

Aboriginal Health and Medical Research Council of New South Wales

COVID-19 Infection Control Manual

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Acknowledgement of Country

The Aboriginal Health and Medical Research Council of New South Wales acknowledges that we operate on the Lands of the Gadigal and Bidjigal people of the Eora Nation. We pay our respect to the Lands and Waters that provide for us pay respect to the Ancestors that walked and managed the Lands and Waters for many generations before us. We recognise the traditional owners' past injustices, and their ongoing fights for land rights, social justice, and cultural freedoms. Their sovereignty and land was never ceded.

Purpose of AH&MRC's COVID-19 Infection Control Manual

AH&MRC's COVID-19 Infection Control Manual is based off COVID-19 resources produced by the New South Wales and Australian Government. AH&MRC has adapted these resources for use in Aboriginal Community Controlled Healthcare Organisation's (ACCHO).

This resource was created to assist those working in ACCHO's to have easy access to the most up-to-date information on COVID-19. This manual will continue to be updated as changed are made to COVID-19 policy.

Acronyms

ABHR: Alcohol-based hand rub

ACCHO: Aboriginal Community Controlled Healthcare Organisation

AH&MRC: Aboriginal Health and Medical Research Council

ARS: Acute Respiratory Symptoms

COVID 19: Coronavirus 19

HCW: Health care worker

NSW: New South Wales

PCR: Polymerase chain reaction

PPE: Personal protective equipment

POC: Point of care

RAT: Rapid antigen test

SARS-CoV-2: Severe Acute Respiratory Syndrome Coronavirus 2

TGA: Therapeutic Goods Administration

Introduction to COVID-19

Background

Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) is a virus that causes that causes the disease Coronavirus 19 (COVID-19)¹. The World Health Organization declared COVID-19 as a pandemic on the 11th of March 2020 after it spread from Wutan, China to over one hundred countries².

How COVID is transmitted

COVID-19 infection occurs through close contact, either directly, or indirectly with infected respiratory droplet¹. Infected respiratory droplets are produced when a person with COVID-19 breathes, talks, coughs, or sneezes³. Behaviours such as singing or shouting also increase the concentration of respiratory droplets in the air³. Infection can occur when a person is in direct contact with, or within 1.5 meters of, a person infected with COVID-19³.

Variants and subvariants

All viruses, including SARS-CoV-2, mutate as they replicate leading to new variants⁴. When a virus acquires enough distinct mutation, its categorised as a variant⁴. New variants of SARS-CoV-2 continue to emerge because of high infection rates worldwide⁴. New variants can potentially lead to increased transmission and severity of disease, and reduced efficacy

¹ Clinical Excellence Commission. COVID 19- Infection Prevention and Control Manual. [Internet]. Sydney, Australia. Clinical Excellence Commission; March 2022. Available from: https://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0018/644004/COVID-19-IPAC-manual.pdf

² Mahase, E. Covid-19: WHO declares pandemic because of “alarming levels” of spread, severity, and inaction. BMJ [Internet]. 2020, March [cited 2022 March]; 12(136):1036-1036. Available from: <https://www.bmj.com/content/368/bmj.m1036>

³ Australian Government. Coronavirus Disease 2019 (COVID 19). CDNA National Guidelines for Public Health Units [Internet]. Canberra Australia: Communicable Disease Network Australia; 2022 March [cited 2022 March]. Available from: [https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/\\$File/COVID-19%20SoNG%20v6.6_CDNA%20endorsed.pdf](https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/COVID-19%20SoNG%20v6.6_CDNA%20endorsed.pdf)

⁴ Australian Government. PHLN statement on reporting of SARS-CoV-2 variants of concern and interest [Internet]. Canberra Australia: Public Health Laboratory Network; 2022 November [cited 2022 March]. Available from: <https://www.health.gov.au/sites/default/files/documents/2021/11/phln-statement-on-reporting-of-sars-cov-2-variants-of-concern-and-interest.pdf>

of countermeasures including a vaccines, treatments, and diagnostics⁵. Examples of variants of concern include Alpha, Delta and Omicron⁵.

From these variants, subvariants arise. If a virus has mutated, but the changes are not distinct enough to be classed as a new variant, then the mutation is described as a subvariant⁶. An example of this is BA.2 which is a subvariant of Omicron (BA.1). Research to date demonstrates that while BA.2 does not appear to be more severe, it is significantly more transmissible than BA.1⁶.

Incubation and infection period

The incubation period is the duration between exposure to the virus, and the onset of symptoms. The median incubation period for COVID-19 is five to six days, but with Omicron the incubation period is only three days¹. COVID-19 is most transmissible one to three days prior to symptom onset¹. People are considered infectious two days prior to the onset of symptoms, and until they fulfil the requirements for completing isolation¹.

What happens to people who get COVID-19?

According to the World Health Organisation, eighty percent of people with COVID-19 recover without needing hospital treatment⁷. Fifteen percent of people with COVID-19 require hospitalisation, and a further five percent of people become critically unwell and need support in intensive care⁷. Complications of COVID-19 that can lead to death include respiratory failure, acute respiratory distress syndrome, sepsis, and septic shock and/or multiorgan failure⁷.

⁵ World Health Organization. Tracking of SARS-CoV-2 variants [Internet]. Geneva Switzerland: World Health Organization; March 2022. [cited 2022 March]. Available from: <https://www.who.int/en/activities/tracking-SARS-CoV-2-variants/>

⁶ Tsirtsakis, A. What does the Omicron sub variant mean for Australia's pandemic response? [Internet]. Melbourne Victoria: Royal Australian College of General Practitioners; 2022 March [cited 2022 March]. Available from: <https://www1.racgp.org.au/newsgp/clinical/what-does-the-omicron-sub-variant-mean-for-austral>

⁷ World Health Organization. Coronavirus disease (COVID-19) [Internet]. Geneva Switzerland: World Health Organization; 2021 May [cited 2022 March]. Available from: <https://www.who.int/news-room/questions-and-answers/item/coronavirus-disease-covid-19>

Who is more at risk of severe illness from COVID-19?

Illnesses and conditions that increase the risk of severe illness from COVID-19 include

- Blood cancers, including leukemia
- Non-haematological cancer
- Childhood cancer
- Chronic inflammatory condition
- Chronic renal failure
- Chronic lung disease
- Heart disease
- Chronic liver disease
- Neurological conditions, including dementia or stroke
- Severe mental health conditions
- Severe obesity⁸.

Treatments that increase the risk of severe illness from COVID-19 include

- Immune suppressive therapy
- Chemotherapy
- Radiotherapy
- Immunotherapy
- Bone marrow transplant ⁸.

Symptoms of COVID-19

The most common symptoms of COVID-19 include

- Fever (37.5°C or higher)
- Cough
- Sore/scratchy throat
- Shortness of breath

⁸ Australian Government. Risk factors for more serious illness. [Internet]. Canberra Australia: Department of Health; 2021 December [cited 2022 March]. Available from: <https://www.health.gov.au/health-alerts/covid-19/advice-for-groups-at-risk/risk-factors-for-more-serious-illness>

- Running nose
- Loss of smell and/or taste¹

Other symptoms that have also been reported include

- Fatigue
- Joint and/or muscle pain
- Headache
- Diarrhea
- Nausea/vomiting
- Loss of appetite
- Chest pain¹

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people are at greater risk from COVID-19 due to several inter-related factors⁹. Factors that lead to Aboriginal and Torres Strait Islander people being at greater risk from COVID-19 include an already higher burden of chronic disease, care not being delivered in a culturally safe manner and a lack of adequate service provision⁹.

Those living in remote and very remote areas are at greater risk from COVID-19 because

- There are often high rates of other health issues
- It can be harder to access health care, particularly tertiary referral hospitals¹⁰.

⁹ Crooks K, Casey D, Ward JS. First Nations peoples leading the way in COVID-19 pandemic planning, response and management. Medical Journal of Australia [Internet]. 2020 August [cited 2022 March];213(4):151–152. Available from <https://doi.org/10.5694/mja2.50704>

¹⁰ Australian Government. Aboriginal and Torres Strait Islander people and COVID-19 [Internet] Canberra Australia: Australian Government; 2022 March [cited 2022 March]. Available from: <https://www.health.gov.au/health-alerts/covid-19/advice-for-groups-at-risk/indigenous>

Diagnostic for COVID-19 testing

Polymerase chain reaction (PCR) testing

PCR testing is a swab of the throat and nose taken at a testing clinic which is then sent to a pathology laboratory¹¹.

Who should do a PCR test?

- People who have symptoms of COVID-19 symptoms but have tested negative on a rapid antigen test (RAT) AND who are at high risk of severe illness
- People who have symptoms of COVID-19 but are unable to access rapid antigen testing
- People who have been asked to get a PCR test from a health care provider¹¹.

Rapid antigen testing

A rapid antigen test (RAT) is an at-home testing kit used to detect COVID-19¹¹.

Who should do a RAT?

- People with symptoms of COVID-19
- Household, social, workplace or education contacts of positive COVID-19 case
- Anyone before going to an event with a large number of attendees
- Anyone before visiting vulnerable family members
- Anyone asked by a school or childcare centre to test
- People arriving from overseas¹¹.

¹¹ New South Wales Government. Getting tested for COVID-19 [Internet]. Sydney New South Wales: New South Wales Government; 2022 February March [cited 2022 March]. Available from: <https://www.nsw.gov.au/covid-19/stay-safe/testing/get-tested-for-covid-19>

Point of care testing

Point of care (POC) testing can be used by a health practitioner, or trained staff, to test a person for COVID-19. POC testing is highly accurate (comparable to a PCR test) but allows results in less than thirty minutes.

Who should do a point of care test?

- Individuals who are at risk of severe illness from COVID-19

Treatment for COVID-19

Vaccinations

The first vaccination for COVID-19 in Australia was provisionally approved by the Therapeutic Goods Administration in January 2021. Vaccines protect all individuals from getting severely ill or dying from COVID-19. The virus (SARS-CoV-2) that causes COVID-19 has spike proteins on each viral particle that allows the virus to attach to cells and cause COVID-19¹². Vaccinations for COVID-19 help the body to recognise that the spike proteins are a threat, and to help the body fight the coronavirus that has these spike proteins¹².

Vaccinations for COVID-19 can be provided by Aboriginal Community Controlled Healthcare Organisations.

There are four COVID-19 vaccinations currently being used in Australia

- AstraZeneca
- Pfizer
- Moderna
- Novavax¹².

Oral treatments for COVID

The first oral treatments, for COVID-19 in Australia were provisionally approved by the TGA in January 2022. Oral treatments are recommended for

- People with mild to moderate COVID-19 who do not require supplemental oxygen AND
- Who are at an increased risk of hospitalisation or death because of COVID-19^{13,14}

Oral treatments, known as oral antivirals, work by inhibiting the replication of SARS-CoV-2, the causative virus of COVID-19¹³

¹² Australian Government. How COVID-19 vaccines work [Internet]. Canberra Australia: Department of Health; 2022 February March [cited 2022 March]. Available from: <https://www.health.gov.au/initiatives-and-programs/covid-19-vaccines/approved-vaccines/how-they-work>

¹³ Clinical Excellence Commission. Drug Guideline: Use of nirmatrelvir and ritonavircapsule for the treatment of COVID-19 in adults [Internet]. Sydney New South Wales: Clinical Excellence Commission; 2022 February [cited 2022 March]. Available from: https://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0020/702821/Information-for-patients-family-and-carers-nirmatrelvir-and-ritonavir.PDF

Oral treatments for COVID-19 can be provided by Aboriginal Community Controlled Healthcare Organisations.

There are two COVID-19 oral treatments currently being used in Australia

- Lagevrio® (molnupiravir)
- Paxlovid® (nirmatrelvir + ritonavir)¹³⁻¹⁵.

Intravenous treatments for COVID

The first intravenous treatment for COVID-19 in Australia was provisionally approved by the TGA in August 2021. Intravenous treatments are recommended for

- People with mild to moderate COVID-19 who do not require supplemental oxygen AND
- Who are at an increased risk of hospitalisation or death because of COVID-19^{13,14}

Intravenous treatments for COVID-19 are a type of monoclonal antibodies therapy. Monoclonal antibodies work by binding to the spike protein of the virus that causes COVID-19 which blocks the virus from entering human cells and multiplying in the body¹⁴. Intravenous treatments for COVID-19 can be provided by some Hospitals. Doctors at ACCHO's can refer patients to local Hospitals for this treatment.

There are two COVID-19 intravenous treatment currently being used in Australia

- Xevudy® (Sotrovimab)
- Ronapreve® (Casirivimab plus imdevimab)^{14,16}.

Pre-exposure prophylaxis

The first pre-exposure prophylactic medication for COVID-19 was provisionally approved by the TGA in February 2022. Pre-exposure prophylaxis for the prevention of COVID-19 in people who are at risk of infection but have not been exposed to the virus¹⁵.

The pre-exposure prophylaxis is recommended for

¹⁴ New South Wales Therapeutic Advisory Group. Use of sotrovimab in adults with COVID-19 [Internet]. Sydney New South Wales: New South Wales Therapeutic Advisory Group; 2021 October [cited 2022 March]. Available from: https://www.nswtag.org.au/wp-content/uploads/2021/11/1.-PATIENT-INFORMATION_use-of-Sotrovimab_in-COVID-19_V1.2_8Oct21_NswVic-Copy.pdf

¹⁵ Therapeutic Goods Administration. TGA provisionally approves AstraZeneca's combination therapy (tixagevimab and cilgavimab, EVUSHELD) - for pre-exposure prevention (prophylaxis) of COVID-19 [Internet]. Canberra, Australian Capital Territory. Australian

- Those who are moderate-severely immunocompromised due to a medical condition or medication OR
- Those who are receiving treatment that makes it likely that they will mount an adequate immune response to COVID-19 vaccination OR
- Those who are unable to be vaccinated due to a history of severe adverse reactions to the COVID-19 vaccine or to a component of the COVID-19 vaccine¹⁵.

Pre-exposure prophylaxis is administered as two separate, sequential intra-muscular injections. Pre-exposure prophylaxis treatments for COVID-19 is a type of monoclonal antibodies therapy. Monoclonal antibodies work by binding to the spike protein of the virus that causes COVID-19 which blocks the virus from entering human cells and multiplying in the body¹⁶. Pre-exposure prophylaxis is **NOT** a substitute for vaccination in individuals for whom COVID-19 vaccination is recommended¹⁵.

There is one pre-exposure prophylaxis treatment currently being used in Australia

- Evusheld® (tixagevimab and cilgavimab)¹⁷.

Government; February 2022 [cited 2022 April]. Available from <https://www.tga.gov.au/media-release/tga-provisionally-approves-astazenecas-combination-therapy-tixagevimab-and-cilgavimab-evusheld-pre-exposure-prevention-prophylaxis-covid-19>

¹⁶ New South Wales Therapeutic Advisory Group. Use of sotrovimad in adults with COVID-19 [Internet]. Sydney New South Wales: New South Wales Therapeutic Advisory Group; 2021 October [cited 2022 March]. Available from: https://www.nswtag.org.au/wp-content/uploads/2021/11/1.-PATIENT-INFORMATION_use-of-Sotrovimab_in-COVID-19_V1.2_8Oct21_NswVic-Copy.pdf

Healthcare workers and COVID-19

Occupational Exposure to COVID-19

An occupational exposure is defined as an incident which occurs during a healthcare workers employment, that involves contact with blood or other bodily substances¹. The greatest occupational exposure risk for COVID-19 is splashes to the eye, nose/nares, or mouth of infected respiratory particles¹.

The risk to healthcare workers varies on the type of work being performed, the potential for interaction with an infected person and the type of personal protective equipment (PPE) worn or not worn¹. Correctly worn PPE drastically reduces the risk that a HCW will contract COVID-19 from a client. Employers have a duty of care to provide HCW's with the appropriate PPE required to safely do their job.

Health Care Worker COVID-19 Exposure Risk

Risk Assessment Matrix

Exposure to COVID-19 should be assessed according to New South Wales Health risk matrix¹⁷.



Health Care Worker COVID-19 Exposure Risk Assessment Matrix

12 January 2022

		CONTACT TYPE – See page 2 for more detailed assessment of a breach		
		Transient Contact – Low Risk Transient, not face-to-face, limited contact that does not meet the definition of face-to-face contact	Medium Risk Scenarios Any face-to-face contact within 1.5 metres and less than 15 minutes OR In general, greater than 30 mins in a closed space OR Based on agreed documented risk assessment including assessments of occupational exposures and of the physical environment	Highest Risk Scenarios Prolonged face-to-face contact within 1.5 metres and greater than 15 minutes OR Aerosol generating behaviours (AGBs e.g. coughing) OR Aerosol generating procedures (AGPs)
PPE worn during contact between health worker and case	1. No effective PPE worn by staff member or case e.g. no PPE or PPE with major breaches such as mask below nose	Moderate Risk	Moderate Risk	High Risk
	2. Surgical mask only worn by staff member i.e. no eye protection ➢ Case no PPE	Low Risk	Moderate Risk	High Risk
	3. Surgical mask only worn by staff member ➢ Case wearing surgical mask	Low Risk	Low Risk	Moderate Risk OR High Risk Depending on risk assessment
	4. Staff member in surgical mask and eye protection* with no concerns or breaches ➢ Case no PPE *Use of gown/apron and gloves should be risk assessed based on individual incident, exposure to body substance and chances of environmental contamination	Low Risk	Low Risk	Moderate Risk OR High Risk Depending on risk assessment
	5. Staff member in surgical mask and eye protection* with no concerns or breaches ➢ Case wearing surgical mask * See note in Category 4 box	Low Risk	Low Risk	Low Risk OR Moderate Risk if no AGP/AGB
	6. Staff member in P2/N95 mask and eye protection* with no concerns or breaches ➢ Case either with or without PPE * See note in Category 4 box	Low Risk	Low Risk	Low Risk

¹⁷ New South Wales Government. Managing Health Care Worker Exposure- high COVID-19 community transmission. [Internet]. Sydney

New South Wales: New South Wales Government. 2022 January [cited 2022 March]. Available from:

<https://www.health.nsw.gov.au/Infectious/covid-19/communities-of-practice/Documents/hcw-exposures.pdf>

Outcomes of risk matrix assessment

The table below represents the outcome for HCW exposure to COVID-19 according to the COVID-19 exposure risk assessment matrix¹⁷.

Low risk	<ul style="list-style-type: none">• HCW can continue to work• HCW to perform a PCR or RAT if becomes symptomatic¹⁷.
Moderate risk	<ul style="list-style-type: none">• HCW can continue to work with risk management plan in place• HCW to perform a RAT no earlier than 2 days post exposure• For 14 days post exposure,<ul style="list-style-type: none">○ Consider redeploying staff to a lower risk patient area if possible○ HCW to wear a mask at all times○ HCW not to enter shared spaces such as tearooms and not to participate in any staff gatherings○ Careful monitoring for symptoms¹⁷.
High risk	<ul style="list-style-type: none">• HCW not to attend the workplace for 7 days post exposure• If the HCW's absence would pose a significant risk to safe service delivery, as determined by a senior manager, the HCW can return to work within 7 days if they undertake daily RATs for 7 days post exposure, OR PCR test on day 2 and day 6 after exposure• For 14 days post exposure,<ul style="list-style-type: none">○ Consider re-deploying staff to lower risk patient area if possible○ HCW to wear mask at all times○ HCW not to enter shared spaces such as tearooms and not to participate in any staff gatherings○ Careful monitoring for symptoms¹⁷.

Managing community exposure for HCW's

<p>HCW is informed that they may have been exposed to COVID-10 in the community, such as from a friend or family member at a social event</p>	<ul style="list-style-type: none"> • The HCW can return to work with the following risk management plan: <ul style="list-style-type: none"> ○ Daily RAT for 7 days post exposure (including on non-workdays) • For 14 days post exposure <ul style="list-style-type: none"> ○ Consider redeploying staff to a lower risk patient area if possible ○ HCW to wear a mask at all times ○ HCW not to enter shared spaces such as tearooms and not to participate in any staff gatherings ○ Careful monitoring for symptoms¹⁷.
<p>HCW is identified as a household or household-like[#] contact of a person who has COVID-19</p> <p># Household like contact is someone who has spent 4</p>	<ul style="list-style-type: none"> • HCW not to attend the workplace for 7 days post exposure if they have NOT had COVID-19 before, or if they had it over 12 weeks ago • If the HCW's absence would pose a significant risk to safe service delivery, as determined by a senior manager, <ul style="list-style-type: none"> ○ Daily RAT for 7 days post exposure (including on non-workdays) AND PCR test on day 2 and 6 (can work while result is pending) • For 14 days post exposure, <ul style="list-style-type: none"> ○ Consider re-deploying staff to lower risk patient area if possible ○ HCW to wear mask at all times ○ HCW not to enter shared spaces such as tearooms and not to participate in any staff gatherings ○ Careful monitoring for symptoms¹⁷. • If HCW HAS HAD COVID-19 within 12 weeks, they are not required to isolate if they are a household, or household-like contact of a person who has COVID-19

<p>hours or more in the same residence/care facility with an infection case</p>	<ul style="list-style-type: none"> • For 14 days post exposure, <ul style="list-style-type: none"> ○ Consider re-deploying staff to lower risk patient area if possible ○ HCW to wear mask at all times ○ HCW not to enter shared spaces such as tearooms and not to participate in any staff gatherings ○ Careful monitoring for symptoms¹⁷.
<p>All other HCW COVID-19 exposures (including HCWs who have returned from overseas)</p>	<ul style="list-style-type: none"> • Continue working • For 14 days post exposure/return from overseas* <ul style="list-style-type: none"> ○ Consider re-deploying staff to lower risk patient area if possible ○ HCW to wear mask at all times ○ HCW not to enter shared spaces such as tearooms and not to participate in any staff gatherings • Careful monitoring for symptoms¹⁷. <p>*HCW's returning from overseas need to comply with RAT requirements as for all overseas returnees.</p>

COVID-19 Infection Prevention and Control for Primary Care

Facilities

Recommendations for COVID-19 Infection Prevention and Control

Telehealth	<ul style="list-style-type: none">• Consider telehealth to connect separate rooms in the same facility to ensure appropriate physical distancing occurs.
Screening	<ul style="list-style-type: none">• Screening of all patients for symptoms of COVID-19 prior to their attendance at appointments.
Waiting room	<ul style="list-style-type: none">• Post signs at entrance and in waiting areas about infection prevention strategies, such as hand hygiene, respiratory hygiene, physical distancing, and reporting to reception if unwell.• If there is a defined number of people who can sit in the waiting room, this should be displayed at the entrance• Remove books, magazines and toys that cannot be cleaned easily from waiting areas.• Pamphlets are to be kept to a minimum.
Physical distancing	<ul style="list-style-type: none">• Place chairs >1.5m apart, consider if floor markings of physical distancing requirements are needed to prevent chairs from being moved.• Determine if there are other ways that patients can be separated, for example: waiting outside until their appointment.
Hand hygiene	<ul style="list-style-type: none">• Provide accessible supplies of alcohol-based hand rub (ABHR).• Ensure bathroom signage is clear so patients can wash their hands with soap and water.
Respiratory hygiene	<ul style="list-style-type: none">• Provide tissues, ABHR and access to waste bins.• Provide posters or information on respiratory hygiene.

Shared patient equipment	<ul style="list-style-type: none"> • Assess what equipment is shared amongst patients in the facility to highlight what needs regular cleaning. • Determine if the equipment requires cleaning with detergent or disinfectant, or both. The manufacturer instructions will provide this information.
Environmental cleaning	<ul style="list-style-type: none"> • Follow routine environmental cleaning standards for primary care facilities. • Determine what high touch-point surfaces require regular cleaning, for example: door handles, light switches, back arms of chairs, telephones, keyboard, external surfaces of ABHR, pamphlet holders. • Assess if surfaces, furniture and equipment can be cleaned easily, for example, avoid fabric chairs.
Family members accompanying patient	<ul style="list-style-type: none"> • Define the number of people/family members allowed. • Consider alternatives such as using telehealth communicate with family members while the patient/clients attend their appointment¹.

Patient Screening

Despite the level of risk at the time, it is important that a screening process remain in place to manage the risk of COVID-19 to primary care facilities.

Pre-screening

Prior to routine or scheduled face-to-face appointments, a risk assessment should be undertaken to identify any potential risk of COVID-19 to primary care facilities.

Pre visit screening options

- SMS and/or telephone call to patient or carer prior to visit
- An example of screening questions may include:
 - Do you have any symptoms of COVID-19?
 - Have you been recently tested for COVID-19?
 - Have you had confirmed COVID-19 in the last 28 days?
 - Have you been identified as a close contact of a COVID-19 case in the past 14 days or is a household member currently undergoing testing for COVID-19?
 - Are you vaccinated against COVID-19?
- Provide a contact number if the answer is "yes" to any at risk questions¹.

Cancellation or rescheduling appointment due to COVID-19

- If the patient states that they have previously been diagnosed with COVID-19, determine if they are still within their period of infectivity or meet the criteria for de-isolation for the purpose of their visit
- If the patient/client cannot be de-isolated for their visit, determine if:
 - Their appointment can be deferred without compromising their care
 - A telehealth appointment or home visit may be an option if their appointment cannot be safely rescheduled¹.

On arrival

If the patient has acute respiratory symptoms, provide them with a surgical mask, and ask them to wait in a pre-determined confined area¹.

Re-screening questions

Rescreen all patients on their arrival prior to their routine or scheduled face-to-face appointment.

- Rescreen patients using suggested screening questions above on arrival
- Ask the patient to perform hand hygiene
- Inform the patient where they are required to wait for their appointment
- Inform the patient of physical distancing requirements¹.

Isolation and Deisolation Guidelines

Community Members

Isolating and de-isolating

- No symptoms at day 7: Community members must isolate for 7 days from the day they were tested. Community members can only leave self-isolation after 7 days if they do not have symptoms (eg: acute respiratory symptoms)
- Symptoms at day 7: If community members still have symptoms at day 7 (eg: acute respiratory symptoms), they must remain in isolation for 24 hours after their symptoms resolve¹.

Attending high risk settings

High risk settings include healthcare, aged care, disability care or correctional facilities.

- Non-immunocompromised community members: Can attend high risk facilities, but must wear a mask for three days after they leave isolation
- Immunocompromised community members: Can attend high risk facilities but must wear a mask for seven days after they leave isolation¹.

Healthcare workers

HCW who are at work during their infectious period should be assessed and contact tracing undertaken¹. Healthcare workers follow the same isolation and de-isolation guidelines as community members. The key difference is when healthcare workers can return to work¹.

Returning to work

Day 6:

- Symptoms: Never symptomatic OR symptoms resolved for at least 24 hours
 - No test: Can return to work at day 10
 - Rapid antigen testing
 - Can return to work at day 8 post negative RAT

- Excluded from work until day 11 post positive RAT¹.

Day 7-13:

- Symptoms: Symptoms resolved for at least 24 hours
 - No test: Return to work after 3 additional days (after symptoms have resolved)
 - Rapid antigen testing
 - Can return to work the following day post negative RAT
 - Can return to work 3 days after positive RAT¹.

Day 14 and later:

- Symptoms: Symptoms have resolved for at least 24 hours
 - Testing not required
- Symptoms: Symptoms ongoing
 - Seek expert advice about the need for additional testing or assessment prior to return to work¹.

It is important to note that if HCW are significantly immunocompromised the isolation may need to be extended until 14 days or longer¹.

Personal Protective Equipment

PPE donning and doffing

PPE donning

PPE should be donned prior to entering the patient's room. PPE should be donned following the sequence below:

1. Perform hand hygiene
2. Fluid resistance long-sleeves gown
3. Surgical mask or P2/N95 respirator
4. Eye protection
5. Perform hand hygiene, and don disposable non-sterile gloves upon entering the room, before contact with the patient

PPE doffing

PPE should be doffed upon exiting the patient's room. PPE should be doffed following the sequence below:

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

Fit Checking Process

Conducting a fit test ensure that P2/N95 respirators fits the wearers face appropriately. This minimizes the number of particles that can bypass the filter through the gaps between the wears skin and the masks seal. A fit check should occur every time a mask is put on¹⁸.



1 SEPARATE THE EDGES OF THE MASK TO FULLY OPEN IT



2 BEND THE NOSE WIRE TO FORM A GENTLE CURVE. THE NOSE WIRE REPRESENTS THE TOP OF THE MASK



3 HOLD THE MASK UPSIDE DOWN TO EXPOSE THE TWO HEADBANDS



4 USING YOUR INDEX FINGERS AND THUMBS, SEPARATE THE TWO HEADBANDS



5 WHILE HOLDING THE HEADBANDS CUP THE MASK UNDER YOUR CHIN



6 PULL HEADBANDS UP AND OVER YOUR HEAD



7 PLACE AND POSITION THE LOWER HEADBAND AT THE BASE OF YOUR NECK (UNDER YOUR EARS)



8 PLACE THE UPPER HEADBAND ON THE CROWN OF YOUR HEAD. THE BAND SHOULD RUN JUST ABOVE THE TOP OF YOUR EARS



9 GENTLY CONFORM/PRESS THE NOSEPIECE ACROSS THE BRIDGE OF YOUR NOSE BY PRESSING DOWN WITH FINGERS UNTIL THE FIT IS SNUG



10 CONTINUE TO ADJUST THE MASK UNTIL YOU FEEL YOU HAVE ACHIEVED A GOOD AND COMFORTABLE FACIAL FIT.

A 'fit check' must be performed each time a P2 / N95 mask is worn



1 GENTLY INHALE. WHEN YOU BREATHE IN THE MASK SHOULD DRAW IN SLIGHTLY TOWARD THE FACE AND COLLAPSE.



2 WHEN EXHALING THE MASK SHOULD FILL UP WITH AIR. IT IS IMPORTANT AT THIS STAGE TO CHECK THERE IS NO AIR LEAKAGE AROUND THE EDGES OF THE MASK. CONTINUE ADJUSTING THE SEAL OF THE MASK IF NEEDED.

¹⁸ New South Wales Government. Education, training, posters and videos [Internet]. Clinical Excellence Commission: Sydney, New South Wales; 2022 January [cited 2022 March]. Available from https://www.cec.health.nsw.gov.au/data/assets/pdf_file/0010/566776/CEC-Principles-of-Fit-checking-chart-2020.pdf

Types of Precautions

Standard Precautions

- Standard precautions apply to all settings where care is provided, or where there is a risk of blood or body fluid exposure
- Standard precautions comprise of the following measures
 - Hand hygiene
 - Respiratory hygiene (cough etiquette)
 - PPE, including gloves if contact with blood or bodily fluid is anticipated¹.

Contact Precautions

- Contact precautions protect the HCW by minimising the COVID-19 transmission risk from direct physical contact with patients or indirect contact from shared patient care equipment or from contaminated environmental surfaces¹.



Droplet Precautions

- Protect the HCW's nose, mouth and eyes from droplets produced by the patient when they cough and sneeze¹.



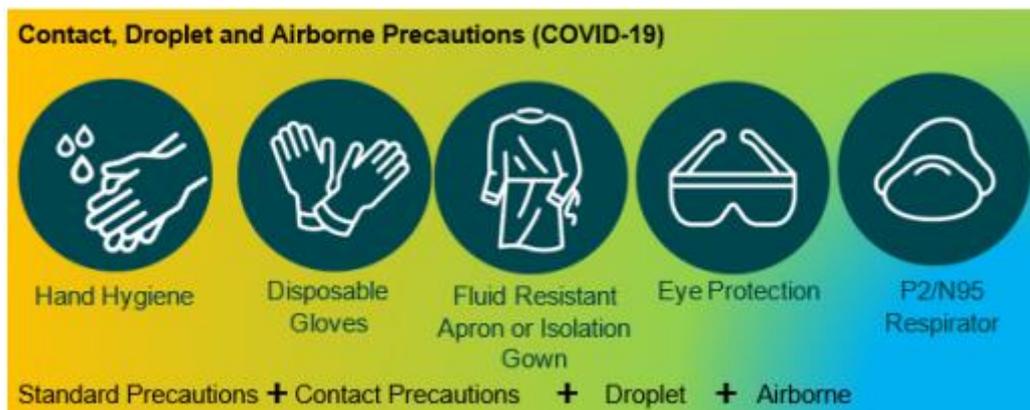
Airborne Precautions

- Protects the HCW's respiratory tract from very small and unseen airborne particles that become suspended in the air¹.



Standard, Contact, Droplet and Airborne Precautions

- Contact, droplet, and airborne precautions are to be worn in combination to protect HCW when caring for cases of confirmed COVID-19 cases
- Contact, droplet, and airborne precautions to be worn when caring for patients with suspected COVID-19 (a person who meets clinical AND epidemiological criteria or a person identified as a high-risk contact by the NSW Public Health Unit, regardless of symptoms)¹.



New South Wales Health Risk Matrix

Low Risk of Transmission

Patients	<ul style="list-style-type: none">• Testing of patients:<ul style="list-style-type: none">○ No routine testing of patients• Mask use for patients:<ul style="list-style-type: none">○ Patients are not required to wear a mask○ All patients with ARS to wear a mask on presentation¹.
Healthcare workers	<ul style="list-style-type: none">• Testing of HCW:<ul style="list-style-type: none">○ No routine testing• PPE for HCW:<ul style="list-style-type: none">○ Standard precautions: required for all patients○ Droplet precautions: required when patients are negative for COVID-19 but has ARI, or recent onset of a fever without an alternative clinical focus○ Contact or airborne precautions: required when providing direct care for:<ul style="list-style-type: none">▪ Patient with suspected or confirmed COVID-19▪ Close contact of a COVID-19 case¹.

Moderate Risk of Transmission

Patients	<ul style="list-style-type: none">• Testing of patients:<ul style="list-style-type: none">○ No routine testing of patients• Mask use for patients:<ul style="list-style-type: none">○ Patients who present directly from the community are required to wear a mask○ Children under 12 are not required to wear a mask¹.
Healthcare workers	<ul style="list-style-type: none">• Testing of HCW:<ul style="list-style-type: none">○ Consider testing for COVID-19 2-3 times per week• PPE for HCW:<ul style="list-style-type: none">○ Use of surgical masks by all HCW when in health care facility, this includes clinical and non-clinical areas○ Eye protection to be used when within 1.5 metres of a patient○ Contact or airborne precautions: P2/N95 respirators and eye protection. Required when providing direct care for:<ul style="list-style-type: none">▪ Patient with suspected or confirmed COVID-19▪ Close contact of a COVID-19 case¹.

High Risk of Transmission

Patients	<ul style="list-style-type: none">• Testing of patients:<ul style="list-style-type: none">○ Appointments should be via telehealth where possible○ It is recommended that patients perform a RAT prior to face-to-face appointments if they will go for longer than 15 minutes and/or if the patient needs to remove their mask• Mask use for patients:<ul style="list-style-type: none">○ Patients who present directly from the community are required to wear a mask○ Children under 12 are not required to wear a mask¹.
Healthcare workers	<ul style="list-style-type: none">• Testing of HCW:<ul style="list-style-type: none">○ Consider testing for COVID-19 2-3 times per week• PPE for HCW:<ul style="list-style-type: none">○ Use of surgical masks by all HCW when in health care facility, this includes clinical and non-clinical areas○ Eye protection to be used when within 1.5 metres of a patient○ Contact or airborne precautions: P2/N95 respirators and eye protection. Required when providing direct care for:<ul style="list-style-type: none">▪ Patient with suspected or confirmed COVID-19▪ Close contact of a COVID-19 case¹.