



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

# **Coronavirus Disease – 2019 (COVID-19)**

## **Infection Prevention and Control in Western Australian Healthcare Facilities**

**Version 18.1**

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## Document Purpose

This document has been developed by the Infection Prevention Policy Surveillance Unit 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:

- Changes in advice based on emerging evidence or national guidelines
- Learnings from COVID-19 management locally, in other jurisdictions and internationally
- Stakeholder engagement and feedback.

Version	Date	Author	Updates / Changes
18.1	10/10/2023	IPPSU	Section 5: Removal of requirement to register positive RAT.

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

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## Definitions/ Abbreviations

**Acute Respiratory Infection (ARI):** is defined as a recent onset of new or worsening acute respiratory symptoms: cough, breathing difficulty, sore throat, or runny nose/nasal congestion.

**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 to [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.

**Airborne precautions:** a set of infection prevention practices used to prevent transmission of infectious agents that are spread 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 PFR, protective eyewear and other PPE as required as per standard precautions. The patient is accommodated in a NPIR when possible.

**Close contact:** [CDNA case definitions](#) need to be accessed to ensure current criteria are referenced. Refer to [HealthyWA](#) for jurisdictional definition of a close contact.

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

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

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

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

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

**COVID-19 positive:** applies to confirmed (PCR positive) and probable (RAT positive) as per [CDNA case definitions](#).

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

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

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

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

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

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

**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.

**Probable case of COVID-19:** [CDNA case definitions](#) need to be accessed to ensure current criteria are referenced. For the purpose of this document a probable case is considered a positive case.

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

**Rapid Antigen test (RAT):** is an alternative testing method that can be self-administered and provides fast results following the collection of a respiratory sample to detect the presence of viral proteins produced by SARS-CoV-2.

**Reinfection:** a subsequent confirmed SARS-CoV-2 infection in a person with a prior history of confirmed or probable COVID-19 that is determined to be a separate episode to the first based on epidemiological and/or laboratory findings.

**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. The use of standard precautions aims to minimise, and where possible, eliminate the risk of transmission of infection.

**Symptomatic:** People who have at least one COVID-19 like symptom. As defined in the [CDNA case definitions](#).

**Transmission Based Precautions (TBP):** Practices used in addition to standard precautions to prevent transmission of infection. TBPs include contact, droplet and airborne precautions and are used for patients known or suspected to be infected or colonised with epidemiologically important or highly transmissible pathogens. They are implemented based upon the mode of transmission of the pathogen.

**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).

This *Guidelines* provides infection prevention and control (IPC) guidance for managing patients with suspected or confirmed COVID-19 and other acute respiratory illnesses (ARIs) in healthcare settings. ARIs are included in this *Guideline* as all persons presenting with ARI symptoms should be managed as suspected COVID-19 until proven otherwise. HSPs should develop guidelines based on their local risk assessments and established IPC principles that are outlined in this *Guideline*.

For further background information on SARS-CoV-2 and COVID-19 refer to [Communicable Diseases Network Australia \(CDNA\) Series of National Guidelines](#), which contains sections on the infectious agent, mode of transmission, case definitions, infectious period, incubation period, testing, and contact tracing. The *Guidelines* is a related document to the WA [Mandatory Policy 0172/22 Personal Protective Equipment in Healthcare Facilities Policy](#) that reflects local WA requirements for personal protective equipment (PPE).

## 2. Key Principles

- SARS-CoV-2 is primarily transmitted by exposure to infectious respiratory particles. Exposure occurs primarily through three routes:
  - Inhalation of respiratory particles
  - Deposits of respiratory particles on mucous membranes (mouth, nose, eyes)
  - Touching of mucous membranes with hands directly contaminated with virus containing respiratory particles or indirectly by touching surfaces contaminated with virus containing respiratory particles
- Variants of Concern (VOCs) will continue to emerge, and this *Guideline* aims to mitigate risks pertaining to variants of differing infectivity and transmissibility
- Understanding standard and transmission-based precautions is essential in preventing the transmission of COVID-19 and ARIs in healthcare settings.
- Any person presenting with symptoms of an ARI should be presumed to have COVID-19 until proven otherwise
- The application of the [hierarchy of controls](#) will significantly reduce healthcare transmission of the virus
- Manage routine care of suspected or confirmed cases of COVID-19 using personal protective equipment (PPE) outlined in this *Guideline*.

## 3. Symptoms of Acute Respiratory Infection

Patients with symptoms of an ARI, also known as influenza-like illness (ILI) should be considered to have COVID-19 until an alternative diagnosis is determined, if in the last 7 days they have experienced:

- recent onset of new, or worsening symptoms, of ARI (e.g. cough, breathing difficulty, sore throat, runny nose/nasal congestion), with or without other symptoms
- other symptoms may include:

- headache, myalgia, fatigue, diarrhoea, nausea/vomiting, loss of appetite loss of smell or loss of taste (less common with new VOC),
  - fever ( $\geq 37.5\text{C}$ ) or history of fever (e.g. night sweats, chills), less common in elderly
  - in the elderly consider, new or increased confusion, change in baseline behaviour, falling, exacerbation of underlying chronic illness.
- Clinical judgement should be applied where there are alternative clinical explanations for symptoms or non-specific symptoms are present.

## 4. Infection Prevention and Control General Principles

### Standard precautions

Standard and transmission-based precautions must be used for all patients presenting with symptoms of an ARI as described in the [Australian Guidelines for the Prevention and Control of Infection in Healthcare](#)

Standard precautions should be used when providing care to all patients, whether or not they are suspected of having COVID-19 and are necessary to help prevent exposure/infection by asymptomatic or pre-symptomatic carriers of COVID-19.

Standard precautions include hand hygiene, appropriate and correct use of PPE, respiratory hygiene and cough etiquette, reprocessing of reusable medical devices, cleaning of shared equipment, aseptic technique, appropriate sharps/waste handling and disposal, appropriate handling of linen and routine environmental cleaning.

### Transmission-based precautions

Transmission-based precautions (TBP) are implemented in addition to Standard Precautions for patients suspected of, or confirmed with, COVID-19, including close contacts.

The use of standard, contact, droplet and airborne precautions in COVID-19 care acknowledges the complex interplay of modes of transmission, and decisions about PPE are made in the context of this continuum of risk. HSP should follow local policy on TBP.

## 5. Patient Risk Assessment, Placement and PPE

All patients presenting to a HCF should be assessed to determine if transmission-based precautions are required and whether COVID-19 testing should be considered if clinically appropriate.

Early recognition and the prompt isolation of COVID-19 positive patients and those symptomatic of an ARI is essential to reduce the transmission of COVID-19.

The [Work Health and Safety Act 2020](#) provides a framework to protect the health, safety and welfare of workers in WA workplaces, and of other people who might be affected by the work. This also applies to the assessment and management of risk related to the transmission of COVID-19.

PPE is a critical part of infection prevention and control. However, PPE should be considered the last line of defence within a broader 'hierarchy of controls' framework, which includes minimisation of risk through the implementation of administrative and engineering controls and other interventions in combination with appropriate PPE.

### 5.1 Mask wearing for healthcare workers

Current advice in this *Guideline* describes requirements for the management of patients during periods of low risk of community transmission of COVID-19, where **additional** IPC measures such as routine healthcare worker mask wearing is not required.

HCFs may reinstall the recommendation of masking for healthcare workers in clinical areas:

- as part of their winter respiratory virus strategy, should the degree of COVID-19 or other acute respiratory virus activity warrant it
- during specific situations, such as a ward respiratory virus outbreak, when local infection prevention and control (IPC) experts and Infectious Disease Physicians/Clinical Microbiologists can advise regarding the use of masking based on a risk assessment
- if an inter-seasonal COVID-19 surge occurs due to the introduction into WA of a new more transmissible and/or more virulent SARS-CoV-2 variant.

In addition, individual HCFs may have specific areas (e.g. bone marrow transplant unit) where mask wearing by HCWs remains routine, to be decided at an individual HCF level.

## Personal Protective Equipment

**HCWs providing care to those patients admitted to a WA HCF who are COVID-19 positive, symptomatic of an ARI or are a COVID-19 close contact must wear the following PPE at a minimum:**

- a fit tested particulate filter respirator (PFR) and protective eyewear (face shield or goggles)

**Standard precautions always apply**, and healthcare workers should continue to:

- wear gloves if there is risk of exposure to blood / bodily fluids
- make use of an apron/long-sleeved gown to protect their uniforms from being soiled during:
  - significant close physical contact with the patient
  - when providing lengthy, face to face care with an infectious patient who is unable to wear a surgical mask
  - when providing care to the patient during aerosol generating procedures, particularly if for lengthy periods of time.

Refer to [Appendix 1](#) and the Australian Government Department of Health, [Guidance on the use of personal protective equipment \(PPE\) for health workers in the context of COVID-19](#).

## 5.2 Testing

All patients presenting to a HCF who are symptomatic for COVID-19 should have a RAT and/or polymerase chain reaction (PCR) performed to guide treatment options and infection prevention and control management.

- COVID-19 is listed as a notifiable disease under the Public Health Act 2016 and hospital clinicians must notify the Communicable Disease Control Directorate (CDCD) of all positive cases.
- The WA Department of Health no longer requires registration of positive RAT results.

- Collect respiratory specimens in accordance with current recommendations in the [Coronavirus Disease 2019 \(COVID-19\) CDNA National Guidelines for Public Health Units](#)
- Refer to [Public Health Laboratory Network COVID-19 swab collection](#) for further details.

### **5.3 Patient room placement**

- HCF have varying types and quantities of patient accommodations. The risk assessment process should involve local IPC experts and consider IPC principles, including transmission-based precautions and the hierarchy of control, the use of negative pressure isolation rooms (NPIR), single rooms, non-COVID-19 isolation requirements (e.g. patients with other airborne pathogens) and a risk assessment.
- Use negative pressure rooms with an anteroom for COVID-19 positive patients where available. Where not available, a standard isolation room with ensuite facilities is preferred with a portable air purifier, and if this option is unavailable, use a single room with a portable air purifier and allocate a dedicated bathroom/toilet.
- When single rooms are utilised without a portable air purifier, consideration is to be given to transferring the patient to an NPIR if an AGP is to be undertaken.
- HCFs should be aware of airflows and ventilation of all rooms to support risk-based room allocation. Risk mitigation strategies to optimise ventilation (including in shared care areas) such as the use of portable air purifiers should be implemented to improve air quality. Refer to [section 9.1.1](#).
- All COVID-19 positive patients, close contacts and symptomatic ARI patients are to be encouraged to wear a surgical mask in shared inpatient and outpatient areas, including the Emergency Department and during transport.
- Supply the patient with additional masks to enable changing the mask every four hours or if damp, soiled or damaged. Ensure the mask is worn correctly. The requirement for patients to wear a mask must not compromise their clinical care.
- Interdepartmental transfers are to be restricted unless patient management will be compromised e.g. admission to intensive care or for necessary procedural investigations.
- 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.
- Signage clearly 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.

### **5.4 Cohorting**

- HCFs should use a risk assessment process to manage the risk of infection in their facility.
- It may be necessary to place COVID-19 cases in shared rooms at times of high COVID-19 prevalence with associated hospitalisations. The decision to create cohort rooms and wards will need to be undertaken in discussion with HCF, Executives, Clinical Leads, Infectious Diseases Physicians and the IPC experts.
- COVID-19 positive patients should not be cohorted with patients who have not yet been diagnosed with COVID-19.

- Signage clearly indicating the appropriate transmission-based precautions and required PPE is to be placed at the entrance of the cohort area.
- HCFs should consider reducing bed numbers in shared rooms e.g. reducing a four-bed room to two beds and include the use of a portable air purifiers. All positive cases, people with acute respiratory symptoms and close contacts should wear a surgical mask if their clinical condition allows.
- In a cohort ward, eye protection, masks and gowns may remain insitu for staff working between patients providing they are not damaged or soiled. Gloves must be changed between patients, and between different procedures on the same patient e.g. mouth care and then urinary catheter care, with adherence to the ‘5 Moments’ for hand hygiene.
- Upon leaving the cohort ward all PPE must be removed and discarded.

## **5.5 Personal patient care**

- Indoor bathrooms are often poorly ventilated, and 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. Staff should avoid getting their mask wet and replace PPE as soon as possible after showering the patient.
- In the case of patients who require minimal assistance with personal hygiene, the risk of disease transmission to staff may be reduced by minimising the time spent in the bathroom with the patient if it is safe to do so.

## **5.6 Patient transport**

Internal and external hospital transfers are to be restricted unless clinical management of the patient will be compromised.

### **5.6.1 Patient transport within HCFs**

Patient transfers within a HCF can be conducted as per standard protocols. COVID-19 positive patients should be encouraged to wear a minimum of a surgical mask if tolerated for the duration of the transfer. Other alternatives may include a personal ventilation hood or similar source control device.

- 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 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 the room or department.
- The HCWs accompanying the patient must don fresh PPE prior to transfer.

### **5.6.2 Patient transport between HCFs**

- Transfer of a COVID-19 case should only occur if medically required. This may include situations where the level of required clinical care is not available or where care can be provided closer to home.
- The decision to transfer a patient to another hospital should be made on a case-by-case basis by the treating and receiving teams and should follow existing processes. Symptomatic patients who are not already identified as cases should undertake a RAT within 24 hours of transfer.

- Patients are to wear a surgical mask, and if on oxygen therapy be 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 oxygen mask prior to transport.

## 5.7 Patient discharge

- The decision to discharge a patient back to a residential facility must be agreed with the consultant/senior medical practitioner and the residential facility to ensure the facility is equipped to clinically manage the patient.
- Residential facilities may include Aged Care, Disability, Mental Health, and group homes.

## 5.8 Isolation and restriction guidance

- All COVID-19 positive patients are to be cared for using transmission-based precautions.
- For isolation and restriction guidance refer to the [Coronavirus Disease 2019 \(COVID-19\) CDNA National Guidelines for Public Health Units](#).
- The requirement for further testing in significantly immunocompromised patients may be determined by the treating clinician, in liaison with a Clinical Microbiologist/ID physician as needed. Refer to local policies/guidelines if available.

## 5.9 Management of the deceased

While the risk of transmission of COVID-19 from the deceased is low, there is likely to be a continuing risk of infection from handling body fluids and tissues of people confirmed as COVID-19 positive.

- There may be a risk of exposure to SARS-CoV-2 during:
  - droplet generation while caring for the deceased
  - post-mortem examination or implant removal involving the use of power tools, which is a risk for aerosol generation
  - direct contact with contaminated material such as soiled clothing or bedding from the deceased and the surrounding environment.
- There is no evidence of an increased risk of transmission of SARS-CoV-2 to those managing the deceased. Standard precautions apply and HCWs are to wear appropriate PPE when preparing the body for transport.
- HCWs should follow standard precautions when moving the body which include:
  - performing hand hygiene before and after contact with the deceased body
  - avoiding unnecessary handling of the deceased body that may expel air from the lungs
  - wearing appropriate PPE while handling the deceased body.
- For transportation, secure the body in a leak-proof body bag to prevent leakage of body fluids. Refer to individual HCF guidance for the care of the deceased.
- Family members can view the deceased. After the viewing, bereaved should immediately wash their hands or use an alcohol-based hand rub.
- Inform mortuary staff of the deceased persons COVID-19 positive status prior to transfer.
- Patient valuables are to be managed in accordance with HSP policy. Where there are personal items the family wish to collect, wipe over them with a disinfectant wipe if

appropriate, and place in a plastic bag. Clothing can be bagged and next of kin advised to launder as per normal practice, with preference for a hot wash.

- Mortuary HCWs are to follow routine institutional guidelines for management of the deceased. Further information for advice for religious or ceremonial preparation and funeral practices can be found in [Advice for funeral directors](#).

## 6. Visitors

- Healthcare facilities should continue to support patients to receive visits from partners, family, friends, participants in care, carers and/or volunteers whilst maintaining a safe environment to minimise the risk of transmission of any infectious disease.
- Visitors to high-risk areas or visiting vulnerable/immunocompromised patients are strongly encouraged to wear a surgical mask.
- Surgical masks should be available for all visitors to access whilst visiting these patients. This will include having surgical masks available at hospital entry points and ward reception areas.
- Visitors unwell with an ARI should not visit patients until symptoms have resolved.

## 7. Contact Tracing

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

### 7.1 Definitions

Case and close contact definitions are available in the [Coronavirus Disease 2019 \(COVID-19\) CDNA National Guidelines for Public Health Units](#). Refer to [HealthyWA](#) for jurisdictional definitions.

### 7.2 Follow up of COVID-19 positive case

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

## 8. Outbreak Escalation Process

The hospital's outbreak management committee should consider the following possible triggers for escalation via their Chief Executive:

- if there are significant exposures within the hospital, for example large numbers of staff are required to be excluded from the HCF
- if there is an outbreak in a vulnerable cohort e.g. immunocompromised patient's
- if there is ongoing wide-spread transmission
- if the hospital exceeds capacity at a specialist level e.g. an oncology ward if affected by the outbreak, or at a hospital wide level.

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

Outbreaks should be notified to WA Department of Health, Communicable Disease Control Directorate, Infection Prevention and Policy Surveillance Unit (IPPSU) via the [Outbreak Notification Form](#).

## **9. Management of the Environment**

### **9.1 Ventilation**

All HCFs should assess the heating ventilation and air conditioning (HVAC) systems determine suitability of accommodations and minimum time required to enable a minimum of six air changes per hour (ACH).

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 the facility's IPC experts.

Consider the use of portable air purifier with high efficiency particulate air (HEPA) filtration in areas where existing HVAC systems are sub-optimal in providing fresh air and circulation, and where negative pressure facilities have been exhausted.

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

For further information refer to the [Optimising ventilation for infection prevention and control in healthcare settings](#).

#### **9.1.1 Use of portable air purifiers**

When using an air purifier:

- ensure the unit has a HEPA filter, which is managed in accordance with local protocols and manufacturer advice;
- ensure the unit is the appropriate size for the space; and
- develop local policies for use and maintenance of devices, including the replacement of HEPA filters as per manufacturer instructions.

Each HCF should assess the need for the use of portable air purifiers. Location and positioning of the air purifiers will vary and will be dependent on individual HCF configurations and risk assessment. Placement of portable air purifiers may include the following settings:

- close to the patient in single rooms without negative pressure air handling
- close to the patient in cohort rooms without negative pressure air handling
- corridors of high-risk areas, such as COVID-19 wards without negative pressure rooms
- in procedure/ treatment rooms following aerosol-generating procedures
- multi-bed shared room
- dialysis setting
- areas of high traffic flow e.g. emergency departments
- where there is an increased risk of transmission such as staff tea rooms, reception areas and nurses' stations
- patient waiting areas

### **9.2 Patient care equipment**

- Disposable, single-use patient care equipment is to be used when possible and disposed of into appropriate waste streams after use.
- Dedicate non-critical items to the patient's room for the sole use of the patient for the duration of their admission e.g. stethoscope, tourniquet.
- Minimal stocks of non-critical disposable items e.g. dressings, kidney dishes etc., are to be stored in the room. On patient discharge, these items are to be disposed of.

- 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.

### **9.3 Environmental cleaning**

- Each HCF is responsible for ensuring documentation is available on the specific products to be used for cleaning and disinfection including instructions for use and safety data sheets.
- Disinfectant must be approved by the [Therapeutic Goods Administration](#) (TGA), hospital grade with viricidal properties and be approved for use by the HCF.
- As disinfectants are inactivated by organic material, cleaning with a neutral detergent solution prior to disinfection is required if visible soiling is evident. The use of a 2 in 1 detergent and disinfectant solution or combined detergent and disinfectant wipes are suitable.
- 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 experts 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 expert. 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.

#### **9.3.1 Daily cleaning**

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.

#### **9.3.2 Terminal cleaning**

- Cleaning staff are to wear PPE as outlined in [section 5](#), without having to wait for a period to access the vacated room.
- 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 following discharge of COVID positive patients.

- 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 environmental surfaces and equipment must be touch dry prior to the next patient admission

#### **9.4 Food services**

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

#### **9.5 Linen services**

- Standard precautions apply when handling linen. Laundry practice is to conform to AS/NZS 4146:2000 Laundry Practice Standards.
- A linen skip is to be dedicated to the room and used linen placed directly into the linen skip. Linen that is heavily soiled should be placed in a plastic or soluble bag as per requirements of the HSP linen provider.
- Avoid contact with used linen by holding items away from the body and avoid agitating the linen which can cause aerosolisation of any infectious particles.
- The linen skip must be replaced when ¾ 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.

#### **9.6 Medical records and patient charts**

- Standard precautions apply to the management of all patient records. Performing hand hygiene prior to and following handling patient records will minimise the risk of contamination and transmission.
- The patient charts are to be left outside the room where possible. When cohort wards are established, placement of patient charts are to be separated from clinical care areas. In ICU areas, chart trolleys are to be positioned as far away from the patient area 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.

## **9.7 Waste management**

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

## **10. Healthcare Worker Management**

- COVID-19 vaccination is recommended for HCWs
- All HCWs should be educated in the application of standard precautions, transmission-based precautions, the use of the hierarchy of controls, and the correct selection and use of PPE including fit checking.
- The combination of PPE required in the care of suspected or confirmed COVID-19 cases can cause fatigue. The impact of PPE fatigue on staff comfort and potential PPE breaches should be monitored

### **10.1 Healthcare worker testing**

All HCWs are to self-monitor for symptoms of ARI. If HCWs experience symptoms of ARI they should self-exclude from work until symptoms resolve and seek testing for ARIs, including COVID-19.

### **10.2 Management of HCW exposed to COVID-19**

- Asymptomatic HCWs who are close contacts of COVID-19 should:
  - wear a surgical mask at a minimum, while at work, and
  - self-monitor for ARI symptoms.
- If symptoms develop, the HCW should self-exclude from work even if they have a negative COVID-19 RAT, until symptoms resolve.
- HCFs may consider developing local policy for high-risk areas within HCFs to risk assess HCW close contacts and their ability to continue working.
- A system-based risk management approach that incorporates risk mitigation strategies aims to reduce exposure in health care settings. However, it is acknowledged that risk cannot be eliminated and that exposures may occur in and out of the healthcare setting. It is the HCFs responsibility to implement contact tracing within their workplace for all HCWs who are at work during their infectious period.

## **10.3 Management of HCW positive for COVID-19 and return to work**

- HCWs who test positive to COVID-19 must be excluded from the work place for at least 5 days from onset of symptoms or COVID-19 positive test, whichever is earliest.
- During the exclusion period, the HCW should follow public health advice for [COVID-19 positive cases](#).
- HCWs are expected to perform a rapid antigen test (RAT) within 24 hours of their planned return-to-work. HCWs whose:
  - RAT is negative and they are asymptomatic, are expected to return to work on day 6 with recommended risk mitigation strategies in place until day 10
  - RAT is positive and they are asymptomatic, can return to work on day 7, with recommended risk mitigation strategies in place until day 10
  - RAT was not performed and they are asymptomatic, can return to work on day 7, with recommended risk mitigation strategies in place until day 10.
- Risk mitigation strategies as per local HSP policy may include that the HCW must be alert to symptoms, must wear a surgical mask or PFR, and avoid where possible or limit time spent in shared staff areas, e.g. tearooms.<sup>16</sup>

## **11. Additional Resources**

[Australian Department of Health and Aged Care Coronavirus](#)

[Australian Health Protection Principal Committee](#)

[World Health Organisation Infection Prevention](#)

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

[COVID-19 in the workplace – Information for employers and employees \(health.wa.gov.au\)](#)

### **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 \(PDF 899KB\)](#)

## **12. Guideline Contact**

Enquiries relating to this Guideline may be directed to:

Infection Prevention and Policy Surveillance Unit (IPPSU)

Directorate: Communicable Disease Control Directorate

Email: [IPPSU@health.wa.gov.au](mailto:IPPSU@health.wa.gov.au)

## **13. Approval**

<b>Approved by</b>	Dr Clare Huppatz, Acting Director, Communicable Disease Control Directorate, Department of Health
<b>Approval date</b>	10 October 2023

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16. NSW Health Clinical Excellence Commission. 2023. [COVID-19 and other ARI - Managing health worker exposures and return to work in a healthcare setting](#)

## **Appendix 1: Personal Protective Equipment**

These guidelines should be used in combination with the Mandatory [Personal Protective Equipment in Healthcare Facilities Policy](#).

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

### **General PPE advice**

- HCWs providing prolonged episodes of care to patients with COVID-19 may choose to wear an approved PAPR following appropriate training in their use. There is little evidence to support that PAPR's provide greater protection than a correctly worn and appropriately fitted PFR, however, they may provide greater comfort for the wearer when PFR use is required for extended periods of time.
- PPE is only protective when used correctly. Training in the use of a 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 use of a 'PPE buddy' is strongly supported to minimise the risk of incorrectly donning and doffing PPE
- The PPE 'buddy' should assess all aspects of PPE, including confirming the HCW has the designated type and size of 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. Mirrors are useful to support donning and doffing.
- Loose hair must be tied back securely prior to donning PPE.
- HCWs must be diligent not to touch their eyes, nose, mouth or hair while wearing PPE.
- Wearing of gloves is not a substitute for hand hygiene. Hand hygiene must always be performed after glove removal. Applying ABHR to gloves is not recommended and can compromise the integrity of the gloves.
- Hand hygiene products and gloves must be available in the room to facilitate compliance with the [5 Moments for Hand Hygiene](#)
- When gloves are worn, avoid touching environmental surfaces such as light switches and door handles to minimise environmental contamination.
- Doffing of gloves and gowns should be done in the anteroom or at the patient's doorway if in a single room i.e. just prior to leaving patient's room. Eyewear and surgical masks or PFRs should be removed in the anteroom or outside the patient room, or greater than 1.5 metres from the patient under precautions.
- Regular breaks for staff to reduce fatigue related to PPE use, and for hydration is recommended. Compliance with the sequence of doffing PPE and hand hygiene must be adhered to prior to taking a break.
- Care is to be taken not to contaminate any clean stocks of PPE stored in the vicinity when doffing PPE.

### **Prevention of PPE related skin damage**

Prolonged use of PPE may cause skin damage which can be painful and if severe can lead to skin breaks that leave the HCW vulnerable to infection. HCWs need to ensure their PPE is

properly fitted and worn only when required. Pressure damage is exacerbated by moisture and wearing PPE for lengthy periods results in the skin getting warm and sweaty.

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

Facial skin damage from masks or eyewear can be minimised by the regular use of alcohol-free barrier creams. The use of pressure reducing dressings for those HCWs experiencing skin damage is approved, however they will need to undertake a repeat PFR fit test to ensure an appropriate mask is 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 HCWs providing care for patients under droplet precautions. When there is a risk of airborne or aerosol transmission a PFR is to be worn.
- 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.
- 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 that they achieved a satisfactory fit to, and have access to that specific mask when required. In situations where a fit test has not yet been performed for the HCW, and a PFR is recommended, a fit-checked PFR is preferred to a surgical mask and the HCW assessed by a PPE buddy to ensure fit check is achieved. The HCW must be prioritised for a fit test as soon as possible.
- All HCWs must receive education, in accordance with the manufacturers' advice, in relation to donning a PFR and the procedure to perform a fit check for each specific mask worn.
- A fit check must be performed after donning a PFR prior to entering the patient's room and each time a new mask is put on. An effective seal will not be achieved when facial hair is present (see [Appendix 2](#)).
- 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.
- For further information see the TGA statement on [Reuse of face masks and gowns during the COVID-19 pandemic](#).

## Protective eyewear

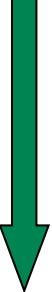
- Designated protective eyewear may include a combined mask/shield, face shield/visor or goggles.
- Personal prescription spectacles provide inadequate protection for transmission of infection through the eyes mucosa and are to be worn with additional protective eyewear.

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

### **Shoe coverings**

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

**Table 1: Sequence for donning and doffing PPE**

<b>Donning PPE</b>	<b>Doffing PPE</b>
 <ul style="list-style-type: none"> <li>Perform hand hygiene</li> <li>Gown</li> <li>Mask</li> <li>Protective eyewear/visor</li> <li>Perform hand hygiene</li> <li>Gloves</li> </ul>	 <ul style="list-style-type: none"> <li>Gloves</li> <li>Perform hand hygiene</li> <li>Gown/apron</li> <li>Perform hand hygiene</li> <li>Protective eyewear</li> <li>Perform hand hygiene</li> <li>Mask</li> <li>Perform hand hygiene</li> </ul>

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

## **Appendix 2: Fit-check and fit-test of particulate filter respirators**

The WA Department of Health has endorsed the [Respiratory Protection Guidelines for Western Australian Healthcare Facilities](#) 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, including beards, moustaches, sideburns and stubble between the sealing surface of the respirator and the wearers skin will prevent a good seal.

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.

## **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 is provided in the [Respiratory Protection Guidelines for Western Australian Healthcare Facilities](#).

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

- that they are performed in a NPIR, if this is not available use a single room with the door closed with the addition of air purifier where possible
- 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: Examples of hierarchy of control measures for minimising the risk of COVID-19 Transmission

Hierarchy of control category	Examples of control measures
<b>Elimination</b> – reduce the opportunities for the virus to spread	<ul style="list-style-type: none"> <li>Do not admit COVID-19 positive patients to hospital unless clinically necessary</li> <li>Staff exclusion from workplace if unwell</li> <li>Screening for symptomatic persons</li> <li>Use of telehealth</li> <li>Reduce number of HCWs who enter isolation rooms.</li> </ul>
<b>Substitution</b> – find alternative ways of providing care that reduces the potential for transmission	<ul style="list-style-type: none"> <li>Administer aerosolised medicine with spacers instead of nebulisers</li> <li>Substitute in-person appointments with telehealth services, when appropriate.</li> </ul>
<b>Isolation</b> - isolate people from the hazard	<ul style="list-style-type: none"> <li>Use NPIR for COVID-19 positive patients where available. If a NPIR is not available, use a standard isolation room or single room with a private bathroom</li> <li>Cohort COVID-19 positive patients in dedicated wards or zones to separate uninfected and those of uncertain COVID-19 status.</li> </ul>
<b>Engineering controls</b> – use physical barriers and other forms of hazard reduction	<ul style="list-style-type: none"> <li>HVAC assessments and improved air changes, air flow, air filtration, temperature and humidity</li> <li>Consider placing physical barriers such as glass or plastic screens in triage and reception areas where physical distancing is difficult to maintain</li> <li>Redesign work areas to limit number of workers at workstations.</li> <li>Maintain airflow direction away from staff workstations towards patient care areas where possible.</li> </ul>
<b>Administrative controls</b> – effective and consistent implementation of policies and procedures	<ul style="list-style-type: none"> <li>Allocate surgical masks for source control to patients or residents with respiratory symptoms to use when they are outside of their ward or room. Educate patients and residents on safe mask use and disposal</li> <li>Hand hygiene</li> <li>Cleaning and disinfection. Give guidance on environmental cleaning and disinfection according to risk. Conduct regular checks with frequency determined by risk</li> <li>Use signage (in appropriate languages) at the facility entrance to alert visitors not to attend while unwell.</li> </ul>
<b>PPE</b> – use of correct personal protective equipment	<ul style="list-style-type: none"> <li>Risk-assess PPE recommendations for specific staff roles and activities</li> <li>Train staff to perform a fit check (seal check) every time a particulate filter respirator (P2/N95 or equivalent) is used</li> <li>Fit test those wearing a PFR</li> <li>Education and communicate on appropriate PPE use for standard, contact, droplet, and airborne precautions</li> <li>Conduct regular staff PPE training and donning (putting on) and doffing (removing) competency assessments.</li> </ul>

Source: [ICEG, The hierarchy of controls for minimising the risk of COVID-19 transmission.](#)

## Version Control History

Revision History			
Version	Date	Revised by	Changes
18	14/8/2023	IPPSU	Section 10.3: Management of HCW positive for COVID-19 and return to work. Updated advice
17	10/3/2023	IPPSU	Removal of mask recommendations for HCW in clinical areas Removal of vaccination requirements for HCW caring for positive patients Duplication and unnecessary detail removed in accordance with ongoing developing capacities of healthcare facilities to manage COVID-19 as business as usual
16	13/11/2022	SHICC IPC	Revocation of COVID Transition (Testing and Isolation) Directions (No 18) Inclusion of exclusion period for high-risk settings Removal of reference to following rescinded guidelines: WA Health COVID-19 Framework for System Alert and Response (SAR) COVID-19 Guidelines for Outpatient Services COVID-19 Guidelines for Discharge and interhospital transfer COVID-19 Guidelines for Public Hospital Visitors TTIQ Plan and HCW Furloughing Guidelines. All relevant information from rescinded guidelines added Inclusion of reference to <a href="#">Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units</a> (SoNG) Inclusion of COVID-19 in the workplace – Information for employers and employee's webpage Inclusion of COVID-19 Transition Recommendations (Appendix 1) Removal of key practice points and PPE checklist Removal of PHOps assistance with contact tracing Inclusion of IPPSU outbreak notification form Inclusion of Department of Health Identification and Use of Personal Protective Equipment in the Clinical Setting Policy Mandatory Policy 0172/22.
15	19/08/2022	SHICC IPC	Updated management of potential SARS-CoV-2 reinfection Changes made to align with the COVID Transition Testing and Isolation Direction no. 17 Removal of quarantine, inclusion of acute respiratory infection (ARI) definition, additional information on cohorting, reinfection time revised, HCW testing requirements revised and inclusion of link to CDDC Respiratory Protection Program for Western Australian Healthcare Facilities.

14.1	6/05/2022	SHICC IPC	Change of directions – links updated.
14	13/05/2022	SHICC IPC	Addition of advice for prescription protective eyewear, management of deceased personal effects, revision of contact tracing, removed reference to epidemiological risk, prolonged episodes of care, revised HCW management section and discharge process. Probable and confirmed cases considered COVID-19 positive case. Reordered and links updated.
13	22/02/2022	SHICC IPC	Inclusion of website links for WA SAR, HCW furlough guidance, transition policies. Inclusion of definition for a rapid antigen test Modification to lift management Inclusion of mask and vaccine exempt essential visitors Change in responsibility of HCW management within a HCF
12	24/01/2022	PHEOC IPC	Definitions added, inclusion of the WA SAR and testing Guidelines, inclusion of WA HCW furlough interim advice. Updated visitor guidelines and testing, revision lift cleaning, showering of patients, types of PPE descriptions expanded.
11	11/08/2021	PHEOC IPC	Lift cleaning - when hospital visit by a person under a direction to quarantine Confirmed vaccination status required to care for suspected and confirmed COVID-19 case Updated guidance for PPE Observer.
10	30/07/2021	PHEOC IPC	Updates to Lift management
9	10/07/2021	PHEOC IPC	Change to mask recommendations Fit testing Updates on PPE breaches, definitions, terminal cleaning
8	31/08/2020	PHEOC IPC	Additional definitions included Added guidance on quarantined visitors entering HCFs on compassionate grounds to visitors' section Added statement in appendix 1 – P2 Masks with exhalation valves are not to be used Added information re minimising PPE pressure related injuries Updated Information on PPE and Table 1 to align with MP 0133/20 V 4.0
7	14/05/2020	PHEOC IPC	Statement on the use of coveralls, head and shoe coverings, self-purchased PPE. Reference to TGA statement on reprocessing single use medical devices, inclusion of table defining differences in levels of gowns and masks. Updates to management of the deceased. Review of contact/airborne precautions
6	08/04/2020	PHEOC IPC	Additional and updated information on care of the deceased, staff uniforms, HCW working requirements, fit checking v fit testing.

5	18/03/2020	PHEOC IPC	Added self-isolation for returned travellers from any country. Added isolation in separate area rather than single rooms
4	03/03/2020	PHEOC IPC	HCW who have travelled in or transited from countries listed as higher risk must not work in a HCF for 14 days since leaving the high-risk country.
3	28/02/2020	PHEOC IPC	Addition to aerosol generating procedures, HCW management, PPE table included, obstetric and neonatal management
2	17/02/2020	PHEOC IPC	Update on breaches in PPE for HCWs
1	14/02/2020	PHEOC IPC	Initial draft developed by PHEOC

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