Coronavirus Disease - 2019 (COVID-19)

Infection Prevention and Control in Western Australian Healthcare Facilities

Version 13
Last updated: 22/02/2022
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@health.wa.gov.au.

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For full revision history please refer to Version Control at the end of this document.
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 contacts: CDNA case definitions need to be accessed to ensure current criteria are referenced.

Community transmission: when there are multiple COVID-19 cases in the community and where the source is unknown and presumed to have been acquired from another case within that jurisdiction.

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.

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.

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

**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.

**Epidemiological risk:** in WA, an epidemiological risk is defined as those persons who are subject to quarantine requirements, including international passengers, international flight and maritime crew, interstate arrivals from restricted locations and persons identified as close contacts of a confirmed COVID-19 case.

**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.

Prolonged episodes of care: direct face to face contact with a patient when duration is 15 minutes or more and where physical distance cannot be maintained.

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.

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.

Symptomatic: People who have at least one COVID-19 like symptom and should be tested for SARS-CoV-2. Refer to CDNA testing guidelines

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).

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.

These 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. These guidelines pertain to the management of confirmed or probable COVID-19 cases and to those persons admitted to hospital under a quarantine Direction i.e. non vaccinated traveller returning from interstate or overseas and identified close contacts of a confirmed case.

The guidance in the COVID-19 Infection Prevention and Control in Western Australian Healthcare Facilities guideline (this document) is 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

This document provides guidance for the management of patients who are admitted to HCFs in WA, including acute mental health facilities, with confirmed or probable COVID-19 and those persons admitted to hospital under a quarantine Direction. These 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).

**Standard precautions** are intended to be applied to the care of all patients in a healthcare setting, regardless of whether the presence of an infectious agent is suspected or has been confirmed. Implementation of standard precautions is the primary strategy for the prevention 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.

**Transmission-based precautions** are implemented for patients known or suspected to be infected or colonised with an infectious agent, where transmission is not completely interrupted using standard precautions alone. The three categories of transmission-based precautions are contact, droplet and airborne precautions and are implemented based on the route of transmission of the infectious agent.

**Use of the Hierarchy of controls** to occupational hazards is the main way to protect staff 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.
### 3.1 Examples of hierarchy of control measures

<table>
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<th>Hierarchy of control measure</th>
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| **Elimination** – reduce the opportunities for the virus to spread | • Vaccination of HCWs, patients and visitors  
• Staff exclusion from workplace if unwell  
• Reduce number of HCWs who enter isolation rooms |
| **Substitution** – find alternative ways of providing care that reduces the potential for transmission | • 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 | • HVAC assessments  
• Use of NPIR  
• Single rooms with ensuite  
• Air purifiers |
| **Administrative controls** – effective and consistent implementation of policies and procedures | • Mandatory vaccination and HCW restrictions  
• Hand hygiene compliance  
• Cleaning and disinfection  
• Signs, posters, information sheets |
| **PPE** – use of correct personal protective equipment | • Surgical masks for all visitors, patients and staff entering a HCF  
• Appropriate PPE  
• Fit test those wearing PFR |
4. Infection Prevention and Control for COVID-19

**KEY PRACTICE POINT 1: MASK DIRECTION**

In the event of community transmission and 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 staff, patients and visitors to don a surgical face mask on entry to the HCF 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 staff, 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 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 a confirmed or probable COVID-19 case OR under a quarantine Direction, must wear a fit tested particulate filter respirator (PFR), protective eyewear, gown and gloves.

HCWs providing prolonged episodes of care to these 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.

Standard and transmission-based precautions must be used for all patients with or suspected to have infections other than COVID-19 as described in the *Australian Guidelines for the Prevention and Control of Infection in Healthcare.*
5. Patient presentations

Placement of patients who are a confirmed or probable COVID-19 case OR under a quarantine Direction OR those presenting with symptoms of COVID-19, in a negative pressure isolation room (NPIR), when available, is the preferred approach to patient management in WA HCFs. See Key Practice Point 4: NPIR Allocation.

Pre-emptive testing with either RAT or 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

All HCFs should assess the heating ventilation and air conditioning (HVAC) systems in their emergency departments or urgent care centres and consider the need to deploy portable air purifiers with high efficiency particulate absorbing (HEPA) filters to improve air quality.

The following actions are to be taken when a patient is a confirmed or probable COVID-19 case OR under a quarantine Direction:

- 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.

- Confirmed or probable COVID-19 patients OR patients under a quarantine Direction that are symptomatic for COVID-19 OR patients presenting with symptoms of COVID-19 are to be isolated and assessed in a NPIR as a priority. If a NPIR is not available, use a standard isolation room or single room with negative airflow and the door closed. Avoid rooms with positive pressure airflow.

- For patients under a quarantine Direction who are asymptomatic for COVID-19, 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.

- 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.

- 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.
If a patient presents to an outpatient setting, including mental health facility, who meets the criteria of a confirmed or probable COVID-19 case OR is under a quarantine Direction OR patients presenting with symptoms of COVID-19, they should be managed in conjunction with the closest COVID-19 clinic or emergency department depending on the patient’s condition.

If admission is not required and the patient can return to the community or to their place of quarantine, ensure:

- the patient knows to isolate at home, if not already, and to minimise contact with other people
- the patient is provided with a patient information sheet on Quarantine after being tested
- 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 for confirmed or probable COVID-19 cases OR for a patient under a quarantine Direction

**KEY PRACTICE POINT 4: NPIR ALLOCATION**

Confirmed or probable COVID-19 case OR those under a quarantine Direction OR patients presenting with symptoms of COVID-19 are to be prioritised to a NPIR with an ante room when possible or a designated COVID-19 ward that has undergone a ventilation review with risk mitigation strategies in place to improve air quality e.g. air purifiers.

For patients under a quarantine Direction who are asymptomatic for COVID-19, if there is no NPIR available, a risk assessment is to be made in discussion with the local IPC team, on any increased risk of SARS-CoV-2 transmission e.g. severe coughing, need for AGPs, or if the patient is exhibiting AGBs.

Rapid COVID tests (GeneXpert) or Rapid Antigen Test (RAT) may be useful in mitigating risk in these situations.

When transferring a guest from a SQF for care in a WA HCF, an assessment on the availability of a NPIR at the receiving facility needs to be considered by the Agency responsible for transfer.

HCFs will need to risk assess if they have patients under a quarantine Direction who are asymptomatic and patients with other infectious diseases spread via the airborne route and which patient has the greater need for a NPIR.

6.1 Patient placement

- Admit patient to appropriate room in accordance with Key Practice Point 4. If single rooms are utilised, those with ensuite facilities are preferred, 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.

- 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.

- Single rooms must be assessed for positive / neutral / negative air pressure and a room with positive pressure to adjacent areas should not be used. 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.

- Interdepartmental transfers are to be restricted unless patient management will be compromised e.g. admission to intensive care or necessary procedural investigations.

- Transfers to other HCFs are to be limited unless medically necessary.

- Transfers to other facilities e.g. residential care, prisons, should be done in conjunction with public health advice.
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.

- Patients with confirmed or probable COVID-19 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. A review of HVAC systems, air flows and air exchanges should be undertaken before any area is designated as an isolation or cohort area.

- HCFs should consider reducing bed numbers in shared rooms e.g. if a four-bed room, reduce occupancy to two beds. 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. catheter care and administration of intravenous therapy. Adherence to the ‘5 Moments’ of hand hygiene is essential.

- Upon leaving the cohort ward all PPE must be removed and discarded.

- The cohort ward may be divided into zones such as red and amber. HCFs may designate amber zones where gowns and gloves may be removed except for the PFR and protective eyewear e.g. the nurse’s station or treatment room. These zones must be clearly identified.

6.3 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.
6.4 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 aerosolisations 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.

6.5 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.

6.6 Environmental cleaning principles

- 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.

6.6.1 Daily cleaning
• Cleaning staff are to wear PPE in accordance with contact and airborne precautions.

• 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.

6.6.2 Terminal cleaning of NPIR and standard rooms
• Cleaning staff are to wear PPE in accordance with contact and airborne precautions, 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

7. Food services
- Non-essential staff should be restricted from patient rooms or cohort wards. Food services staff should deliver all food and beverages to the 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 and placed in a designated collection area. In a designated cohort ward a dedicated catering staff member may be allocated with appropriate PPE training.
- 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.

8. 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.
- Used linen is to be 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.
- Avoid agitating the linen which can cause aerosolisation of any infectious particles.
- The linen skip must be replaced when ⅔ 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.
9. 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, bedside 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. 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.

11. 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.

- All waste shall be bagged and securely sealed prior to exiting the patient room.

12. 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.

12.1 Patient transport within HCFs

Patient transfers within a HCF can be conducted as per standard protocols if the confirmed or probable COVID-19 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 confirmed or probable COVID-19 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 cordonning 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.

12.2 Patient transport between HCFs

- If transfer to another HCF is required for medical management, the inter-hospital patient transport provider and receiving facility must be advised of the patient’s status and condition prior to transport.
- 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.

12.3 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.
13. Patient discharge

- The treating team may consider discharging and managing confirmed COVID-19 cases who have not yet met release from isolation criteria at home with appropriate services if the following occurs:
  - a risk assessment is conducted regarding the suitability of the accommodation and living arrangements, including who else is in the home and their vulnerability to disease
  - it can be assured that the home environment permits separation of the case from other household members
  - the case and household contacts are counselled about the risk, and appropriate infection prevention and control measures are in place
- These cases may be considered suitable for entry into the WA COVID Care at Home program if they still require monitoring of COVID-19 symptoms.
- If the patient is discharged while still infectious, ensure the patient and family members are instructed on appropriate IPC in the home. Please note additional resources for Aboriginal people.
- Public Health Operations is to be notified of the discharge or transfer to another facility of any confirmed or probable COVID-19 patients or those transferring back to a SQF. Telephone 1300 316 555 (8am to 5pm, 7 days a week). Handover information should include:
  - name and date of birth, patients’ contact details and discharge destination
  - COVID clearance status i.e. if already cleared during admission, or if handing over to be completed in the community
  - support status on discharge i.e. can they reply to SMS, is there a next of kin better placed to reply, are they better place to receive a phone call
  - symptom status on day of discharge to inform clearance, where applicable.
- A confirmed COVID-19 case recuperating at home must remain in isolation until the release from isolation criteria are met.
- Patients who are confirmed COVID-19 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 or warm soapy water
  - alternatively, the HCF transport service can be used and the HCFs vehicle cleaning procedure followed.

14. Release from isolation

- All confirmed COVID-19 patients are to remain under transmission-based precautions until the patient is discharged or the release from isolation criteria are met. The criteria are:
  - if a patient has no symptoms after 7 days since their first positive test, they may leave isolation
  - if acute respiratory symptoms remain after 7 days have passed since their first positive test, the patient should remain in isolation until their acute symptoms have resolved
confirmed cases who are severely immunocompromised may have reduced ability to effectively clear the virus and have a prolonged infectious period and therefore may be required to meet additional criteria prior to release from isolation.

- 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.
- Discontinuation of precautions must be discussed with the HCFs IPC team. See Department of Health WA Release from isolation - Information for all clinicians.

15. 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.
- HCWs are to wear PPE consistent with contact and airborne precautions 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.
- 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.
- Deceased persons must be placed in a leak proof body bag for transport
- Inform mortuary staff of the deceased persons confirmed or probable status prior to transfer.
- 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.

16. 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
- HCF’s are encouraged to use the Safe WA or Service WA application or maintain a register to log visitor attendance in the event contact tracing is required.
- 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.
- Alcohol-based hand rub (ABHR) is to be readily available throughout the facility.
• 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.

16.1 Visitors to confirmed or probable COVID-19 patients

• The decision to allow visitors to a confirmed or probable COVID-19 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 confirmed or probable COVID-19 case 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.

16.2 Visitors under quarantine Direction

• There are specific circumstances where a request may be made by a person who is under a quarantine Direction i.e. unvaccinated international arrival to visit an HCF e.g. family member is critically unwell and unlikely to survive the visitors quarantine period.

• These visits must be carefully planned prior to the presentation of the visitor. Please refer to the Principles for healthcare and residential care facilities - visits from people in quarantine.

• These visitors will require approval from WAPOL to receive a Temporary Centre Direction Amendment to allow them to leave the place of quarantine, proof of a recent COVID-19 ‘not detected’ laboratory result and approval from the Chief Executive of the HCF where the visit will occur.

• Visitors must comply with the Directions for testing and must have a negative COVID-19 result prior to their visit.

• Visitors displaying any COVID-19 like-symptoms are not to visit.

• A surgical mask must be worn once the visitor leaves their accommodation and until they return, this includes while they are in the room with the patient.

• They are not to visit a patient in a shared room or an open area i.e. the patient being visited is to be in a room by themselves, with the door closed.

• The HCF is to:
  – ensure consultation with their IPC team occurs for the management of these visits
  – consider making the scheduled visit outside of busy times
  – provide an escort for the visitor from commencement of the visit to conclusion.
  – the escort is required to wear a PFR and protective eyewear and maintain physical distance, where possible.
  – the escort is to ensure the visitor does not touch any surfaces along the route and within the lift if utilised
- establish a predetermined route for the visitor that minimise contact with others
- no other visitor is allowed in the room
- should clinical staff need to enter the room whilst the visitor is present, they need to don a PFR and eyewear
- if the above protocol has been followed, additional cleaning of the lift does not need to occur.
- items the visitor has touched in the patient room must be cleaned and disinfected.

17. Healthcare worker management

17.1 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. Refer to the Testing Guidelines for further information.

• 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.

17.2 Healthcare worker testing

• The WA SAR provides guidance on COVID-19 testing for HCWs:
  - HCWs are to seek immediate testing is they develop any symptoms compatible with COVID-19
  - when a breach in IPC protocols is found
  - who are asymptomatic but are working in high-risk settings.

• Asymptomatic HCWs do not have to quarantine while awaiting test results.

17.3 Rostering and staff placement

• HCFs are to minimise exposure of staff to confirmed or probable COVID-19 or those under a quarantine Direction 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 confirmed or probable COVID-19 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.
• It is preferable HCWs who are permanent employees or on a fixed term contract, without secondary employment, are assigned to care for confirmed or probable COVID-19 patients or those under a quarantine Direction.

• It is preferable that HCWs assigned to care for confirmed or probable COVID-19 patients or those under a quarantine Direction 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 patient with confirmed or probable COVID-19 or those under a quarantine Direction.

• HCFs are to have protocols in place for student HCWs and students undertaking work experience.

• A staff log should be maintained of all staff entering the room of a confirmed or probable COVID-19 patient to allow for monitoring of potential IPC breaches and contact tracing. This document should be managed with consideration for staff privacy. See Appendix 4: Staff Register.

17.4 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.

17.5 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.
17.6 Management of HCW exposed to COVID-19

- HCFs are responsible for implementing contact tracing within the hospital for all HCWs as per the Guidelines for management and contact tracing of COVID-19 with exposure in the hospital setting and managing the impact on their workforce.

- 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 confirmed or probable COVID-19 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 confirmed case of COVID-19 are not considered close contacts unless there has been a breach of PPE.

- When a HCW has had an exposure to a confirmed or probable COVID-19 case or a symptomatic person under a quarantine Direction, 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.

- HCFs should notify outcomes to Public Health Operations via email to ncovcontact@health.wa.gov.au.

- 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.

- Positive HCWs will be contacted by the Public Health Operations team and advised of proper management.

18. Contact tracing and management of patients

Refer to the CDNA National Guidelines for definitions of contacts and the management of contacts.

Contact tracing will need to be undertaken by the HCF IPC team for inpatients as per the Guidelines for management and contact tracing of COVID-19 with exposure in the hospital setting.
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.

- 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.

• 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

<table>
<thead>
<tr>
<th>Characteristics*</th>
<th>Level 1 barrier</th>
<th>Level 2 barrier</th>
<th>Level 3 barrier</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application</td>
<td>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</td>
<td>For use in emergency departments, dentistry, changing dressings on small wounds or healing wounds where minimal blood droplet exposure may occur</td>
<td>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</td>
</tr>
<tr>
<td>Bacterial filtration efficiency (BFE), %</td>
<td>≥95</td>
<td>≥98</td>
<td>≥98</td>
</tr>
<tr>
<td>Differential pressure, mm, H₂O/cm²</td>
<td>&lt;4.0</td>
<td>&lt;5.0</td>
<td>&lt;5.0</td>
</tr>
<tr>
<td>Resistance to penetration by synthetic blood, minimum pressure in mmHg for pass result</td>
<td>80 mmHg</td>
<td>120 mmHg</td>
<td>160 mmHg</td>
</tr>
</tbody>
</table>

*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.
- 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.

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

<table>
<thead>
<tr>
<th>Donning PPE</th>
<th>Doffing PPE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Perform hand hygiene</td>
<td>Gloves</td>
</tr>
<tr>
<td>Gown</td>
<td>Perform hand hygiene</td>
</tr>
<tr>
<td>Mask</td>
<td>Gown/apron</td>
</tr>
<tr>
<td>Protective eyewear/visor</td>
<td>Perform hand hygiene</td>
</tr>
<tr>
<td>Perform hand hygiene</td>
<td>Protective eyewear</td>
</tr>
<tr>
<td>Gloves</td>
<td>Perform hand hygiene</td>
</tr>
<tr>
<td></td>
<td>Mask</td>
</tr>
<tr>
<td></td>
<td>Perform hand hygiene</td>
</tr>
</tbody>
</table>

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

PPE use in COVID-19 cohort wards

- Donning and doffing should be performed in dedicated and separated areas that are clearly identified with signage.
- Gowns, masks and protective eyewear do not need to be removed between patients unless they are visibly soiled.
- Gloves must be changed between patients with adherence to the 5 Moments of Hand Hygiene.
- Upon leaving the cohort ward all PPE must be removed and discarded.
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 confirmed or probable COVID-19 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: Staff register

The following information is to be captured for each HCW providing care to a confirmed or probable COVID-19 patient or those under a quarantine Direction.

<table>
<thead>
<tr>
<th>STAFF REGISTER</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>DATE</td>
<td>FULL NAME</td>
<td>JOB DESCRIPTION</td>
<td>TIME IN</td>
<td>TIME OUT</td>
<td>COVID Vaccination Status</td>
<td>Correct fit PFR worn</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>F = fully</td>
<td>Y / N</td>
</tr>
<tr>
<td>CONTACT NUMBER (mobile preferred)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Fit-check and fit-test of particulate filter respirators

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 6: PPE Observer Checklist

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

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

Comments / Actions:

* Particulate Filter Respirator
Appendix 7: 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)


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


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

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

<table>
<thead>
<tr>
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<th>Changes</th>
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<tr>
<td>12</td>
<td>24/01/2022</td>
<td>PHEOC IPC</td>
<td>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.</td>
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| 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                                                                                                        |