying the patient/client</strong></td>
<td>• Define the number of people/family members allowed; this will be determined by the type of setting and the services provided • Consider alternatives such as using telehealth to communicate with family members while the patient/client attends the visit</td>
</tr>
<tr>
<td><strong>Physical distancing</strong></td>
<td>• Place chairs &gt;1.5 metres apart; consider if floor markings of physical distancing areas are required to prevent chairs being moved • Determine if there are other ways in which patients can be separated e.g., patients waiting in their motor vehicle until their appointment • If the healthcare setting is expecting babies/children in strollers, additional space will need to be allocated • Create or define separate areas for patients with ARI and well patients • Assess how clinic spaces are currently set up and if they can be rearranged to enable improved physical distancing • Assess if decluttering is required for improved physical distancing</td>
</tr>
<tr>
<td><strong>Hand hygiene</strong></td>
<td>• Provide accessible supplies of alcohol-based hand rub (ABHR) • Ensure bathroom signage is clear</td>
</tr>
<tr>
<td><strong>Respiratory etiquette/hygiene</strong></td>
<td>• Provide information, tissues, ABHR and access to a waste bin • Posters or information on a television channel may be beneficial</td>
</tr>
</tbody>
</table>
| **Personal protective equipment (PPE) stock levels** | - Assess and restock PPE levels on a regular schedule  
- The stock level will be determined by the services provided and risk of attendance of patients with COVID-19  
- Consider the level of contact required and the number of procedures performed for the number of patients who attend appointments |
| **Shared patient equipment** | - Assess what equipment is shared  
- Determine if any alternative single patient use or single use equipment is available  
- Review manufacturer instructions for cleaning equipment that is used on multiple patients  
- Ensure that there are adequate and accessible cleaning products available  
- Determine if equipment requires cleaning with detergent or a disinfectant, or both. The manufacturer instructions will provide this detail  
- Determine what requires a full clean or the surface that requires cleaning on high touch-point surfaces e.g., door handles, light switches, back of chairs/arms of chairs, telephones, keyboards  
- Check that detergent and disinfectant are compatible |
| **Environmental cleaning** | - Follow routine environmental cleaning standards within community health centres, primary care services, community services, and outpatient settings  
- Focus on high touch surfaces from patients/clients, HWs and accompanying people  
- Determine if any particular surfaces, rooms or equipment require more regular cleaning e.g., patient/client chairs, external surfaces of ABHR dispensers  
- Assess if surfaces, furniture and equipment can be cleaned easily e.g., avoid fabric chairs  
- Develop a plan for cleaning which should include terminal cleaning, type of chemical, scope of cleaning  
- For a COVID-19 clinic the cleaning plan should also include the frequency of cleaning |
| **Toys/books/magazines** | - Remove books, magazines and unnecessary pamphlets from waiting areas  
- Pamphlets required are to be kept to a minimum  
- Remove toys that cannot be cleaned |
| **Health promotion material** | - Clean holders regularly - the frequency will depend on how often the materials are accessed by patients/clients |
Pre-screening for routine and scheduled appointments

Prior to routine and scheduled face-to-face appointments, a risk assessment should be undertaken to identify any potential risk of COVID-19:

- Walk in visits are not encouraged during the pandemic as they are unable to be screened and assessed adequately
- Assessment screening responses should be documented in clinical notes.

There are several mechanisms to determine the patient/client’s risk of COVID-19 infection and other risks prior to a routine or scheduled appointment.

Vulnerable patients (at risk for COVID-19) should be identified and risks associated with specific COVID-19 vulnerability should be considered in the provision of primary, community or outpatient care. If the patient/client requests specific IPAC practices from healthcare or care providers, it should be considered in context of high community transmission of COVID-19 and patient/client vulnerability e.g., patient requests provider to wear a surgical mask. Information regarding COVID-19 and influenza vaccination should be documented in the patients’ health record.

The number of healthcare or care providers and contacts for vulnerable patients should be minimised as much as possible whilst maintaining the health and wellbeing of the patient/client. For example, reviewing the appropriateness of the number of students and HWs visiting per appointment and the duration of time spent with the patient/client within 1.5 metres.

The table below provides suggestions for COVID-19 patient screening and actions. Refer also to the NSW Ministry of Health webpage on outpatient clinics for further details.
### Table 9: COVID-19 Patient Screening to Determine Infection Prevention and Control Requirements

#### Before the Patient/Client Arrives

<table>
<thead>
<tr>
<th>Pre visit screening options</th>
<th>Screening questions or action required</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMS and/or telephone call to patient/client or carer prior to visit</td>
<td>• Reminder of appointment</td>
</tr>
<tr>
<td>Or Pre-visit phone call if pre-screening questions were answered more than 24 hours prior to visit due to a cancelled or rescheduled appointment</td>
<td>• Range of screening questions regarding COVID-19 (specific questions to be decided by the healthcare providers). The following examples are provided however, the LHD/SHN may determine the final screening questions. Screening questions may change over time due to risks identified by the outpatient department. Examples may include:</td>
</tr>
<tr>
<td></td>
<td>o Any symptoms for COVID-19</td>
</tr>
<tr>
<td></td>
<td>o Testing for COVID-19 undertaken recently</td>
</tr>
<tr>
<td></td>
<td>o Confirmed COVID-19 infection in the last 28 days</td>
</tr>
<tr>
<td></td>
<td>o Have you been identified as a close contact of a COVID-19 case in the past 14 days or household member currently undergoing testing for COVID-19</td>
</tr>
<tr>
<td></td>
<td>o COVID-19 vaccination status</td>
</tr>
<tr>
<td></td>
<td>o Check NSW Health COVID-19 screening at NSW healthcare facilities for any updates in screening requirements</td>
</tr>
<tr>
<td></td>
<td>• Provide a contact number if answers ‘yes’ to any at risk question</td>
</tr>
<tr>
<td></td>
<td>• Reminder that if they develop respiratory symptoms or fever to attend a COVID-19 testing clinic, call their GP for a telehealth assessment or contact the National Coronavirus Helpline on 1800 020 080</td>
</tr>
<tr>
<td>Cancellation or rescheduling appointment due to COVID-19</td>
<td>• If a patient/client states that they have previously been diagnosed with COVID-19, determine if they are still within their period of infectivity or meet the criteria for de-isolation for the purpose of their visit (see Appendix 2A: Deisolation criteria for COVID-19 within NSW healthcare facilities)</td>
</tr>
<tr>
<td></td>
<td>• If the patient/client cannot be de-isolated for their visit, determine if:</td>
</tr>
<tr>
<td></td>
<td>o Their appointment can be deferred without compromising their care</td>
</tr>
<tr>
<td></td>
<td>o A virtual (telehealth) appointment or home visit may be an option if their appointment cannot be safely rescheduled</td>
</tr>
</tbody>
</table>
### WHEN THE PATIENT/CLIENT ARRIVES

<table>
<thead>
<tr>
<th>On arrival</th>
<th>Re-screening question and actions required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reception area</strong></td>
<td>• Rescreen using suggested screening questions above</td>
</tr>
<tr>
<td>If patient/client has ARI symptoms, provide them with a surgical mask (if not wearing one) and ask them to wait in the pre-determined area (containment area)</td>
<td>• Ask the patient/client to perform hand hygiene</td>
</tr>
<tr>
<td></td>
<td>• Inform the patient/client where they are required to wait for the appointment</td>
</tr>
<tr>
<td></td>
<td>• Remind the patient/client of physical distancing requirements</td>
</tr>
<tr>
<td></td>
<td>• Physical distancing will also apply to the person accompanying the patient/client</td>
</tr>
<tr>
<td></td>
<td>• If possible, observe the waiting area for any person showing ARI symptoms</td>
</tr>
<tr>
<td></td>
<td><strong>OR</strong></td>
</tr>
<tr>
<td></td>
<td>• Provide their contact number to the home visiting team or GP if answers ‘yes’ to any at risk question to perform follow up screening</td>
</tr>
</tbody>
</table>

### DURING THE APPOINTMENT

<table>
<thead>
<tr>
<th>Risk screening and respiratory symptom assessment to be undertaken by the allocated person</th>
<th>• Risk screening and respiratory symptom assessment should be documented in the clinical notes; information is to be shared across the team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Ask the patient/client and accompanying person to perform hand hygiene prior to entering the room</td>
</tr>
<tr>
<td></td>
<td>• Action should be taken to mitigate respiratory symptom risk factors e.g., respiratory hygiene, use of a surgical mask</td>
</tr>
<tr>
<td></td>
<td>• Consider the need for interpreter services (telehealth where practicable or face-to-face)</td>
</tr>
<tr>
<td>General safety advice</td>
<td>• Limit the time spent with close face-to-face contact</td>
</tr>
<tr>
<td></td>
<td>• Stand to the side of the patient/client when able</td>
</tr>
<tr>
<td></td>
<td>• Do not shake hands</td>
</tr>
<tr>
<td></td>
<td>• Review what items are handled by the patient/client and passed to HW that require cleaning</td>
</tr>
<tr>
<td></td>
<td>• Provide a designated area for patients to place handbags etc. (i.e., not placed on beds, benches or chairs)</td>
</tr>
<tr>
<td></td>
<td>• Maintain physical distancing when able</td>
</tr>
<tr>
<td></td>
<td>• Always have a supply of PPE within easy reach for Standard Precautions</td>
</tr>
</tbody>
</table>
Patients without symptoms or risk factors for COVID-19

- No change to routine care, treatment or assessment. Use Standard Precautions and adhere to the current NSW Health risk level and LHDs local guideline. Physical distance of >1.5 metres when applicable.

Patient/client with suspected or confirmed COVID-19 or a contact for COVID-19 who requires an appointment

- For case definitions refer to CDNA National guidelines for public health units
- Consideration must be given to postponing an appointment or alternate model of care until the patient/client has met the criteria for de-isolation applicable to the specific healthcare setting (see Appendix 2A: Deisolation criteria for COVID-19 within NSW healthcare facilities)
- If postponing is not possible, Transmission-Based Precautions must be applied

Re-opening or scaling up outpatient services

During periods of increased community transmission of COVID-19, health facilities may cease or reduce their outpatient services. Re-opening or scaling up of outpatient services should align with usual routine operations and meet the requirements within the NSW Health Outpatient Services Framework GL2019_011. Additional IPAC and COVID-19 transmission risk strategies should be aligned with routine operations. Ensuring that the most appropriate provision of care remains paramount.

The scope of outpatient services includes:

- Procedures
- Medical consultation
- Mental health consultations
- Diagnostic services (for example fine needle or punch biopsies, venepuncture)
- Allied Health and/or clinical nurse specialist intervention.

Prior to re-opening and establishing outpatient services, overlaying IPAC principles is of paramount importance. The following IPAC risk elements should be considered in addition to all requirements detailed in this manual (also see table 10):

- Governance
- Current NSW Health risk escalation level
- Screening and early identification and management of symptoms
- Design and layout of venue/outpatient’s department to be able to implement IPAC strategies
- Entrance screening - consideration for use of QR codes as required
- Education and training of HWs that will include compliance monitoring
- Scheduling of patients, pretesting where recommended, risk assessment and managing based on status, contact and association with area of increased transmission
- Considerations for accommodating and managing carer and support persons
- HW meeting and breakrooms set up in compliance with IPAC recommendations
• Reviewing workflows and methods of care to safely accommodate procedures required in this environment so they are compliant with IPAC recommendations.

7.3 Advice for Breast Screen NSW services

The following advice is provided for the safe operation of breast screening services as NSW transitions from pandemic to endemic COVID-19.

The recommendations are based on known transmission risks for COVID-19 and, as for all IPAC precautions, an individual risk assessment is required.

These recommendations should be read in conjunction with relevant LHD guidelines.

Recommendations

1. Limit the number of people in clinics and maintain physical distancing measures
2. Undertake minimal contact check-in processes
3. On presentation, reception HW to ask all clients the COVID-19 pre-screening questions. Clients displaying any respiratory symptoms will be triaged by a clinical HW and rescheduled as appropriate
4. Triage the following clients to an alternative appointment:
   a) Clients with ARI
   b) Close contacts of known positive cases (until isolation period ends)
   c) Clients with COVID-19, who have not yet received clearance from their GP or the relevant Public Health Unit. For more information on deisolation criteria see Appendix 2A: Deisolation criteria for COVID-19 within NSW healthcare facilities
5. Implement increased cleaning of frequently touched surfaces
6. Provide hand hygiene products for HWs and clients
7. Radiographers to use Transmission-Based Precautions if indicated by risk assessment
8. Radiographers to undertake mammograms with minimal face to face contact by standing behind, or to the side of the client while positioning for the mammogram
9. Clean medical imaging equipment between clients as per usual practice.

7.4 Group community sessions and meetings

The purpose of this guidance is to enable LHD/SHNs to assess and manage risks associated with re-establishment of community group meetings/sessions in a COVID-19 safe environment.

Given the diversity of group community sessions/meetings, the risk assessment framework is principle-based to enable each individual specialty service to design their own COVID-19 safe environment.

The lines of communication in each setting and for each group will need to be very clear so that when risks are identified, they are escalated to the person with the appropriate level of knowledge and authority to respond and mitigate the risks.
Community sessions/meetings are held within various types of venues. These may include:

- Community health centres
- Schools
- Healthcare facilities
- Youth Centres
- Early Childhood Centres
- Parent groups in parks
- Cardiac/respiratory rehabilitation gyms
- NSW Health funded non-government organisations.

The type of venue will guide the extent of the risk assessment.

Guiding principles

- HWs need to remain vigilant in practicing IPAC principles including COVID-19 safe behaviours in health and outreach facilities
- Services should continue to use telehealth models where this is a viable option. The appropriateness of telehealth will depend on the patient/client cohort and the health service/modality being offered. It is acknowledged there are certain interventions that are unsuitable to conduct via telehealth
- HWs need to maintain COVID-19 safe behaviours and model how they want the community to act within the group sessions/meetings
- As far as possible, HWs should implement physical distancing in the workplace - refer to guidance in Chapter 2: Infection prevention and control strategies for COVID-19
- Services need to maintain physical distancing in waiting rooms/areas
- Floor markings in pre-determined areas should be used to encourage physical distancing of patients/clients/carers who may not understand or are unable to maintain physical distance. Household/family members do not need to practice physical distancing
- NSW Public Health have developed a communications pack containing suggested language for health professionals to use. Suggested phrases from the communication pack include: “we’d like to protect you,” “we really need to keep everyone safe” and “could you please give me the space to work”
- For information on COVID-19 safety for Early childhood education centres, see here.

Completing the risk assessment

Completion of the risk assessment should be conducted by HWs responsible for coordinating and/or running the community session/meeting. Progress of the actions and recommendations from the risk assessment is to be overseen by the senior manager responsible for the community session/meeting. The LHD/SHN should determine who is responsible for approving the re-establishment of community sessions/meetings following the risk assessment.

A communication process should also be established should a risk or an infection prevention
and control breach occur during the re-establishment of group meetings/sessions.

**TABLE 10: GUIDANCE ON COVID-19 INFECTION PREVENTION AND CONTROL RISK ASSESSMENT FOR GROUP COMMUNITY SESSIONS AND MEETINGS**

<table>
<thead>
<tr>
<th>Themes and questions to consider when completing a risk assessment</th>
<th>Links to information that may assist with the risk assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Governance</strong></td>
<td></td>
</tr>
<tr>
<td>Decisions on when to reopen group sessions:</td>
<td><em>Chapter 3: Response and Escalation Framework</em></td>
</tr>
<tr>
<td>• Review of community transmission within facility/LHD/SHN</td>
<td><em>NSW Health COVID-19 Risk Monitoring Dashboard</em></td>
</tr>
<tr>
<td>• Prioritisation categories for patients/clients to return to group sessions/meetings</td>
<td><em>COVID-19 weekly surveillance reports</em></td>
</tr>
<tr>
<td>• Consideration of telehealth versus face-to-face sessions/meetings or a combination of both has been conducted</td>
<td><em>Resumption of cardiac rehabilitation in NSW: Guiding principles</em></td>
</tr>
<tr>
<td>• Minimum number of patients/clients wishing to participate in the sessions/meetings is available</td>
<td><em>Restoration of rehabilitation services - advice for NSW health services</em></td>
</tr>
<tr>
<td>• Determination of staffing levels including availability of support HW to provide group sessions/meetings</td>
<td><em>What you can and can't do under the rules</em> if hiring a venue or session/meeting is not owned and operated by NSW Health</td>
</tr>
<tr>
<td>• Decision on minimum/maximum number of patients/clients to be in each session/meeting</td>
<td><em>NSW Health Care Coordination</em></td>
</tr>
<tr>
<td>• Risk assessment completed prior to decision to determine additional actions required</td>
<td><em>Safe Work Australia – COVID-19 Information for workplaces</em></td>
</tr>
<tr>
<td>• Ability to perform COVID-19 screening questions and symptom checks in available venues prior to the session/meeting</td>
<td><em>NSW Health Communities of Practice</em> for specific guidelines available for clinical specialty groups</td>
</tr>
<tr>
<td>• If hiring premises, the service will be required to adhere to their COVID-Safe plan</td>
<td></td>
</tr>
<tr>
<td>• Does travel to the facility and/or participation in the group pose an additional risk to the patient/client/carer</td>
<td></td>
</tr>
<tr>
<td>• Consideration given to hold/run groups outdoors if appropriate and weather/shade suitable</td>
<td></td>
</tr>
</tbody>
</table>

| Review of the methodology on how the group sessions/meetings are held to determine if the method is still relevant and suitable in a COVID-19 safe environment | *Food Standards COVID-19*                                    |
|                                                                                                                                  | *Australian Government - Social distancing guidance – sharing of food* |
| • If modifications are required                                                                                                  |                                                              |
| • The number of people for coordinating or conducting the group session/meeting                                                |                                                              |
| • Types of activities to be undertaken and any shared items used in the session/meeting                                         |                                                              |
### Themes and questions to consider when completing a risk assessment

| Areas available to conduct the sessions/meetings and any restrictions on use of facilities e.g., kitchen, showers |
| Decisions on provision of food and/or drinks and safety of communal areas |
| Medication management for clients/patients |

### Links to information that may assist with the risk assessment

- **Cleaning of the Healthcare Environment Policy**
- **Safe Work Australia**

### Review of commercial cleaning adequacy and scope of cleaning for return of group sessions/meetings

- When should cleaning be scheduled after a community session/meeting?
- Will the cleaning need to change e.g., cleaning areas used by the community group?

- **Coronavirus (COVID-19) Information about routine cleaning and disinfection in the community**

### Review physical space for patient/client personal belongings – each can be kept separate

- **NSW Health Posters**
- **Health worker safety**

### Review of equipment used for group sessions/meetings and their requirements for cleaning/disinfection

- Check if any equipment has manufacturer instructions for cleaning?
- Detergent is adequate for cleaning items/equipment. Check if disinfection required?
- What is the process for returning equipment and/or resources to place of storage – any cleaning or hygiene procedures required, for example if using trolley, wheeled back, fleet car?

- **NSW Health Posters**
- **Health worker safety**

### Will additional resources need to be considered/developed prior to group session/meeting?

- Posters on COVID-19 safe behaviours and/or practices available?
- Resources for patients/clients (electronic or paper based)?

- **Infection Control in childcare settings**
- **Respiratory Community of Practice**

### Review spatial capacity in the group session/meeting environment to enable physical distancing

- Consideration given to prams, wheelchairs, mobility aids?
- Number of family/household members who are required to be present?
- Interpreters/support workers required?
- Encourage patients and carers to limit personal belongings when attending group sessions/meetings?

- **Infection Control in childcare settings**
- **Respiratory Community of Practice**
### Themes and questions to consider when completing a risk assessment

<table>
<thead>
<tr>
<th>Training and information on safe work practices available for HWs and participants for infection prevention and control:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Physical distancing</td>
</tr>
<tr>
<td>- Hand hygiene</td>
</tr>
<tr>
<td>- Standard Precautions</td>
</tr>
<tr>
<td>- Cleaning of shared equipment</td>
</tr>
<tr>
<td>- Donning/doffing PPE (if required)</td>
</tr>
<tr>
<td><strong>Links to information that may assist with the risk assessment</strong></td>
</tr>
<tr>
<td>CEC Training Resources and Posters</td>
</tr>
</tbody>
</table>

### Preparation

<table>
<thead>
<tr>
<th>Communal areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Bathrooms adequately stocked for handwashing</td>
</tr>
<tr>
<td>- Baby change/feed areas (ability to clean change tables between babies)</td>
</tr>
<tr>
<td>- Reminders for handwashing (simple poster)</td>
</tr>
<tr>
<td>- Regular cleaning scheduled</td>
</tr>
<tr>
<td>- Kitchens stocked (if open)</td>
</tr>
<tr>
<td>- Limit or stop access to kitchens by patients/clients/visitors</td>
</tr>
<tr>
<td>- Change facilities for older children or adults who may require assistance with toileting</td>
</tr>
<tr>
<td><strong>Links to information that may assist with the risk assessment</strong></td>
</tr>
<tr>
<td>NSW Health Posters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Preparation for groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Physical distancing marking if required</td>
</tr>
<tr>
<td>- What will the flow of patients/clients be in relation to physical distancing</td>
</tr>
<tr>
<td><strong>Links to information that may assist with the risk assessment</strong></td>
</tr>
<tr>
<td>NSW Health Posters</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Staggering participant arrival/departure times</td>
</tr>
<tr>
<td>- Plan for changes to people who arrive/depart by various modes of transport – may arrive early or pick up late</td>
</tr>
<tr>
<td>- Could impact on numbers/schedules</td>
</tr>
<tr>
<td>- Parents with prams</td>
</tr>
<tr>
<td>- People with disabilities</td>
</tr>
<tr>
<td>- Vision/hearing impairment</td>
</tr>
<tr>
<td>- Vulnerable, frail or elderly</td>
</tr>
<tr>
<td>- Young children running around and/or children on the floor</td>
</tr>
<tr>
<td>- Need for carer/visitor attendance</td>
</tr>
<tr>
<td>- Cultural and linguistic needs, such as interpreters or resources in different languages</td>
</tr>
<tr>
<td><strong>Links to information that may assist with the risk assessment</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Themes and questions to consider when completing a risk assessment

<table>
<thead>
<tr>
<th>HW, patient/client and visitor screening</th>
<th>Links to information that may assist with the risk assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HWs are aware that they are not to attend work if they are unwell with respiratory symptoms</strong></td>
<td><strong>NSW Health COVID-19 screening at NSW healthcare facilities</strong></td>
</tr>
<tr>
<td><strong>Before attending</strong>&lt;br&gt;• Procedure for screening prior to attendance – documentation of results in eMR (or other)&lt;br&gt;• Consideration be given to people who may have been screened at the entry to a healthcare facility and may wear a screening sticker – do not require re-screening</td>
<td></td>
</tr>
<tr>
<td><strong>On attendance</strong>&lt;br&gt;Pre-screening program available for community members&lt;br&gt;• Screening questions&lt;br&gt;• Symptom checks&lt;br&gt;• Hand hygiene product available&lt;br&gt;• Record of visitors entering the facility (correct details)</td>
<td><strong>Advice to give to patients sent home/COVID-19 testing</strong></td>
</tr>
<tr>
<td><strong>Rapid management action plan for people who are febrile or answer ‘yes’ to a screening question</strong>&lt;br&gt;• Confidentiality maintained&lt;br&gt;• Rapid assessment in an area away from other community members&lt;br&gt;• PPE and hand hygiene product available for HWs&lt;br&gt;• Surgical mask and hand hygiene product available for community member&lt;br&gt;• Ability to maintain physical distance&lt;br&gt;• Referral for testing and requirements for self-isolation</td>
<td><strong>Advice to give patients sent home/COVID-19 testing</strong></td>
</tr>
<tr>
<td><strong>Patients/clients who are transported by the facility for group sessions/meetings</strong></td>
<td><strong>Refer to Chapter 2: Section 2.15 Transport</strong></td>
</tr>
<tr>
<td><strong>Decisions on:</strong>&lt;br&gt;• Screening and symptom check prior to entering vehicles – who will perform, escalation pathways&lt;br&gt;• Number of people in transport vehicle&lt;br&gt;• Hand hygiene prior to entry&lt;br&gt;• Mask requirements&lt;br&gt;• Personal items in transport vehicle&lt;br&gt;• Seating arrangements</td>
<td></td>
</tr>
<tr>
<td>Themes and questions to consider when completing a risk assessment</td>
<td>Links to information that may assist with the risk assessment</td>
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<td>---------------------------------------------------------------</td>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td><strong>On arrival</strong></td>
<td></td>
</tr>
<tr>
<td>What is the process and who is responsible for acting as a COVID-19 safe hygiene marshal</td>
<td>NSW COVID-19 Safe Hygiene Marshal</td>
</tr>
<tr>
<td>Community members are aware of the conditions for entering the community group session/meeting</td>
<td>NSW Health Posters</td>
</tr>
<tr>
<td>• Communicated during the booking appointment</td>
<td></td>
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<tr>
<td>• Reminders prior to attending session/meeting</td>
<td></td>
</tr>
<tr>
<td>• Displays in the community centres</td>
<td></td>
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<tr>
<td>• Reminders at reception during screening</td>
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<tr>
<td>Reminders during the session if required</td>
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</tbody>
</table>

| Strategies for managing groups/individuals that may congregate immediately outside the community centre such as drop off and pick up zones, entry ways, verandas |                                                          |

| **Completion of the session/meeting**                          |                                                          |
| • Cleaning of frequently touched surfaces                       | Refer to Chapter 2: Section 2.8 Environmental cleaning |
| • Routine cleaning of community centres, including those areas accessed by members of the community |                                                          |
| • Cleaning of equipment – frequency will change depending on when and how they are used |                                                          |
| • How will the session/meeting be evaluated to determine if COVID-19 safety rules were applied (HW and patients/clients) |                                                          |

| **External groups hiring or using the premises**                |                                                          |
| If external agencies use/hire health facilities after hours, they are required to develop their own COVID-19 Safety Plan for group sessions/meetings. Copy of COVID-19 Safety Plan available to health facility or community health centre. | Information on community centres and halls – COVID Safety Plans |

. 
## Template for risk assessment and action plan

<table>
<thead>
<tr>
<th>Risk element</th>
<th>Identified risk(s)</th>
<th>Risk level / risk category*</th>
<th>Risk mitigation actions</th>
<th>Responsibility (position)</th>
<th>Escalation required</th>
<th>Evidence link</th>
</tr>
</thead>
<tbody>
<tr>
<td>Governance</td>
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<tr>
<td>Preparation</td>
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<tr>
<td>HW, patient/client and visitor screening</td>
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<tr>
<td>Patients/clients who are transported by the facility for group sessions/meetings</td>
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<td>On arrival</td>
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<tr>
<td>Completion of the session/meeting</td>
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<tr>
<td>External groups hiring or using the premises</td>
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</tbody>
</table>

7.5 COVID-19 testing clinics

When establishing drive-through, pop-up or mobile van COVID-19 testing clinics, it is important to consult with the local infection prevention and control team and to consider a range of infection prevention and control practices as follows:

Physical set up of the COVID-19 testing clinic

- Location and workflow of the clinic
- Ventilation for enclosed pop-up clinics (established or temporary building or a pop-up tent)
- Set up that enables physical distancing of > 1.5 metres wherever possible
- Signage to direct and inform patients, control traffic and/or queues, limit speed etc.
- Separate areas for HWs to don and doff PPE safely
- Allocated PPE-free zone for a HW break area
- Separated and enclosed storage for both used and reprocessed items, i.e., shared patient equipment and PPE. All reusable equipment/items must be reprocessed as per their manufacturer’s instructions for use
- Waste collection areas
- Bathrooms for HWs.

Equipment/resources/consumables

Access to:

- ABHR at the point of care
- Equipment to enable specimen collection, security of specimens and access for pathology couriers to collect specimens
- PPE for Standard and Transmission-Based Precautions including uniforms (variations required for different weather conditions, operational hours, drive-through vs walk-in clinics)
- Products to enable routine and enhanced environmental cleaning
- Products to enable cleaning of shared patient care equipment (including chairs) after each use
- Patient information resources.

Staffing

- Allocation and delineation of various HW roles
- Orientation and education program for HWs in the pop-up clinic on infection prevention and control
- Ensure HWs have the training and resources to enable good practice in taking swabs
• Adequate security for HW safety
• HWs who can maintain a distance > 1.5 metres from patients, apply Standard Precautions and a surgical mask.

High visibility apparel

High-visibility (high-vis) apparel is protective equipment for highlighting the physical location of a person/object and may be required for the safety of HWs working in outdoor environments such as COVID-19 drive-through clinics where:

- There is movement of machinery (motor vehicles)
- The clinic is open during evening or night-time hours
- Protection from the weather may be required.

High-vis apparel is not:

- A hierarchy of control for infection prevention and control strategies
- Intended for Standard, Contact and Droplet Precautions
- Protecting HWs from exposure to transmissible infections, such as SARS-CoV-2.

The workflow should consider who performs the administrative role (e.g., traffic control) and clinical role to ensure appropriate utilisation of PPE. High-vis apparel should be allocated to HWs responsible for directing traffic and/or where their work location requires high visibility.

It is recommended that HWs collecting specimens or assessing patients within 1.5 metres do not wear high-vis apparel. This will avoid added risk for self and cross-contamination between patient interactions and during doffing.

Collecting specimens

When collecting respiratory specimen Transmission-Based Precautions should be observed whether or not respiratory symptoms are present. For most patients, the collection of respiratory specimens is a low-risk procedure and can be performed using Contact and Droplet Precautions. Based on risk assessment, Airborne Precautions with eye protection to be used (refer to Chapter 3: Response and escalation framework for further information).

- Prepare all respiratory specimen collection items, biohazard bag and pathology request form; labels or information should be on the collection tube prior to the procedure
- Complete all patient/client safety checks and consent
- Perform hand hygiene before donning an apron and surgical mask. Use eye protection as per Standard, Contact and Droplet or Airborne precautions; perform hand hygiene and put on gloves when ready to perform the procedure
- To collect a throat, deep nasal or nasopharyngeal swab stand slightly to the side of the patient/client to avoid exposure to respiratory secretions, should the patient/client cough or sneeze
- At completion of specimen collection, remove PPE (in the correct sequence) and perform hand hygiene between steps and immediately after removing all PPE
- If any item of PPE is touched with bare hands during removal, perform hand hygiene using ABHR or soap and water for at least 20 seconds if hands are visibly soiled
- Place tube into biohazard bag, with the pathology request form
- Wipe any contacted/contaminated surfaces with detergent/disinfectant
• The room surfaces (high touch surfaces) should be wiped clean with detergent/disinfectant wipes by a person wearing gloves and an apron (Standard Precautions).

For more information see:

• [Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units SARS-CoV-2 Laboratory testing information](#)
• [NSW Health COVID-19 testing clinics](#)

7.6 Telehealth

If patients/clients are unable to be managed through Telehealth Services, infection prevention and control home visit guidance is required for healthcare and care providers to enable the patient/client to be seen safely in the home; refer to *Chapter 8: Home Visits*. 
Chapter 8: Home visits

This chapter is part of the COVID-19 Infection Prevention and Control Manual, Clinical Excellence Commission, 2022.

The publication summarises current evidence about COVID-19 infection prevention and control strategies and interventions, and their implementation in healthcare settings. The publication will continue to evolve with additional chapters over time that address infection prevention and control in other settings. As new resources become available, they will be added as hyperlinks of the resources section in each chapter or to the appendices.

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Key points

- The impact of COVID-19 recognition and prevention must not impede routine and necessary patient/client models of care, safety and quality programs
- Providers of home care are to ensure that there is minimal impact on patient/client care activities
- Home care providers should maintain adequate supplies of appropriate personal protective equipment (PPE) if caring for a patient/client with suspected or confirmed COVID-19, and have supplies of cleaning materials and alcohol-based hand rub as part of their work health and safety obligations
- Early recognition of patients/clients who have suspected or confirmed COVID-19 is essential to maintaining the health and wellbeing of providers, carers, HWs and the community
- It is important that patients/clients who require a home visit are provided with basic infection prevention and control education
- COVID-19 risk assessment should be aligned with the recommendations in Chapter 3: Response and Escalation Framework

Acronyms and abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tr>
<td>ABHR</td>
<td>Alcohol-based hand rub</td>
</tr>
<tr>
<td>AGP</td>
<td>Aerosol-generating procedure</td>
</tr>
<tr>
<td>ARI</td>
<td>Acute respiratory infection</td>
</tr>
<tr>
<td>CDNA</td>
<td>Communicable Diseases Network of Australia</td>
</tr>
<tr>
<td>CEC</td>
<td>Clinical Excellence Commission</td>
</tr>
<tr>
<td>CPAP</td>
<td>Continuous positive airway pressure</td>
</tr>
<tr>
<td>HW</td>
<td>Health worker</td>
</tr>
<tr>
<td>LHD/SHN</td>
<td>Local health district / Special health network</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-government organisation</td>
</tr>
<tr>
<td>NSW</td>
<td>New South Wales</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal protective equipment</td>
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<tr>
<td>WHS</td>
<td>Work health and safety</td>
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</table>

8.1 Introduction

The purpose of this chapter is to provide specific infection prevention and control guidance to NSW Health and non-government organisations (NGOs) that deliver care, assessment,
treatment or support to patients/clients in their home. It is not intended for NSW Ambulance as they have specific procedures and guidance available.

Home visits from healthcare and NGO providers enable personalised and individualised care for patients/clients. Providers of home care will continue to ensure that there is minimal impact on patient/client care activities. The impact of COVID-19 recognition and prevention must not impede routine and necessary patient/client models of care, safety and quality programs.

It is expected that home care providers maintain adequate supplies of appropriate PPE, cleaning materials and alcohol-based hand rub (ABHR) to protect themselves if caring for a patient/client with suspected or confirmed COVID-19, as part of their work health and safety (WHS) obligations.

Please check the NSW Health, Department of Health Coronavirus for Home Care Providers and Clinical Excellence Commission websites for the most up to date COVID-19 information.

The Commonwealth Department of Health Guide for Healthcare or care providers remains the key document for providers for persons living at home.

Information for disability support providers webpage has several guidance documents and information for community-based services and home visiting to reduce the risk of COVID-19 for their residents.

For patients/clients and household members WITHOUT symptoms or risk factors for COVID-19, there is no change to care, treatment or assessment. Usual infection prevention and control principles and practices are to be followed as per the Infection Prevention and Control Practice Handbook. Use of Standard Precautions, PPE according to the risk escalation framework (see Chapter 3 of this manual) and physical distancing of >1.5 metres when applicable is recommended.

8.2 Key IPAC principles for home visit

Early recognition of patients/clients who have suspected or confirmed COVID-19 is essential to maintaining the health and wellbeing of providers, carers, HWs and the community. The following key elements are important factors:

1. **Triage** and risk assessment through a screening process prior to arrival at the home or premises should be conducted. COVID-19 risk assessment of patients/clients should be undertaken by providers of care in the home prior to each visit.

2. **Physical distancing** is to be practiced in order to limit transmission of COVID-19. Where practical, HWs and patients/clients are to remain >1.5 metres apart except for the provision of clinical examinations, direct care, assessments and procedures. This can be achieved with sequencing preparation and conversations with patients/clients between direct care.

3. **Respiratory hygiene and cough etiquette** to contain respiratory secretions are recommended for everyone and should be communicated to patients/clients:
   - Cover the mouth and nose with a tissue when coughing or sneezing
   - If no tissues are available, cough or sneeze into an elbow, if physically able to do so
   - Use the nearest waste bin to dispose of the tissue after use
   - Perform hand hygiene e.g., hand washing with soap and water for 20 seconds or...
use ABHR after coughing or sneezing or if contaminated objects, materials or equipment are touched

- Clean surfaces and equipment potentially contaminated by respiratory secretions.

4. **Standard Precautions** represent the minimum infection prevention measures that apply to all patient/client care, regardless of suspected or confirmed infection status of the patient/client, in any setting where healthcare and home care is delivered. These evidence-based practices are designed to both protect and prevent spread of infection among patients/clients, care providers and HWs.

Standard Precautions comprise of the following measures:

- Hand hygiene
- Respiratory hygiene (cough etiquette)
- PPE if in contact with blood or body fluids
- Aseptic technique for clinical procedures
- Prevention of needlestick/sharps injuries or blood and body fluid splashes
- Cleaning and disinfection of the healthcare/home environment and shared patient/client care equipment (see Appendix 8A: Cleaning in a patient or client’s home)
- Appropriate waste disposal.

5. **Transmission-Based Precautions** should be used when Standard Precautions alone are insufficient to interrupt the transmission of a microorganism (transmissible infection or communicable disease). Precautions are applied and based on the mode(s) of transmission.

- **Contact Precautions** protect HWs or care providers and prevent them transmitting COVID-19 from direct physical contact with the patient/client, or indirectly from shared patient/client care equipment or from environmental surfaces directly contaminated by the patient/client

- **Droplet Precautions** protect HW or care provider’s nose, mouth and eyes from droplets produced by the patient/client coughing and sneezing

- **Airborne Precautions** protect HW or care provider’s respiratory tract from much smaller droplets nuclei that become suspended in the air and may travel several metres. During aerosol-generating respiratory procedures (AGPs) droplets nuclei become aerosolised. A fitted P2/N95 respirator will prevent these aerosolised droplets nuclei from entering the respiratory tract of the wearer during AGPs.

- **Contact, Droplet and Airborne Precautions** (P2/N95 respirator) with eye protection (face shield or goggles) are required when providing direct care for:
  - patients with suspected or confirmed COVID-19
  - high-risk contact of a COVID-19 case.

6. **Challenging behaviours** include shouting or behaviours that result from agitation or difficulty following instructions. These behaviours in patients/clients can be particularly concerning during the first week of infection when viral load may be high, and risk of transmission is increased.

The Infection Control Expert Group (ICEG) has provided the following guidance:

Recommended minimum requirements for the use of masks or respirators by health and residential care HW in areas with significant community transmission of COVID-19.
The guidance outlines the minimum PPE that should be used when in contact with patients/clients who are suspected or confirmed COVID-19. It also articulates that in areas of increased community transmission, HWs and care providers may be required to wear a particulate filter respirator (P2/N95 respirator) when caring for patients/clients with cognitive impairment or challenging behaviours.

7. **Assess and monitor risk** through routine risk screening and monitoring for patients/clients and the HW or care provider at each point in the episode of care. The risk screening and risk management required for the patient/client is inclusive and required for others who will be present at the appointment and/or living in the home. Consideration should be given to patients/clients who may be poor historians and may not have capacity to answer COVID-19 screening or risk assessment questions accurately. If possible, alternative sources of reliable information to inform the risk assessment should be sought in this case.

8. **HW or care providers** must follow all requirements for assessing, monitoring and reporting their own health and risk factors associated with COVID-19 to ensure their own safety and the safety of those they provide care for.

HW, care providers, healthcare students and volunteers who are suspected or confirmed with COVID-19 should follow the NSW Health Self Isolation and Testing guidance. Before returning to work, HWs must follow the NSW Health Release from Isolation criteria and ensure that they check that any additional requirements of their employer are met.

9. **Vulnerable patients/clients** (at risk for COVID-19) should be identified and risks associated with specific COVID-19 vulnerability should be considered in the provision of home care e.g., HWs or care providers wearing a surgical mask during the home visit to protect more vulnerable patients/clients. If the patient/client requests specific infection prevention and control practices from HWs or care providers, the request should be considered in the context of high community transmission of COVID-19 and patient/client vulnerability. The number of care providers and contacts for vulnerable patients/clients should be minimised as much as possible whilst maintaining the health and wellbeing of patients/clients.

For example, in this vulnerable group:

- Different care providers from other home visit organisations should not have the same appointment time/date
- Check the appropriateness of the number of students visiting per appointment and the duration of time spent with the patient/client within 1.5 metres.

10. **Vulnerable HWs and care providers** should be individually risk assessed to determine their suitability for care of patients/clients with suspected or confirmed COVID-19.

- All HWs or care providers (including volunteers and non-clinical community support HWs) who may be required to provide care to patients/clients with suspected or confirmed COVID-19 must complete minimum level education and training in infection prevention and control related to COVID-19. This includes donning and doffing of PPE if required. Training videos are available on My Health Learning and on the Clinical Excellence Commission website

- Use evidence-based practice ensuring culturally safe work environments and health
services. See NSW Aboriginal Health Plan 2013-2023 and NSW Plan for Healthy Culturally and Linguistically Diverse Communities: 2019-2023

- Ensure requirement for annual influenza vaccination and vaccinations for adults, children and adolescents are met as outlined in resources below:
  - NSW Immunisation Schedule
  - The NSW Health Occupational Assessment, Screening and Vaccination Against Specified Infectious Diseases Policy for HWs
  - Commonwealth Department of Health Aged Care Provider Responsibility for Influenza Vaccination requirements

- Access to hand hygiene products when entering patient/client homes. Hand hygiene products should be accessible and available for consultation, assessment, care, clinical procedure, treatment or diagnostic procedure.

8.3 Education of patients/clients

It is important that patients/clients who require a home visit are provided basic infection prevention and control education. This should include:

- Hand hygiene
- How to store and handle any sterile medical consumables required for dressings and/or treatment
- Reporting of an ARI, gastrointestinal symptoms or rashes prior to a home visit by a HW or care provider
- What PPE the HW or care provider will be wearing and why it is required
- Up to date information on COVID-19 relevant to the patient/client.

Information on COVID-19 for patients/clients such as wearing a mask, self-isolation, hand hygiene, COVID-19 testing, physical distancing, protection from viruses, who to call, mental health and other topics can be found on the NSW Health webpage COVID-19 posters and print resources.

8.4 Scenarios associated with COVID-19 risk

The scenarios detailed below provide examples of situations associated with risk of COVID-19 exposure to HWs or care providers. For each scenario, guidance is provided on the appropriate implementation of Standard and Transmission-Based Precautions for patients/clients with suspected or confirmed COVID-19 or contacts of COVID-19.
<table>
<thead>
<tr>
<th>Scenario</th>
<th>Standard and Transmission-Based Precautions required</th>
</tr>
</thead>
</table>
| You are a HW doing home visits. On arrival at a patient’s home, the patient’s partner stops you at the front door and states that the patient has developed a fever in the last 2 hours and was complaining of loss of taste and smell yesterday. The patient lives in a suburb that is currently experiencing high levels of local transmission of COVID-19. You are wearing a surgical mask as NSW is currently in Amber Alert and in the past, the patient usually opens the front door when you arrive. | • You are wearing a surgical mask  
• Maintain physical distancing as you are not currently wearing protective eyewear or PPE for Contact, Droplet and Airborne Precautions  
• Let the partner know that you will phone them from the vehicle to discuss what is now required  
• Perform hand hygiene  
• Contact the patient’s partner to recommend immediate COVID-19 testing of the patient using a rapid antigen test or at the nearest drive through COVID-19 clinic. Encourage the partner to also have testing as they will be a high-risk contact if they live in the same household or interact closely  
• Check with the partner if the patient requires a medical assessment and their current status  
• Check with the patient that their visit can be rescheduled to allow time for the patient and partner to have COVID-19 testing  
• Notify your manager of the situation  
• If the patient is unable to have their visit rescheduled, don PPE for Contact, Droplet and Airborne Precautions outside the front door; put on gloves before contact with the patient or their environment  
• Ask the patient to wear a mask while the visit is in progress  
• Ask the partner and any other household members present to remain in another room with the door closed  
• When finished with the patient, remove gloves and perform hand hygiene  
• Remove remaining PPE in the correct sequence and perform appropriate hand hygiene just inside or outside the patients front door and place PPE into general waste  
• Advise patient’s partner to wear a mask when in contact with the patient until COVID-19 test results are available |
| You are requested to conduct COVID-19 swabbing at a client’s home as the client cannot visit a testing clinic and does not have access to a rapid antigen test. You are advised that the client was identified as a high-risk contact with a confirmed COVID-19 | • Before entering the client’s home, ask the client to ensure that any other household members present in the residence remain in a separate room with the door closed for the duration of your visit. This can be arranged by ringing ahead.  
• Organise swabbing equipment for the procedure  
• Perform hand hygiene  
• Don PPE for Contact, Droplet and Airborne Precautions outside the front door (apron/gown, P2/N95 respirator which has been fit checked and eye protection); put on gloves before contact with the patient or their environment. If an assistant is present, they should be using Airborne precautions including eye protection  
• Depending the LHD procedure perform the swab as per the Public Health Laboratory Network – COVID-19 swab collection: upper respiratory specimen |
Scenario

When finished with the patient, remove gloves and perform hand hygiene
- Remove remaining PPE in the correct sequence and performing appropriate hand hygiene just inside or outside the patient’s front door and place PPE into general waste
- Transport swab as per NSW Health Pathology requirements
- Ask the patient to follow Public Health advice on isolation and mask wearing for high-risk contacts

FAQs for Child and Family Health Network (CFHN)

**Question**: During a home visit for a newborn assessment, extended family members want to be present. Should they be present?

**Answer**:
1. Check current Public Health Orders if visitors are allowed in the home
2. Check if they can all maintain physical distancing from the nurse and are able to wear a mask. If unable to achieve this, extended family members should be asked to wait in another room of the house until the assessment has been completed and the nurse has left the residence
3. Both parents can remain during the assessment.

**Question**: A parent/carer has an exemption for wearing a mask and is attending a CFHN clinic. How do we manage them in a room with other parents/carers?

**Answer**:
1. This question should be included in appointment questions
2. Check if the parent/carer has been vaccinated
3. Schedule the visit at the beginning or end of the clinic times to reduce contact with other parents/carers
4. HWs to conduct the clinic visit in a room that enables physical distancing between themselves and the parent/carer(s). Both parents/carers can attend the visit
5. If the nurse is concerned, a face shield can be used with the surgical mask.

**Question**: Some nurses may do 4 home visits to newborn babies in a day, should they be concerned that they could cause transmission between them?

**Answer**: No. By following usual infection prevention and control standard precautions and current PPE requirements as per the risk escalation framework in Chapter 3, this will not be a risk.

**Question**: Are there any additional infection prevention and control measures required for day stay facilities where mothers and babies stay for the day for breast feeding or settling sleep problems?

**Answer**: No. By following usual infection prevention and control standard precautions and current PPE requirements as per the risk escalation framework in Chapter 3, this will not be a risk.
8.5 Screening prior to a home visit

There are several mechanisms to determine patient/client and household members risk of COVID-19 infection prior to a home visit appointment. Details are provided below.

**TABLE 12: SCREENING PRIOR TO A HOME VISIT AND INFORMATION REQUIRED REGARDING PATIENT/CLIENT/HOUSEHOLD MEMBERS**

<table>
<thead>
<tr>
<th>Communication</th>
<th>Actions required or proposed</th>
</tr>
</thead>
</table>
| SMS and/or telephone call to patient or carer prior to visit Or Pre-visit phone call if pre-screening questions were answered more than 24 hours prior to visit due to a cancelled or rescheduled appointment | Reminder of appointment date/time Range of screening questions regarding COVID-19 (specific questions to be decided by the healthcare providers). The questions may include:  
  - Any ARI symptoms  
  - Testing for COVID-19 undertaken recently or RAT if available  
  - In self-isolation e.g., awaiting COVID-19 test results or a high-risk contact of a confirmed case of COVID-19  
  - Household member currently undergoing testing for COVID-19  
  Provide their contact number if answers ‘yes’ to any at risk question to perform any follow up questions from home visiting team or GP  
  Reminder to the patient/client that if they develop respiratory symptoms or fever they should get tested and self-isolate  
  See NSW Health website regarding Self-isolation guideline. |
| Risk screening and assessment should be undertaken for the patient/client and any person that will be in the home | Risk screening and assessment to be undertaken by the allocated person  
  Risks that should be included: Screening questions above; cognitive or behavioural issues (patient/client and/or household member); need for interpreter services  
  Risk screening and assessment should be documented in the client or clinical notes. Information to be shared across the team  
  If a patient/client has ARI symptoms suggestive of COVID-19, they should be referred to a COVID clinic or emergency department (if unwell) for testing  
  Action should be taken to mitigate any risk factors identified during the assessment process. |
### Communication

<table>
<thead>
<tr>
<th>Patient/client has been provided an information card/sheet with designated contact details if COVID-19 infection risk e.g., onset of symptoms, household member with symptoms, confirmed COVID-19 test result, household member in self-isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient/client/carer or household member will contact the designated number (depending on the LHD). Consider alternative methods for conducting the home visit during prior to <a href="#">release from isolation</a>. Determine if any AGPs are likely to be performed during a home visit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Education of patient/client prior to visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide local information sheet on COVID-19 Reminder on preparation required prior to visit e.g., anyone present in the home using a nebuliser must have completed using the device a minimum of 30 minutes prior to home visit Suggest that a nebuliser is used in another room, on the verandah or other suitable outdoor area.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancellation or rescheduling appointment due to COVID-19 (patient/client/household member)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Determine if a home visit is required within the period of infectivity or self-isolation. Telehealth may be an option If a home visit is required, see below.</td>
</tr>
</tbody>
</table>

### 8.6 Preparation for a home visit

It is essential that each HW or care provider has the necessary infection prevention and control supplies and equipment to provide routine care, treatment and/or assessments. Any additional equipment or supplies for infection prevention and control required for managing a patient/client with suspected or confirmed COVID-19 should be available. The number and type of supplies will depend on the type of service provided and the number of patients/clients as detailed in Table 13.
**TABLE 13: PREPARATION FOR A HOME VISIT**

<table>
<thead>
<tr>
<th>Equipment</th>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Usual or routine supplies and equipment required for a home visit</td>
<td>Each HW or care provider to determine their usual or routine supplies and equipment needed for a home visit</td>
</tr>
</tbody>
</table>
| PPE for the infection prevention and control precautions required for the patient/client | Routine for Standard Precautions: gloves, surgical masks, eye protection, apron/gowns  
Additional for Transmission-Based Airborne Precautions: P2/N95 respirator  
Prepare an emergency backup PPE kit in a sealed plastic bag that includes one of each of the following items: surgical mask and P2/N95 mask, eye protection, apron or gown, gloves  
This should be included in the home visit bag if there is high community transmission |
| Hand hygiene products                                                      | ABHR and/or a hand wash solution and paper towels                                                                                             |
| Cleaning wipes for reusable equipment                                     | An approved detergent/disinfectant wipe for cleaning and disinfection of reusable equipment e.g., flat environmental surfaces in the home, spot cleaning in a motor vehicle, cleaning external surfaces of bags taken into the home visit |
| Waste disposal bags                                                        | Plastic bag to dispose of waste into the patient/client’s home waste bins  
NSW Health state that there are no additional controls required for disposing of waste related to COVID-19 in the home. Waste generated during a home visit should follow routine processes for disposal (placed into the general waste bin) |
| Thermometer (optional)                                                     | Depending on the local risk for screening of the patient/client  
Screening other household members is not required                                                                 |

**Household member with suspected or confirmed COVID-19**

Consideration must be given to postponing a home visit until the household member has either completed their period of quarantine/isolation or they are able to be released from isolation. If not, the household member is to be asked to remain in another room of the house for 30 minutes prior to the visit and for the duration of the home visit. This information is to be documented in the patient/client health record.

The following steps are to be considered by the HW when a household member is unable to comply with infection prevention and control precautions due to behavioural or cognitive issues:
• Pre-visit risk assessment should identify if the household member is able to remain in a different room during the home visit
• HW or care provider to use Contact, Droplet and Airborne Precautions PPE before entering the household
• Maintain physical distance of >1.5 metres
• Use distraction approaches for managing the household member e.g., asking them to watch TV or listen to music away from the patient/client
• Ask household member to wear a surgical mask and perform hand hygiene
• If the HW or care worker is unable to gain cooperation from the household member, they should leave the household and reschedule the appointment
• The non-cooperation should be immediately reported to the manager of the HW or care provider. An update on the patient/client condition at the time of the visit should be documented and/or escalated if required.

Patient/client with suspected or confirmed COVID-19 or a contact for COVID-19

If the patient/client lives with someone who has COVID-19 or is positive for COVID-19 then they must follow the NSW Health Self Isolation Guidelines and self-isolate for 7 days.

They must also follow the NSW Health Self-Isolation Guidelines for 7 days if they have been notified to do this by NSW Health.

Consideration must be given to postponing the home visit until the patient/client has either completed their period of isolation or they are able to be released from isolation.

If the home visit is to go ahead the recommendations in the following table will apply.

<table>
<thead>
<tr>
<th>Location or activity</th>
<th>Risk assessment guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>On arrival to house (while in the car)</td>
<td>Risk Assess</td>
</tr>
<tr>
<td>Prepare equipment, documentation and PPE as required for home visit</td>
<td>Risk assess when to put on PPE</td>
</tr>
<tr>
<td>Contact, Droplet and Airborne Precautions will be required</td>
<td>Consideration for privacy of patient/client and their COVID-19 status</td>
</tr>
<tr>
<td>Contact the patient/client and inform them of arrival</td>
<td>Gloves should not be put on until there is direct contact with the patient/client</td>
</tr>
<tr>
<td>Check if any new risks e.g., another member of the household with confirmed COVID-19, a support person or carer are to be present</td>
<td>Options include:</td>
</tr>
<tr>
<td>Check that pets and household members are not in the room</td>
<td>• P2/N95 respirator and protective eyewear put on before entering the house</td>
</tr>
<tr>
<td></td>
<td>• Gown/apron and gloves put on at entry (doorway) to the house</td>
</tr>
<tr>
<td>Location or activity</td>
<td>Risk assessment guidance</td>
</tr>
<tr>
<td>----------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Check if patient/client remains well enough for home visit</td>
<td>P2/N95, gown/apron and protective eyewear put on before entering the patient zone See sequence for putting on PPE in Chapter 4: Personal protective equipment</td>
</tr>
<tr>
<td>Communicate that PPE will be put on for the home visit</td>
<td></td>
</tr>
<tr>
<td>Remind patient/client they are required to wear a surgical mask. They must also perform hand hygiene before the HW or care provider enters the house</td>
<td></td>
</tr>
</tbody>
</table>

### On entry to house (doorway)

<table>
<thead>
<tr>
<th>Risk Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Observe patient/client for any deterioration in their condition</td>
</tr>
<tr>
<td>Explain to patient/client that the HW is required to wear the PPE while within 1.5 metres while performing an assessment or procedure (if PPE required put on prior to entry)</td>
</tr>
<tr>
<td>Ask patient/client to perform hand hygiene and use respiratory etiquette</td>
</tr>
<tr>
<td>Perform hand hygiene:</td>
</tr>
<tr>
<td>• After contact with respiratory secretions or surfaces touched by the person with symptoms e.g., doorknobs, light switches, counter tops, coffee tables, sinks</td>
</tr>
<tr>
<td>If patient condition has deteriorated, call an Ambulance (if required)</td>
</tr>
<tr>
<td>Check they have tissues, ABHR and a bin to dispose of tissues within easy reach</td>
</tr>
</tbody>
</table>

### During home visit

<table>
<thead>
<tr>
<th>Risk Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients/clients who require invasive and non-invasive ventilation or CPAP will pose a risk of transmission to the HW or care provider if they have suspected or confirmed COVID-19</td>
</tr>
<tr>
<td>Apply Contact, Droplet and Airborne Precautions</td>
</tr>
<tr>
<td>Home visit care, treatments or assessments to be completed in the 'usual' way but with the additional support of infection prevention and control precautions. Putting on and removing the PPE requires training and practice to enable it to be performed safely</td>
</tr>
<tr>
<td>All disposable items are considered general waste and can be disposed of in the patient/client’s home</td>
</tr>
<tr>
<td>When wearing PPE limit the spread of contamination by keeping hands away from face</td>
</tr>
<tr>
<td>When performing an AGP, PPE (except gloves) is to remain on until HW or care provider leave the house</td>
</tr>
<tr>
<td>Location or activity</td>
</tr>
<tr>
<td>----------------------</td>
</tr>
<tr>
<td>Hand hygiene must be performed, and gloves must be changed when performing different procedures on the patient e.g., shower and a dressing change</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>End of life care</th>
<th>Risk Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide support when end of life care is provided at home, where this is desired by the patient and is feasible Determine the intensity and frequency of care needed and the resources available Patients/clients not requiring a lot of hands-on care could be considered on a case-by-case basis</td>
<td>Assess the risk to determine if one HW member is adequate during end-of-life care Follow LHD specific guidelines where applicable The risk assessment should consider: - Family availability to provide care - COVID-19 risks to family members who are considered vulnerable - Ability of HW to provide the level of care in a home environment with the type of PPE required For confirmed or suspected cases refer to NSW Health <a href="#">Handling of Deceased Bodies with suspected and confirmed COVID-19 by hospital staff (non-coroners) - Communities of Practice</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cleaning in a patient/client home</th>
<th>Risk Assess</th>
</tr>
</thead>
<tbody>
<tr>
<td>If HW undertakes cleaning duties, they should refer to <em>Appendix 8A: Cleaning in a patient or client’s home</em> Equipment should also be cleaned when tasks are complete</td>
<td>If cleaning occurs more than 1.5 metres from client, disposable gloves and disposable apron to be worn For cleaning within 1.5 metres of clients, see PPE requirements for Contact, Droplet and Airborne Precautions</td>
</tr>
<tr>
<td>Location or activity</td>
<td>Risk assessment guidance</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Conducting self-care (e.g., showering of clients)</td>
<td>Risk Assess</td>
</tr>
</tbody>
</table>
| For these tasks Contact, Droplet and Airborne Precautions will be required | Supporting a client with self-care requires sustained close contact between the care worker and the client  
While showering, leave the bathroom door open, window open (if possible) and the exhaust fan on                                                                 |
| Cooking in a client's homes       | Risk Assess                                                                                                                                                                                                            |
| Usual food safety preparation practices apply:  
• Washing hands between handling raw and cooked food  
• Cooking and proper handling of meat products  
• Using different chopping boards for raw meat and cooked foods  
• Ensuring all meats are cooked thoroughly  
• When preparing food always practice good respiratory etiquette | Current information states that COVID-19 is not transmitted by food                                                                                                                                                    |
| Laundry Assistance                | Risk Assess                                                                                                                                                                                                            |
| If HW or care provider supports the individual with laundry, then they should not shake dirty laundry before washing. This minimises the possibility of dispersing virus through the air  
Wash items as appropriate, in accordance with the manufacturer instructions  
Dirty laundry that has been in contact with an ill person can be washed with other people's items  
The laundry can be taken to a public laundromat if required. The laundry should be taken in a plastic bag if soiled or damp  
Items heavily soiled with body fluids, for example vomit or diarrhoea, or items that cannot be washed in a washing machine, should be disposed of, with the owner's consent | Standard Precautions to be applied                                                                                                                                       |
<table>
<thead>
<tr>
<th>Location or activity</th>
<th>Risk assessment guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td>When providing multiple roles</td>
<td>Risk Assess</td>
</tr>
</tbody>
</table>
| When undertaking multiple roles in the patient/client home, perform patient care duties first | P2/N95 respirator and protective eyewear can be worn for the entire period of time of the home visit if continuing to return to the patient/client  
Apron or gown must be removed after direct patient/client contact  
Gloves must be removed and hand hygiene performed after direct patient/client contact |
| Loan Equipment                                            | Risk Assess                                                                                                                                                                                                              |
| Patients/clients who are provided care in the home may require loan/rental equipment | Equipment should have cleaning and/or disinfection instructions for use and before returning to the rental/loan company. Refer to the manufacturers’ instructions  
If no instructions are provided, all loan/rental equipment is to be cleaned with both a detergent and disinfectant. This should be checked/verified with a local infection prevention and control consultant |
| At the end of the home visit                              | Risk Assess                                                                                                                                                                                                              |
| Clean all external surfaces of the kit before placing in the motor vehicle  
Perform hand hygiene and restock kit as required | Any infection prevention and control risk(s) identified during the home visit are to be communicated within the team                                                                                                                                 |
| Home visits that provide 24-hour care                    | Risk Assess                                                                                                                                                                                                              |
| See ACI Information on COVID-19 for people with spinal cord injury - Frequently asked questions and Clinical practice guide for respiratory support in adults with COVID-19 | Use Contact, Droplet and Airborne Precautions for direct care, including for AGPs protection.                                                                                                                                  |

8.7 When to put on (don) and remove (doff) PPE

If a patient/client is considered a suspected or confirmed COVID-19 case, Transmission-Based Precautions are required. Decisions on where and when to don or doff PPE will be dependent on the home visit location, type of dwelling (caravan, apartment or house), area available to don and doff PPE and accessible entry to the dwelling. Table 15 may assist in HW decision making on donning and doffing PPE during a home visit.

NOTE: In humid and hotter days masks may need to be changed regularly if they become wet or moist.
### TABLE 15: DONNING AND DOFFING PPE FOR HOME VISITS

<table>
<thead>
<tr>
<th>PPE</th>
<th>Risk assessment guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Donning</strong></td>
<td><strong>Before entry into the dwelling</strong></td>
</tr>
<tr>
<td></td>
<td>• Is there adequate space to enable PPE to be donned?</td>
</tr>
<tr>
<td></td>
<td>• Is there any risk of contamination of PPE by pets or other animals?</td>
</tr>
<tr>
<td></td>
<td>• Is the space clean?</td>
</tr>
<tr>
<td></td>
<td>• Will donning PPE cause any negative issues for the patient/client with neighbours?</td>
</tr>
<tr>
<td></td>
<td>• Does the patient/client know that the HW or care provider will be wearing PPE prior to entering the dwelling?</td>
</tr>
<tr>
<td></td>
<td>• Does the patient/client have a risk of producing aerosols e.g., non-invasive ventilation, high flow oxygen or other AGP?</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> gloves are to be donned prior to contact with the patient/client. Hand hygiene to be performed prior to donning gloves</td>
</tr>
<tr>
<td><strong>On entry</strong></td>
<td>• Is there adequate space to enable PPE to be donned?</td>
</tr>
<tr>
<td></td>
<td>• Is there any risk of contamination of PPE by pets or other animals?</td>
</tr>
<tr>
<td></td>
<td>• Is the space clean?</td>
</tr>
<tr>
<td></td>
<td>• Will there be adequate physical distancing prior to donning PPE?</td>
</tr>
<tr>
<td></td>
<td>• Is direct contact with the patient/client (within 1.5 metres) required?</td>
</tr>
<tr>
<td></td>
<td>• Will the HW or care provider be in contact with possible COVID-19 aerosols due to patient/client having non-invasive ventilation or high flow oxygen (or other AGP)?</td>
</tr>
<tr>
<td><strong>Doffing</strong></td>
<td><strong>Before leaving the dwelling</strong></td>
</tr>
<tr>
<td></td>
<td>• Is there adequate space to doff PPE safely?</td>
</tr>
<tr>
<td></td>
<td>• Is the space clean?</td>
</tr>
<tr>
<td></td>
<td>• Will there be adequate physical distancing after doffing PPE?</td>
</tr>
<tr>
<td></td>
<td>• Will the HW or care provider be in contact with possible COVID-19 aerosols due to patient/client having non-invasive ventilation or high flow oxygen (or other AGP)?</td>
</tr>
<tr>
<td></td>
<td>• Is there a waste bin/bag available for the disposal of PPE?</td>
</tr>
<tr>
<td><strong>Outside the dwelling</strong></td>
<td>• Is there adequate space to doff PPE safely?</td>
</tr>
<tr>
<td></td>
<td>• Is the space clean?</td>
</tr>
<tr>
<td></td>
<td>• Will doffing PPE cause any negative issues for the patient/client with neighbours?</td>
</tr>
</tbody>
</table>
8.8 Aerosol-generating procedures

Respiratory AGPs refer to Appendix 4C: Aerosol-generating procedures, for a more details refer to Clinical practice guide for respiratory support in adults with COVID-19 and Appendix 8B: Cardiopulmonary resuscitation.

AGPs are generally hospital related procedures but for the purpose of infection prevention and control it is important to understand the risk and identification of an AGP and particular care should be taken during such procedures.

The use of nebulisers should be avoided during a home visit and alternative means of delivering medication used (such as a spacer) as they produce aerosols. The patient/client is to be informed that they should finish using a nebuliser at least 30 minutes prior to a home visit if they have suspected or confirmed COVID-19.

Collection of respiratory specimens are not generally regarded as aerosol-generating, although Contact, Droplet and Airborne Precautions should be considered for symptomatic patients/clients with COVID-19.

8.9 Disability information

There are many resources available for people with disability and their carers or supporters. Table 16 includes links to resources, email contact if PPE is not available and Disability Gateway.

TABLE 16: COVID-19 RESOURCES FOR PEOPLE WITH A DISABILITY AND THEIR CARERS OR SUPPORTERS

<table>
<thead>
<tr>
<th>Information</th>
<th>Link or email</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers unable to obtain sufficient PPE from existing supply sources</td>
<td>Email: <a href="mailto:MOH-NDIS@health.nsw.gov.au">MOH-NDIS@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>• Transitioned to ‘Disability Gateway’</td>
<td></td>
</tr>
<tr>
<td>• Resources for COVID-19 – easy read, AUSLAN</td>
<td></td>
</tr>
<tr>
<td>Information</td>
<td>Link or email</td>
</tr>
<tr>
<td>---------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>

Further information is provided in Appendix 8C: Further information relevant to home visits.
### Appendix 8A: Cleaning in a patient or client’s home

The following guidance is provided for providers who have responsibility for cleaning in a patient or client home.

<table>
<thead>
<tr>
<th>Process / surface</th>
<th>Summary of steps for cleaning in a patient/client’s home</th>
</tr>
</thead>
</table>
| **Clean**         | Clean hard surfaces with a multipurpose spray, detergent wipe or soap and water  
|                   | Wear gloves to clean (clean hands before putting on and after removing them)  
|                   | Use disposable cloths or change cloths after cleaning a room/area  
|                   | Bathrooms and toilets require separate cloths  
|                   | Use firm cleaning strokes in an ‘S’ pattern (top to bottom) and clean in sections. ‘Cleaner’ areas should be cleaned before ‘dirtier’ areas  
|                   | Focus on high touch points such as doorknobs, light switches, countertops, handles, chairs, keyboards, desks, phones, bathrooms, sinks, writing materials (if shared)  
|                   | Remove gloves when the cleaning is completed and perform hand hygiene |
| **Disinfect**     | After cleaning, use a disinfectant wipe or spray if required (e.g., patient frequently touches the surface, equipment or device – high touch surfaces)  
|                   | Some manufacturers have a disinfectant/detergent disposable cloth which are suitable for cleaning  
|                   | Diluted household bleach solution may be suitable (follow instructions on bottle)  
|                   | Don’t mix a detergent and disinfectant together in a bucket or container as they do not mix  
|                   | Let the disinfectant dry as it requires a certain amount of contact time to disinfect the surface (check manufacturer instructions for use)  
|                   | Wear gloves to disinfect (clean hands before putting on and after removing them)  
|                   | Remove gloves when the disinfection is completed |
| **Soft surfaces** | These include carpeted floor, rugs, curtains, blinds  
|                   | Vacuum daily  
|                   | Spot clean as required with a suitable cleaning agent  
<p>|                   | Wear gloves to clean (clean hands before putting on and after removing gloves) |</p>
<table>
<thead>
<tr>
<th>Process / surface</th>
<th>Summary of steps for cleaning in a patient/client’s home</th>
</tr>
</thead>
</table>
| **Electronics**  | Items such as phones, touch screens, keyboards, remote controls, tablets  
Consider having a wipeable cover  
Check manufacturer instructions for cleaning and types of cleaning chemicals that are able to be used  
Check that cloths are compatible with the electronic device |
| **Mechanical equipment** | Ensure patient/client does not have any sensitivities or allergies to chemicals  
If patient/client is suspected or confirmed to have COVID-19, cleaning of the medical/mechanical equipment should occur frequently and at least daily  
Patients/clients should have a regular cleaning schedule for their medical/mechanical equipment regardless of COVID-19 |
| **Biomedical equipment** | Equipment should be cleaned according to the manufacturer’s instructions |

Further information:

- [Principles of environmental cleaning: product selection](#)  
- [Disinfectants for use against COVID-19 in the ARTG for legal supply in Australia](#)
Appendix 8B: Cardiopulmonary resuscitation

First responders (HWs performing the home visit) can take the following action(s):

- If they have a mobile phone dial the emergency number for an ambulance, activating the speaker or hands-free option
- Can commence chest compressions, using Contact, Droplet and Airborne Precautions while awaiting the arrival of NSW Ambulance to undertake airway manoeuvres
- Rescue breaths are not recommended for adults. Airway management - the choice of technique will be dependent on the practitioner experience, the type of equipment available and the circumstances of the resuscitation
- Consider providing rescue breaths to infants and children in addition to chest compressions.
### STANDARD RESUSCITATION GUIDELINES

**D**
- **Dangers?**

**R**
- **Responsive?**

**S**
- **Send for help**
  - Call 000

**A**
- **Open Airway**

**B**
- **Normal Breathing?**

**C**
- **Start CPR**
  - 30 compressions : 2 breaths

**D**
- **Attach Defibrillator (AED)**
  - as soon as available, follow prompts

- **Continue CPR until responsiveness or normal breathing returns**

- **Wash hands thoroughly and clean equipment after use**

### COVID-19 CONSIDERATIONS

- Early CPR commencement is associated with better survival
- The risk of acquiring COVID-19 is lowered if the rescuer is fully vaccinated and wears a mask

- Give rescue breaths (if rescuer is willing and able)
- Rescue breaths are associated with better survival in certain populations, including:
  - all children
  - an adult drowning
- Use a **bag valve mask** if available and rescuer is trained in its use

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**Reference:**

1. COVID-19 infection risk to rescuers from patients in cardiac arrest
2. Caring for people with COVID-19
3. Preparedness for cardiopulmonary resuscitation during the COVID-19 pandemic
   (current until 30 September 2021)
Appendix 8C: Further information relevant to home visits

- For national updates – Department of Health and Ageing
- CDNA National Guidelines for Public Health - Coronavirus Disease 2019
- Coronavirus (COVID-19) guidelines for outbreaks in residential aged care
- NDIS Quality and Safeguards Commission: NDIS Commission coronavirus (COVID-19) information
- Disability Services Australia: Coronavirus (COVID-19)
- NSW Health COVID-19 (Coronavirus) - Guidance for community-based and outpatient health services
- Community Motor Vehicle: Community-based and outpatient health services
- NSW Health Communities of Practice