SUBMISSION TO
FAIR WORK COMMISSION

Matter No:

AM2020/13

S157 Variation of Modern Awards to achieve the Modern Awards Objective

HEALTH SECTOR AWARDS – PAID PANDEMIC LEAVE

JUNE 2020

SUBMISSION IN RESPONSE TO
Applicants' Outline of Submissions

SUBMISSION BY
PRIVATE HOSPITAL INDUSTRY EMPLOYER ASSOCIATIONS

Australian Private Hospitals Association
Australian Private Hospitals Association – New South Wales
Australian Private Hospitals Association – South Australia
Australian Private Hospitals Association – Tasmania
Australian Private Hospitals Association – Victoria
Australian Private Hospitals Association – Western Australia
Day Hospitals Australia
Private Hospitals Association of Queensland

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INTRODUCTION

[1] This submission is being lodged on behalf of the Private Hospital Industry Employers' Associations (PHIEA) which include: Australian Private Hospitals Association (APHA), APHA – New South Wales APHA – South Australia; APHA – Tasmania, APHA – Victoria; APHA – Western Australia, Private Hospitals Association of Queensland (PHAQ) and Day Hospitals Australia.

PHIEA only has an interest in the **Nurses Award** and the **Health Professionals and Support Services Award** and therefore our response is limited to these two awards and we make no comment in relation to any of the other health awards which form part of the applicants' claim.

[2] PHIEA considered that the Commission's decision of 8 April 2020, to vary 99 modern awards, including the health awards, to provide for two weeks unpaid leave and enable employees to access twice as much annual leave at half pay, was a balanced and necessary response to the COVID-19 pandemic.

As noted in paragraphs [132-133] of the Full Bench decision [2020] FWCFB 1837:

[132] By assisting in maintaining employment and the viability of businesses, these measures will directly contribute to the sustainability and performance of the national economy. This is a factor that weighs in favour of making the variation sought.

[133] We confirm our provisional view that taking into account the s.134 considerations, the modern award variations ……..are necessary to achieve the modern awards objective.

[3] As noted in paragraphs [116] and [117] of the Full Bench Decision of 8 April 2020 in AM2020/12 – *Variation of awards on the initiative of the Commission* - [2020] FWCFB 1837 Section 138 of the Fair Work Act emphasises the importance of the modern awards objective:

[116] ***Section 138 Achieving the modern awards objective***

A modern award may include terms that it is permitted to include, and must include terms that it is required to include, only to the extent necessary to achieve the modern awards objective and (to the extent applicable) the minimum wages objective.

[117] What is 'necessary' to achieve the modern awards objective in a particular case is a value judgement, taking into account the s.134 considerations to the extent they are relevant having regard to the context, including the circumstances pertaining to the particular modern award, the terms of any proposed variation and the submissions and evidence. *[emphasis added]*

CONTEXT

[4] In assessing the merits of the applicants' claim, the current context is relevant as is an understanding of the specific measures and protocols implemented in hospitals to minimise the risks of contamination and infection.

In an uncontrolled environment with poor pandemic preparation measures in place and insufficient Personal Protective Equipment (PPE), health care workers who, as part of their employment are required to personally attend to persons who have COVID-19 or suspected COVID-19, would be at significantly heightened risk of exposure to the virus. However, in Australia, we are not in an uncontrolled environment.

[5] Government undertaken modelling of the impact of COVID-19 identified that the health system in Australia would cope if we:

- Have effective social distancing
- Increase our health system capacity
- Isolate people with the virus and their close contacts

As noted in the *Australian Health Sector Emergency Response Plan for Novel Coronavirus (COVID-19)* the aim of the Australian Government health response is to:

- Minimise the number of people who become infected or sick with COVID-19
- Minimise how sick these people become and how many people die
- Reduce the burden on our health system so they can continue to provide the regular health care Australians need and
- Help Australians to reduce their own risk and the risk to their families and communities

Specific interventional strategies have focussed on six areas:

- Identifying cases
- Isolating cases
- Tracing and quarantining contacts of cases
- Improving hygiene
- Restricting travel
- Social distancing

[6] Government responses to COVID-19 interventions have been informed by expert medical advice and recommendations arising from the Australian Health Protection Principal Committee (AHPPC) which is the key decision making committee for health emergencies. It is comprised of all State and Territory Chief Health Officers and is chaired by the Australian Chief Medical Officer.

Copies of statements and recommendations issued by the AHPPC are available from the link below.

https://www.health.gov.au/committees-and-groups/australian-health-protection-principal-committee-ahppc

[7] In addition to AHPPC recommendations, individual State and Territory Chief Health Officers have on occasion, imposed further restrictions in response to local circumstances or specific cluster outbreaks.

The combined interventions of the Commonwealth & State Governments and their Departments of Health have been extremely successful to date, in minimising the spread of COVID-19 in Australia.

[8] Of particular relevance, are specific measures applicable to hospitals which have been introduced in response to COVID-19. Some of these include, but are not limited to:

- Public Health directives strictly limiting visitors to hospitals
- Strict social distancing requirements within hospitals
- Establishment of Fever Clinics and/or separate zones for suspected COVID-19 patients that require higher levels of precaution
- Enhanced screening of patients prior to admission to hospital for non-COVID related treatment
- Amendments to the Medical Benefits Schedule to facilitate telehealth consultations and reduced reliance on face to face consultations where clinically appropriate.
- Provision of additional training resources in how to perform certain procedures and the correct use of PPE - e.g.
    - Infection Prevention and Control COVID-19 Personal Protective Equipment
    - Special precautions for COVID-19 Designated Zones
- Commonwealth partnership agreements with private hospital providers (administered via the State & Territory governments) guaranteeing their viability, in return for private hospitals making infrastructure, essential equipment including ventilators, supplies including PPE, workforce and additional resources, fully available to the State and Territory hospital system or the Australian Government as required, to support the COVID-19 response, thereby significantly boosting system capacity.
- Formal restrictions on all non-urgent elective surgery procedures in public and private hospitals whilst the National Medical Stockpile of personal protective equipment (PPE) was increased and supply chains stabilised.

- On 25th March National Cabinet announced the temporary suspension of all non-urgent elective surgery in public and private hospitals – limiting surgery to treatment which was required within 30 days.

- Effective from 27 April 2020, in response to decreasing COVID-19 cases and the associated risk of transmission, AHPPC recommended the gradual reintroduction of elective surgery where public and private hospitals could aim to reopen 25% of theatre and endoscopy lists currently closed, subject to local circumstances and in accordance with selection principles outlined by AHPPC which included, types of procedures which could be undertaken and patient selection criteria.

- In a statement published by AHPPC on 22 May 2020 it was noted that the spread of the COVID-19 outbreak had slowed, with the number of new cases decreasing nationally, since the restoration of elective surgeries. Whilst PPE supplies still needed to be carefully managed, supply lines were firming. There was still unused hospital capacity in all jurisdictions across both the public and private sectors and therefore it was considered safe to further increase the level of elective surgery activity in accordance with a range of principles outlined by the AHPPC. Briefly, these principles can be summarised as:

  - Access to surgery to be based on clinical urgency
  - Preservation and appropriate use of PPE – i.e. availability, quantity, type and quality of PPE to ensure a safe working environment for clinicians and patients
  - Ensuring numbers of staff are at a safe and clinically appropriate level
  - Restoration of elective surgery to be consistently applied in both public and private hospitals
  - Decisions to be based on local hospital capacity, jurisdiction capacity, transport availability and any other relevant quarantine arrangements in place
  - Every patient to undergo a pre-operative risk assessment as per national guidelines
  - National COVID-19 testing and screening guidelines to be adhered to in line with the national disease surveillance strategy
  - Easing of elective surgery restrictions to be in 3 stages with each State/Territory to determine when each stage will apply.

    - Stage 1 – up to 50% of normal surgical activity levels
    - Stage 2 – up to 75% of normal surgical activity levels
    - Stage 3 – up to 100% of normal surgical activity levels

  - From May 2020, elective surgery activity is to be reviewed monthly by the Australian Health Ministers Advisory Council to ensure that it remains safe and sustainable and in line with the agreed principles.

- Elective surgery activity may be reduced on a national, state or local basis in response to future COVID-19 outbreaks.

[9] Federal and State Government directives and guidelines detailing procedures and processes to be followed and adhered to, by not only hospitals but other health care settings, are thorough and extensive. These are highly controlled environments.

[10] The Australian Government's Pandemic Health Intelligence Plan provides a framework for collecting the information required to support decision making about COVID-19. It is accompanied by a document that provides the status of the plan's measures and ***a copy of the most recent report – 25 May 2020 is appended as Attachment 1***.

Significantly, the key measures of transmission potential; outbreaks and clusters; burden on the healthcare system, disease incidence; community transmission; community and primary care surveillance; hospital system capacity and testing and laboratory capacity were all within threshold limits.

[11] Appropriately, hospitals are highly regulated organisations. Not only must they meet the National Safety and Quality Health Service Standards (NSQHSS), be independently assessed by an approved accreditation agency and satisfy the requirements of the Australian Health Service Safety and Quality Accreditation Scheme (AHSSQAS), but in the case of private hospitals, they must also satisfy the licensing requirements of the jurisdiction in which they operate – many of which impose additional quality and safety requirements. Following the easing of restrictions on elective surgery from 27 April 2020, the Australian Commission on Safety and Quality in Health Care issued some ***key actions for health service organisations*** – ***a copy of which is appended as Attachment 2.***

[12] Since the outbreak of COVID-19 all hospitals have had to continually modify their policies and procedures in line with evolving national requirements and guidelines in order to safely manage a suspected, probable or confirmed case of COVID-19. By way of example, ***appended as Attachment 3 is a copy of Ramsay Health Care's Infection Prevention and Control Precautions for Management of COVID-19 document - v5.0 – 26 May 2020.*** As is evident from this example, hospitals have significant protocols in place to minimise the risk of transmission or contraction of COVID-19 in the workplace.

[13] At the time the Fair Work Commission initiated its Variation of Awards in response to the COVID-19 pandemic, the number of new cases daily had been increasing rapidly, reaching a peak towards the end of March. Therefore, in assessing the merits of the applicants claim, it is highly relevant to take into consideration the current status of COVID-19 in Australia.

On 5th April, 2020 the Department of Health commenced publication of a daily COVID-19 status infographic, which provides a summary by State and Territory of hospitalisations; Intensive Care Unit (ICU) admissions; total tests concluded; cases in aged care

services; total cases/deaths and cases by source of infection. In addition, the infographic also includes 4 bar graphs of national information relating to the daily number of reported cases, cases in aged care services, cases by age group and sex and deaths by age group and sex. ***Appended as Attachment 4*** is a copy of the 5 April 2020 and 15 June infographics.

[14] A comparative review of the infographics for 5 April 2020 and the most recent one at the time of writing, is most instructive with a few of the more salient comparisons noted below:

Extract – Department of Health – Coronavirus (COVID-19) Infographics from April & June

	5 April 2020	15 June 2020
Total Cases	**5,687**	**7,335**
Current cases in ICU	**91**	**4**
Current cases admitted to hospital	**408**	**17**
Total Tests conducted & % positive	**297,154** **1.9% positive**	**1,828,149** **0.4% positive**
Total confirmed cases in Aged Care Services	**25**	**68**
Total confirmed cases in Home Care	**7**	**31**
Source of infection – locally acquired and under investigation	**9.3% - locally acquired** **2.1% - under investigation**	**9.9% locally acquired** **0.2% under investigation**

[15] The number of new cases per day peaked on 28th March 2020 with 460 cases. However, in the period 16 May - 15 June 2020, the average number of new cases per day nationally, was just 10. The majority of new cases being persons in quarantine having returned from overseas.

Of significance is the data for cases by source of infection.

- 4,555 cases or 62.1% were overseas acquired – i.e. the person was infected while overseas (including at sea)
- 2,038 (27.8%) cases were locally acquired but the person was infected in Australia through contact with someone confirmed to have COVID-19.
- 728 (9.9%) cases were locally acquired where the person was infected in Australia, but the source of infection was not known.
- 14 (0.2%) cases are currently under investigation with the source of infection not yet determined.

- As at 15 June, 102 people had died, 17 people were currently hospitalised nationally, 6,851 cases had recovered leaving a total of only 484 cases active amongst the Australian population of approximately 25.5 million people.

This data demonstrates that in Australia community transmission rates are low and nothing like as prevalent as many overseas countries. This is entirely due to the various control measures which have been implemented in Australia.

The Applicant's Claim

[16] Without reproducing the entire proposed clause, the key elements of the applicants' claim include:

Paid Pandemic Leave
Any employee is entitled to take up to 2 weeks on each occasion the employee is

- *required by government or medical authorities to self-isolate*
- *required by their employer to self-isolate*
- *required on the advice of a medical practitioner to self-isolate or*
- *is prevented from working by measures taken by government or medical authorities in response to the COVID-19 pandemic*

And is entitled to a paid day of leave on each occasion the employee is tested for COVID-19 save where such test is performed at the employee's usual workplace and counted as working time

Special leave where an employee contracts COVID-19

- *Upon being informed of an employee's diagnosis with COVID-19, the employer must allow the worker to be absent from work, and not perform work, without loss of pay, until the employee has had medical clearance to return to work*
- *An employee shall not be required by an employer to take personal leave because of a COVID-19 diagnosis prior to exhausting their entitlement to special leave under this clause.*

[17] The applicants' claim would give **any** employee covered by the health awards an entitlement to paid pandemic leave – irrespective of the circumstances which gave rise to a requirement to self-isolate.

As written, under the proposed clause, a person could be exposed to someone with COVID-19 or suspected COVID-19, completely outside of their place of employment. For example, an employee could be exposed to a potential COVID-19 risk via a close contact who is employed at an enterprise where there is a cluster outbreak such as Cedar Meats, meat processing plant in Melbourne or Qantas baggage handling at Adelaide airport. This exposure is completely unrelated to any risk associated with the employee's work and yet merely by virtue of being covered by a health award, under the

proposed clause, the employee would be entitled to up to two weeks paid leave on each occasion they may be required to self-isolate.

[18] The Australian Government has directed that a person with coronavirus (COVID-19) or who has come into contact with a person who has been confirmed to have COVID-19 is to go into mandatory isolation. Under the Applicants' claim it could be possible for two friends who come into contact out of work time with a person with COVID-19 to both be required to go into mandatory isolation. One who happens to work in the health care industry is paid for this time away from work, the other who does not work in the health care industry, is not. Such an outcome is inequitable.

[19] A potential unintended consequence, is that if paid leave provisions were made available to any employee covered by the health awards, irrespective of whether or not they have any direct contact with suspected or confirmed COVID-19 patients, it could lead to some employees choosing not to act responsibly in their activities outside the workplace, by disregarding public health directives relating to gatherings, social distancing and hand hygiene, safe in the knowledge that should their activity give rise to a need to self-isolate, they would be paid for the absence from work. There is no requirement for any employee accountability.

[20] The Applicants' claim introduces an unreasonable financial burden for employers in the health care industry. Where an employee acquires COVID-19 through community contacts i.e. not work related, the employer is to be financially penalised. A similar financial burden is to be imposed if the employee is required to self-isolate because they came into contact with a known carrier outside of work.

As noted, since the outbreak of COVID-19, hospitals have modified their policies and procedures in line with evolving national guidance, and many hospitals have also implemented protocols to minimise the number of staff who work in areas where they may be exposed to a COVID-19 positive patient, or suspected COVID-19 positive patient. For these staff, strict guidelines exist regarding the use of PPE.

[21] In a statement issued by The Australian Health Protection Principle Committee (AHPPC) on 12 March 2020 in relation to the testing of health care workers (HCWs), a HCW was defined as "*anyone working in health and aged care sectors that has* ***direct contact*** *with patients or residents*." (emphasis added).

The applicants' claim is contrary to this AHPPC definition of a health care worker as it does not confine the proposed entitlements to health care workers who have ***direct contact*** with patients and residents.

[22] The second part of the applicants' claim makes provision for paid special leave where an employee contracts COVID-19 until such time as the employee has a medical clearance to return to work. Employees would not be required to utilise any accrued personal leave entitlements ahead of accessing this special leave. Again, **any** employee covered by the health awards would be eligible for this leave as it is not limited to those who may have direct contact with patients and residents. In many jurisdictions and depending on

the specific circumstances, if an employee contracts COVID-19 via a workplace exposure it may trigger a worker's compensation claim.

[23] As mentioned earlier in this submission, PHIEA considers that the Commission's decision of 8 April 2020 to vary 99 modern awards including the health awards, which now provide for two weeks of unpaid leave and enable employees to access double the period of annual leave through half pay agreements, was a balanced response to the COVID-19 pandemic.

[24] PHIEA does not consider that any further variations are warranted to the Nurses Award or Health Professionals & Support Services Award. PHIEA believes that it is neither fair nor reasonable to introduce inequitable financial arrangements for people who contract COVID-19 through non-work related activities, or to introduce unreasonable financial burdens for employers in the health care industry and therefore opposes the applicants' claims in their entirety.

[END OF SUBMISSION]

SUBMISSION TO
FAIR WORK COMMISSION

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HEALTH SECTOR AWARDS – PAID PANDEMIC LEAVE

JUNE 2020

ATTACHMENTS TO ACCOMPANY

SUBMISSION IN RESPONSE TO
Applicants' Outline of Submissions

SUBMISSION BY
PRIVATE HOSPITAL INDUSTRY EMPLOYER ASSOCIATIONS

ATTACHMENT 1

Australian Government – Status of Measures related to the COVID-19 Pandemic Health Intelligence Plan as at 25 May 2020

Australian Government

BE COVIDSAFE

PHIP INPUTS AND STATUS

The following documents the status of measures related to the COVID-19 Pandemic Health Intelligence Plan, as at 25 May 2020.

Key

- = Within threshold;
- = Partially within threshold or Inadequate Data
- = Threshold exceeded/indicates it is not safe to proceed to next step of lifting restrictions.

MEASURE / NDSP[1] GOAL (IF RELEVANT)	STATUS
MODELLING OF COVID 19 IN AUSTRALIA	
Transmission potential	
Outbreaks and clusters	
Burden on the Healthcare system	
PPE demand	
Testing demand	
Public Adherence	
EPIDEMIOLOGICAL SITUATION	
Disease Incidence	
Community Transmission	

[1] National Disease Surveillance Plan

MEASURE / NDSP GOAL (IF RELEVANT)	STATUS
Populations of Interest Aboriginal and Torres Strait Islander persons	
People aged 65 years and over	
Outbreak reporting	
Community and Primary Care Surveillance	
Prioritised enhanced testing	Under development
Risk of Disease Introduction from International Travel	
HEALTH CARE SYSTEM CAPACITY	
Hospital System Capacity	
Health Consumables PPE	
Medicines	
Ventilators	
In-vitro Diagnostics	
Testing and Laboratory Capacity Testing	
Availability of tests, extraction kits and swabs	
On-shore production of COVID-19 tests and extraction kits	

MEASURE / NDSP GOAL (IF RELEVANT)	STATUS
PUBLIC HEALTH SYSTEM CAPACITY	
Public Health System Capacity to Respond to Increase in Cases	
COVIDSafe App uptake and utility	
COMMUNITY ACCEPTANCE AND ADHERENCE	
Public Acceptability	
Public Adherence	
MEDIUM TERM	
Sero-surveillance	
Molecular Surveillance	

ATTACHMENT 2

Australian Commission on Safety & Quality in Health Care

COVID-19: Elective Surgery and Infection Prevention and Control Precautions

AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

NSQHS
STANDARDS

KEY ACTIONS
for health service
organisations

COVID-19: elective surgery and infection prevention and control precautions

This guidance supports health service organisations with implementation of partial easing of restrictions on elective surgery, investigations and procedures and standard and transmission-based infection prevention and control precautions.

For immediate action

Following a National Cabinet decision, Australian hospitals have commenced easing restrictions on elective surgery, investigations and procedures from 27 April 2020. Health service organisations are required to:

Prepare and implement an organisational wide Risk Management Strategy to manage and reduce the risk related to the transmission of COVID-19 noting that:

- Work related risk is managed under the Work Health and Safety Act (2011), Regulations and the approved code of practice, 'How to Manage Work Health and Safety Risks' (2011). These require all Australian workplaces to assess and manage risk 'so far as is reasonably practicable.'
- The National Safety and Quality Health Service (NSQHS) Clinical Governance and Preventing and Controlling Healthcare-Associated Infection Standards require health service organisations to identify and act to reduce healthcare-associated infection risks.
- Health service organisations are required to apply standard and transmission-based precautions that are consistent with the current **Australian Guidelines for the Prevention and Control of Infections in Healthcare**.

The Australian Health Protection Principal Committee (AHPPC) has issued a **Statement on restoration of elective surgery** (**Attachment 1**), which should be read in conjunction with this guidance. Health service organisations will apply the following principles from the AHPPC Statement, and ensure there is:

- Equitable access for all patients determined by clinical decision making and safety
- Preservation and appropriate use of PPE
- Compliance with monitoring requirements.

Australian Health Protection Principal Committee guidance on implementation of standard and transmission-based infection control precautions

Implementation of standard and transmission-based infection prevention and control precautions will provide high-level protection to patients, healthcare workers and other people in healthcare settings.

Use of personal protective equipment (PPE) in operating suites and procedure rooms should be consistent with **Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019** published by the Australian Commission on Safety and Quality in Health Care (ACSQHC).

General patient population

The current prevalence of Coronavirus Disease 2019 (COVID-19) in the Australian context does not require all asymptomatic individuals to be classified as suspected COVID-19 cases. AHPPC and local public health units will amend that advice as appropriate.

Surgery on patients with or suspected of having COVID-19 should be delayed until they have recovered or performed only in an emergency.

For patients not suspected of having COVID-19, the risk of infection when performing aerosol-generating

procedures (AGPs) is minimal, and routine operating suite attire, i.e. surgical mask, theatre cap, eye protection, gown, and gloves is adequate.

Use of PPE

The care of patients who are not suspected of, or who do not have, confirmed COVID-19 PPE in operating suites and procedure rooms should be consistent with **Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019**.

There are **specific recommendations** for the use of PPE during hospital care of people with COVID-19, which are not applicable to patients who are negative for COVID-19. These specific recommendations are included in the Commission's resources: **Infection Prevention and Control COVID-19 Personal Protective Equipment** (**Attachment 2**) and **Special precautions for COVID-19 Designated Zones** (**Attachment 3**).

Performing aerosol-generating procedures (AGPs) on non-COVID-19 patients

Given the relatively low prevalence of COVID-19 in Australia, standard precautions and the use of standard operating theatre attire and PPE, are adequate for the performance of AGPs (such as intubation) on patients who are not suspected of or not confirmed cases of COVID-19, in the absence of another airborne-transmissible infectious agent. A surgical mask, theatre cap, eye protection, gown, and gloves should typically be worn. A P2 respirator is not necessary in this context.

Previous advice to use airborne precautions for the care of patients with severe coughing has been withdrawn because:

- Viral load does not necessarily correlate with the clinical condition
- Coughing generates droplets, predominantly, and
- Surgical masks used by the patient, if possible, and healthcare worker provide adequate protection.

Performing aerosol-generating procedures on COVID-19 patients

Contact and droplet precautions are adequate for managing COVID-19 patients unless AGPs are being performed.

If AGPs are being performed on COVID-19 patients, contact and airborne precautions should be used.

Screening

Compliance with the NSQHS Standards will ensure appropriate management of risks to patient and health care worker safety.

An example of a peri-operative checklist is included at **Attachment 4**. This resource will assist health service organisations to:

- Determine that patients do not meet the current **Australian definition** of a suspect or confirmed COVID-19 case and therefore are eligible to be considered for elective surgery
- Support appropriate PPE use
- Support assessment of risks to health system capacity associated with the planned surgery, procedure or investigation.

Patients who, on screening, require further investigation of COVID-19 risk should only be considered for emergency surgery, procedures or investigations.

Patients for elective surgery, an investigation or procedure do not require prior testing for COVID-19 or quarantine.

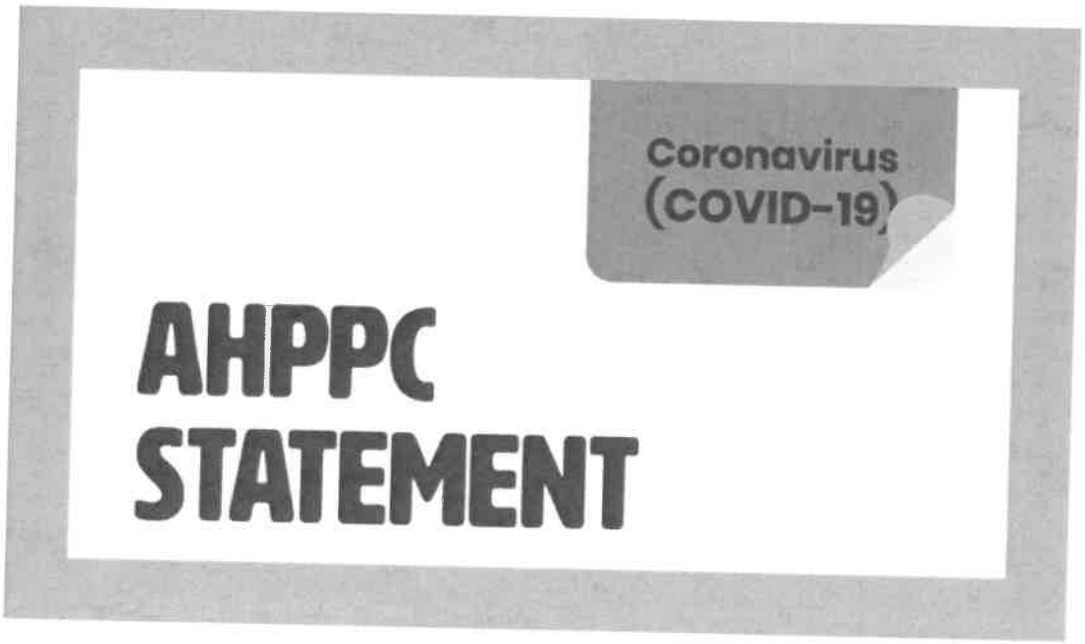
Health services should ensure that they meet physical distancing requirements at all times during planning, preparation and post treatment. This applies to all staff, patients and relatives.

Informed consent

Health services are required to ensure all patients, prior to preparing for their procedure have an opportunity to discuss with a suitably qualified clinician:

- The rationale for the procedure
- The risks and benefits to them of having the surgery, investigation or procedure at this time
- The actions that will be taken to reduce their risks
- The likely outcomes for them should they not proceed with the surgery, investigation or procedure at the recommended time
- The alternatives to the proposed surgery, investigation or procedure.

Attachment 1: A statement from the Australian Health Protection Principal Committee (AHPPC) about the restoration of elective surgery



Objective

To be able to increase the availability of elective surgery in a safe and equitable way on a nationally consistent basis. Elective surgery to become incrementally available without increasing the risks of the COVID-19 pandemic and ensuring the capacity of the hospital system is maintained to respond when needed.

Context

A large proportion of hospital care has been deferred to ensure adequate hospital capacity to respond to COVID-19.

Activity in hospitals has slowed and much of this has been due to formal restrictions on non-urgent treatment, but also, in part, this has resulted from clinician and patient perceptions of risks including COVID-19 transmission risk, system capacity constraints and personal protective equipment (PPE) availability.

While an initial large peak in COVID-19 infections has currently been mitigated by the successful public health measures, there will be a need to prevent secondary outbreaks for months to come. Continuing current levels of general healthcare deferral for that period could result in significant harm to patients, with diagnosed conditions deteriorating and missed opportunities for early diagnosis and intervention. There is currently excess hospital capacity in all jurisdictions, and these harms can be reduced by taking initial steps to restore some care.

In line with National Cabinet decisions, any restoration of elective surgery also needs to take into account PPE modelling, the proper use of PPE in clinical settings, as per national PPE clinical guidelines, intensive care unit (ICU) availability and flow on health system requirements (for example rehabilitation, physiotherapy etc).

A cautious approach may achieve this without reducing COVID-19 preparedness.

Existing national restrictions will not be reversed, but rather relaxed to reflect the current situation.

Restrictions will be lifted in an incremental way to ensure effects can be comprehensively assessed and to avoid risks associated with increased patient density and flow through hospitals.

Elective surgery restoration is reliant on agreements between jurisdictions and private hospitals being in place, in line with the National Partnership Agreement on Private Hospitals and COVID-19 (COVID-19 NPA).

Risks

Re-introduction of elective surgery presents the following risks:

- Increased burden on ICUs leading to diminished capacity to treat COVID-19;
- Increased infection control risks and the potential for a hospital based outbreak;
- Increased burden on PPE supplies due to increased use in theatres and clinical staff requesting excessive enhanced PPE when it is not indicated; and
- Increased burden on testing regime presented by some individual clinicians conducting pre-operative testing as a perceived risk mitigation strategy, leading to undermining of the surveillance activities of Public Health Units.

Principles around reintroduction of hospital activity

1. Equity of access for all patients determined by clinical decision making and safety.
    1. Clinical urgency and risk of the health to the patient due to further delays should guide restoration of elective surgeries at the local level and in all cases.
2. Preservation and appropriate use of PPE including consideration of:
    1. Availability, quantity, type and quality to ensure a safe working environment for clinicians and patients;
    2. Compliance with clear and consistent national guidelines on use of PPE, released by the Commonwealth;
    3. Hospital and day surgery reporting of PPE usage on a minimum weekly basis (PPE burn rate) in both public and private settings; and
    4. Ensuring numbers of staff are at a safe and clinically appropriate level.
3. Clear timeframes to monitor and review the situation:
    1. Weekly monitoring and review of PPE supplies in public and private settings, and the number of positive tests; and
    2. An overall review/reassessment at 2 and 4 weeks based on:
        1. Number of positive cases (health care worker or patient) linked to increased activity;
        2. PPE use and availability; and
        3. Volume of procedures and hospital/system capacity.
4. Restoration of elective surgery will be consistently applied in both public and private settings.
    1. Work in private sector should be consistent with national guidance and agreement with Commonwealth and States regarding COVID-19 NPA and viability guarantee.
    2. For private hospitals, restoration of elective surgeries need to be agreed with the respective state government to ensure there is ample hospital capacity for COVID-19 health response.
5. Decisions on elective surgery are subject to local hospital capacity, jurisdiction capacity, transport availability and any other relevant quarantine arrangements in place.
    1. Every patient undergoes pre-operative risk assessment as per national guidelines.
6. Restrictions may be reintroduced depending on whole of system demand constraints related to COVID-19 and will be based on outcomes of review and reassessment mechanisms. Restrictions may also be introduced at a hospital or regional level in the event of an outbreak.
7. National COVID-19 testing guidelines will be adhered to, in line with the national disease surveillance strategy.

Patient selection principles for first tranche of elective activity re-commencement

1. Restoration of elective activity will be guided by avoiding harm and mitigating risk of deferral of procedure or services in line with clinical guidelines, and appropriate use and supply of PPE. This will be based on clinical decisions with a focus on:
    1. Procedures representing low risk, high value care as determined by specialist societies;
    2. Selection of patients who are at low risk of post-operative deterioration (based on ASA category 1 and 2);
    3. Children whose procedures have exceeded clinical wait times;
    4. Assisted reproduction;
    5. Endoscopy;
    6. Cancer Screening programs (noting that National Cabinet has not previously supported the cessation of these programs); and
    7. Expand dental services to level 2 restrictions (see Appendix 1).

Suggested approach for elective surgery

Consistent with these principles and to allow some volume regulation while patient selection processes are refined, it is proposed that in the initial two week period of recommencement (from Monday 27 April 2020) the following will apply:

- Public and private Health Services will aim to reopen approximately 1 in 4 (25%) of theatre and endoscopy lists currently closed, subject to local circumstances;
- Health services and their clinicians will be responsible for selection of patients for these lists based on clinical urgency, PPE use, ICU capacity and consistent with the principles in this document;
- Procedures should focus on those normally categorised in the public hospital system as category 2 and can include assisted reproduction and other non-surgical interventional procedures. Category 1 procedures continue unchanged. Some category 3 procedures will also recommence, such as arthroplasty and cataract extraction;
- Cosmetic or other procedures not addressing significant medical conditions must not be included;
- Physical distancing should be applied in the lead up and management of surgery – for example with telehealth for perioperative assessments;
- The National Medical Stockpile should not be used for elective activity, and private hospitals will continue to source PPE through their own procurement processes. A notional state allocation of the stockpile should be predetermined to ensure no state uses up its own supply becoming reliant on the National Medical Stockpile for any surge required and potentially resulting in inequity of access in the longer term;
- States focus their efforts on specialties with longest wait times, however have flexibility to manage their work consistent with the principles;
- Jurisdictions can choose to perform lower clinical urgency work which requires limited or no routine PPE – i.e. outpatients, breast screen and other screening programs, and diagnostic procedures; and
- Activity volumes are reported fortnightly.

These arrangements will be reviewed at the end of the initial two week period.

Appendix 1

Dental services expansion

AHPPC has previously supported a 4 level infection control-based restriction of dental services during the COVID-19 outbreak. Dental services are currently operating at level 3 restrictions. AHPPC supports the current recommendation by the Australian Dental Association (ADA) that Dentists now move to level 2 restrictions, which will allow a broader range of interventions to be undertaken, including all dental treatments that are unlikely to generate aerosols or where aerosols generated have the presence of minimal saliva/blood due to the use of rubber dam.

The ADA advises that dentists can now procure their own supply of PPE to enable this expansion.

Attachment 2:

Infection Prevention and Control COVID-19 Personal Protective Equipment

INFECTION PREVENTION AND CONTROL COVID-19

Personal protective equipment (PPE)

Gloves should be changed in between patients; change or remove if contaminated or moving from dirty to clean site on the same patient or when damaged or torn.

Gown/apron should be removed and discarded appropriately upon leaving the room/zone.

Reusable eye protection should be cleaned/disinfected between use.

Surgical mask fluid-resistant (Level 1, 2 or 3) can be worn for up to 4 hours unless moist or contaminated, or if not removed or pulled down to drink or eat.

P2/N95 masks can be worn for up to 8 hours uninterrupted or continuous use. The wearer should not touch the contaminated surface of the mask and the mask should be discarded if contaminated with blood or bodily fluids and following AGPs[3].

Extended use[4] can also cause discomfort to the wearer from wearing it for longer than usual. Remove or replace if the mask becomes hard to breathe through or no longer fitting correctly, or becomes moist or loose.

[3]Aerosol-generating procedures (AGPs) are those procedures that are more likely to generate excessive small respiratory droplets (aerosols). AGPs potentially put healthcare personnel and others at an increased risk for pathogen exposure and infection. There is currently no uniformed or consensus list of all AGPs for healthcare settings. Although aerosols may carry small amounts of virus, they diffuse as distance from the patient increases and are effectively managed by modern ventilation systems. The requirement for airborne precautions for AGPs is based on the risk of preventing droplet spread infection.
[4]Extended or sessional use refers to a period of time where a health worker is undertaking duties in a specific care setting/exposure environment. A session ends when the health worker leaves the care setting/exposure environment. Extended/sessional use should always be risk assessed and considered where there are high rates of hospital cases.

Recommended PPE for health workers in clinical units

Context	Disposable gloves	Disposable plastic apron	Disposable fluid-resistant gown	Surgical mask fluid-resistant (Level 1, 2 or 3)	P2/N95 mask	Eye protection[1]
Working in an inpatient area with probable or confirmed case(s)[2] (not within 1.5m). Use standard precautions.	✕	✕	✕	✕	✕	✕
Performing a single aerosol-generating procedure (AGP) on probable or confirmed case(s)[2].	✓ Single use[3]	✕	✓ Single use[3]	✕	✓ Single use[3]	✓ Single use[3]
Working in any inpatient area with probable or confirmed case(s)[2] - direct patient care (within 1.5m), no AGPs.	✓ Single use[3]	✓ Single use[3] - application as per risk assessment[4] OR	✓ Single use[3] - application as per risk assessment[4]	✓ Single use[3] - application as per risk assessment[4]	✕	✓ Single use[3]
All individuals transferring probable or confirmed case(s)[2] (within 1.5m).	✓ Single use[3]	✓ Single use[3] - application as per risk assessment[4]	✕	✓ Single use[3]	✕	✕
Primary care, ambulatory and outpatient areas with probable or confirmed case(s)[2] - direct patient care (within 1.5m).	✓ Single use[3]	✓ Single use[3] - application as per risk assessment[4] OR	✓ Single use[3] - application as per risk assessment[4]	✓ Single use[3]	✕	✓ Single use[3]
Protection for vulnerable patient groups during COVID-19.	✓ Single use[3]	✓ Single use[3]	✕	✓ Single use[3]	✕	✕

1. This may be a single or reusable face/eye protection/face shield, mask visor, safety glasses or goggles.
2. A case is any individual who meets the current definition for a probable or confirmed case of COVID-19 as provided in *CDNA National Guidelines for Public Health Units Coronavirus Disease 2019 (COVID-19)*.
3. Single use refers to disposal of PPE or decontamination of reusable items e.g. eye protection or respirator after each patient and/or following completion of a procedure, task or session. PPE should be disposed of after each use or earlier if damaged, soiled, moist or uncomfortable.
4. Risk assessment refers to utilising PPE when there is an anticipated/likely risk of contamination with splashes, droplets, or blood or body fluids.

The contribution of the Clinical Excellence Commission, NSW Health in this work is acknowledged

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Attachment 3:

Special precautions for COVID-19 Designated Zones

SPECIAL PRECAUTIONS FOR COVID-19 DESIGNATED ZONES

BEFORE entering the COVID-19 zone to see the FIRST PATIENT

Follow these steps

1. Perform hand hygiene
2. Put on a fluid-resistant long sleeved gown or apron
3. Put on a fluid-resistant surgical mask
4. Put on protective eyewear
5. Perform hand hygiene
6. Put on disposable, non-sterile gloves

When MOVING BETWEEN patients in the designated COVID-19 zone

Follow these steps

Gown and glove change is always required for a patient that has a Multi-Resistant Organism (MRO) or other infection.

1. Dispose of gloves
2. Perform hand hygiene
3.

Check if PPE is contaminated or damaged in this order (gown, eyewear, mask)

⚠ **If one or more items are contaminated or damaged go to 4**

If no items are contaminated or damaged go to 6

4.

All contaminated equipment should be removed in this order (gown, eyewear, mask) with hand hygiene between steps

5. Put on clean set of PPE (Repeat blue entry steps 1–4)
6. Perform hand hygiene
7. Put on disposable, non-sterile gloves

Outside of COVID-19 designated zones standard precautions apply.

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Attachment 4: Example of perioperative checklist

Date of procedure:	Patient label
Procedure planned:	

Screening checklist for patients for theatre not known to be COVID-19 positive

Each check to be completed once for all emergency and elective patients.

Preoperative screening checklist (to be asked the day before or day of surgery)	**Yes**	**No**
Recent overseas travel in the past 2 weeks?		
Recent contact with known or suspected COVID-19 case in the past 2 weeks?		
Reside in or visited a known high-risk area with a cluster of cases?		
Recently tested for COVID-19? If YES: Date: Time: Result:		
Does the patient have:		
▪ A temperature of ≥38°C?		
▪ A cough?		
▪ A sore throat?		
▪ Shortness of breath?		
▪ Other respiratory symptoms?		
▪ A recent loss of the sense of smell?		
If the patient answered 'Yes' to any of the above, notify the anaesthetist and surgical team.		

Preoperative vulnerability checklist (complete the day before or day of surgery	**Yes**	**No**
Pregnant		
Age >65 years		
Respiratory comorbidity		
Immunocompromised		
Frail		
Other comorbidities (e.g. CCF, diabetes, obesity, renal insufficiency)		

ICU need and availability checklist (complete the day before or day of surgery	**Yes**	**No**
Is ICU likely to be needed post-op?		
Is ICU aware of the case?		
If ICU admission required post op, is an ICU bed available?		
Have goals of management been defined?		
Expected ICU length of stay (in days)?		days

ICU need and availability checklist (complete the day before or day of surgery	**Yes**	**No**
Are there significant aerosolisation risks with this procedure?		
Is everyone wearing the appropriate level of PPE for this procedure?		
Are there non-essential staff in the theatre or procedure room?		
Are there vulnerable perioperative team members?		
Advise: re-deploy vulnerable staff and non-essential staff in high-risk or aerosolising procedures. Discuss with proceduralist/surgeon, anaesthetist and/or NUM.		

This checklist, which has been reproduced with permission from Safer Care Victoria can be modified and locally adapted by individual hospitals and health services. It can be used for both elective and emergency surgery and should accompany the patient from peri-op to theatre, and from there to the ward or ICU. This checklist is available on the Commission's website:
https://www.safetyandquality.gov.au/covid-19

ATTACHMENT 3

Ramsay Health Care

Infection Prevention and Control Precautions for Management of COVID-19 – v5 26/5/2020

COVID-19

Infection Prevention and Control Precautions for Management of COVID-19

26 May 2020
VERSION: 5.0

Ramsay Health Care

Table of Contents

Precautions to reduce the risk of transmission or contraction of COVID-19 in the workplace 3
General Principles for Standard Precautions 3
Standard Precautions and Use of PPE 4
Standard precautions and use of PPE in clinical areas with increased risk 5
Screening of patients for COVID-19 9
Care of patients who develop fever or respiratory symptoms 11
What precautions to apply if the respiratory infection is not COVID-19 12
Precautions for the management of probable, suspected or confirmed cases of COVID-19 12
Standard PLUS contact and droplet precautions 13
PPE for Standard PLUS contact and droplet precautions 14
Aerosol-generating procedures (AGPs) 14
AGPs Outside of the Intensive Care Unit (ICU) ..... **Error! Bookmark not defined.**
Care of patients in the ICU 15
Use of PAPR in Theatre or ICU 16
Operating Theatres - Key points for infection prevention and control planning for COVID-19 18
Preparation 18
During Surgery 19
Following surgery 20
Donning and Doffing PPE 21
Waste, Linen and Cleaning 24
Management of a deceased COVID-19 patient 25
At-risk Health Care Workers 25
Medical records and patient charts for COVID-19 suspected, probable or confirmed cases 26
Visitors 26
Where can I get more information? 27
APPENDIX A: Mask Guide 28

Updates from the previous version are highlighted in yellow

Ramsay Health Care

Precautions to reduce the risk of transmission or contraction of COVID-19 in the workplace

This guide has been developed to support the infection prevention and control precautions required to safely manage a suspect, probable or confirmed case of COVID-19. For the care of all patients and the safety of all healthcare workers, consistent safe work practices for infection prevention and control activities should be used in the care of every patient as part of standard and transmission-based precautions.

General Principles for Standard Precautions

Standard precautions are a series of safe work practices including hand hygiene and appropriate use of PPE that must be used for all patients including those suspected of acute respiratory infections. These include:

- hand hygiene with soap and water, or alcohol base hand rub, consistent with 5 Moments for Hand Hygiene in the National Hand Hygiene Initiative
- all clinical staff should be adhering to 'bare below the elbows' so they can comply with hand hygiene
- make sure patients and visitors have access to hand hygiene products
- minimise touching of your face especially eyes, nose and mouth; if you see others touch their face, remind them to perform hand hygiene
- cough etiquette and respiratory hygiene including disposing of used tissues in waste bins
- appropriate patient assessment and placement on admission
- observe social distancing of at least 1.5metres or >4sqm
- appropriate use of PPE when undertaking direct patient care and there is a risk of contact with blood or body substances or when splash or splatter is anticipated. Refer to Table 1.0 PPE Guidelines
- always use aseptic technique when handling indwelling devices, undertaking dressings, or performing procedures
- Single use items must be only used once, and not reused or reprocessed
- correct handling and reprocessing of shared patient equipment and reusable medical devices to protect the workforce and patients. Increased awareness of cleaning between use of items that may be shared e.g. BP cuffs, walking and mobility aids, ECG machines, portable ultrasound machines
- routine environmental cleaning and disinfection, especially frequently touched surfaces with appropriate PPE being used for cleaning activities
- safe handling, use, and disposal of sharps and other forms of waste generated in the healthcare setting
- safe handling and disposal of used/soiled linen in all clinical areas, linen that is wet or heavily soiled should be placed into a clear plastic bag prior to being put into a linen skip

Standard Precautions and Use of PPE

- Standard precautions include hand hygiene and the use of PPE when there is a risk of exposure to blood and body substances
- Masks must not be reused for the duration of a shift, i.e. repeatedly taken off and put back on. Once removed or the front of the mask is touched, masks should be discarded into the appropriate waste bin and hand hygiene performed
- Once you are wearing a mask, you should not touch the front of the mask as this can cause wicking for moisture and microorganism transfer as well as hand contamination, if the front of the mask is touched, then it should be removed, discarded into the appropriate waste bin and hand hygiene performed
- Masks must not be worn around a staff member's neck
- Masks do not have to be changed between every patient when caring for multiple patients requiring the same level of precaution. For example, a PACU in which all patients require droplet precautions for airway management. That is, staff do not need to change masks between patients except if the mask becomes soiled or moist. However, when clinical care is completed, the mask should be removed, and hand hygiene preformed
- Surgical masks should not be worn for longer than four hours
- As part of standard precautions, droplet precautions (surgical mask) should be worn for aerosol generating activities (e.g. during reprocessing of endoscopes) or procedures on patients who have no identified risk factors for COVID-19. GESA/GENCA PPE for Reprocessing Endoscopes LINK
- Gloves do not replace hand hygiene and must be changed, and hand hygiene performed between each patient and between tasks with the same patient if the gloves are contaminated e.g. assisting with toileting and then oral hygiene

NOTE: Ramsay Health Care provide PPE for all the workforce that is sourced to meet the relevant Australian and/or international standards. The workforce is advised that they should only use PPE that is provided by the facility. Any additional requests for specific PPE should be directed to the facility Director of Clinical Services (DCS) for advice and assessment.

Standard precautions and use of PPE in clinical areas with increased risk

- The COVID-19 **Oncology** Guide makes recommendations on patient assessment, screening, management and care. Link
    - When there is a known or suspected risk of droplet transmission of an infectious agent, health care workers (HCWs) providing direct patient care, or coming within 1.5metres of patients in Haematology/Oncology services can wear surgical mask for up to four hours without needing to change it between patients unless it was contaminated, moist or touched by the HCW. Protective eye wear can also be worn for up to four hours if there is a risk of droplet transmission
    - The staff in the haematology/oncology services should always use the same principles to support appropriate and effective use of PPE by having a buddy system to observe appropriate wearing and safe use of PPE especially for donning (putting on) and doffing (removal) of PPE
    - P2/N95 respirator (masks) are used for connection and disconnection of chemotherapy treatment - staff can wear the mask for an extended period (up to four hours) without needing to change it unless it was contaminated, moist or touched by the HCW

- For the **Emergency Department (ED)**, the current recommendations of screening all presentations for risk of respiratory infection or COVID-19 allow for the identification and management of clinically suspected cases and asymptomatic cases that fit the epidemiological criteria. The asymptomatic patient who may have no epidemiological risk factors but has asymptomatic infection from community transmission may not be identified in the initial stages of assessment or at all
    - If there is an identified local risk of community transmission, HCWs can wear a surgical mask in the ED for up to 4hrs without needing to change it unless it was contaminated, moist or touched by the HCW. Protective eye wear can also be worn for up to four hours if there is a risk of droplet transmission. This is consistent with CDNA (Link) the Australian College for Emergency Medicine (ACEM) recommendations, Qld and NSW public hospital recommendations
    - The staff in the ED should always use the same principles to support appropriate and effective use of PPE by having a buddy system to observe appropriate wearing and safe use of PPE especially for donning (putting on) and doffing (removal) of PPE
    - Maintain the recommendation that any patient who meets the screening criteria or is symptomatic of a respiratory infection also wear a surgical mask in the ED as this will reduce the environmental contamination whilst the patient is being assessed and treated
    - P2/N95 respirator masks should only be used as currently indicated for Aerosol generating procedures (AGPs) on suspected or confirmed COVID-19 patients

Table 1.0 Selection of PPE for Standard and Transmission-based Precautions

Selection of PPE for Standard and Transmission-based Precautions

Precautions	Single use disposable gloves	Fluid Resistant Surgical masks	P2/N95 respirator masks	Protective eye wear/visor or full-face shield	Fluid resistant long-sleeved gown/apron	Hat or balaclava	Other PPE
Standard precautions	Only if contact with blood and body substances	Only if there is a chance of splash or splatter with blood and body substances	No	Only if there is a chance of splash or splatter with blood or body substances	Fluid resistant apron only if contact with blood and body substances	No	No
Contact precautions (put PPE on before entering the room and remove PPE before leaving the room)	Yes for contact with patient or contaminated surfaces or equipment	As for standard precautions	No	As for standard precautions	Yes Fluid resistant apron or long-sleeved gown if contact patient or contaminated surfaces or equipment	No	No
Droplet precautions (put PPE on before entering the room and remove mask and eye protection after leaving the room)	Yes if contact with patient or contaminated surfaces or equipment	Yes Before entry to the room	No	Yes If you are going to be closer to the patient than 1.5m or providing direct patient care	As for standard precautions	No	No
Droplet plus Contact precautions (put PPE on before entering the room and remove gloves and gown/apron in the room and mask and eye protection after leaving the room)	Yes For contact with patient or contaminated surfaces or equipment	Yes Before entry to the room	No	Yes If you are going to be closer to the patient than 1.5m or providing direct patient care	Yes Fluid resistant apron or long-sleeved gown if contact patient or contaminated surfaces or equipment	No	No
Airborne precautions (put PPE on before entering the room and remove mask and eye protection after leaving the room)	As for Standard precautions	No	Yes# Fit check to be confirmed before entering the room	Yes To protect eyes from aerosols	As for Standard precautions	No	No
Airborne plus Contact precautions (put PPE on before entering the room and remove gloves and gown/apron and other PPE in the room. Respirator mask, eye protection and balaclava (if used) after leaving the room)	Yes For contact with patient or contaminated surfaces or equipment	No	Yes # Fit check to be confirmed before entering the room (#facial hair impedes the ability to get an adequate seal to the face)	Yes To protect eyes from aerosols	Yes Fluid resistant long-sleeved gown if contact patient or contaminated surfaces or equipment	Yes If part of surgical attire and for prolonged contact in the room or performing an aerosol generating procedure to protect head and neck	Yes* *If part of surgical attire - Overshoes in the operating theatre to protect shoes from contamination

Table 2.0 Mask Selection Guide (see also APPENDIX A)

Type of activity, procedure, care	No identified risk of COVID-19 Determined by location, clinical risk assessment, infectious diseases and public health advice	Patient suspected or confirmed of COVID19 but without pneumonia	Patient suspected or confirmed of COVID-19 and pneumonia
Standard nursing care or medical treatment	Standard precautions: Level 2 or 3 surgical mask if there is a chance of splash or splatter with blood or body fluid	Level 2 or 3 surgical mask	Level 2 or 3 surgical mask
Emergency Department – where patients cannot be isolated	Standard precautions: Level 2 or 3 surgical mask – as part of standard precautions	Level 2 or 3 Surgical mask	Level 2 or 3 surgical mask
Intensive care unit – including extended or prolonged care	Standard precautions: Level 2 or 3 surgical mask if there is a chance of splash or splatter with blood or body fluid	Level 2 or 3 Surgical mask	P2/N95 respirator mask
Non aerosol generating procedures • nasopharyngeal swab • oropharyngeal swab • sputum (not induced)	Level 2 or 3 surgical mask	Level 2 or 3 surgical mask	Level 2 or 3 surgical mask
Aerosol generating procedures (AGP) include: • Induced sputum • Tracheal intubation and extubation • Ventilation via supraglottic airways (insertion and removal) • Non-invasive ventilation (BiPAP, CPAP, HFOV) • Manual ventilation before intubation (bag and mask ventilation) Intubation • Open oropharyngeal or tracheal suctioning Use of nebulisers • Anaesthetic for women during labour • Surgical or postmortem procedures on respiratory tract involving high-speed devices • Intercostal catheter insertion for relief of pneumothorax • Thoracic surgery that involves entering the lung • Transoesophageal echocardiography	Level 2 or 3 surgical mask	P2/N95 respirator mask	P2/N95 respirator mask
Procedural or surgical AGPs include: • Bronchoscopy • Bronchoalveolar lavage •	P2/N95 respirator mask	P2/N95 respirator mask	P2/N95 respirator mask
Reprocessing reusable medical devices (RMDs) in CSSD or Endoscopy units	Level 2 or 3 surgical mask	Level 2 or 3 surgical mask (or P2/N95 if AGP)	Level 2 or 3 surgical mask (or P2/N95 if AGP)
Cleaning a room <30 minutes after an AGP was performed	Level 2 Surgical mask	Level 2 Surgical mask	P2/N95 respirator mask
Cleaning a room >30 minutes after an AGP was performed	Level 2 surgical mask – if required as part of standard precautions	Surgical mask – as part of standard precautions	Surgical mask – as part of standard precautions
Cleaning a room where no AGP has been performed	Level 2 if there is a chance of splash or splatter with blood or body fluid – as part of standard precautions	Level 2 Surgical mask	Level 2 Surgical mask

Standard Precautions Standardised Signage

Source: Australian Commission on Safety and Quality in Health Care

https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approach-3-standard-precautions-photo

Screening of patients for COVID-19

- Wherever possible and appropriate, contact patients the day before their scheduled day of admission and ask the risk screening questions in Table 3.0. If a patient answer 'Yes' to any of the screening questions, their admitting doctor must be contacted to determine whether the patient's admission should be deferred
- All patients will be screened for risk factors for respiratory infection on arrival in the hospital and assessed for respiratory infection whilst they are inpatients
- On arrival ask the risk screening questions in Table 3.0
- Patients must also have their temperature checked using a tympanic thermometer (or other means of checking peripheral body temperature) by clinical staff on admission. If the patient's temperature is recorded above ≥37.5°C, they will be given a surgical mask to wear and they will be checked to make sure they are wearing it correctly to cover their mouth and nose. The patient's admitting doctor must be contacted to determine whether the patient's admission should be deferred
- Their admission may be deferred; however, the treating medical officer will need to consider the patient's diagnosis and determine the risk of postponing treatment
- If the patient is to be admitted, place the patient in a single room, follow standard plus contact and droplet precautions until their respiratory infection has resolved or alternative diagnosis confirmed. Refer to *Care of patients who develop fever or respiratory symptoms* in this document
- For all patients who have answered **'No'** to all risk screening questions, refer to *If a patient does not have any identified risk factors for COVID-19* in this document
- For additional information on screening and precautions, refer to RHC COVID-19 Resources Link

Table 3.0 Risk Screening Questions

Ask the following risk assessment questions of **all patients** to be treated in or admitted to your hospital. Document the responses and any actions implemented in the patients' clinical record.

Question	Action
In the last 14 days have you had symptoms of respiratory illness?	Yes - delay admission or transfer until the patient is recovered or if they cannot be delayed, seek advice from the treating medical officer regarding admission to an alternative (e.g. tertiary) facility. If there is no alternative and it is considered critical that the patient be admitted to the facility, admit and implement contact and droplet precautions until their respiratory infection has resolved or alternative diagnosis confirmed. No – complete other risk assessment questions
Have you been identified as a close contact* of a positive or probable case of COVID-19?	Yes – Where appropriate, delay admission until the patient has completed at least 14 days home isolation and has remained well with no symptoms of respiratory infection. If admission cannot be delayed, seek advice from the treating medical officer regarding admission or transfer to alternative facility. No – complete other risk assessment questions
Have you travelled from overseas or returned from a cruise in the last 14 days?	Yes –Where appropriate delay admission until the patient has completed at least 14 days home isolation and has remained well with no symptoms of respiratory infection. If admission cannot be delayed, seek advice from the treating medical officer regarding admission or transfer to alternative facility. No – complete other risk assessment questions
Have you travelled interstate to a state requiring isolation?	Yes –Where appropriate delay admission until the patient has completed at least 14 days home isolation and has remained well with no symptoms of respiratory infection. If admission cannot be delayed, seek advice from the treating medical officer regarding admission or transfer to alternative facility. No – complete other risk assessment questions
Have you had close contact* with someone who is unwell, or who has travelled overseas or returned from a cruise in the past 14 days?	Yes – determine if the contact person has a respiratory infection. If they do, delay the patient's admission or transfer, OR If the patient's admission cannot be delayed, admit and monitor the patient for respiratory infection If the contact does not have a respiratory infection, admit the patient and ask the patient to report any signs or symptoms of a respiratory infection until the contact has completed the 14 days home isolation No – complete other risk assessment questions

* **Close contact definition**

A close contact is defined as requiring:

• face-to-face contact in any setting with a confirmed or probable case, for greater than 15 minutes cumulative over the course of a week, in the period extending from 48 hours before onset of symptoms in the confirmed or probable case, or

• sharing of a closed space with a confirmed or probable case for a prolonged period (e.g. more than 2 hours) in the period extending from 48 hours before onset of symptoms in the confirmed or probable case.

Reference: Communicable Diseases Network of Australia (CDNA) Guidelines for COVID-19 version 2.9 5 May 2020 – Case Definitions Link

If a patient does not have any identified risk factors for COVID-19

- Ask patients when arriving for admission to come to the hospital without family members or carers, if possible, and observe the visitor restrictions that are in place for the hospital
- Ask patients to attend for scheduled appointments without family members or carers, if they can, to reduce the risk of contracting or spreading the infection
- Minimise time in the waiting area by:
    - careful or staggered scheduling
    - do not allow patients to queue or congregate at the admission desk; mark the floor with tape at a minimum of 1.5metre distances to ensure social distancing
    - encouraging patients not to arrive early
    - agree with the patient prior to arriving that (if appropriate) you may text them when you are ready to see them, so that they can wait in their car, for example
    - Where patients must wait due to incorrect arrival times, space chairs in waiting areas at appropriate distances >1.5metres apart. Remove additional chairs and any non-essential items including magazines and water coolers
- During admission, minimise direct contact with the patient, or maintain a distance of 1.5metres
- For all patients who have answered '**no'** to screening questions please follow standard precautions for care

Care of patients who develop fever or respiratory symptoms

Note: COVID-19 is not the only cause of fevers in patients, and staff should be guided by discussions with the treating medical officer

- Clinical assessment of a patient with a fever or respiratory infection needs to be undertaken on a case by case basis
- Screen using *Table 3.0 Risk Screening Questions* in this document
- For patients with fever or other symptoms of infection, a comprehensive evaluation should be performed as per usual medical practice
- If the patient meets the criteria for a suspect case, place a surgical mask on the patient and move to a single room using standard plus contact plus droplet precautions until further consultation with the treating medical officer can be undertaken
- Testing should be conducted as per the direction of the treating medical officer or where relevant, infection prevention and control or the public health unit
- All staff must use **standard plus contact plus droplet precautions** in caring for patients while awaiting the patient's test results. Refer to *Table 1.0 PPE Selection guide for standard and transmission-based precautions*
- Confirm that the facility has the necessary services available to adequately care for the patient and where necessary alternate facility arrangements should be made

- If the patient is medically assessed as well enough to go home, discharge may be considered
- For more information on Patient Management refer to RHC COVID 19 intranet resources Link

NOTE: For stand-alone Rehabilitation guidance, and for Mental Health facilities, refer to Link

What precautions to apply if the respiratory infection is not COVID-19

- Standard PLUS Droplet precautions should be applied for most other respiratory infections, Refer to *Table 1.0 PPE Selection guide for standard and transmission-based precautions*
- Place patient in single room with the door closed and air-conditioning that does not circulate to other areas in the hospital (if possible)
- AGPs performed on patients who are NOT suspected or confirmed cases of COVID-19, P2/N95 respirators (masks) are not necessary, a surgical mask is sufficient.

Precautions for the management of probable, suspected or confirmed cases of COVID-19

Transmission-based precautions must be used for patients with suspected or confirmed COVID-19:

- **Standard precautions PLUS contact and droplet precautions** can be safely used for routine patient care of inpatients with suspected or confirmed COVID-19. **Standard PLUS contact and airborne precautions** are recommended when performing **aerosol generating procedures (AGPs),** or for the care of critically ill patients with suspected or confirmed pneumonia

Table 4.0 Precautions

Patient Category	Precautions	Use and Example
Routine care of suspected or confirmed COVID-19 patient	Standard precautions PLUS Contact and Droplet precautions Single room with door closed	Fluid resistant gown Fluid resistant surgical mask Protective eyewear/face shield Single use disposable gloves
Aerosol generating procedures in suspected or confirmed COVID-19 patient	Standard precautions PLUS Contact and Airborne Precautions Single room with door closed Negative pressure air handling (if available)	Fluid resistant gown P2/N95 respirator mask Balaclava if part of surgical attire Protective eyewear/face shield Single use disposable gloves Overshoes, or theatre specific shoes if in operating suite if apart of surgical attire

Standard PLUS contact and droplet precautions

Standard precautions PLUS contact and droplet precautions can be safely used for routine patient care of inpatients with suspected or confirmed COVID-19.

- Place a surgical mask on the patient on arrival into the facility. Once inside the room, the mask can be removed from the patient
- Place patient in single room with the door closed. The door to the single room should be kept closed with contact and droplet precautions poster displayed as a reminder to staff to put on PPE before entering the room
- The room air-conditioning should be set so that it is 100% fresh air that does not circulate to other areas in the hospital (if possible). This should be assessed in consultation with your air-conditioning maintenance providers
- Use a single room with negative pressure air handling (if available) for specimen collection or any aerosol generating procedures
- If a sputum culture is to be collected, ideally the patient should be asked to do this without the healthcare worker in the room, as it reduces the risk of exposure to aerosols during the specimen collection
- The use of nebulisers should be avoided and alternative medication administration devices (e.g. spacers) used
- If transfer outside of the room is required, place a surgical mask on the patient that covers both nose and mouth and leave the mask in-place for the time the patient is out of their single room and follow respiratory hygiene and cough etiquette
- If the patient is wearing the surgical mask and does not require direct contact or patient care during transfer, then HCWs do not require a surgical mask to be worn for transfers. If direct contact or patient care is required, then droplet and contact precautions PPE should be used for the HCW during a transfer. The PPE worn in the patient's room should be removed, hand hygiene performed, and clean PPE must be applied outside the patient's room for the transfer
- If oxygen therapy is required, place nasal prongs under the surgical mask. Ideally oxygen therapy via nasal prongs should not exceed 4-6L/min
- If the patient is transferring to another facility or another unit/ward in the same facility, notify the receiving area/facility of the required precautions and PPE requirements in place prior to arrival
- If the patient is an inpatient, when the diagnosis is made, notify Hospital Coordinator who will review staff rosters and patient lists for potential contacts whilst admitted and notify Public Health. For rooms where Standard PLUS airborne or droplet precautions are being used, a staff log for each room entry should be maintained, to allow monitoring of potential breaches of infection control and allow follow-up of contacts, if necessary. If any breaches are identified, notify the Hospital Coordinator so an assessment of risk can be completed.

PPE for Standard PLUS contact and droplet precautions

For most inpatient contacts between healthcare staff and patients, the following PPE is safe and appropriate if it is worn correctly and should be put on **before** entering the patient's room:

- Long-sleeved gown (disposable and fluid resistant)
- Level 2 or 3 surgical mask, fitted to cover the nose and the mouth snugly, do not touch the front of the mask once it has been fitted and when removing, use the ties and dispose of into the waste bin, do not leave around your neck and after removal, perform hand hygiene
- Face shield or goggles (protective eye wear)
- Disposable non-sterile gloves when in contact with patient (use hand hygiene before putting on (donning) and after removing (doffing) gloves)
- Refer to *Table 1.0 PPE Selection guide for standard and transmission-based precautions*

NOTE: For hospitalised patients who are very unwell or requiring frequent attendance by medical and nursing staff, a P2/N95 respirator (mask) should be considered for prolonged or very close contact.

If a P2/N95 respirator (mask) is to be used, then the healthcare worker must fit check with each use to ensure it is providing correct protection by giving an airtight seal on the face and this may not be able to be achieved with facial hair.

Aerosol-generating procedures (AGPs)

Standard PLUS contact and airborne precautions are applied when AGPs are to be performed on suspected or confirmed cases of COVID-19 and for the care of clinically ill patients requiring high/level volume hands-on contact.

Examples of AGPs include:

- insertion or removal of endotracheal tube;
- intentional or inadvertent disconnection/reconnection of closed ventilator circuit;
- high frequency oscillatory ventilation (HFOV);
- open oropharyngeal or tracheal suctioning
- upper respiratory instrumentation or surgery
    - e.g. bronchoscopy, tracheotomy, ear nose throat surgery
- surgical or post-mortem procedures on respiratory tract involving high-speed devices
- intercostal catheter insertion for relief of pneumothorax;
- thoracic surgery that involves entering the lung
- manual or non-invasive ventilation (NIV);
    - bi-level positive airway pressure ventilation (BiPAP) or continuous positive airway pressure ventilation (CPAP)
- collection of induced sputum
- high flow nasal oxygen (HFNO)
- transoesophageal echocardiography (TOE)

PPE to be used when AGPs are being performed should be put on before entering a patient's room including:

- Long-sleeved gown (disposable and fluid resistant)
- P2/N95 respirator (mask) – should be fit-checked with each use to ensure an air-tight seal around the mask is achieved. This will be difficult to achieve if the wearer has facial hair and facial hair should be removed if this HCW is required to attend the patient
- Face shield or goggles
- Disposable nonsterile gloves when in contact with patient (hand hygiene before putting on (donning) and after removing (doffing) gloves)

P2/N95 respirators (mask) should be used only when required

Unless used correctly (i.e. with fit check), a P2/N95 respirator (mask) is unlikely to protect against airborne pathogen exposure.

- An airtight seal may be difficult to achieve for people with facial hair
- Health care workers may need to try different P2/N95 respirators (masks) to get the necessary fit to achieve a protective seal
- If a tight seal cannot be achieved, facial hair should be removed
- Using tape on P2/N95 mask to provide a seal to the face is not recommended
- It is recognised that eight hours is the maximum time for continuous use of a P2/N95 however this can cause fatigue and a mask change at four hours should be considered. Extended use can also cause discomfort to the wearer from wearing it for longer than usual. Remove or replace if the mask becomes, contaminated, hard to breathe through or no longer fitting correctly, or becomes moist or loose

Refer to *Table 1.0 PPE Selection guide for standard and transmission-based precautions*

Care of patients in the ICU

- Patients who require admission to ICU with severe COVID-19 may have a high viral load, particularly in the lower respiratory tract
- Standard plus contact and **droplet** precautions should be used for general care of COVID-19 patients in ICU e.g. a patient not requiring ventilation or AGPs
- Standard precautions PLUS contact and airborne precautions are required for extended or prolonged patient care and are adequate for most AGPs
- The risk of aerosol transmission is reduced once the patient is intubated with a closed ventilator circuit but there is a potential for transmission from inadvertent circuit disconnection or from non-invasive ventilation, if it is used
- The risk of transmission from other body fluids such as diarrhoeal stool or vomitus is unknown

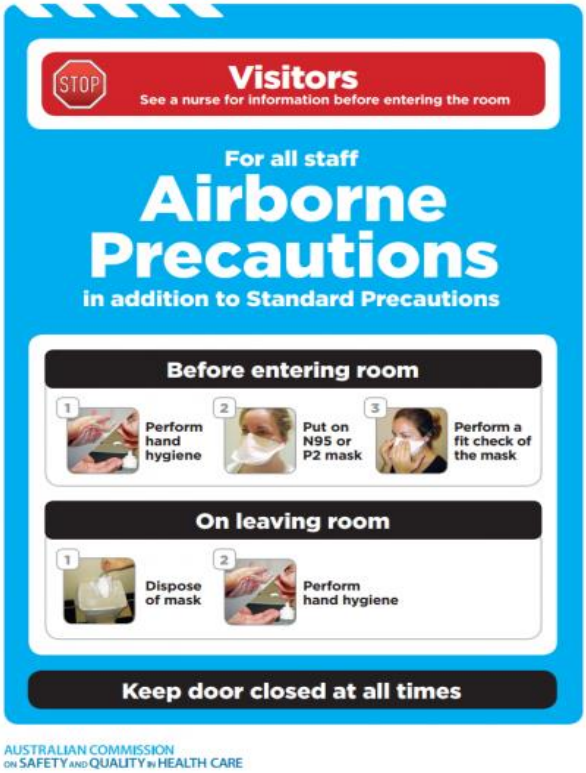
- Only **PPE marked as reusable** should be reused after **reprocessing** according to manufacturer's instructions. All other PPE must be worn as per manufacturer's instructions and disposed of after use
- ICU staff caring for patients with COVID-19 (or any other potentially serious infectious disease) should be trained in the correct use of all the available options of PPE that they will use when providing care for the patient

Use of PAPR in Theatre or ICU

- If a health care professional is required to remain in the patient's room continuously for a long period (e.g. more than one hour) because of the need to perform multiple procedures, an assessment of the PPE should be undertaken and discussed with the DCS. If determined appropriate, the use of a powered air purifying respirator (PAPR) may be considered for additional comfort and visibility
- Any HCW who is going to need to use PAPR requires training in its use prior to using it for airborne precautions. There are several different types of relatively lightweight, comfortable PAPRs and they should be used according to the manufacturer's instructions. Special care is needed with removal of PAPR to avoid contamination of the user
- PAPR that are designed for use in other settings outside of healthcare are not recommended for use in healthcare
- Manufacturer's instructions for reprocessing of reusable PAPR components and management of filters should strictly followed
- For additional information refer to Australian Society of Anaesthetists N95 vs PAPR for AGPs Link

Signage:

Signage should be implemented in wards and units caring for probable, suspected or confirmed COVID-19 positive cases. Standardised signage for contact, droplet and airborne precautions are available from the Australian Commission on Safety and Quality in HealthCare (ACSQHC).



Source: Australia Commission on Safety and Quality in Health Care
https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approach-3-standard-precautions-photo

Ceasing isolation for COVID-19 patients

- Patients under investigation with no respiratory symptoms can have precautions ceased following two consecutive swabs taken at least 24 hours apart which are negative for SARS-CoV-02 by PCR, could be sent home to compete home quarantine at home with GP follow-up. If they have respiratory infection symptoms, then precautions should remain in place until diagnosis is confirmed and if the diagnosis requires droplet and/or contact precautions then they should continue.
- For information on when a person can be released from isolation refer to the current CDNA advice.

Operating Theatres - Key points for infection prevention and control planning for COVID-19

Preparation

For additional information refer to the RHC Airway Management Guide for COVID-19 Link

Procedures being performed in the operating theatre on patients who are not suspected or confirmed cases of COVID-19 should use the routine principles of infection prevention and control for elective surgery. Usual surgical attire should be used for these cases including surgical mask, protective eye wear, surgical gown, cap and gloves.

Limit unnecessary entry and exit from the operating theatre during cases and the number of people in the theatre during the case to those required for clinical and educational purposes only.

For suspected or confirmed COVID-19 cases

Surgical procedures should only be performed on COVID-19 cases in an emergency.

Consider where the anaesthetic and surgery will be undertaken, including:

- an anaesthetic bay/procedure room that can be closed off to traffic, have air conditioning set to negative pressure (if possible) and ability to move the patient directly to the designated operating theatre once closed-circuit ventilation has been achieved
- review air-conditioning supply for the operating theatre, if air supply can be isolated and set to low positive pressure or neutral pressure compared to surrounding areas to minimise any risk of non-HEPA filtered air moving into the operating theatre and to allow adequate air changes/hr (minimum 20air changes/hr) to maintain a clean air environment for surgery
- Prepare the anaesthetic room and operating theatre with essential items only for the case, all outer items are to be removed or covered and sealed in plastic for the case

Consider having a COVID-19 resource box that contains all necessary items to prepare for the case:

- Infection control signage/anaesthetic report and operating room (OR) registered nurse's operation report/pen
- Task cards for each key OR person
- A ziplock bag for IDs, mobile phones and other personal items not allowed in the theatre that have not been secured in personal lockers prior to the case
- PPE for each person to be present in the case and the cleaning staff including:
    - Disposable yellow gowns
    - Shoe covers
    - Theatre hair covers (blue caps & balaclavas)
    - Eye shields & frames
    - Surgical masks and P2/N95 respirator masks
- Hand sanitiser
- Contaminated waste bags
- Linen bags
- Surface cleaning wipes and disinfectant wipes or solution.

Where possible, place a suspected or confirmed COVID-19 case last on the last to allow time for preparation and post procedure recovery of the patients, documentation, decontamination, cleaning and a team debrief following the case.

Post signs on all access points to restrict traffic to or from the anaesthetic room or operating theatre to essential staff only (no students/observers and contractors should be in the operating theatre). Outside members of the team should have ready items that could be required available to minimise waiting time during the procedure. Use a comms phone to communicate between those inside and support team outside the theatre.

Briefing - Ensure all involved in the case understand their roles and are aware of the precautions to be in place and are prepared prior to the patient coming to the theatre unit. No food, drinks or personal items allowed in the operating theatre.

Porter transfer of the patient to theatre should be arranged to avoid/minimise contact with any other staff or patients (especially in lifts, if possible, lock lift for transfer to theatre), the patient should wear a surgical mask for the transfer from their room to the anaesthetic room.

During Surgery

The patient's bed that they have been transferred to theatre on should remain in the anaesthetic room or the operating theatre during the case. The patient should be transferred to this bed and back to their room (or to ICU) at the completion of the case following recovery in the operating room.

During the case, inside theatre, staff will remain inside the theatre and rely on outside theatre staff to support them with supplies. All case and patient paperwork to remain outside the anaesthetic room and operating theatre, the outside anaesthetic support person to record information for the anaesthetist to

complete the anaesthetic form at the completion of induction. The accountable items count for the procedure should be done with the inside scout nurse to record the count.

All reusable instrumentation and equipment used in the case will be placed in designated boxes (with lids) for transfer to sterilising services (CSSD) care must be taken to minimise contamination of the outside of the transport containers.

Extubate and recover the patient in the operating theatre whilst wearing PPE. If patient to go to post anaesthetic care unit (PACU), inform staff of necessary precautions to be used for the care and management of this patient.

Following surgery

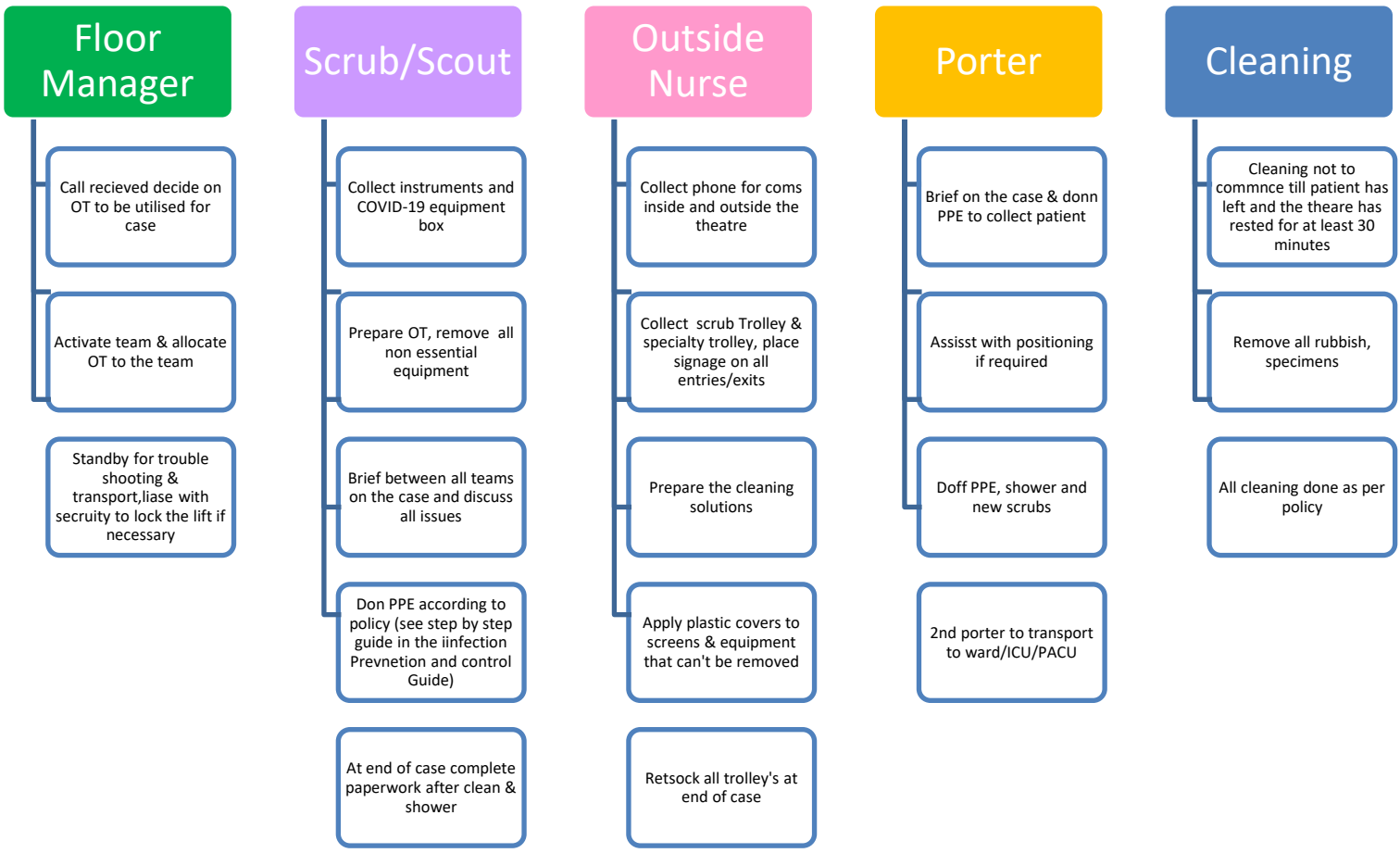
Rest the operating theatre and anaesthetic room for at least 30 minutes (dependent on number of air changes) after the patient has been removed prior to cleaning and then reuse.

At the completion of the case, all members of the team and support staff (including porters and cleaners) need to doff all PPE and then should shower and put on clean scrubs. All used scrubs and towels go into normal linen bags for laundering.

Debrief – all members of the team plus theatre manager to review processes and make any improvements to the plan. Reaffirm all the processes that went well and maintained safety for HCWs and patients.

An example of task cards to each theatre staff role

Developed with assistance from North Shore Private and Linacre Private Operating Theatres



Donning and Doffing PPE

Please be aware there are several ways PPE can be removed depending on the precautions applied, and it is always important to be follow guidance from your local educators and infection prevention and control staff.

CEC (NSW) PPE training video https://youtu.be/qk6ai3JUL9U

For additional information the Tasmanian Infection Prevention and Control Unit have provided new healthcare worker education as instructional videos on **PPE donning and doffing of PPE for combined droplet/contact precautions and airborne/contact precautions** in addition to standard, contact, droplet and airborne precautions

Donning PPE – Suggested Sequence for putting on (donning) PPE

Where possible, use a buddy to check PPE is correctly applied before entering the patient's room or procedure area

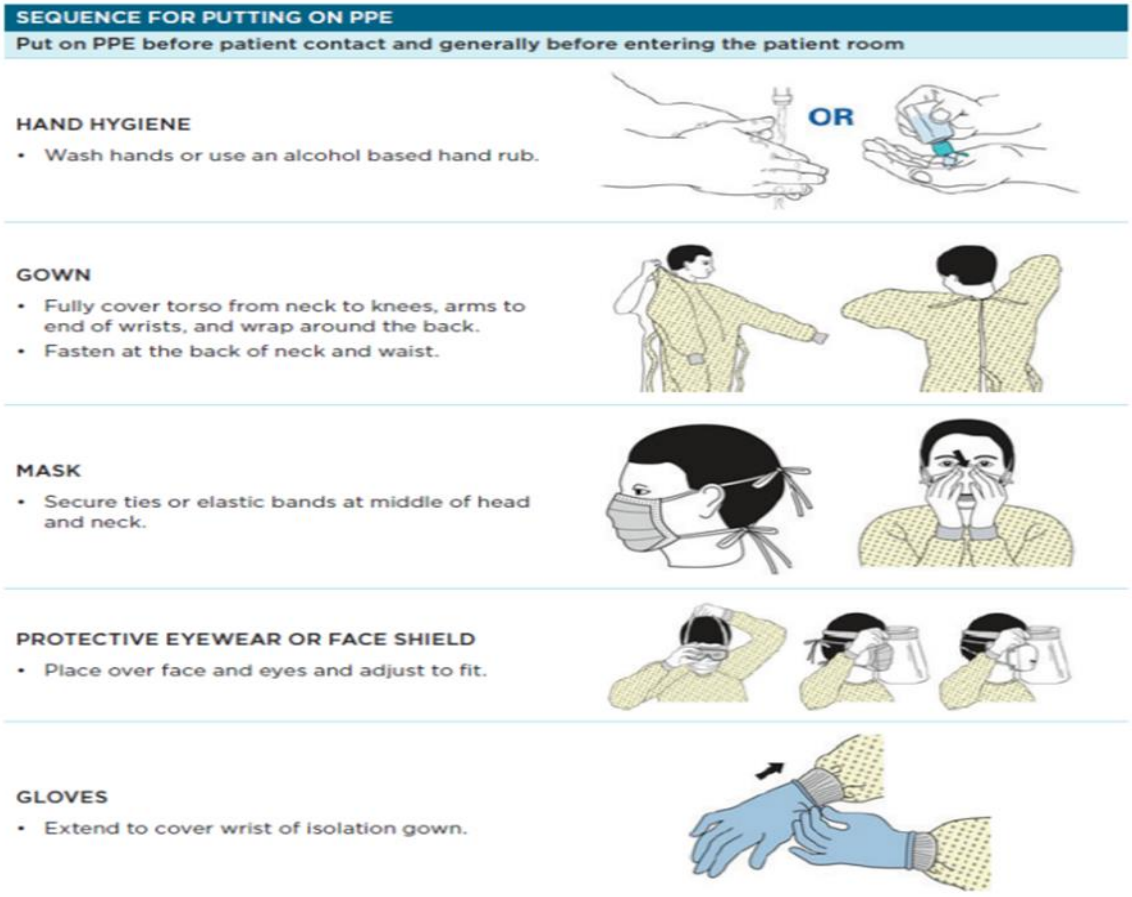


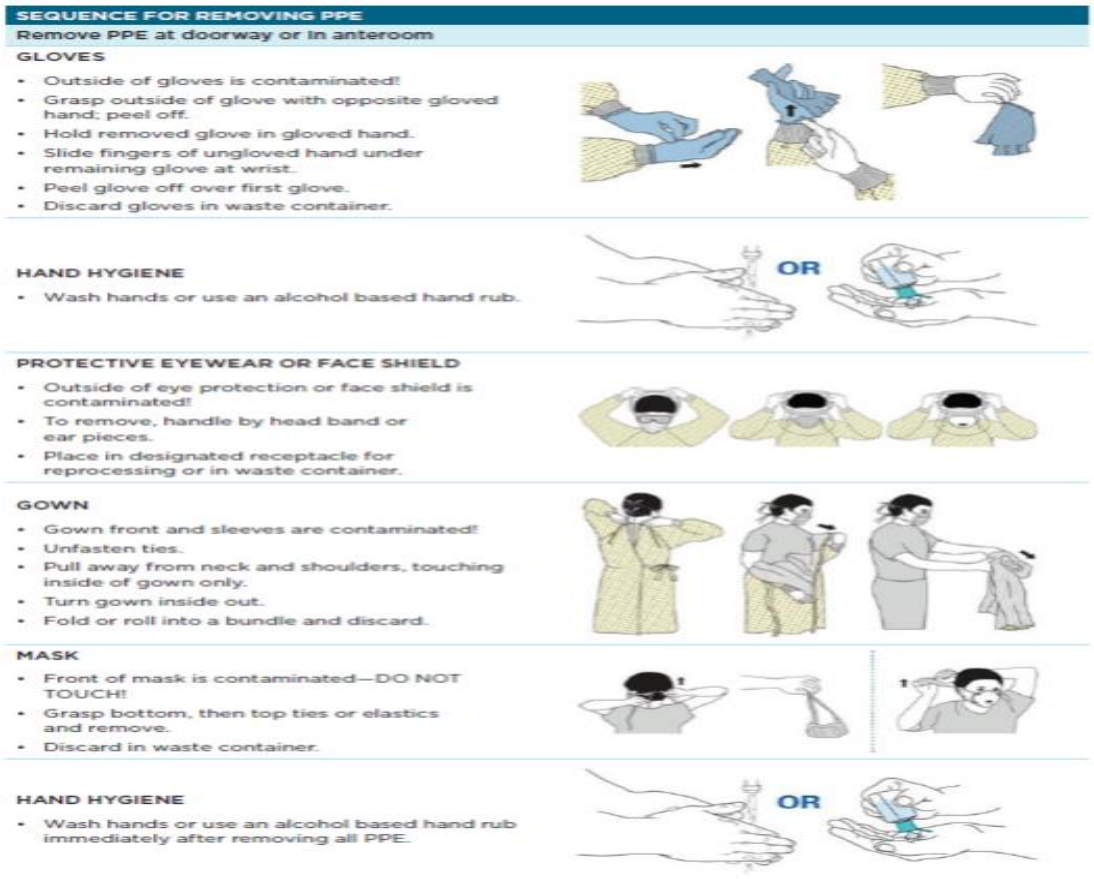
Table 1: Sequence of putting on PPE. Source: Australian Guidelines for the Prevention and Control of Infection in Healthcare, Section 3.3 PPE (2019) https://www.nhmrc.gov.au/health-advice/public-health/preventing-infection

If you are using airborne precautions, then substitute a P2/N95 mask for the surgical mask and remember to fit check the mask each time you put one on.

Doffing PPE Option 1 – Suggested sequence for removing (doffing) PPE

Important safety measures when removing PPE:

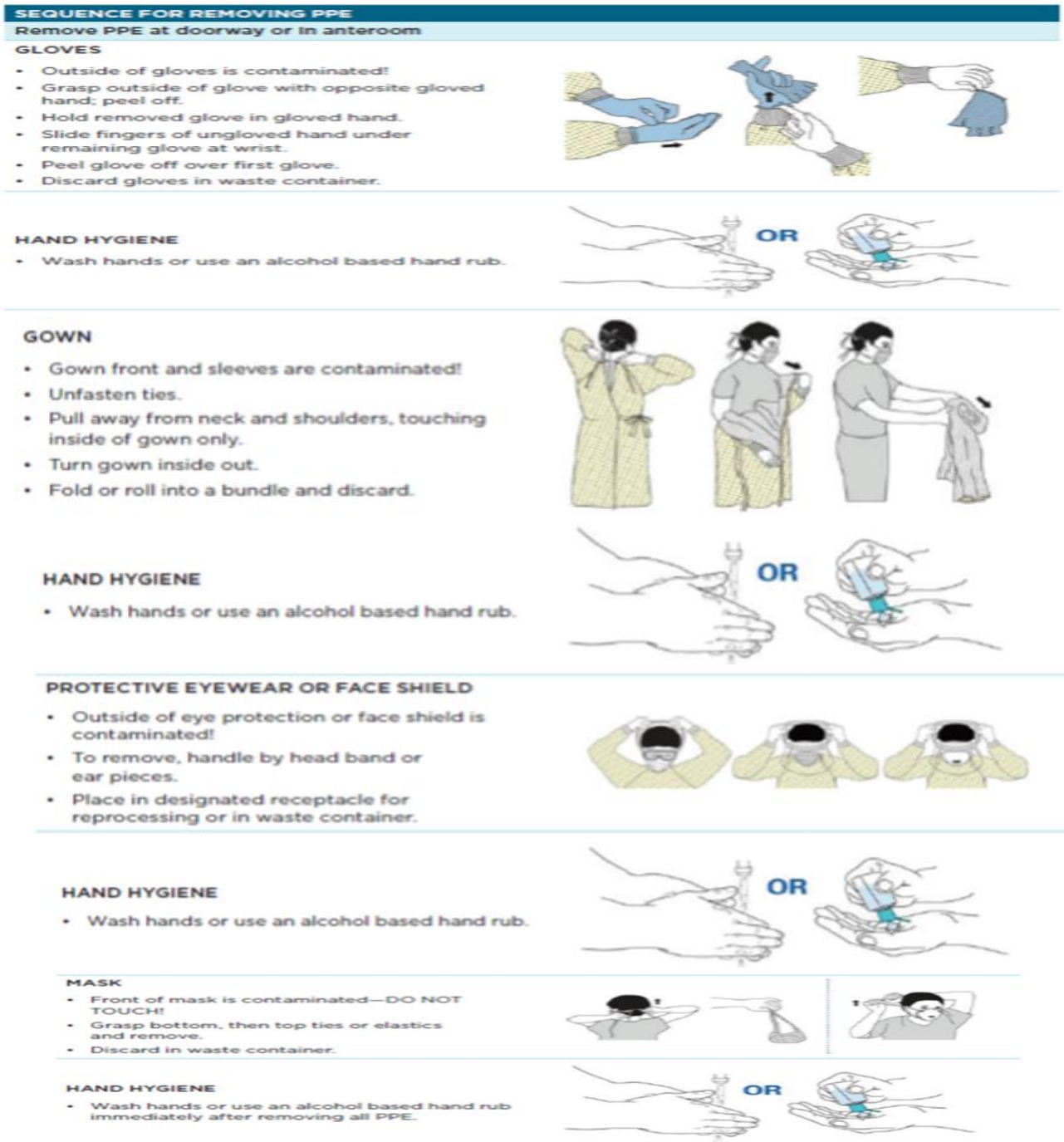
- Use a consistent sequence every time that minimises contamination risks to you or your clothing
- Remove PPE near the exit of the room, at least 1.5metres away from the patient
- For airborne precautions, remove your mask and protective eye wear/shield outside the room
- Where possible, use a buddy to assist and check PPE is safely removed at each step. The buddy should stop donning or doffing if PPE is not correctly worn or there is a risk of contamination of the wearer
- Don't rush, take your time to remove each piece of PPE and **if you think your hands may have been contaminated at any time, perform hand hygiene before proceeding**. Especially if the next step is to touch your face
- When removing PPE (gown, mask, face and eye protection) lean forward to reduce risk of contamination of self
- Discard used PPE into a waste bin for disposal. Never reuse single use PPE
- If PPE is reusable, then it must be cleaned and dried before reuse



Sequence for removal on PPE. Source: Australian Guidelines for the Prevention and Control of Infection in Healthcare, Section 3.3 PPE (2019) https://www.nhmrc.gov.au/health-advice/publichealth/preventing-infection

Doffing PPE Option 2 – Suggested sequence for removing (doffing) PPE

Safely remove PPE without contaminating your skin, mucous membranes or clothing. Remove gown and gloves before exiting the room and place into the waste bin. Perform hand hygiene. Leave the room and then remove protective eye wear/face shield, perform hand hygiene and finally the P2/N95 respiratory mask and discard in the waste bin and perform hand hygiene.



Sequence for removal on PPE. Source: Adapted from the Australian Guidelines for the Prevention and Control of Infection in Healthcare, Section 3.3 PPE (2019) https://www.nhmrc.gov.au/health-advice/publichealth/preventing-infection

Waste, Linen and Cleaning

For additional information refer to the IPC precautions for environmental services Link

Disposal of PPE and other waste

- PPE with no visible contamination can be discarded into general waste, PPE that has been visibly contaminated should be disposed of into clinical waste.
- Waste should be disposed in the normal way for clinical waste and sharps
- All non-clinical waste is disposed of into general waste

Handling of linen

- Routine procedures for handling of used linen should be followed.
- If linen is heavily soiled/wet or odourous then it is placed into a clear plastic bag that is securely closed before being placed into a linen bag at point of generation (in the patient's room)
- As an added precaution place a linen bag can be lined with a clear plastic bag for additional protection and containment of used/soiled linen
- Dissolving/soluble bags for spoiled/wet linen should not be used as they can disintegrate prematurely and put their staff and HCWs at risk during handling and transport of the line

Environmental cleaning of patient care areas

General Cleaning

- Cleaners should observe standard precautions when cleaning patients' rooms where there are no transmission-based precautions in place

Cleaning for COVID-19 patient rooms

- Cleaners should observe standard precautions PLUS contact and droplet precautions when cleaning patients' rooms where there are transmission-based precautions in place
- Frequently touched surfaces (such as door handles, bedrails, tabletops, light switches, patient handsets) in the patient's room should be cleaned daily or more frequently if required
- Remove all disposable items e.g. privacy screens and when cleaning completed replace with new screens
- Terminal cleaning of all surfaces in the room (plus spot cleaning or walls, blinds and ceilings) should be performed after the patient is discharged
- A combined cleaning and disinfection procedure should be used, either 2-step – detergent clean, followed by disinfectant; or 2-in-1 step – using a product that has both cleaning and disinfectant properties. Any hospital-grade, TGA-listed disinfectant that is commonly used against norovirus is suitable, if used according to the manufacturer's instructions

Management of a deceased COVID-19 patient

- Staff handling deceased should wear PPE (including gown, single use disposable gloves, surgical mask, face shield/goggles)
- Unless jurisdictional regulations for care of the deceased patient vary, the deceased patient is to be double bagged in airtight, sealed bag to prevent any possible contamination or leakage
- Each facility should ensure that they have appropriate body bags on site
- If unsure, check with the Nurse Unit Manager or Hospital Coordinator

At-risk Health Care Workers

The Australian Health Principle Protection Committee (AHPPC) recommends

- that special provisions apply to essential workers who are at higher risk of serious illness
- where the risks cannot be sufficiently mitigated e.g. using PPE, should not work in high risk settings

The AHPPC considers that, based on limited current evidence, the following people are, or are likely to be, at higher risk of serious illness if they acquire COVID-19

- Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic medical conditions
- People aged 65 years and older with chronic medical conditions
- People aged 70 years and older
- There is limited evidence currently regarding the risk in pregnant women however if they can avoid contact with known COVID-19 cases this is preferable
- HCWs at higher risk include:
    - returned international or interstate travellers. Some of the Australian states have travel restrictions in place for interstate travel or residents returning home (e.g. Queensland and WA) must self-isolate for 14 days and not undertake work in a RHC facility during this period
    - those who have had close contact with a confirmed COVID-19 patient without wearing appropriate PPE must self-isolate for 14 days and not undertake work in a RHC facility during this period

HCW uniforms

- HCWs should ensure that they have adequate uniform supplies to enable them to wear a clean uniform each shift. There is limited evidence that the uniforms of HCWs can become contaminated with a variety of pathogens and therefore HCWs should avoid wearing their uniforms home from work. If possible, staff should change out of uniforms before leaving work and shower or at least wash face and hands on arrival home. For home laundering of uniforms, follow manufacturer instructions, noting a hot wash is preferred and uniforms should be washed separately from other household items.

Medical records and patient charts for COVID-19 suspected, probable or confirmed cases

- Standard precautions apply to the management of all patient charts/medical records
- No patient chart/record is to be left in the patient rooms
- HCWs are not to perform any documentation, either paper based or electronic, without first removing PPE and performing hand hygiene
- If using electronic patient management systems ensure the shared computer equipment can be cleaned and disinfected, especially screens, keyboards and phones
- There is no requirement to quarantine medical records prior to returning to health information/medical record management services
- Medical records staff do not need to wear gloves to handle patient's medical records, but should perform hand hygiene after handling the medical records

Visitors

Screening visitors on entry to the facility

- A single point of public access entry point must be established at the facility; where a single point of access has not been achieved, each public access entry point must be staffed in order to ensure screening questions are asked and temperature checking occurs
- Social distancing of at least 1.5metres is required for visitors waiting to be screened
- The screening must include the following questions:
    - are you currently unwell with any cold or flu like symptoms?
    - have you travelled overseas in the past 14 days?
    - have you been on a cruise ship in past 14 days?
    - have you been identified as a close contact of a COVID-19 case?
    - have you been identified as a close contact of a suspect or probable COVID-19 case?
- If the individual answers 'yes' to any of the above questions, they cannot enter the facility
- If the individual answers '**no'** to all the above questions, their temperature can be taken

Considerations for temperature checking of visitors:

- Non touch temperature checking via forehead thermometers is recommended, however, availability of non-touch thermometers is rare in acute hospital settings
- Where non touch thermometers are not available, tympanic temperature is recommended
- Alcohol based hand rub should be available at the screening station

Steps for temperature checking:

- If the visitor's temperature is ≤ 37.4°C, the visitor can enter the facility
- If the visitor's temperature is ≥ 37.5°C they cannot enter the facility

If a visitor has a temperature ≥ 37.5°C:

- The visitor's name should be recorded
- The visitor should be advised that their temperature is elevated and that they should seek medical attention
- Visitors can be directed to the Emergency Department (ED) for triage and assessment
- For sites without an ED, the visitor should be directed towards their GP

- Visitors for patients who are confirmed cases of COVID-19 should be restricted. In the case of palliative care, an exception may be granted to allow visitors
- A visitor log for any patients who are diagnosed as having COVID-19 infection should be maintained, to allow for follow-up of contacts, if necessary

Where can I get more information?

For additional information the Tasmanian Infection Prevention and Control Unit have provided healthcare worker education as instructional videos on PPE donning and doffing, **PPE for combined contact and droplet precautions and contact and airborne precautions** as well as standard, contact, droplet and airborne precautions

Department of Health - COVID-19 Infection prevention and control training. This is a free resource, but you need to register to complete this training and on completion you receive a certificate of completion.

This information is consistent with the information the Commonwealth Department of Health is providing on PPE use for COVID-19 and the Australian Guidelines for the Prevention and Control of Infection in Health Care (2019)

For the latest advice, information and resources go to www.health.gov.au

Call the National Coronavirus Health Information Line on 1800 020 080. The line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450.

The telephone number of your state or territory public health authority is available on the coronavirus page at www.health.gov.au/state-territory-contacts

For the PHLN guidance on laboratory testing for SARS-CoV-2 (the virus that causes COVID-19)

This information has been adapted from the Australian Department of Health advice for Novel Coronavirus and may change as the outbreak evolves.

Mask	No identified risk of COVID-19	Patient suspected or confirmed of COVID-19	Patients suspected or confirmed of COVID-19 cared for in open settings
Surgical Mask **(≤ 4 hours continuous wear)** 	• Standard nursing care or medical treatment if there is a risk of blood or body fluid exposure (Standard Precautions) e.g. inserting IV, removing catheter • **NON-Aerosol generating procedures (AGP):** ○ nasopharyngeal swab ○ oropharyngeal swab ○ sputum (not induced) NOTE: For AGPs performed on patients who are NOT suspected or confirmed cases of COVID-19, P2 respirators are not necessary, i.e., a surgical mask is sufficient. **AGPs may include**: • Induced sputum • Tracheal intubation and extubation • Ventilation via supraglottic airways (insertion and removal) • Non-invasive ventilation (BiPAP, CPAP, HFOV) • Manual ventilation before intubation (bag and mask ventilation) • Intubation • Suctioning • Use of nebulisers • Anaesthetic for women during labour **Procedural or surgical AGPs including**: • Tracheostomy • Transoesophageal echocardiography • Any surgical procedure involving high speed devices • **Reprocessing** reusable Medical Devices (RMDs) in CSSD or Endoscopy Units	• Standard nursing care or medical treatment • **NON-Aerosol generating procedures in patients with or without pneumonia (fever and breathlessness and/or severe, frequent, or productive cough):** ○ nasopharyngeal swab ○ oropharyngeal swab ○ sputum (not induced) • **Reprocessing** reusable medical devices (RMDs) in CSSD or Endoscopy units • **Cleaning** a room >30 minutes after an AGP was performed • **Cleaning** a room where no AGP was performed	• Emergency Departments where suspected and confirmed COVID-19 patients cannot be isolated or cared for in a separate acute respiratory area • **Reprocessing** reusable medical devices (RMDs) in CSSD or Endoscopy units • **Cleaning** a room >30 minutes after an AGP was performed • **Cleaning** a room where no AGP was performed

Mask	No identified risk of COVID-19	Patient suspected or confirmed of COVID-19	Patients suspected or confirmed of COVID-19 cared for in open settings
N95 / P2 Respirator **(< 8 hours continuous wear)** 	**Procedural or surgical AGPs including**: • Bronchoscopy • Bronchoalveolar lavage	• Patient care in an Intensive Care Unit when performing AGPs • **AGPs including:** ○ Induced sputum ○ Tracheal intubation and extubation ○ Ventilation via supraglottic airways (insertion and removal) ○ Non-invasive ventilation (BiPAP, CPAP, HFOV) ○ Manual ventilation before intubation (bag and mask ventilation) ○ Intubation ○ Suctioning ○ Use of nebulisers ○ Anaesthetic for women during labour • **Procedural or surgical AGPs include:** ○ Bronchoscopy; Bronchoalveolar lavage; Tracheostomy ○ Intentional or inadvertent disconnection/reconnection of closed ventilator circuit ○ Surgical or post mortem procedures on respiratory tract involving high-speed devices ○ Intercostal catheter insertion for relief of pneumothorax ○ Thoracic surgery that involves entering the lung ○ Transoesophageal echocardiography • **Cleaning** a room <30 minutes after an AGP was performed	• In an open ICU cohorted area with one or more COVID-19 patients, the whole area is recommended to require airborne PPE precautions

Extended Use of Masks*

- **Extended use can also cause discomfort to the wearer from wearing it for longer than usual. Remove or replace if the mask becomes hard to breathe through or no longer fitting correctly, or becomes moist or loose. Eight hours is the maximum for a P2/N95 and it is acknowledged that this can cause fatigue and a mask change at four hours may be required**
- A surgical or P2/N95 mask should be removed if it becomes moist or soiled
- A mask should not be pulled down to drink or eat and reused
- Masks must not be worn around a staff member's neck
- A surgical mask can be worn for up to four hours uninterrupted or continuous use
- P2/N95 masks can be worn for up to eight hours uninterrupted or continuous use
- Staff must perform a fit check with each use of a P2/N95 mask to ensure it is providing correct protection by giving an airtight seal on the face. This may not be possible with facial hair
- The wearer should not touch the contaminated surface of the mask, and the mask should be discarded if contaminated with blood or bodily fluids and following AGPs

***** Extended use refers to the practice of wearing the same mask for repeated close contact episodes with several patients, without removing the mask between patient care.

Updated information in this version is highlighted in yellow.

Ramsay Health Care sources masks that have been certified for their intended purpose in accordance with the relevant Australian Standard.

Reference:

1. NSW Government, Clinical Excellence Commission. *COVID-19 Infection Prevention and Control Advice for Health Workers V2 – 3 April 2020*
2. Communicable Diseases Network of Australia – COVID-19 SoNG 2.9, 5 May 2020
3. The Royal Australasian College of Surgeons Guidelines for the management of surgical patients during the COVID-19 pandemic 17 April 2020
4. ASOHNS Guidelines Addressing The Covid-19 Pandemic – The Re-Introduction Of Elective Surgery http://www.asohns.org.au/CMS/Uploads/ASOHNS%20GUIDELINES%20ADDRESSING%20THE%20COVID%2023%20April%202020.pdf

ATTACHMENT 4

Australian Government – Department of Health

COVID-19 – Infographics – April & June 2020

Australian Government
Department of Health

Coronavirus (COVID-19)

CURRENT STATUS OF CONFIRMED CASES

5,687	34	2,315
Total cases	Total deaths	Cases recoverd

91
CURRENT CASES INTENSIVE CARE UNITS (ICU)

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
3	39	0	11	8	2	11	17

408
CURRENT CASES ADMITTED TO HOSPITALS

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
6	118	23	47	19	11	123	61

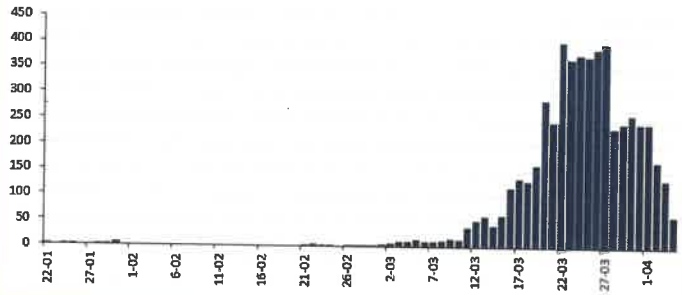
297,154
TOTAL TESTS CONDUCTED

1.9 % POSITIVE

ACT	NSW	NT	QLD
5,258	121,443	2,753	57,795
% POSITIVE	% POSITIVE	% POSITIVE	% POSITIVE
1.8%	2.1%	0.9%	1.6%

SA	TAS	VIC	WA
32,863	2,845	56,000	18,197
% POSITIVE	% POSITIVE	% POSITIVE	% POSITIVE
1.2%	2.8%	2.0%	2.5%

DAILY NUMBER OF REPORTED CASES

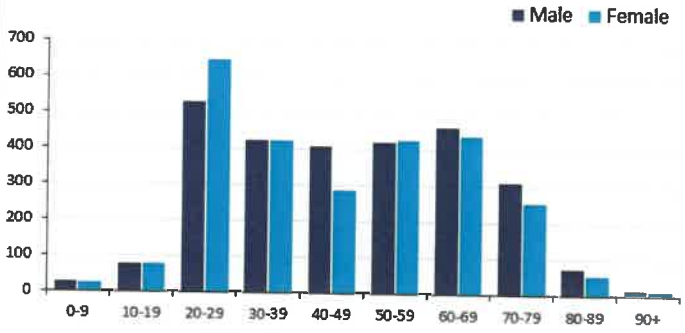


CASES IN AGED CARE SERVICES

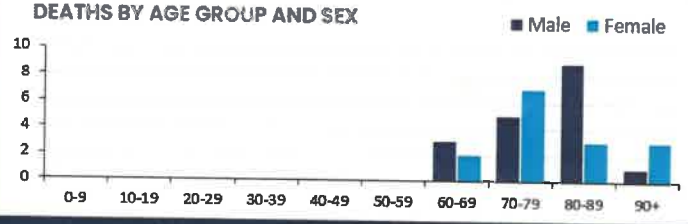
Confirmed cases	Australia	ACT	NSW	NT	Qld	SA	Tas	Vic	WA
Residential Care	25 [4] (6)	0	23 [4] (5)	0	1 (1)	0	0	1	0
In Home Care	7 (1)	0	3	0	2	0	1 (1)	1	0

Cases in care recipients [recovered] (deaths)

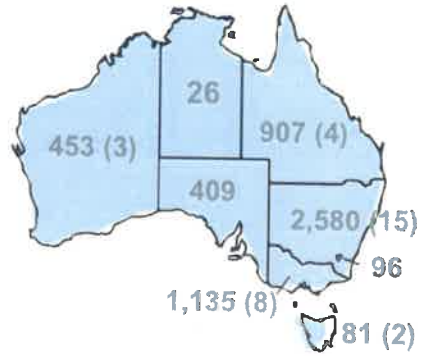
CASES BY AGE GROUP AND SEX



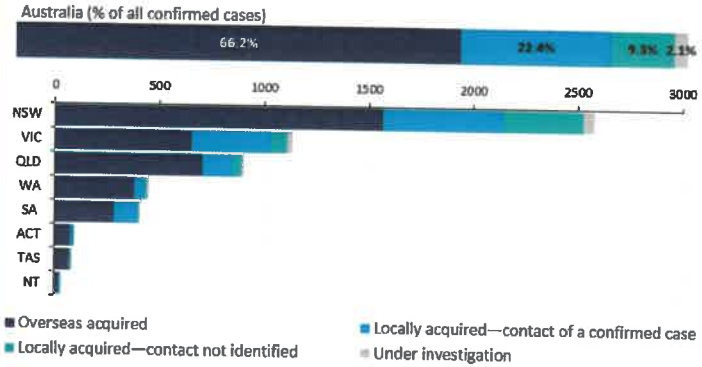
DEATHS BY AGE GROUP AND SEX



CASES (DEATHS) BY STATE AND TERRITORIES

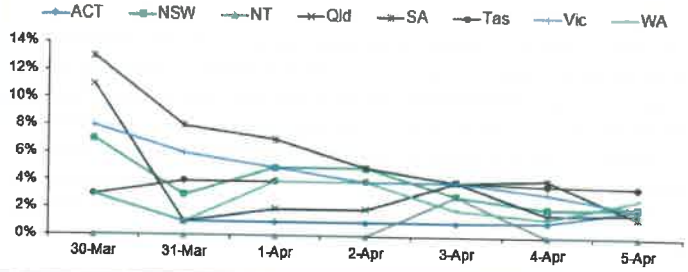


CASES BY SOURCE OF INFECTION



PUBLIC HEALTH RESPONSE MEASURE

Proportion of total cases under investigation



Last updated 5 April 2020

This infographic is updated every afternoon based on the data we receive by 3.00pm from states and territories

Australian Government
Department of Health

BE COVIDSAFE

CURRENT STATUS OF CONFIRMED CASES

7,335	102	6,851
Total cases	Total deaths	Cases recovered

4 CURRENT CASES INTENSIVE CARE UNITS (ICU)

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
0	0	0	1	0	0	3	0

17 CURRENT CASES ADMITTED TO HOSPITALS

ACT	NSW	NT	QLD	SA	TAS	VIC	WA
0	9	0	1	0	0	7	0

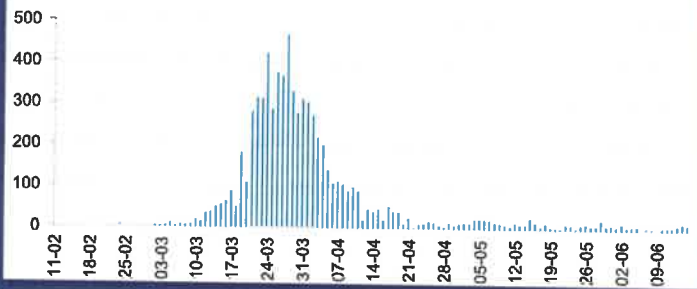
1,828,149 TOTAL TESTS CONDUCTED

0.4% POSITIVE

ACT	NSW	NT	QLD
23,571	641,442	10,488	251,322
POSITIVE	POSITIVE	POSITIVE	POSITIVE
0.5%	0.5%	0.3%	0.4%

SA	TAS	VIC	WA
126,572	36,471	594,865	143,418
POSITIVE	POSITIVE	POSITIVE	POSITIVE
0.3%	0.6%	0.3%	0.4%

DAILY NUMBER OF REPORTED CASES

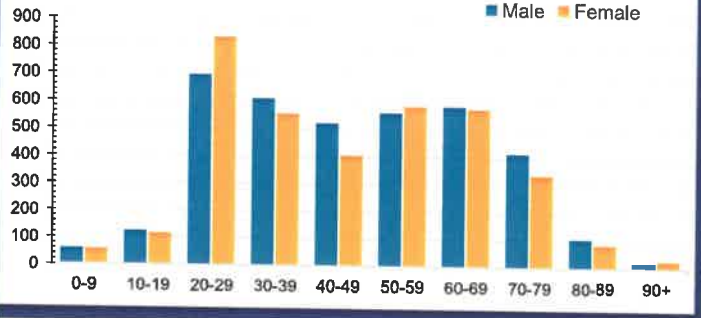


CASES IN AGED CARE SERVICES

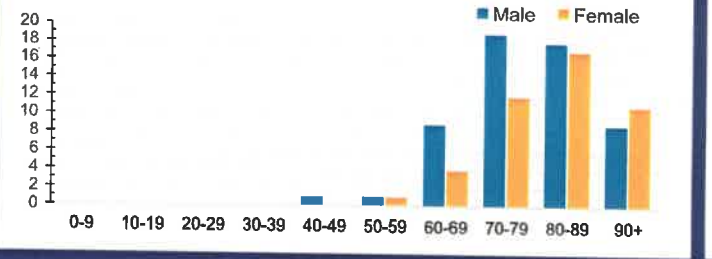
Confirmed Cases	Australia	ACT	NSW	NT	QLD	SA	TAS	VIC	WA
Residential Care Recipients	68 [39] (29)	0	61 [34] (27)	0	1 (1)	0	1 (1)	5 [5]	0
In Home Care Recipients	31 [28] (3)	0	13 [13]	0	8 [8]	1 [1]	5 [3] (2)	3 [3]	1 (1)

Cases in care recipients [recovered] (deaths)

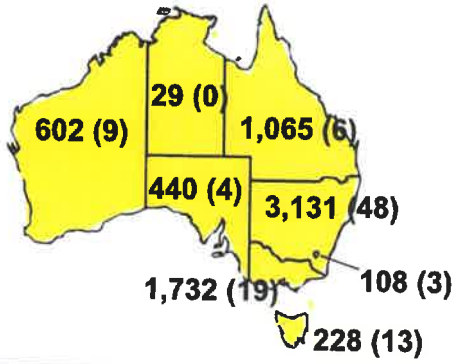
CASES BY AGE GROUP AND SEX



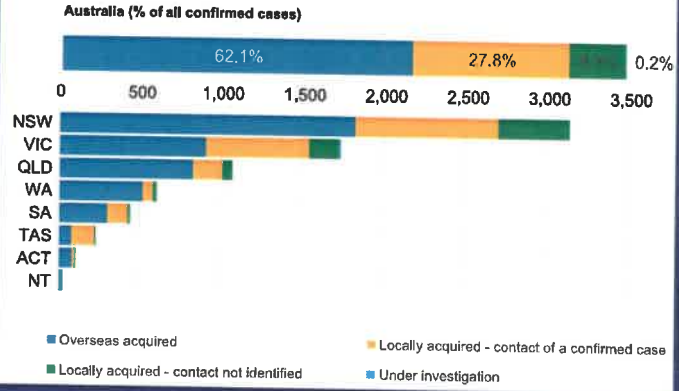
DEATHS BY AGE GROUP AND SEX



CASES (DEATHS) BY STATE AND TERRITORIES

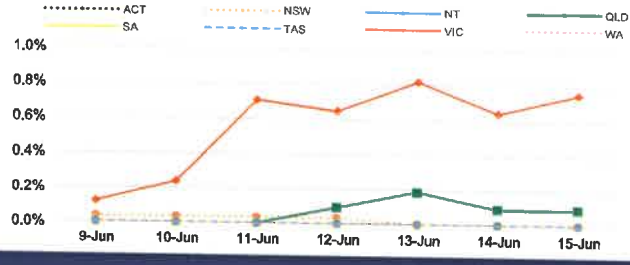


CASES BY SOURCE OF INFECTION



PUBLIC HEALTH RESPONSE MEASURE

Proportion of total cases under investigation



Last updated 15 June 2020

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