



Government of **Western Australia**
Department of **Health**

Coronavirus Disease - 2019 (COVID-19)

Infection Prevention and Control in Western Australian Healthcare Facilities

Version 14

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Document Purpose

This document has been developed by the COVID-19 infection prevention and control team within the Department of Health using the best available evidence and resources and is believed to be accurate at the time of publication. Information in this document is subject to change and it is essential that users of this document ensure they are accessing the most up to date online publication. These Guidelines are dynamic and will continue to evolve as the COVID-19 pandemic unfolds. Healthcare facilities are to remain flexible in their approach and be prepared to adapt based on the latest information available as directed.

Version Control

This Guideline should be considered a 'live document' and will be reviewed and updated regularly in response to:

- New legislation or statutory directions
- Changes in advice based on emerging evidence or national guidelines
- Learnings from outbreak management locally, in other jurisdictions and internationally
- Stakeholder engagement and feedback.

Review and update of this Plan is coordinated by the Infection Prevention and Control team in response to the SARS-CoV-2 pandemic, which can be contacted with feedback at PHEOC.IPC@health.wa.gov.au.

Version	Date	Author	Updates / Changes
V 14	13/05/2022	SHICC IPC	Addition of advice for prescription protective eyewear, management of deceased personal effects, revision of contact tracing, removed reference to epidemiological risk, prolonged episodes of care, revised HCW management section and discharge process. Probable and confirmed cases considered COVID-19 positive case. Reordered and links updated. Highlighted sections in the document refer to new content from previous version.

For full revision history please refer to [Version Control](#) at the end of this document.

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Definitions/ Abbreviations

Aerosols: are microscopic particles < 5 microns in size that are the residue of evaporated droplets and are produced when a person coughs, sneezes, shouts, or sings. These particles can remain suspended in the air for prolonged periods of time and can be carried on normal air currents in a room or beyond, to adjacent spaces or areas.

Aerosol Generating Procedures (AGPs): are those procedures that promote the generation of fine airborne particles (aerosols) that may result in the risk of airborne transmission of disease. Refer [Appendix 3](#) for more detailed descriptors.

Aerosol Generating Behaviour (AGB): are behaviours that are likely to generate higher volumes of respiratory secretions and thus increase the risk of transmission via aerosols. Examples include persistent and/or severe coughing, screaming and shouting, women in active labour who exhibit heavy breathing and panting.

Asymptomatic: a person infected but not showing any signs of disease. Refer to [Coronavirus Disease 2019 \(COVID-19\) Communicable Diseases Network Australia \(CDNA\) national guidelines for public health units](#).

Airborne precautions: a set of infection prevention practices used for patients known or suspected to be infected with pathogens transmitted person-to-person by the airborne route via particles in the respirable size range that remain infective over time and distance. Airborne precautions require the use of a particulate filter respirator (PFR), protective eyewear and other PPE as required as per standard precautions. The patient is accommodated in a negative pressure isolation room (NPIR) when possible.

Close contact: applies to a person as defined in the [COVID TRANSITION Testing and Isolation Direction no. 13](#) paragraph 29.

Cohorting: cohorting refers to the grouping of individuals with the same condition and or same laboratory confirmed organisms in the same location e.g. room, ward section, ward or building).

Communicable Diseases Network Australia (CDNA): the organisation that provides national public health advice for the prevention and control of communicable diseases. The CDNA has published a Series of National Guidelines (SoNGs) to provide nationally consistent advice including [Coronavirus Disease 2019 \(COVID-19\) CDNA national guidelines for public health units](#).

Confirmed case of COVID-19: [CDNA case definitions](#) need to be accessed to ensure current criteria are referenced. Requires laboratory definitive evidence. For the purpose of this document a confirmed case is considered a positive case.

Contact Precautions: a set of infection prevention practices used to prevent transmission of infectious agents that are spread by direct or indirect contact with the patient or the patient's environment which cannot be contained by standard precautions alone. Contact precautions include the use of gloves with an apron or fluid resistant gown (dependant on the degree of risk of contact with blood and body fluids) and other PPE as required as per standard precautions.

Coronavirus disease 2019 (COVID-19): the name of the disease caused by the virus SARS-CoV-2, as agreed by the World Health Organization, the World Organization for Animal Health and the Food and Agriculture Organization of the United Nations.

COVID-19 positive: applies to confirmed (PCR positive) and probable (RAT positive) as per [CDNA case definitions](#) and is not a recent case. Refer to [COVID TRANSITION Testing and Isolation Direction no. 13](#).

Direction: includes a direction under the Emergency Management Act 2005 or the Public Health Act 2016, whether the direction is given orally or in writing, in response to the declared WA State of Emergency and Public Health State of Emergency in respect of COVID-19 to help protect the WA community.

Droplet precautions: a set of infection prevention practices used for patients known or suspected to be infected with agents transmitted by respiratory droplets i.e. large particle droplets > 5 microns. Transmission via large droplets requires close contact as the droplets do not remain suspended in the air and generally only travel short distances. Droplet precautions include the use of a surgical mask and protective eyewear and other PPE as required for standard precautions.

Fit check: A fit check is the minimum requirement at the point of use for staff using particulate filter respirators (PFRs). No clinical activity shall be undertaken until a satisfactory fit check has been achieved. It involves a check each time a PFR is put on to ensure it is properly applied, that a good seal is achieved over the bridge of the nose and mouth and there are no gaps between the face and respirator.

Fit test: A quantitative fit test is a validated method to determine whether the type of respirator being worn provides an adequate seal with a person's face. The testing is done while a person is wearing a PFR attached to a testing unit while performing several physical movements and talking exercises.

Healthcare Facilities (HCFs): for this document, HCFs refers to all public hospitals in WA. The guidance provided in this document can be adopted by private hospitals, and the same principles, where applicable, applied in residential and primary care settings.

Healthcare Workers (HCWs): any person whose activities involve the provision of care either direct or indirect to patients in a healthcare or laboratory setting and includes those who are employed, honorary, contracted, on student placement or volunteering at the facility. The term is generally applied to all persons working in a HCF.

Historical case of COVID-19: [CDNA case definitions](#) need to be accessed to ensure current criteria are referenced.

Isolation: separates people with symptoms of a contagious disease from people who are not sick – see quarantine.

Negative Pressure Isolation Room (NPIR): a room in which the air pressure differential between the room and the adjacent indoor airspace directs the air flowing into the room i.e. room air is prevented from leaking out of the room and into adjacent areas such as the corridor. Refer to the [Australasian Health Facility Guidelines - Part D](#)

Powered Air Purifying Respirators (PAPR): are an alternative to P2 or N95 respirators for the care of patients requiring airborne precautions and should only be used by those trained and who are considered competent in their use.

Particulate Filter Respirators (PFR): respirators that filter at least 94 percent of 0.3-micron particles from the air. PFRs are used when implementing airborne precautions. Both P2 and N95 respirators are appropriate for use with airborne precautions.

People under a quarantine Direction: this includes international and interstate arrivals who are unvaccinated for SARS-CoV-2 and those people identified as close contacts who will be directed to quarantine for a prescribed period.

Probable case of COVID-19: a probable case includes individuals who have laboratory suggestive evidence with detection of SARS-CoV-2 by rapid antigen testing (RAT). [CDNA case definitions](#) need to be accessed to ensure current criteria are referenced. For the purpose of this document a probable case is considered a positive case.

Quarantine: separates and restricts the movement of people who have or may have been exposed to a contagious disease to see if they become sick. These people may have been exposed to a disease and do not know it, or they may have the disease but do not show symptoms.

Rapid Antigen test (RAT): a test that can be used at the point-of-care by health professionals or for self-testing by a person at home to detect the presence of viral proteins produced by SARS-CoV-2. The sensitivity of RATs is inherently lower i.e. less likely to detect the virus in a person with COVID-19 than PCR for detecting SARS-CoV-2.

Recent case: a person previously COVID-19 positive who has completed their isolation period and no more than 12 weeks have passed since completion of isolation.

Reinfection: a subsequent confirmed SARS-CoV-2 infection in a person with a prior history of confirmed or probable COVID-19 that is determined to be a separate episode to the first based on epidemiological and/or laboratory findings. SARS-CoV-2 RNA detection must be greater than 12 weeks after release from isolation from the first infection to be considered reinfection

Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2): The formal name of the coronavirus that causes COVID-19, as described by the [International Committee on Taxonomy of Viruses](#).

Standard precautions: Standard precautions are the work practices required to achieve a basic level of infection prevention and control for all patients at all times, regardless of their perceived infectious status. The use of standard precautions is to minimise, and where possible, eliminate the risk of disease transmission. Standard precautions include hand hygiene, respiratory hygiene, reprocessing of reusable medical devices, aseptic techniques, the use of PPE, sharps/waste and linen disposal and environmental cleaning.

Symptomatic: People who have at least one COVID-19 like symptom. To apply to a person who has symptoms (as defined in the [COVID TRANSITION Testing and Isolation Direction no. 13](#)) who is not a close contact, recent case or a diagnosed person.

Transmission Based Precautions: Extra work practices in situations where standard precautions alone may be insufficient to prevent infection e.g. for patients known or suspected to be infected or colonised with infectious agents that may not be contained with standard precautions alone. The three categories of transmission-based precautions are **contact**, **droplet** and **airborne** precautions, these are implemented based on the route of transmission of the infectious agent.

Variants of concern: SARS-CoV-2 variants continue to emerge throughout the pandemic. Some variants are classified as 'variants of concern' (VOC), as there is evidence for epidemiological, biological, or immunological features of concern. Some SARS-CoV-2 VOC may be associated with increased transmissibility or higher mortality compared with other lineages.

1. Introduction

Coronaviruses are a large group of viruses that can cause illnesses ranging from a mild common cold to severe disease such as Severe Acute Respiratory Syndrome (SARS). The novel coronavirus disease (COVID-19) was identified in December 2019 and is caused by the SARS coronavirus 2 (SARS CoV-2).

It is critical that healthcare workers (HCWs) use appropriate infection prevention and control (IPC) precautions from point of entry to the healthcare setting when caring for patients with novel respiratory viruses to minimise the possibility of transmission between patients, visitors, HCWs and environmental surfaces.

The Coronavirus Disease-2019 (COVID-19) Infection Prevention and Control in Western Australian Healthcare Facilities Guideline (the *Guidelines*) are based on the current available evidence, the status of COVID-19 in Australia, current knowledge of the transmission of coronaviruses and may change as more evidence becomes available. The *Guidelines* provide detail on IPC measures to minimise the transmission of SARS-CoV-2 and the management of COVID-19 positive patients, symptomatic cases awaiting test results and those under a quarantine Direction (i.e. close contacts).

The *Guidelines* are based on the incidence of COVID-19 in Western Australia (WA) and the recommendations vary depending on the burden of infection in the health system. The WA Health COVID-19 Framework for System Alert and Response describes the distinct levels of risk (alert levels) and the associated responses.

2. Transmission of SARS-CoV-2

Respiratory droplets are generated when an infected person coughs, sneezes, sings or shouts. Transmission of respiratory viruses occurs when large respiratory droplets (>5 microns) carrying infectious pathogens are expelled from the respiratory tract of the infectious individual and land on susceptible mucosal surfaces of the recipient. Studies have shown that the nasal mucosa, conjunctivae, and less frequently the mouth, are susceptible portals of entry for respiratory viruses.

SARS-CoV-2 can be transmitted through respiratory droplets, smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces (fomite transmission). Live SARS-CoV-2 virus can survive on surfaces for several hours to a few days depending on the surface type and environmental conditions, however, the virus is rapidly inactivated by alcohol, household bleach and other chemicals.

There is some evidence that COVID-19 infection may lead to intestinal infection and SARS-CoV-2 can be present in the faeces of infected persons. However, to date, there is no evidence of faecal-oral transmission.

Aerosol Transmission

There is a gradient from large droplets to smaller aerosols, which may contribute to transmission of SARS-CoV-2 in certain situations. These include during aerosol generating procedures (AGP) as listed in [Appendix 3](#) and aerosol generating behaviours (AGBs), such as singing and shouting and in certain environmental conditions. These behaviours and conditions can increase the force and range of spread of both large and small particles. In an indoor environment with reduced air exchange rate, smaller particles that are normally rapidly dispersed may remain suspended or be recirculated for longer periods. The particles may be moved around by natural airflow, fans or air conditioners. In these situations, airflow may play a role in transmission.

3. Infection Prevention and Control general principles

The *Guidelines* reflect advice provided in the Australian Government Department of Health [Guidance on the use of personal protective equipment in hospitals during the COVID-19 outbreak](#), [Coronavirus Disease 2019 \(COVID-19\) CDNA National Guidelines for Public Health Units](#) (the SoNG) and should be used in combination with the WA Mandatory Policy 0133/20 [Identification and Use of Personal Protective Equipment in the Clinical Setting During the Coronavirus \(COVID-19\) Pandemic Policy](#) that reflects local WA requirements for personal protective equipment (PPE).

The two tiers of precautions to prevent the transmission of infectious agents are standard and transmission-based precautions. Detailed information on standard and transmission-based precautions can be found in the [NHMRC Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#).

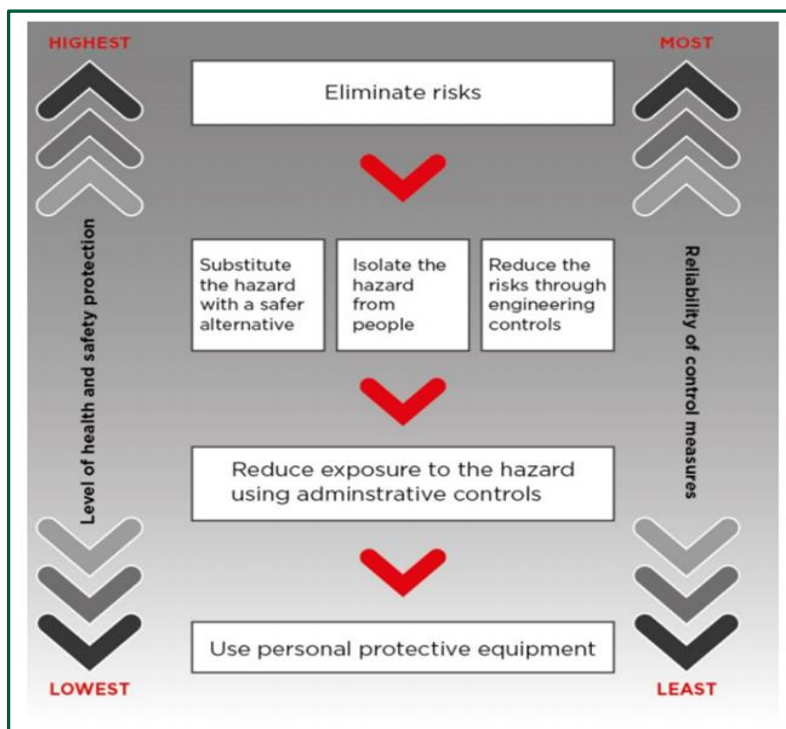
4. Safe working principles

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

The [Work Health and Safety Act 2020](#) provides a framework to protect the health, safety and welfare of workers in WA workplaces, and of other people who might be affected by the work. 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. The [hierarchy of controls](#) (Figure 1) may be used to achieve practical and effective controls of workplace hazard by undertaking a system based risk assessment. The hierarchy lists different risk avoidance or mitigation strategies in decreasing order of reliability. Multiple control strategies should be used until the hazard is eliminated or effectively minimized. There are several hazard control measures, including elimination, substitution, administrative and engineering controls followed using PPE. These strategies have been shown to be more effective in risk mitigation than the reliance on the use of PPE alone, which has the least reliability of control. Refer Figure 1 and Table 1.

Figure 1 Hierarchy of control



Source: Safe Work Australia, [How to manage work health and safety risks Code of Practice May 2018](#)

4.1 Examples of hierarchy of control measures

Hierarchy of control measure	Examples of measures
Elimination – reduce the opportunities for the virus to spread	<ul style="list-style-type: none"> • Vaccination • Staff exclusion from workplace if unwell • Screening for symptomatic persons • Reduce number of HCWs who enter isolation rooms.
Substitution – find alternative ways of providing care that reduces the potential for transmission	<ul style="list-style-type: none"> • Physical distance • Working from home • Telehealth • COVID care at home services • Symptomatic streaming at point of entry to HCFs.
Engineering controls – use physical barriers and other forms of hazard reduction	<ul style="list-style-type: none"> • HVAC assessments and improved air changes • Negative Pressure Isolation Room • Single rooms with ensuite • Air purifiers.
Administrative controls – effective and consistent implementation of policies and procedures	<ul style="list-style-type: none"> • Mandatory vaccination and HCW restrictions • Hand hygiene compliance • Cleaning and disinfection • Signs, posters, information sheets
PPE – use of correct personal protective equipment	<ul style="list-style-type: none"> • Surgical masks for all visitors, patients and staff entering a HCF • Appropriate PPE • Fit test those wearing PFR.

5. Infection Prevention and Control for COVID-19

KEY PRACTICE POINT 1: COMMUNITY MASK DIRECTION

When the Chief Health Officer implements a *Direction* for mandatory mask use for the WA public, all HCFs need to ensure this is implemented within their HCF. This requires all persons entering a HCF to don a surgical face mask and wear, with appropriate changes, for the duration of their stay within the HCF. HCFs need to ensure adequate supplies of surgical masks are available for all patients and visitors in all areas. If the patient has a fabric mask on it must be replaced with a surgical mask. Alcohol based hand rub (ABHR) is to be available at all entry points to the HCF.

KEY PRACTICE POINT 2: WA HEALTH COVID-19 FRAMEWORK FOR SYSTEM ALERT AND RESPONSE

The [WA Health COVID-19 Framework for System Alert and Response \(SAR\)](#) describes the different levels of risk (alert levels) and associated responses that will be applied across WA HCFs, in a living with COVID-19 context. Alert levels will be determined by the Chief Health Officer. The SAR describes infection prevention strategies and the level of PPE required for the four alert levels.

KEY PRACTICE POINT 3: PERSONAL PROTECTIVE EQUIPMENT

The WA Health SAR provides the guidance on the level of PPE staff are required to wear for each Alert Level.

All HCWs must undergo training in the correct use of PPE and be competent in safely donning and doffing their PPE.

Staff providing care to those patients admitted to a WA HCF who are COVID-19 positive, symptomatic awaiting for testing results **OR** under a quarantine Direction (i.e. close contacts), must wear a fit tested particulate filter respirator (PFR), protective eyewear, gown and gloves.

KEY PRACTICE POINT 4: NEGATIVE PRESSURE ISOLATION ROOMS

HCFs should undertake a risk assessment for allocating and prioritising a negative pressure isolation room (NPIR) for patients with an increased risk of disease transmission e.g. severe coughing, need for AGPs, or if the patient is exhibiting AGBs.

Patients with other infectious diseases spread via the airborne route should also be prioritised for NPIR.

5. Patient presentations

Early recognition and the prompt isolation of COVID-19 positive patients, symptomatic cases awaiting test results and those under a quarantine Direction (i.e. close contacts), is essential to reduce the transmission of COVID-19.

A risk assessment of **all** patients presenting as either emergency presentations, outpatients or direct admissions is recommended. Pre-emptive testing with either a rapid antigen test (RAT) or polymerase chain reaction (PCR) will assist with patient bed management. [The WA COVID-19 SAR](#) will provide guidance on testing.

5.1 Presentations to an emergency department or urgent care centre

The following actions are to be taken for a patient that is COVID-19 positive, symptomatic cases awaiting test results and those under a quarantine Direction (i.e. close contacts).

- Ask the patient to don a surgical mask. If the patient already has a surgical mask on ensure it is worn correctly and hasn't been on for longer than four hours or is damp or soiled. If the patient has a fabric mask on it must be replaced with a surgical mask.
- The patient is to be instructed to cover their mouth and nose with a flexed elbow or tissue when coughing or sneezing, dispose of the tissue immediately and perform hand hygiene.
- Room placement of high-risk patients e.g. severe coughing, need for AGPs, or if the patient is exhibiting AGBs:
 - should ideally be assessed in a NPIR with anteroom. Where not available, a standard isolation room or a single room where there is neutral airflow and placement of a portable air purifier is an acceptable alternative
 - if a NPIR or a single room is not available, other designated isolation areas may be considered in consultation with the facility IPC team. Patients in the designated isolation area are to be separated by a distance of at least 1.5 metres from other patients and the area is not to be used as a thoroughfare.
- Donning and doffing areas should be clearly identified. Any person entering the patient room or designated isolation area is to don PPE prior to entry to the room or isolation area. Non-essential personnel are not to enter these rooms or designated isolation areas.
- Clear signage indicating the appropriate transmission-based precautions and required PPE is to be placed at the entrance of the patient room or in a prominent position at the entry to the designated isolation area or zone.
- Conduct a medical assessment and collect respiratory specimens in accordance with current recommendations contained in the [Testing Criteria for SARS-CoV-2 in WA](#). A symptomatic patient who has refused COVID testing should be managed as if they are a positive case.
- If a patient presents to an outpatient setting, including mental health facility, who meets the criteria they should be risk assessed in conjunction with their treating medical team to determine if their appointment/treatment should be continued or deferred until testing or isolation/quarantine period has completed.

- If admission is not required and the patient can return to the community or to their place of quarantine, refer to [COVID-19 Guidelines for public hospital discharge and interhospital transfer of positive or suspect COVID-19 positive](#) and ensure :
 - the patient knows to isolate at home, a hotel, other private accommodation, accommodation arranged by the State Welfare Incident Coordination Centre (SWICC), residential facility or a vessel
 - the patient is provided with information [on testing positive for COVID-19](#)
 - the patient is aware of what action to take if their condition deteriorates e.g. who to call
 - the patient is aware that further testing may be required if the illness persists beyond 72 hours and no other cause is found
 - arrangements are in place for the patient to be contacted with the test result.
- If admission is required, including to a mental health facility, maintain transmission-based precautions and implement the recommendations outlined in this document.

6. In-patient management

6.1 Patient room placement

- Placement of patients with a high risk of disease transmission should ideally be in a NPIR with anteroom. Where not available, a standard isolation room with ensuite facilities are preferred, and if this option is unavailable, use a single room and allocate a dedicated bathroom / toilet. Toilet lids should be closed prior to flushing to minimise risk of aerosolisation of faecal matter.
- Single rooms not immediately adjacent to other rooms are preferred. Risk mitigation strategies to optimise ventilation such as the use of portable air purifiers should be implemented to improve air quality.
- When single rooms are utilised, consideration is to be given to transfer the patient to a NPIR if an AGP is to be undertaken.
- Patients are to always wear a surgical mask (where tolerated) and be supplied with additional masks to enable them to change them every four hours or when damp, soiled or damaged. The requirement for patients to wear a surgical facemask must not compromise their clinical care.
- Interdepartmental transfers are to be restricted unless patient management will be compromised e.g. admission to intensive care or necessary procedural investigations.

6.2 Cohorting

- The decision to create cohort wards will need to be undertaken in discussion with HCF Executives, Clinical Leads, Infectious Diseases Physicians and the IPC team.
- COVID-19 positive patients are **not** to be cohorted with patients who have **not** yet been diagnosed with COVID-19.
- Clear signage indicating the appropriate transmission-based precautions and required PPE is to be placed at the entrance of the cohort ward.

- HCFs may consider creating cohort wards, especially in those facilities where heating, ventilation air conditioning (HVAC) systems can be isolated. Cohort wards should be separate from other patient areas and are not to be used as a thoroughfare.
- HCFs should consider reducing bed numbers in shared rooms e.g. if a four-bed room, reduce occupancy to two beds. All patients will be required to wear a surgical mask if their clinical condition allows.
- In a cohort ward, eye protection, masks and gowns may remain insitu between patients providing they are not damaged or soiled. Gloves must be changed between patients, and between different procedures on the same patient e.g. mouth care and then urinary catheter care with adherence to the '5 Moments' of hand hygiene.
- Upon leaving the cohort ward all PPE must be removed and discarded
- Zoning may be considered in a cohort ward however each zone must be clearly identified.

6.3 Personal patient care

- Indoor bathrooms are often poorly ventilated, hence prolonged periods of time spent in these environments could increase the risk of infection transmission to HCWs. In addition, the wet conditions may cause PPE to become ineffective.
- Showering a patient may result in the aerosolisation of shower mist. This mist could act as a potential source of infection. This has been proven in relation to other pathogens such as legionella but has not yet been demonstrated in the transmission of COVID-19.
- In the case of patients who require minimal assistance with personal hygiene, the risk of transmission of COVID-19 to staff may be reduced by minimising the time spent in the bathroom with the patient if it is safe to do so.
- The risk of infection transmission may also be mitigated by using a gentle stream of water from a handheld shower head, which would reduce the risk of aerosols. Staff should avoid getting their mask wet and replace PPE as soon as possible after the shower.
- In the case of patients who require direct support with their personal hygiene, alternative hygiene care e.g. bed bath, may be provided outside of the bathroom environment if the risk of showering is deemed unacceptably high until the person is cleared of their COVID-19 status.

6.4 Patient transport

Inter and intra hospital transfers are to be restricted unless clinical management of the patient will be compromised. All hospitals should undertake regular scenario testing and planning for transfers.

6.4.1 Patient transport within HCFs

Patient transfers within a HCF can be conducted as per standard protocols. COVID-19 positive patient can wear a surgical mask for the duration of transfer or a McMonty Hood or similar source control device is utilised.

If on oxygen therapy, the patient should be transitioned to nasal prongs if their condition allows. A surgical mask is to be worn over the top. If the patient is unable to transition to nasal prongs a surgical mask should be placed over the Hudson mask prior to transport within the HCF.

The following process is to be adhered to for all COVID-19 positive patients who are unable to wear a surgical mask or who are not transferred using a McMonty Hood:

- The route of transfer should be clearly articulated and planned, with the shortest route possible preferred.
- The receiving department must be notified of pending arrival of the patient prior to patient transfer and agree to transfer time to ensure a smooth transfer of the patient and to avoid delays in access to room or department.
- Where possible, all non-essential HCWs, visitors and patients should be excluded from the transfer route.
- The HCWs accompanying the patient must don fresh PPE prior to transfer, so they are not wearing the same PPE they had on in the patient room. All HCWs accompanying the patient are to wear a PFR, gown, gloves and protective eyewear for the duration of transfer.
- A designated HCW is to act as a scout to clear the route, act as a spotter and facilitate cordoning of affected areas. This HCW should wear as a minimum a PFR and protective eyewear. They are not to touch the patient. The scout should perform hand hygiene after touching frequently touched surfaces e.g. lift buttons, door pushes.
- The forward scout must carry detergent/disinfectant wipes and wipe over the high touch areas of the lift after patient exits.
- The lift can be returned for use as soon as patient transfer and clean is completed.
- If appropriate lift management practices or PPE have not been followed, this should be escalated to the IPC team for exposure management.

6.4.2 Patient transport between HCFs

- The decision to transfer a patient should be made on a case-by-case basis by the treating and receiving teams and should follow existing processes used by public and private hospitals.
- All public hospitals are required to care for COVID-19 positive cases and as such the transfer a COVID-19 case should only occur if medically required. This may include situations where the required clinical care for the primary diagnosis is not available, when care can be provided closer to home to free up an acute care bed, or if a COVID-19 case requires acute or intensive care and this is not available at the current site.
- Transfer of a patient between hospitals in a very high caseload environment should be via the hospital Patient Flow Coordinator who will liaise with the Department of Health Patient Flow Command Centre.
- Refer to [COVID-19 Guidelines for public hospital discharge and interhospital transfer of COVID-19 cases](#)
- Patients are to wear a surgical mask, and if on oxygen therapy transitioned to nasal prongs if their condition allows, when transported via ambulance between HCFs. If the patient is unable to transition to nasal prongs a surgical mask should be placed over the Hudson mask prior to transport.

6.4.3 Patient transfer back to State quarantine facilities

- For those patients requiring transfer back to a SQF, liaison with the SHICC Hotel Quarantine Team is required on 13 268 43.
- The SHICC team will organise the transport and driver.
- The patient needs to be escorted to point of departure and is to wear a surgical mask for the duration of transfer and until they return to their room at the SQF. The HCW escorting the patient is to wear a minimum of a PFR and protective eyewear for duration of transfer.

6.5.4 Discharge patient transport

- Patients who are COVID-19 positive and are ready for discharge and have not yet completed the clearance criteria, can be transported home by family, friend or support person and both the patient and driver is to wear a surgical mask during transport.
- HCFs are to supply the surgical mask and instructions on how to don and doff on completion of transport, cleanable surfaces in the vehicle can be wiped over with a detergent/disinfectant wipe.
- Alternatively, the HCF transport service can be used and the HCFs vehicle cleaning procedure followed.
- Patients requiring transport home whereby a family/friend/carer is unable to transport refer to the [Infection prevention and control information for public & private transport drivers/operators – transporting COVID-19 cases](#).

6.6. Patient discharge

- In addition to usual discharge protocols and processes, having a suitable discharge plan that considers isolation requirements for a patient who is a COVID-19 positive case is critical to minimising the risk of transmission and ensuring Quarantine Directions are followed.
- Refer to [COVID-19 Guidelines for public hospital discharge and interhospital transfer of positive COVID-19 cases](#)
- The discharge destination for a patient who is a COVID-19 positive case should be decided in consultation with the patient's Medical Practitioner and Multidisciplinary Team (MDT) and may include the patient's home, a hotel, other private accommodation, accommodation arranged by the State Welfare Incident Coordination Centre (SWICC), residential facility or a vessel.
- A patient under a Schedule A Centre Quarantine Requirement will require discharge to a State Quarantine Facility.
- Patients requiring ongoing care for their COVID-19 post-discharge should enrol online with the [WA COVID Care at Home program](#). If the patient is unable to self-register, others including clinical staff, can assist with the registration process. Once registered, the patient will be assessed for eligibility for the program and if eligible, WA COVID Care at Home will provide ongoing COVID-19 monitoring and GP support.
- The decision to discharge a patient back to a residential facility must be agreed with the consultant and the residential facility to ensure the facility is equipped to manage the patient. Residential facilities may include Aged Care, Disability, Mental Health, group homes etc.

- For further information and a discharge checklist for discharge to a Residential Aged Care Facility [Refer to COVID-19 Residential Aged Care Facilities Guidelines for resident transfer to and from hospital](#)

- If the patient is discharged while still infectious, ensure the patient and family members are instructed on appropriate IPC in the home. Please see additional COVID-19 [resources for Aboriginal people](#).

6.7. Release from isolation

- All COVID-19 positive patients are to remain under transmission-based precautions until the patient is discharged or the release from isolation criteria are met.
- [Release from isolation criteria](#) should consider both patient factors (presence of immunocompromise and acute respiratory symptoms) and high-risk settings. Discontinuation of precautions can be discussed with the HCFs IPC team or clinical microbiology/ID physician for additional guidance.
- Clearance testing is not advised for most cases as it is likely to reflect residual shedding, however in some high-risk clinical settings, cases who are severely immunocompromised may be requested to have clearance testing.
- Recovered cases do not need to be retested within 12 weeks after release from isolation. In a hospital setting consideration of retesting can be made with clinician discretion. If at least 12 weeks have passed after release from isolation, recovered cases should be tested for SARS-CoV-2 if they develop new symptoms of COVID-19. Re-infection requires confirmatory PCR testing.
- If a patient presents to a HCF within this 12-week period with new respiratory symptoms, implement transmission-based precautions and test for all respiratory viruses including SARS-CoV-2.

6.8. Management of the deceased

- There is no evidence of an increased risk of transmission of SARS-CoV-2 to those managing the deceased. Standard precautions apply and HCWs to wear appropriate PPE when preparing the body for transport.
- A surgical mask is to be placed on the deceased prior to movement of the body and for duration of care until the body is placed in a shroud, to minimise contamination by respiratory secretions. Deceased persons must be placed in a leak proof body bag for transport.
- Family members are allowed to view the deceased but should refrain from touching or kissing them. If this has occurred, the bereaved should immediately wash their hands or use an alcohol-based hand rub.
- Inform mortuary staff of the deceased persons is a **COVID 19 positive** status prior to transfer.
- Patient valuables are to be managed in accordance with HSP policy. Where there are personal items the family wish to collect, wipe over with a disinfectant wipe if appropriate, and place in a plastic bag. Clothing can be bagged and next of kin advised to launder as per normal practice, with preference for a hot wash.
- Mortuary HCWs are to follow routine institutional guidelines for management of the deceased. Further information can be found in [Advice for funeral directors](#) and [Advice](#)

[for the Aboriginal Sector on Funerals and Sorry Business during the coronavirus pandemic.](#)

7. Visitors

- All HCFs are to have a visitor restriction policy that minimises visitors. Refer to the [COVID-19 Public hospital visitor guidelines](#).
- The WA Health SAR and the visitor Guidelines will provide guidance on when testing is to be conducted for visitors to high risk settings and vulnerable patient cohorts.
- Visitors entering any HCF are required to wear a surgical mask from entry into the HCF facility in accordance with public health safety measures.
- Any visitor who is unwell is not to visit any patient within the HCF. Signage informing the public of this precaution must be clearly visible
- All visitors are to be encouraged to perform hand hygiene on entry to the HCF, prior to entering the patient room and at regular intervals during their visit.
- Proof of vaccination is required by all visitors on entry to HCFs.
- All HCFs are to have well documented procedures to manage exemptions for mask exempt, vaccine exempt or unvaccinated essential visitors or carers in accordance with the COVID-19 Visitor Guidelines for WA Public Hospital and Health Services.

7.1 Visitors to COVID-19 positive patients

- The decision to allow visitors to a COVID-19 positive patient is to be managed on a case by case basis in conjunction with the treating medical and IPC teams. The decision should be based upon a risk assessment dependant on patient condition and visitor profile. See WA Department of Health [COVID-19 Public hospital visitor guidelines](#) for further information.
- When a visitor is allowed entry, they must be met at the HCF entrance and escorted to the patient room. The visitor is to be instructed on how to don PPE that includes a surgical mask, protective eyewear, gown and gloves. Strict adherence to hand hygiene procedures during the doffing procedure must be observed.
- Visitors to a COVID-19 positive patient are not to visit any other patients or any shared areas within the HCF such as cafeterias and are to be escorted off the premises at the end of their visit.

8. Contact tracing

The HCF IPC, Occupational staff health nurses or their delegate (the HCF designated person) are responsible for follow up of COVID-19 exposures in the hospital setting.

The Public Health Operations (PHOs) cell of the State Health Incident Coordination Centre (SHICC) may assist hospitals with outbreak management, as needed.

8.1 Definitions

Case and close contact definitions for Western Australia (WA) are available in the [WA COVID-19 TTIQ Plan](#).

Refer to the [WA COVID-19 Healthcare Worker Furloughing Guidelines](#) for contact definitions relating to HCWs.

8.2 Follow up of COVID-19 positive case

The HCF designated person should interview the case to determine close contacts during the infectious period, and any possible source of infection within the facility. When to contact PHOs:

- if there is suspicion of COVID-19 transmission occurring within a hospital, or if a cluster or outbreak is identified
- if further contact tracing advice or support is required
- example script templates for case and close contacts can be obtained from PHOs if required
- COVID positive deceased patients
- PHOs can be contacted via email ncovcontact@health.wa.gov.au or phone 1300 316 555.

8.3 For cases and close contacts

- For discharged close contacts the HCF designated person is to notify PHOs with discharged patient details. PHOs are responsible for follow up of discharged close contacts.
- Testing, isolation and what to do if symptoms gets worse for cases: [What to do when you test positive for COVID-19 \(healthywa.wa.gov.au\)](https://www.health.wa.gov.au/healthywa/what-to-do-when-you-test-positive-for-covid-19)
- Testing and isolation information for close contacts: [What to do if you are a COVID-19 close contact](https://www.health.wa.gov.au/healthywa/what-to-do-if-you-are-a-covid-19-close-contact)
- [Testing and isolation protocols](https://www.health.wa.gov.au/healthywa/testing-and-isolation-protocols)
- [How to isolate or quarantine, including how to isolate or quarantine away from your household: Quarantine and isolation \(healthywa.wa.gov.au\)](https://www.health.wa.gov.au/healthywa/how-to-isolate-or-quarantine-including-how-to-isolate-or-quarantine-away-from-your-household)
- [Advice for looking after yourself when you have COVID-19 including mental health support information: Looking after yourself \(healthywa.wa.gov.au\)](https://www.health.wa.gov.au/healthywa/advice-for-looking-after-yourself-when-you-have-covid-19-including-mental-health-support-information)
- [COVID-19 symptoms – what to expect \(healthywa.wa.gov.au\)](https://www.health.wa.gov.au/healthywa/covid-19-symptoms-what-to-expect)
- [Pandemic Leave Disaster Payment Information \(servicesaustralia.gov.au\)](https://www.servicesaustralia.gov.au/pandemic-leave-disaster-payment-information)

9. Outbreak escalation process

- The hospital's outbreak management committee should consider the following possible triggers for escalation via their Chief Executive to the State Health Incident Coordination Centre (SHICC) or the WA Country Health Service (WACHS) Emergency Operations Centre (EOC):
 - if there are significant exposures within the hospital, for example large numbers of staff are required to quarantine
 - if there is an outbreak in a vulnerable cohort e.g. immunocompromised patient's
 - if there is ongoing transmission
 - if the hospital exceeds capacity at a specialist level e.g. an oncology ward if affected by the outbreak, or at a hospital wide level.

The trigger for escalation will vary depending on the size and location of a hospital. For a small hospital in a remote location in regional WA escalation may be more rapid.

10. Management of the environment

10.1 Ventilation

All HCFs should assess the heating ventilation and air conditioning (HVAC) systems and consider the need to deploy portable air purifiers with high efficiency particulate absorbing (HEPA) filters to improve air quality.

Any single room or designated isolation area must be assessed for positive / neutral / negative air pressure and a room or area with positive pressure to adjacent areas should not be used. Planning for these areas must be done in conjunction with facility IPC team

A review of HVAC systems, air flows and air exchanges should be undertaken before any area is designated as an isolation or cohort area.

10.1.1 Use of portable air purifiers

Each HCF should assess the need for the use of portable air purifiers, fitted with a HEPA filter, which can aid in the reduction of viral load in the following settings

- multi-bed shared room
- dialysis setting
- areas of high traffic flow e.g. emergency departments
- resuscitation bays or rooms where intubation occurs
- staff shared areas.
- patient waiting areas.

Location and positioning of the air purifiers will vary and will be dependent on individual HCF configurations.

Refer to [Use of Air Purifiers in WA Healthcare Facilities](#) guideline and [additional information](#) on environmental controls and air ventilation.

10.2 Patient care equipment

- Disposable, single-use patient care equipment is to be used when possible and disposed of into appropriate waste streams after use.
- Dedicate non-critical items to the patient's room for the sole use of the patient for the duration of their admission e.g. stethoscope, tourniquet.
- Minimal stocks of non-critical disposable items e.g. dressings, kidney dishes, are to be stored in the room. On patient discharge, these items are to be disposed of.
- Patient charts are to be left in the anteroom of a NPIR or outside single or multi-bed rooms. Gloves must be removed, and hand hygiene performed prior to any documentation.
- Where possible, procedures should be performed within the patient room. All reusable medical devices/equipment must be cleaned and disinfected following use and prior to removal from the room.
- Impregnated disinfectant wipes, as per HCF policy, may be used for cleaning specialised medical equipment such as X-ray equipment, ECG and ultrasound machines. The manufacturers' recommendations for compatible products must be followed.
- Intensive care units (ICUs) must ensure mechanical ventilation equipment is protected with viral filters and utilisation of inline suction systems.

10.3 Environmental cleaning

- Each HCF is responsible for ensuring documentation is available on the specific products to be used for cleaning and disinfection including instructions for use and safety data sheets.
- Disinfectant must be approved by the [Therapeutic Goods Administration](#) (TGA), hospital grade with viricidal properties and be approved for use by the HCF.
- As disinfectants are inactivated by organic material, cleaning with a neutral detergent solution prior to disinfection is required if visible soiling is evident. The use of a 2 in 1 detergent and disinfectant solution or combined detergent and disinfectant wipes are suitable.
- All solutions need to be prepared and used in accordance with the manufacturers' instructions for use.
- Cleaning regimens must ensure all items in the room are cleaned and disinfected both daily and on patient discharge i.e. terminal cleaning.
- Increased cleaning schedules may be advised by the IPC team e.g. twice daily, to reduce environmental contamination in shared and public areas and for frequently touched items.
- Enhanced environmental cleaning and disinfection will be required in the event of an outbreak at the HCF, under the direction of the IPC team. This applies to all areas in the outbreak zone including patient care, communal and staff only areas.
- Cleaning regimens must include all horizontal surfaces, any walls that are visibly contaminated and frequently touched items e.g. door handles, bed rails, IV poles, light switches, call bells, bedside lockers, over-bed tables, lift buttons.
- Disposable cleaning cloths are to be discarded after each use.
- If reusable cloths are used, they are to be laundered according to the AS/NZS 4146:2000 Laundry Practice Standards.
- Re-useable mop heads can be used but must be bagged and sent for laundering at the completion of each use. Mop handles are to be cleaned and disinfected after each use. Alternatively, disposable mop heads with a detachable cleanable handle may be used.
- Damp dusting procedures are to be utilised. Vacuums, if utilised, must be fitted with a HEPA filter.
- All cleaning equipment is to be cleaned and stored dry.

10.3.1 Daily cleaning

- Cleaning staff are to wear PPE in accordance with WA SAR.
- Cleaning staff must have been fit tested for a PFR and deemed competent in wearing and performing a fit check.
- The room and patient care equipment are to be cleaned using both a detergent and disinfectant product. This can be performed by either using a 2-step clean procedure or a 2-in-1 product, which contains both a detergent and disinfectant agent.

10.3.2 Terminal cleaning of NPIR and standard rooms

- Cleaning staff are to wear PPE in accordance with the WA SAR, without having to wait for a period to access the vacated room.
- An assessment on the number of air exchanges per hour in the room is required to ensure the minimum time has passed to allow for the removal of 99% of airborne contaminants, prior to the admission of the next patient.
- Further details can be found in Victorian Health and Human Services Building Authority [HVAC system strategies to airborne infectious outbreaks, Rev B](#) and [Centres for Disease Control and Prevention - Environmental Infection Control Guidelines - Appendix B Air](#). Terminal cleaning can occur within this time.
- All disposable items in the room are to be discarded on patient discharge.
- Unused clean linen, patient bed screens, privacy curtains (and window curtains, if fitted) are to be sent for laundering/dry cleaning or disposed of (if disposable).
- Any soft furnishings that cannot be removed from the room are to be steam cleaned.
- The room and patient care equipment are to be cleaned using both a detergent and disinfectant product, using either a 2-step clean procedure or a 2 in 1 product, which has both a detergent and disinfectant agent.
- If an air purifier is used the unit should be cleaned and disinfected in the room, prior to removal, ensuring the vents are clear and clean.
- All surfaces must be touch dry prior to the next patient admission

10.4. Food services

- Dedicated catering staff that have being fit tested and have received PPE training can enter patient rooms and deliver meals. At a minimum these staff are to wear a PFR and protective eyewear and perform hand hygiene after exiting the room.
- Food services staff that have not received PPE training and fit testing should deliver food and beverages to a designated clean area. These should then be delivered to the patient and collected from the room once the meal is consumed by HCWs directly caring for the patient and placed in a designated collection area.
- Standard precautions should be used when handling used crockery and cutlery.
- The combination of hot water and detergents used in automatic dishwashers is sufficient to decontaminate these items.
- Unopened food items or food waste is to be discarded into general waste.
- Food trolleys that have been used in designated COVID-19 clinical areas should be cleaned and disinfected before reuse.

10.5. Linen services

- Standard precautions apply when handling linen. Laundry practice is to conform to AS/NZS 4146:2000 Laundry Practice Standards.
- A linen skip is to be dedicated to the room and used linen placed directly into the linen skip. Linen that is heavily soiled should be placed in a plastic or soluble bag as per requirements of the HSP linen provider.

- Avoid contact with used linen by holding items away from the body and avoid agitating the linen which can cause aerosolisation of any infectious particles.
- The linen skip must be replaced when $\frac{3}{4}$ full.
- Ensure the soluble bag and the linen bag is securely tied prior to transporting from the patient room to the collection area.
- Stockpiling supplies of linen in the patient rooms is not to occur.

10.6. Medical records and patient charts

- Standard precautions apply to the management of all patient records. Performing hand hygiene prior to and following handling patient records will minimise the risk of contamination and transmission.
- The patient charts are to be left outside the room. When cohort wards are established, placement of patient charts are to be separated from clinical care areas. In ICU areas, chart trolleys are to be positioned as far away from the patient zone as possible.
- HCWs are not to perform any documentation, either paper based or electronic, without first removing gloves and performing hand hygiene.
- HCFs that utilise electronic systems are to ensure shared computer equipment can be cleaned and disinfected.
- There is no requirement to quarantine medical records prior to returning to health information / medical record management services.
- Paper records may require handling by patients during their hospital journey. The risk of contamination can be mitigated by asking patients to perform hand hygiene before touching records/forms. Clean and disinfect pens after use or dispose of.

10.7. Laboratory specimens

- Standard precautions apply for handling and transport of specimens.
- Refer to Laboratory Testing information in the [CDNA National Guidelines](#) for further details on samples and collection techniques.

10.8. Waste management

- Standard precautions apply.
- [WA Health](#) and the HCFs guidelines for classification and disposal of general, clinical and sharps waste are to be followed.
- Any waste that is contaminated with blood and or body fluids is classified as clinical waste. Most waste, including PPE, can be classified as general waste.
- The need for increased frequency of emptying waste bins used for the disposal of PPE in clinical areas should be considered.
- All waste shall be bagged and securely sealed prior to exiting the patient room.

11. Healthcare worker management

11.1 General risk mitigation

- COVID-19 vaccination is mandatory for all staff working in public and private healthcare facilities in WA and this includes staff who attend a facility to provide contracted services or attend advisory committees or any other service provision.
- HCWs who have received a medical exemption for vaccination are to ensure their workplace is aware as specific workplace arrangements and exclusions may need to be considered.
- HCWs that are unwell **are not** to attend the workplace and are to exclude themselves until asymptomatic. HCWs who have any influenza-like illness are to self-isolate and be tested for SARS-CoV-2. There should be a low threshold for testing HCWs for SARS-CoV-2.
- All HCWs must comply with the current health Directions, the [WA SAR](#) for PPE use and any requirements for SARS-CoV-2 testing.
- HCWs are not to eat or drink in clinical areas.

11.2 Healthcare worker testing

- The [WA SAR](#) provides guidance on COVID-19 testing for HCWs and includes:
 - HCWs are to seek immediate testing if they develop any symptoms compatible with COVID-19 with a WA Health issued RAT. If the RAT is negative and symptoms persist, exclude themselves from the workplace and repeat RAT in 24 hours. A positive RAT is considered a COVID-19 positive case
 - when a breach in IPC or PPE protocols is found
 - asymptomatic screening of HCWs are to be provided with sufficient supply of WA Health issued RAT to enable required testing
- HCWs who have recovered from COVID-19, who are within 12 weeks of release from isolation and are asymptomatic are not required to be re-tested within the 12 weeks.
- HCWs that are symptomatic should remain off work, be tested for all respiratory viruses and seek further advice from HCF IPC or Staff Health.

11.3 Management of HCW exposed to COVID-19

- HCFs are responsible for implementing contact tracing within the hospital for all HCWs.
- A system-based risk management approach that incorporates risk mitigation strategies, reduces the risk of exposure in health care settings. However, it is acknowledged that risk cannot be eliminated and that exposures may occur.
- All HCWs caring for **COVID-19 positive cases** should carefully monitor their own health. If they develop signs and symptoms of illness compatible with COVID-19 they are to:
 - cease work immediately or not attend work
 - present for COVID-19 testing immediately
 - notify their line manager and await testing results.

- HCWs who have taken recommended IPC measures, including the correct use of PPE, while caring for a COVID-19 positive case are not considered close contacts unless there has been a breach of PPE.
- When a HCW has had an exposure to a COVID-19 positive case, symptomatic or those under a quarantine Direction (i.e. close contact), a risk assessment is to be performed to determine the level of risk and the recommended work permissions and restrictions that may be required. Refer to the [WA COVID-19 Healthcare Worker Furloughing Guidelines](#) and the [TTIQ](#) plan for management of cases and close contact guidelines.
- The assessment is to be undertaken in liaison with the HCFs Infectious Disease Physician or Clinical Microbiologist, IPC and OSH department.
- Initial first aid, following an exposure, should include, where relevant:
 - remove PPE, perform hand hygiene
 - skin exposure - wash the exposed site at once with soap and water or ABHR
 - eye exposure - rinse thoroughly, while eyes are open, with sterile normal saline / water
 - mouth exposure - spit out and rinse with water several times
 - clothing exposure - remove any contaminated clothing, shower if necessary
 - line manager is to be notified as soon as practicable.

11.4 Rostering and staff placement

- HCFs are to minimise exposure of staff to COVID-19 positive case, symptomatic or those under a quarantine Direction (i.e. close contacts) cases by ensuring non-clinical staff are in non-patient care areas e.g. moving staff to office areas away from wards, or initiate working from home where possible. Consider installing impermeable screens at reception desks or providing other means of maintaining physical distancing for staff required to greet patients and the public.
- HCWs caring for a patient with COVID-19 positive cases or those under a quarantine Direction are to be:
 - fully vaccinated (3 doses), completed PPE training and undertaken a fit test for PFR use.
 - preferable HCWs who are permanent employees or on a fixed term contract, without secondary employment.
 - preferable that HCWs assigned to care should not be providing care to other patients on the same shift to minimise risk to other HCW's and patients.
- Consideration of rostering to avoid fatigue of HCWs is to be considered. The wearing of PPE, especially PFRs is only tolerated for limited periods of time.
- HCWs working across multiple sites must inform their line manager if they have been caring for a COVID-19 positive patient or those under a quarantine Direction (i.e. close contacts).
- HCFs are to have protocols in place for student HCWs and students undertaking work experience.

11.5 HCWs at increased risk of serious illness

- The Australian Health Principle Protection Committee (AHPPC) recommends that special provisions apply to essential workers who are at higher risk of serious illness

and, where the risks cannot be sufficiently mitigated e.g. vaccination and use of PPE. Each HCF will need to undertake a risk assessment for any HCWs within their employment who are at [higher risk of serious illness](#).

- Refer to the Australian Government [website](#) for detailed information.

11.6 Uniforms

- HCFs are to ensure HCWs have access to adequate uniform supplies to enable a clean uniform to be worn each shift.
- In areas of clinical practice where there is a high risk of exposure to blood and body fluids, uniforms should be worn as well as the appropriate PPE.
- There is some evidence from several small prospective trials, that the uniforms of HCWs can become contaminated with a variety of pathogens and therefore HCWs should avoid wearing their uniforms home. If the uniform has been contaminated with blood or body fluid the hospital laundry facility should be used wherever possible. If home laundering, removal of any blood or body fluids initially, followed by a hot wash is preferred.
- Recommended PPE is designed to protect HCWs clothing. Clothing exposed outside of PPE e.g. shoes, trousers, are not considered a significant transmission risk unless contaminated with blood or body fluids. Any footwear needs to be appropriate to wear in a HCF i.e. cleanable and enclosed.
- If clothing outside of PPE coverage becomes contaminated with blood or body fluids, the HCW needs to change out of soiled items at once.

Appendix 1: Personal Protective Equipment

KEY PRACTICE POINT 5: PPE DONNING AND DOFFING

These guidelines should be used in combination with the Mandatory Policy 0133/20 [Identification and Use of Personal Protective Equipment in the Clinical Setting During the Coronavirus \(COVID-19\) Pandemic Policy](#).

The sequencing of donning and doffing PPE varies internationally and between Australian States and Territories.

The sequence detailed in this document takes a conservative approach and is supported by reports of poor adherence to donning and doffing procedures and the risk of self-contamination.

The procedure has been agreed to by senior IPC practitioners, Infectious Diseases Physicians and Clinical Microbiologists within WA.

The use of a 'PPE buddy' is strongly supported to minimise the risk of incorrectly donning and doffing PPE.

Please refer to [Educational material on the correct sequencing of PPE](#) for additional resources.

General PPE advice

- HCWs should only wear PPE that has been approved for use by the HCF. This involves the routine practice of formal product evaluation and assessment.
- HCWs providing prolonged episodes of care to patients may choose to wear an approved PAPR following appropriate training in their use. There is little evidence to support that PAPR's provide greater protection than a correctly worn and appropriately fitted PFR, however, they may provide greater comfort for the wearer when PFR use is required for extended periods of time.
- PPE is only protective when used correctly. Training in the use PAPR, fit checking of PFRs and donning and doffing procedures are essential for correct use and subsequently reducing exposure risk.
- PPE is to be available outside the patient room or in the anteroom.
- Donning of PPE should occur in the anteroom or outside the single room.
- The PPE 'buddy' should assess all aspects of PPE, including confirming the HCW has the designated type and size PFR they achieved a fit test with, the PFR straps are positioned correctly, a fit check is performed and the PFR is fitting correctly i.e. no fogging is occurring once eyewear is donned. A checklist may be utilised (see [Appendix 6](#)).
- Mirrors are useful to support donning and doffing.
- Loose hair must be tied back securely prior to donning PPE.
- HCWs must be diligent not to touch their eyes, nose, mouth or hair while wearing PPE.

- Wearing of gloves is not a substitute for hand hygiene. Hand hygiene must always be performed after glove removal. Applying ABHR to gloves is not recommended and can compromise the integrity of the gloves.
- Hand hygiene products and gloves must be available in the room to facilitate compliance with the [5 Moments for Hand Hygiene](#)
- When gloves are worn, avoid touching environmental surfaces such as light switches and door handles to minimise environmental contamination.
- Doffing of gloves and gowns should be done in the anteroom or at the patient's doorway if in a single room i.e. just prior to leaving patient's room. Eyewear and surgical masks or PFRs should be removed in the anteroom or outside the patient room, or greater than 1.5 metres from the patient under precautions.
- Regular breaks for staff to reduce fatigue related to PPE use, and for hydration is recommended. Compliance with the sequence of doffing PPE and hand hygiene must be adhered to prior to taking a break.
- Care is to be taken not to contaminate any clean stocks of PPE stored in the vicinity when doffing PPE.

Prevention of PPE related skin damage

Prolonged use of PPE may cause skin damage which can be painful and if severe can lead to skin breaks that leave the HCW vulnerable to infection. HCWs need to ensure their PPE is properly fitted and worn only when required. Pressure damage is exacerbated by moisture and wearing PPE for lengthy periods results in the skin getting warm and sweaty.

Gloves should be removed as soon as no longer required e.g. when no longer providing direct patient care or in contact with contaminated surfaces. Hand hygiene is to be performed immediately following removal of gloves, using either soap and water or ABHRs. Hand moisturisers should be used regularly.

Facial skin damage from masks or eyewear can be minimised by the regular use of alcohol-free barrier creams. The use of pressure reducing dressings for those HCWs experiencing skin damage is approved, however they will need to undertake a repeat PFR fit test to ensure an appropriate mask if identified with the use of the dressing.

Types of PPE

Gowns

- Worn to protect the healthcare worker's exposed body areas and prevent contamination of clothing with potentially infectious material during direct care.
- 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.

Aprons

- A plastic apron is a suitable alternative in situations where the risk of splash is low. Aprons may also be a suitable alternative for brief AGPs in asymptomatic patients e.g. suctioning in ICU, intubation and extubating.

Coveralls

- At present, coveralls are not part of the recommendations for PPE use in a HCF setting.
- The use of coveralls for HCWs requires significant training in donning and doffing and requires additional HCWs to support the doffing procedure. The risk of self-contamination during the doffing procedure is significant.

Gloves

- Non-sterile, latex free single use medical gloves can protect both patients and healthcare workers from exposure to infectious agents that may be carried on hands.
- Hand hygiene must be performed before donning and after the removal of gloves.
- Double gloving is not recommended as a protective measure against COVID-19 transmission. Double gloving is only recommended in theatre settings and/or on a risk-based approach for specifically determined procedures.
- The use of ABHR on the outside of gloves is not to occur as it can affect the integrity of the glove.

Head Coverings

- Head coverings are not routinely required except in the setting of theatre attire or when a sterile procedure is performed. They can be worn to contain hair or for comfort reasons i.e. to form a barrier from mask or face shield straps.
- Disposable head coverings are preferable, however, if fabric ones are used, they must be laundered daily.

Note: Head coverings add an extra step to PPE doffing and care must be taken by HCWs to avoid the risk of contaminating themselves.

Masks

- Surgical masks are utilised to contain respiratory secretions of the wearer or to prevent droplet inhalation by the wearer. Surgical masks are recommended for the HCWs for patients under droplet precautions. When there is a risk of airborne or aerosol transmission a PFR is to be worn.
- Surgical masks can be worn for the care of more than one patient in ward cohorts.
- Surgical masks should be removed when moist, soiled, following any AGP or AGB, or when it is difficult to breathe through. Masks should be replaced following any shift or meal breaks and at least every four hours or more frequently as required to relieve pressure.
- Surgical masks must comply with the Australian Standard AS/NZS 4381:2015.

Table 1 Types of surgical masks

Characteristics*	Level 1 barrier	Level 2 barrier	Level 3 barrier
Application	For general purpose medical procedures, where the wearer is not a risk of blood or body fluid splash, or to protect staff and/or the patient from droplet exposure to microorganisms	For use in emergency departments, dentistry, changing dressings on small wounds or healing wounds where minimal blood droplet exposure may occur	For all surgical procedures, major trauma first aid or in any area where the healthcare worker is at risk of bloody or body fluid splash
Bacterial filtration efficiency (BFE), %	≥95	≥98	≥98
Differential pressure, mm, H₂O/cm²	<4.0	<5.0	<5.0
Resistance to penetration by synthetic blood, minimum pressure in mmHg for pass result	80 mmHg	120 mmHg	160 mmHg

*Note that these characteristics are based on unworn masks, and may differ or not meet performance expectations due to individual fit characteristics.

Source: Standard AS 4381: 2015

- The most common PFRs are P2 or N95 respirators
 - P2 respirators are those that comply with the Australian Standard AS/NZS 1716:2012 Selection, use and maintenance of respiratory protective devices
 - N95 respirators are those that comply with the United States National Institute for Occupational Safety and Health (NIOSH) 42 CFR part 84, which is a less stringent standard.
- All HCWs wearing a PFR must have undertaken a fit test, know the brand and size of PFR they achieved a satisfactory fit to, and have access to that specific mask when required. In situations where a fit test has not yet been performed for the HCW, and a PFR is recommended, a fit-checked PFR is preferred to a surgical mask and the HCW assessed by a PPE buddy to ensure fit check is achieved. The HCW must be prioritised for a fit test as soon as possible.
- All HCWs must receive education, in accordance with the manufacturers' advice, in relation to donning a PFR and the procedure to perform a fit check for each specific mask worn.
- A fit check must be performed after donning a PFR prior to entering the patient's room and each time a new mask is put on. An effective seal will not be achieved when facial hair is present (see [Appendix 5](#)).
- Where the HCW fails a fit check after appropriate education and assessment, the HCW must undertake a repeat fit test and an alternative size or style of mask must be sourced.
- Respirators with exhalation valves that do not include a filter are not to be worn.
- The reprocessing of single use medical devices to enable their reuse could expose patients and medical staff to unnecessary risks and is strongly discouraged. For further information see the TGA statement on [Reuse of face masks and gowns during the COVID-19 pandemic](#) .

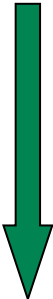
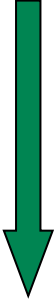
Protective eyewear

- Designated protective eyewear e.g. combined mask/shield, visor or goggles, are to be utilised.
- Personal prescription spectacles are inadequate and are to be worn with additional protective eyewear.
- Protective eyewear should be single use and disposed of after use, or if reusable protective eyewear is used, it must be cleaned and disinfected with approved products and kept for use by the same HCW.
- Wearing double protective eyewear e.g. both goggles and a face shield, is not recommended and may lead to increased fatigue and poor visibility.
- Protective eyewear must comply with Australian/New Zealand Standards AS/NZS 1336:2014 and prescription protective eyewear with AS/NZS 1337.6:2012 to prevent impact injury. Prescription protective eyewear can be assessed by IPC or OSH as suitable for blood or body fluid splash if they are close fitting, particularly from the corners of the eye and across the brow, they include side protection that is indirectly vented and can be cleaned and disinfected between use.

Shoe coverings

- Shoe coverings pose an occupational safety and health risk due to the risk of slipping and self-contamination at removal and are not recommended unless gross contamination is anticipated or required as per standard attire e.g. operating or trauma rooms.
- Shoes should be non-slip and intact over the bridge, toes and heel of the foot and made of material that can be cleaned and disinfected.

Sequence for donning and doffing PPE

Donning PPE		Doffing PPE	
	Perform hand hygiene Gown Mask Protective eyewear/visor Perform hand hygiene Gloves		Gloves Perform hand hygiene Gown/apron Perform hand hygiene Protective eyewear Perform hand hygiene Mask Perform hand hygiene

Please refer to the [Donning and doffing poster](#) and the [Donning and doffing video](#)

Appendix 2: Conservation of PPE

All HCWs are to use PPE that is appropriate for use and be mindful that at times there may be global shortages.

Minimise the need for PPE

Use physical barriers or alternative communications to reduce exposure to COVID-19 such as glass or plastic windows, intercom systems and phones to communicate with someone in isolation rather than having to enter their room. Bundle clinical activities to minimise the number of times a room is entered.

Use PPE appropriately

PPE use should be based on the risk of exposure and the route of disease transmission. Local HCF policy should be adhered to when assessing the requirement for using PPE i.e. potential occupational exposure to body fluids, or transmission-based precautions. PPE training should utilise expired stock, PPE should be rotated to avoid expiration.

Extended use of PPE

The extended use of some forms of PPE may be considered where a local risk assessment has occurred in conjunction with staff training. This strategy can be applied to masks, protective eyewear and face visors and gowns as outlined below:

Surgical masks and particulate filter respirators

Surgical and PFRs do not need to be removed between each patient. These masks can remain in place until they become damp with the wearer's respirations, or they are visibly soiled. Care should be taken not to touch the mask whilst in use. If a HCW touches the front of a mask, hand hygiene is to be performed immediately and the mask replaced.

Note: *The reprocessing of single use masks, including PFRs is not permitted.*

Protective eyewear

Protective eyewear includes goggles and face shields and they do not need to be removed between each patient. These items can remain in place for extended periods. Care should be taken not to touch protective eyewear whilst in use.

Protective eyewear is required to be worn whenever a surgical mask or PFR is worn.

Single use protective eyewear should not be reused. Re-use may be considered if the item is reserved for individual staff members. They are to be cleaned and disinfected using an appropriate hospital grade solution or wipe each time the goggles or visors are removed. See [ICEG guidelines on cleaning and disinfection of protective eyewear in health and residential care facilities](#)

Gowns

In COVID-19 cohort wards and clinics, gowns do not need to be removed between patients unless they are visibly soiled or high risk/close contact tasks are being performed. All PPE is required to be changed when leaving the COVID-19 clinical area or moving between COVID-19 clinical areas and non-COVID-19 areas.

Appendix 3: Aerosol generating procedures

AGPs are those that stimulate coughing and promote the generation of fine airborne particles or aerosols, resulting in a possible risk of airborne transmission. A list of AGPs can be found in the [Mandatory Policy 0133/20 Identification and Use of Personal Protective Equipment in the Clinical Setting During the Coronavirus \(COVID-19\) Pandemic Policy](#)

Where AGPs are performed on a COVID-19 positive patient or ensure:

- that they are performed in a NPIR, if this is not available use a single room with the door closed
- the number of HCWs in the room is limited to essential HCWs only
- all HCWs in the room must wear a PFR, protective eyewear, gown and gloves.

Nebulisers are not recommended for use and should be replaced by dedicated single patient use spacers where clinically appropriate.

Appendix 4: Fit-check and fit-test of particulate filter respirators

KEY PRACTICE POINT 6: FIT CHECK and FIT TEST

The WA Department of Health has endorsed the implementation of a mandatory Respiratory Protection Program that includes a quantitative fit-test component.

HCWs are to perform a fit check each time they don a particulate filter respirator (PFR). This is to ensure it is correctly applied and a correct seal is obtained. The PFR must be securely fitted over the bridge of the nose and under the chin ensuring there are no gaps between the mask and the face. Facial hair will prohibit this seal occurring.

A correct seal is indicated when on inspiration, the mask is drawn inwards and on expiration the mask should fill up with air. There should be no air leakage from around the edges of the mask at any time.

HCWs are potentially at risk of exposure to infectious agents when patients are confirmed or suspected of having a disease that is transmitted by aerosols or via the airborne route. The implementation of standard and airborne precautions is required to minimise this risk and includes the use of PFRs as part of the PPE that HCWs are required to wear. The term PFR includes the P2 or N95 respirators.

P2 respirators are those that comply with the Australian Standard AS/NZS 1715:2009 Selection, use and maintenance of respiratory protective equipment and AS/NZS 1716:2012 Respiratory Protective Devices.

N95 respirators are those that are approved and certified as such by the United States National Institute for Occupational Safety and Health (NIOSH Guidelines – Procedure No. TEB-APR-STP-0059).

For a PFR to offer the maximum desired protection, it is essential that there is a correct facial fit i.e. a tight seal between the mask and the wearer's face. The two distinct procedures used to achieve this are known as the 'fit test' and the 'fit check'.

HSPs need to ensure HCWs receive appropriate training on donning and doffing and performing a fit check for all types of PFRs they have been correctly fitted for.

Principles of use of PFRs

- PFRs should be used only in the context of when airborne precautions are required for patient care.
- HCWs who use PFRs must be trained in their correct use and undergone the fit test procedure.
- Unless used correctly, protection against airborne pathogen transmission will be compromised.

Fit check

Fit checking describes the process that HCWs **must** perform each time a PFR is donned to check that a good facial seal is achieved i.e. a seal is obtained over the bridge of the nose and there are no gaps between the respirator and face. A good seal is indicated when the

PFR is drawn in towards the face, when a deep breath is taken, indicating a negative pressure seal.

Where a HCW reports failure to achieve a seal following fit check, and again after further training and assessment, an alternative size or style of mask must be sourced. HCWs who fail to achieve a seal following fit check of an alternative mask, should be excluded from caring for patients under airborne precautions. If a suitable PFR cannot be found and the specialist skills of the specific HCW are required, an alternative respirator e.g. PAPR – may require consideration.

Fit test

A fit test is a validated method to determine whether the type of respirator being worn provides an adequate seal with a person's face. The testing is done while a person is wearing a respirator attached to a testing unit and carrying out several physical movements. There are 2 types of fit test methods - the qualitative or the quantitative fit test.

WA public HCFs are responsible for ensuring a quantitative fit-test is performed on all staff identified as high risk for exposure to pathogens transmitted by the airborne route or where there may be an increased risk of disease transmission when aerosol generating procedures are performed.

HCFs should keep a register of all staff tested including date, time, respirator brand, style, size and the result for each respirator tested.

HCFs should ensure alternative airborne protection via a PAPR or re-deployment if the fit testing process is unsuccessful in finding a suitable respirator from available supplies.

All HCWs must be able to identify the PFR that they have achieved a pass for.

If a new type of mask is offered to the HCW or there is a notable change in the wearer's facial characteristics that could alter the facial seal e.g. facial surgery, change in body weight, the HCW must undergo repeat fit testing.

An airtight protective seal is difficult to achieve for people with facial hair that underlies the mask at its edges. Facial hair which impedes achieving a seal should be removed except in special circumstance - refer to beard exemption below.

A fit test does not guarantee that a respirator will not leak if incorrectly applied to the face. No clinical activity shall be undertaken until a satisfactory fit check has been achieved.

Exemption for the removal of facial hair and use of beard covering technique

- The following exemptions will be allowed for the wearing of a PFR with facial hair for HCWs who are unable to remove facial hair
 - due to medical reasons
 - due to cultural or religious observance.
- To allow for an exemption the HCW will need to provide to their Manager
 - a medical certificate from their general practitioner if for a medical reason
 - a letter from their faith leader if for religious observance.
- Once an exemption has been approved the HCW can then be fit tested using an approved beard cover technique (Interim Advice: please refer to [NSW CEC protocols](#)).
- Where a successful fit test with the beard cover technique cannot be achieved consideration for a loose fitting PAPR may be appropriate.
- HCWs who cannot be successfully fit tested with a PFR or are unable to wear a loose fitting PAPR may require deployment to another clinical area.

Appendix 5: PPE Observer Checklist

Date: _____ Spotter: _____ Staff member providing care: _____

DONNING	Episode of care 1 Time in:	Episode of care 2 Time in:	Episode of care 3 Time in:	Episode of care 4 Time in:
Is the HCW donning in anteroom or the designated area?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Have you determined the type and size of the PFR* fitted to HCW with either their lanyard card or electronic record?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the HCW bare below elbows?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Is the HCW clean shaven?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Is the HCW hair tied back?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Hand Hygiene: Has the HCW performed hand hygiene?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Don Gown: Is the gown with ties done up at the back of neck and waist?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has HCW selected the correct type and size of PFR that matches their fit test record?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Don PFR: Is the PFR donned correctly? <i>Ensure mask straps are appropriately applied (above & below ears)</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the HCW undertaken a fit check? <i>Observe for any air leaks</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Don protective eyewear: Has the HCW donned protective eyewear e.g. face shield or goggles correctly? <i>Check for fogging of eyewear.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hand Hygiene: Has the HCW performed hand hygiene?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Don gloves: Has the HCW covered the cuff of gown with gloves?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

* Particulate Filter Respirator

DOFFING	Time out:	Time out:	Time out:	Time out:
Did the HCW doff gown & gloves at the doorway just prior to leaving the patient's room?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Doff Gloves: Has the HCW removed and discarded gloves, correctly?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the HCW performed hand hygiene?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Doff and dispose Gown: Has the HCW removed and disposed of gown correctly? <i>Untie gown at neck and waist, lean forward slightly, pull from neck & shoulder, then arms turning them inside out. Roll outside of gown inward into a parcel.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hand Hygiene: Has the HCW performed hand hygiene prior to exiting the room?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hand Hygiene: Has the HCW performed additional hand hygiene after exiting the room if touched door handles?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Doff Protective Eyewear: Has the HCW removed protective eyewear correctly? <i>Remove eyewear by the strap/arms. Dispose of single use face shields.</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the HCW cleaned and disinfected reusable eyewear using cleaning/disinfection wipes?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>
Hand Hygiene Has the HCW performed hand hygiene?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Doff and dispose PFR: Has the HCW removed PFR correctly? <i>Remove mask by handling at the ties only, leaning forward and discarding immediately</i>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Hand Hygiene: Has the HCW performed hand hygiene?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has the HCW cleaned and disinfected any potentially contaminated surfaces prior to exiting and performed hand hygiene?	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> N/A <input type="checkbox"/>

Comments / Actions:

* Particulate Filter Respirator

Appendix 6: Advice for WA HCWs who wish to use their own PPE

Note: During the COVID-19 pandemic, appropriate use of PPE is required to reduce transmission of SARS-CoV-2. Appropriately chosen PPE that is used in accordance with infection prevention guidance is required to reduce transmission of the virus and protect HCWs.

In the setting of increasing COVID-19 cases in Australia and concerns about supplies of PPE, many HCWs sought to obtain or make their own PPE.

PPE is classified as a medical device and must be regulated by the TGA under the Therapeutic Goods Act 1989 and must be included in the Australian Register of Therapeutic Goods (ARTG) before they can be supplied.

All PPE must also be approved, prior to use, by existing WA Department of Health and Health Supply Services procurement and product evaluation processes.

Whilst WA Department of Health understands HCWs desire to protect themselves in these unprecedented times, it strongly encourages all HCWs to use TGA listed and WA Department of Health approved masks, gowns and gloves.

WA Department of Health has procured more PPE which has been formally assessed to ensure that stocks conform to proven manufacturing standards with correct documentation that shows compliance. Approved PPE has been and will continue to be provided to all sites. PPE from international manufacturers outside of usual procurement has also been sought which will undergo a thorough compliance assessment prior to its use within WA.

As such, WA Department of Health does not support individual HCWs supplying their own purchased or home-made PPE e.g. masks, gowns or aprons and gloves as there is no guarantee of their effectiveness and suitability for use.

Any PPE that has already been purchased will need to be reviewed through local Product Evaluation and Standardisation Committees or processes.

Should WA health employees not be able to access appropriately approved PPE, they must report this through their line manager to local procurement staff to ensure appropriate stocks can be provided.

The WA Department of Health is committed to ensuring all HCWs have access to appropriate PPE.

Bibliography

1. [Australian Guidelines for the Prevention and Control of Infection in Healthcare](#), Canberra: National Health and Medical Research Council (2019)
2. [Coronavirus Disease 2019 \(COVID-19\) CDNA National Guidelines for public health units](#). Australian Government Department of Health.
3. [Guidance on the minimum recommendations for the use of personal protective equipment \(PPE\) in hospitals during the COVID-19 outbreak](#)
4. Department of Health [Minimising the risk of infectious respiratory disease transmission in the context of COVID-19 the hierarchy of controls](#)
5. Australian Commission on Safety and Quality in Healthcare 2021 [Preventing and Controlling Infections Standard](#)
6. Victorian Health and Human Services Building Authority. [HVAC System Strategies to Airborne Infectious Outbreaks](#). Health Technical Advice ATA-2020-001-Rev B. November 2020
7. [Australian Health Sector Emergency Response Plan for Novel Coronavirus \(COVID-19\)](#)
8. [Interim advice on non-inpatient care of persons with suspected or confirmed Coronavirus Disease 2019 \(COVID-19\), including use of personal protective equipment \(PPE\)](#)
9. [Infectious Diseases Emergency Management Plan \(IDEMP\), WA Health System](#)
10. [Australian Government Infection Control Expert Group \(ICEG\) – Endorsed Infection Control Guidance](#)
11. [Infection Control Expert Group Guidance on the use of personal protective equipment \(PPE\) for healthcare workers in the context of COVID-19](#)

Additional COVID-19 Resources

[Western Australia Department of Health](#)

[Australian Department of Health Coronavirus](#)

[Australian Health Protection Principal Committee](#)

[World Health Organisation Infection Prevention](#)

[Further COVID-19 guidelines for specific settings](#)

Additional Educational resources

- [Donning and fit checking the Cupped respirator \(external site\)](#)
- [Donning and fit checking the Duckbill style P2 or N95 respirator \(external site\)](#)
- [Donning and fit checking the flat fold respirator \(external site\)](#)
- [New South Wales Clinical Excellence Commission – donning and fit check videos](#)
- [Donning and doffing PPE poster \(PDF 1MB\)](#)
- [How to wash hands poster \(PDF 1MB\)](#)
- [N95 and P2 respirator options for WA Health care facilities \(PDF 207KB\)](#)
- [Protect yourself and others poster \(PDF 882KB\)](#)
- [Stop the spread poster \(PDF 848KB\)](#)
- [Wearing a cup style respirator \(PDF 899KB\)](#)
- [Wearing a flat style respirator \(PDF 899KB\)](#)

Version Control History

Revision History			
Version	Date	Revised by	Changes
14	13/05/2022	SHICC IPC	Addition of advice for prescription protective eyewear, management of deceased personal effects, revision of contact tracing, removed reference to epidemiological risk, prolonged episodes of care, revised HCW management section and discharge process. Probable and confirmed cases considered COVID-19 positive case. Reordered and links updated.
13	22/02/2022	SHICC IPC	Inclusion of website links for WA SAR, HCW furlough guidance, transition policies. Inclusion of definition for a rapid antigen test Modification to lift management Inclusion of mask and vaccine exempt essential visitors Change in responsibility of HCW management within a HCF
12	24/01/2022	PHEOC IPC	Definitions added, inclusion of the WA SAR and testing Guidelines, inclusion of WA HCW furlough interim advice. Updated visitor guidelines and testing, revision lift cleaning, showering of patients, types of PPE descriptions expanded.
11	11/08/2021	PHEOC IPC	Lift cleaning - when hospital visit by a person under a direction to quarantine Confirmed vaccination status required to care for suspected and confirmed COVID-19 case Updated guidance for PPE Observer.
10	30/07/2021	PHEOC IPC	Updates to Lift management
9	10/07/2021	PHEOC IPC	Change to mask recommendations Fit testing Updates on PPE breaches, definitions, terminal cleaning
8	31/08/2020	PHEOC IPC	Additional definitions included Added guidance on quarantined visitors entering HCFs on compassionate grounds to visitors' section Added statement in appendix 1 – P2 Masks with exhalation valves are not to be used Added information re minimising PPE pressure related injuries Updated Information on PPE and Table 1 to align with MP 0133/20 V 4.0
7	14/05/2020	PHEOC IPC	Statement on the use of coveralls, head and shoe coverings, self-purchased PPE. Reference to TGA statement on reprocessing single use medical devices, inclusion of table defining differences in levels of gowns and masks. Updates to management of the deceased. Review of contact/airborne precautions
6	08/04/2020	PHEOC IPC	Additional and updated information on care of the deceased, staff uniforms, HCW working requirements, fit checking v fit testing.
5	18/03/2020	PHEOC IPC	Added self-isolation for returned travellers from any country. Added isolation in separate area rather than single rooms

4	03/03/2020	PHEOC IPC	HCW who have travelled in or transited from countries listed as higher risk must not work in a HCF for 14 days since leaving the high-risk country.
3	28/02/2020	PHEOC IPC	Addition to aerosol generating procedures, HCW management, PPE table included, obstetric and neonatal management
2	17/02/2020	PHEOC IPC	Update on breaches in PPE for HCWs
1	14/02/2020	PHEOC IPC	Initial draft developed by PHEOC

Last updated 13/05/2022 – SHICC IPC V14

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