



Infection Prevention and Control Guidelines for Western Australian Residential Care Facilities

Version 3.0 – November 2022

Version control

This Guideline will be reviewed and updated in response to:

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

Review and update of this Guideline is coordinated by the Infection Prevention, Policy and Surveillance Unit (IPPSU) which can be contacted with feedback at IPPSU@health.wa.gov.au.

For full revision history please refer to Version Control at the end of this document.

This document provides IPC advice for Western Australian (WA) Residential Care Facilities (RCF) should be read in conjunction with:

- [Supporting information for the management of Acute Respiratory Infection \(including COVID-19 and Influenza\) in Residential Aged Care Facilities](#)
- [National Guidelines for the Prevention, Control and Public Health Management of Outbreaks of Acute Respiratory Infection \(including COVID-19 and Influenza\) in Residential Care Facilities](#)
- [Guidance on the use of face masks and shields by health care workers in areas with significant community transmission of COVID-19](#)
- [Coronavirus \(COVID-19\) Environmental cleaning and disinfection principles for health and residential care facilities](#)

Table of Contents

Definitions / Abbreviations.....	4
Purpose.....	7
Background.....	7
General principles.....	7
Staff training.....	8
Staff health.....	8
Hand hygiene.....	8
Personal protective equipment (PPE).....	9
Gowns/Aprons.....	9
Gloves.....	9
Masks.....	9
Use of PFRs.....	10
Protective eyewear.....	10
Outbreak Management.....	10
Cohorting/zoning of residents.....	11
Cohorting.....	11
Zoning.....	11
Considerations when setting up Zones.....	13
Workforce.....	13
Staff amenities.....	14
Zone entry, exit and traffic flows.....	14
PPE stations.....	14
Ventilation.....	15
Environmental cleaning and disinfection.....	15
Emerging disinfection technologies.....	16
Shared equipment.....	16
Personal resident care.....	17
Linen handling.....	17
Food service and utensils.....	17
Waste management.....	18
Visitors.....	19
Resident transfers.....	19
Management of the deceased.....	19
Appendix 1: Use of appropriate PPE.....	20
Appendix 2: Routine environmental cleaning.....	21
Appendix 3: Outbreak IPC resources.....	22

Definitions / Abbreviations

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

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

Aerosol generating procedures (AGPs): are those procedures that promote the generation of fine airborne particles (aerosols) that may result in the risk of airborne transmission of disease; for example, continuous positive airway pressure ventilation (CPAP) and cardiopulmonary resuscitation (CPR). Nebulisers are not recommended for use and should be replaced by dedicated single resident use spacers where clinically appropriate.

Aerosol generating behaviour (AGB): are behaviours that are likely to generate higher volumes of respiratory secretions and thus increase the risk of transmission via aerosols. Examples include persistent and/or severe coughing, singing, screaming and shouting.

Asymptomatic: a person infected but not showing any signs of disease. Refer to [CDNA Series of National Guidelines \(SoNGs\) | Australian Government Department of Health and Aged Care](#)

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

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

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

Communicable Diseases Network Australia (CDNA): the organisation that provides national public health advice for the prevention and control of communicable diseases. The CDNA has published a Series of National Guidelines (SoNGs) to provide nationally consistent advice including [CDNA Series of National Guidelines \(SoNGs\) | Australian Government Department of Health and Aged Care](#)

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

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

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

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

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

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

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

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

Infectious period: the infectious period is generally considered to commence 48 hours prior to symptom onset, or positive test date if asymptomatic, until the time the COVID-19 case is cleared of infection or can cease isolation, as advised by Public Health, a treating medical practitioner or in accordance with the guideline for release from isolation

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

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

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

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

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

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

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

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

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

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

Purpose

This document has been prepared to support residential care facility (RCF) Infection Prevention and Control (IPC) Leads and outlines key IPC responsibilities. It is recognised that providers move to a more independent approach in identifying and managing COVID-19 outbreaks, supported by resources and tools provided. RCFs should read these guidelines in conjunction with the [Australian Guidelines for the Prevention and Control of Infection and Healthcare \(2019\)](#).

Background

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

SARS-CoV-2 can be transmitted through respiratory droplets and smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces. While the exact contribution of these routes remains unclear, those who have been in close contact with a COVID-19 case are at highest risk.

General principles

All RCFs should use a risk assessment process to manage the risk of infection in their facility including using the [IPC hierarchy of controls](#) to mitigate risks.

- General risk mitigation strategies to limit transmission of SARS-CoV-2 should include:
 - provision of information about routine IPC to staff, residents and visitors
 - signage that promotes physical distancing, hand hygiene and respiratory hygiene
 - alcohol-based hand rub (ABHR) at the entrance to the facility, reception areas, resident rooms and on every floor/corridor and lift areas for visitors, residents and staff to use.
- The RCF should:
 - ensure COVID-19 outbreak management plan is updated and reviewed regularly
 - enable residents' access to the influenza and COVID-19 vaccinations as well as age-specific vaccinations e.g. pneumovax, shingles
 - maintain register of vaccination status of all staff and residents
 - ensure visitors do not attend the facility if they are unwell
 - maintain a visitor's log
 - have a documented procedure for managing staff who become unwell with COVID-19 symptoms while at work
 - have laboratory testing arrangements in place
 - have documented environmental cleaning, linen and waste management procedures
 - In the event of outbreaks
 - be prepared for visitor restrictions
 - limit unnecessary movement of residents within the facility
 - limit movement of staff between facilities, including implementing single site workforce arrangements, where appropriate.
 - consider the use of RAT screening for visitors and staff

Staff training

- All staff are to be trained in IPC practices, including standard and transmission-based precautions, on commencement of employment, in response to outbreaks and at regular intervals.
- Recognition of COVID-19 symptoms in residents should be included in staff training.
- IPC education should be appropriate to staff roles and include hand hygiene and the selection and use of personal protective equipment (PPE).
- Regular monitoring of staff adherence to IPC practices should be undertaken. Free education and training are available online from these approved Government sites (register for access):
 - Australian Department of Health: [COVID-19 infection control training](#)
 - Australian Commission on Safety and Quality in Health Care: [National Hand Hygiene and Infection Control Modules](#)

Staff health

- All staff must be advised to:
 - not attend work if they are unwell
 - practice respiratory hygiene by coughing or sneezing into their elbow or tissue and disposing of used tissues immediately and perform hand hygiene after
 - immediately report to their manager and seek medical advice if they become unwell with [COVID-19 symptoms](#) e.g. fever, cough, shortness of breath, malaise, fatigue, loss of smell or taste, sore throat, headache, diarrhoea, loss of appetite
 - test for COVID-19 as soon as they can even if symptoms are mild, inform their employer if they test positive for COVID-19, and follow the facility guidelines about any exclusion period until their symptoms resolve. If their test is COVID-19 negative, consider testing for other respiratory viruses in consultation with their GP.

Hand hygiene

Hand hygiene is essential in helping to prevent the spread of infection.

- All staff are to have access to hand hygiene facilities and perform hand hygiene frequently.
- Hand hygiene can be performed by using liquid hand soap and thoroughly washing hands under running water, and thoroughly drying their hands preferably with paper towels or by using an ABHR that contains 60-80% alcohol.
- Hand hygiene must be performed:
 - at the beginning of a shift, prior to donning PPE, after doffing each piece of PPE, after touching contaminated objects or surfaces, before and after any meal or rest break, after using the bathroom and at the end of each shift
 - prior to and immediately after any contact with residents
 - after contact with companion animals
 - after any environmental cleaning or handling of waste or used linen.
- Staff providing clinical care to residents must adopt a 'bare below the elbows' approach i.e. remove hand and wrist jewellery, avoid wearing long sleeves and have short, clean fingernails to facilitate effective hand hygiene.
- Artificial nails e.g. gel / acrylic and nail polish should not be worn.
- Any cuts or abrasions to staff skin should be covered with a waterproof dressing.

- Containers used for dispensing liquid hand soap or ABHR should preferably be single use. If refillable containers are in use, these must not be “topped up”. The container and dispenser are to be washed in warm to hot soapy water, rinsed in cold water and allowed to air dry prior to being refilled.
- All containers should be labelled appropriately and safety data sheets (SDS) available for compliance with Work Health and Safety requirements.

Personal protective equipment (PPE)

It is the responsibility of the RCF to provide the appropriate PPE for staff use. The type of PPE selected is dependent on the level of transmission-based precautions required.

- All staff should be trained and assessed on the correct sequence for donning and doffing PPE on commencement of employment and at regular intervals.
- Staff must be careful not to touch their eyes, nose, mouth or hair while wearing PPE.
- Staff are encouraged to work with a PPE buddy when donning and doffing to minimise the risk of self-contamination.
- PPE is to be removed for meal or toilet breaks and disposed of into general waste bins and hand hygiene performed.
- Prolonged use of PPE may cause skin damage. Staff need to ensure that PPE is properly fitted and worn only when required.

Gowns/Aprons

- Gowns meeting the ANSI/AAMI PB70:2012 are suitable for the care of suspect or confirmed COVID-19 residents.
- Gowns should be level 1 or 2 fluid repellent, have cuffed wrists and tie at the back or side – not at the front.
- Plastic aprons are a suitable alternative in situations where the risk of splash is low.

Gloves

- Gloves are not a substitute for hand hygiene – hand hygiene must be performed every time gloves are removed.
- Gloves should be latex free and powder free. Vinyl gloves are not suitable for clinical care.
- Gloves should be worn when in contact with blood/body fluids.
- Gloves must not be sanitised using hand sanitiser or surface cleaner.
- Staff should avoid touching unnecessary objects when wearing gloves e.g. do not answer telephones or use a computer with gloves on.
- If gloves become contaminated during a task, they are to be removed immediately and disposed of in a rubbish bin and hand hygiene performed. New gloves can then be put on if required.
- Always remove gloves and perform hand hygiene prior to performing new tasks.
- Gloves should be available in each resident’s room.

Masks

- Masks used include surgical masks and particulate filter respirators (PFRs). All masks are single use and once removed are to be replaced with a new mask.

- Masks with ties should be provided for staff who wear a head covering for cultural reasons.
- Surgical masks are utilised to contain respiratory secretions of the wearer or to prevent droplet inhalation by the wearer.
- Irrespective of mask type, staff should not touch the front of the mask or wear the mask incorrectly i.e. around the neck, under the nose or chin or on top of the head.
- Masks must be changed after four hours or sooner if they become moist, soiled, or if it is difficult to breathe through the mask, following any aerosol generating procedure, or if a resident exhibits aerosol generating behaviours.

Use of PFRs

All staff wearing a PFR must have undertaken a fit test, must know the brand and size of PFR they used to achieve a satisfactory fit, and have access to that mask when required. To see the names of companies or individuals who can perform a fit test, see the Respiratory Fit Testing Training and Accreditation ([RESP-FIT](#)) Webpage. This should be a quantitative test with medical grade PFRs.

Commonly used PFRs are the P2 or N95 respirator; masks must be medical quality and not for dust/asbestos exposure.

All staff wearing a PFR must undergo training in how to don and doff correctly, including how to perform a fit check. A fit check is the procedure an RCF worker undertakes each time they don a PFR to ensure it is correctly applied, that a good seal is achieved over the bridge of the nose and mouth and there are no gaps between the respirator and face and a positive pressure seal is achieved i.e. no air leaks are felt by the wearer.

Refer to [Wearing a flat style respirator](#) / [Wearing a cup style respirator](#).

Protective eyewear

- Designated protective eyewear e.g. combined mask/shield, visor or goggles, are to be worn.
- Personal prescription spectacles are inadequate and are to be worn with additional protective eyewear.
- Face shields labelled single use are to be disposed of after each use.
- Reusable protective eyewear must be cleaned and disinfected after each use and used only by the same staff member and not shared between staff.

Outbreak Management

The first 24 hours in managing a confirmed COVID-19 case in a RCF are critical to minimise the spread of the virus and its impact on residents and staff.

Residential Care Providers must take all possible steps to prepare for and manage a COVID-19 outbreak. RCFs should be prepared to manage a COVID-19 outbreak independently as much as possible. The facility Outbreak Management Plan should be up to date and well-rehearsed for immediate activation.

Where possible, residents should be cared for in a single room with ensuite facilities, using transmission-based precautions. As numbers of confirmed COVID-19 cases increase, confirmed cases may need to be placed in shared rooms. It is recommended that no more than two confirmed cases are cohorted where the facility layout allows.

Residents with a different infectious condition, such as influenza, or a multi-drug resistant organism colonisation/infection are not appropriate for inclusion in a COVID-19 room cohort. These residents should be allocated a single room with a dedicated ensuite facilities.

Cohorting/zoning of residents

Cohorting refers to grouping individuals with the same status in the same location. The goal of cohorting residents, and the staff that attend to them, is to minimise opportunities for infection transmission. Cohorting minimises interactions between those who are infectious and those who are not. Zoning is a technique used to support cohorting within a facility. Zoning is relative to the size of the outbreak i.e. number of cases and layout of the facility.

Outbreak Management Plans should include floor-maps which have been colour coded and labelled with instructions for how to cohort/zone in response to infection patterns.

Cohorting

Cohorting uses three risk categories:

- **Confirmed/probable case** - residents with the same confirmed pathogen are grouped together during the infectious period.
- **Symptomatic** - residents suspected to have an infection caused by the same pathogen are cohorted separately from those confirmed to have the infection and separately to those residents/residents not suspected of having the infection.
- **No identified infection risk** - residents not suspected of having the infection, or those deemed to be cleared of a previous infection, are grouped together.

Staff caring for residents with suspected or confirmed infections, where possible, should be cohorted. Each cohort should be assigned to work with either confirmed/probable or symptomatic people to minimise risk of transmission.

Zoning

Zones (See Table 1) may be:

- one room e.g. single room isolation
- a few rooms geographically co-located or separately located in the same area ward/wing/building
- an entire ward, wing, or building.

Table 1 Definition of zones

Blue zone	<ul style="list-style-type: none"> • Buffer areas between potentially contaminated and non-contaminated zones. • Staff only areas with no resident access e.g. nurses' station, corridors, staff lunchrooms, office spaces, meeting rooms, drug rooms. • Blue zones also include transition points from one zone to another where staff must don or doff PPE. • This zone may not be possible or necessary in areas that only include Red and Amber zones.
Green zone	<ul style="list-style-type: none"> • Residential care areas where there are no COVID-19 cases. • Residents who have met the release from isolation criteria or who have been released from quarantine following a risk assessment. Note: in the initial stages of an outbreak all residents are usually considered close contacts and will be in quarantine. • Non-residential areas e.g. administration, reception, main kitchen, offices where there is no resident access.
Amber zone	<ul style="list-style-type: none"> • Residential care areas with individuals or cohorts who require quarantine, such as those identified as close contacts including household or household like contacts, who are not symptomatic and have not tested positive to COVID-19. • Residents in this zone should be encouraged to maintain physical distancing and not congregate in communal areas where possible.
Red zone	<ul style="list-style-type: none"> • Residential care areas used for single room isolation or cohort isolation. • Residents have confirmed COVID-19 and have not been cleared. • Residents suspected to have COVID-19 that have not been confirmed or cleared. These residents should not share a room or interact with confirmed cases. • This zone may be a single room of a resident with COVID-19 or multiple rooms in one area or an entire wing. Single room/s may be managed separately as a Red zone within an Amber zone corridor or wing.

Implementation of zoning requires a coordinated multidisciplinary approach. Zoning should be reviewed regularly, and adjustments made as required. A clear command structure,

monitoring procedures and communication pathways should be established when zoning is implemented, changed, or stood down.

Considerations when setting up Zones

There are **two types** of zoning:

- Single room zone
- Multiple room zone
 - separate rooms located in the same area e.g. corridor/ward/wing/building
 - an entire ward/wing/building.
- When **planning zones**, consideration should be given to:
 - Building layout and available space.
 - Availability of single and shared rooms within a specific area e.g. single rooms should be prioritised for residents with significant symptoms.
 - Availability and location of bathrooms and toilets.
 - The ability of the resident to remain in their room.
 - Workforce capacity to support zoning.
 - Access to supplies e.g. linen, to enable easy access without crossing zones.
 - Location of donning/doffing stations in each zone.

Zoning must be accompanied by a robust staff education and training program.

- **Red** and **Amber** zones should:
 - Ideally be geographically separated from blue zones and green zones.
 - Be decluttered as much as possible. Items and equipment that are not frequently used should be put away in easy to clean storage containers, cupboards, or drawers.
 - Have limited entry/access. Whenever possible, the entry point and the exit point for each zone should be separated and monitored.

Workforce

- Cohort staff and assign each cohort to one zone. Ideally, staff should not work across **Red, Amber** and **Green** zones for the duration of the outbreak.
- Wherever possible, staff assigned to **Red** and **Amber** zones should be experienced and should not work or be assigned to non-COVID-19 areas simultaneously.
- When possible, cleaning and kitchen staff should be assigned to one zone.
 - ensure a system is in place to support delivery and collection of meal trays in **Red** and **Amber** zones.
- All staff working in or entering **Red** zones and **Amber** zones should be trained and competent in the use of PPE including having been fit tested for a PFR and able to perform a fit check of their respirators.
- Consider additional staff above baseline numbers when there is an outbreak, for example:
 - a runner to support staff in PPE, fetch items such as additional PPE/ linen to reduce the need for PPE changes, or deliver food
 - a trained buddy / spotter to observe and support safe infection control practice and PPE use
 - cleaning staff to meet the increased cleaning and disinfection requirements

- staff to manage waste removal for all areas
- an allied health or leisure and lifestyle staff member to provide activities for residents who are well enough and are in quarantine or isolation.

Staff amenities

- Staff from each zone should ideally have their own designated break room and bathroom facilities which are not shared with staff from other zones. If dedicated segregated staff break areas are not achievable, staff break areas should be organised in such a way as to promote physical distancing.
- Identify appropriate areas within the **Red** zone and **Amber** zone for nursing stations and bathroom facilities so that they do not interact with staff working in green zones. Staff bathroom/toilet facilities inside the **Red** zone and **Amber** zones should not be used if there is insufficient space for safe donning and doffing stations.
- Designate areas where staff can change out of their work uniform before leaving work if they choose to do so.

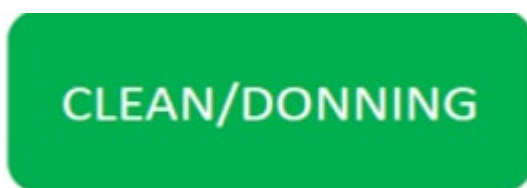
Zone entry, exit and traffic flows

- Use laminated signage or floor markings if there is a lack of structural barriers such as doors to identify the beginning and end of a zone.
 - if a zone is an individual room, use signage to identify the zone type and to support selection and use of the required PPE.
- Wherever possible establish clear one-way and one-person-only direction of movement along corridors. If this is not possible, consider the use of signage or floor markings to designate the desired direction of movement e.g. left-hand side in and right-hand side out.

PPE stations

- PPE donning and doffing stations should be set up to establish a clear one-way direction of movement along corridors. Donning and doffing stations should be clearly marked with signage or floor markings i.e. **Green** for donning and **Red** for doffing (See Figure 1).
- **Donning stations:**
 - donning stations should be at the entry to a room or defined area and stocked with PPE and ABHR.
 - donning stations should not be overstocked and free from clutter.
 - all PPE should be dry and protected from contamination.
 - display donning sequence posters and consider the use of mirrors to support correct donning technique
- **Doffing stations:**
 - doffing stations must be separate to donning stations
 - have a supply of ABHR
 - be provisioned with non-touch waste bins/bags
 - set up at the exit to each zone i.e. room, corridor, or wing
 - display doffing sequence posters and consider the use of mirrors to support correct doffing technique.

Figure 1: Donning Doffing Stations



Ventilation

- The supply of outdoor air to Heating Ventilation and Air Conditioning (HVAC) systems that is, air dilution, should be increased as much as reasonably possible.
- If the number of air exchanges or the availability of fresh air cannot be increased, use of air purifiers with a high-efficiency particulate air (HEPA) filter should be considered. An occupational physician or ventilation professional can advise where these devices should be located.
- In **Red** and **Amber** zones portable fan use is discouraged. When use is necessary, these should be placed in locations where fan air flow will not be directed from one person directly towards another.
- Further information on ventilation and air purifiers can be sourced from the WA Department of Health website:
 - [COVID-19 and air purifiers/cleaners](#)
 - [COVID-19 and building ventilation](#)

Environmental cleaning and disinfection

- RCFs should have documented cleaning schedules and procedures for all resident and staff areas. These should include products to be used and how to prepare them in accordance with manufacturers' instructions.
- Cleaning products chosen are to be appropriate for the surface to be cleaned. In general, combined detergent / disinfectant solutions or wipes are suitable for hard surfaces. Some products such as bleach can damage fabrics or corrode metals. If separate detergent and disinfectant solutions are used, they must be prepared fresh each day. Use approved products to clean any electronic equipment.
- Information on which disinfectants are effective against SARSCoV-2 is available on the [Therapeutic Goods Administration](#) website.
- Enhanced cleaning and disinfection must occur based on the number of staff and movement of residents, and to include a focus on frequently touched surfaces e.g.

resident call bells, handrails, bedside tables, tables, doors, door handles, taps, toilets and shared equipment including medical equipment. See [Appendix 2](#).

- General surfaces and fittings should be cleaned immediately when visibly soiled and after any spills.
- Residents' rooms and care equipment should be cleaned with a detergent followed by the application of a disinfectant or by using a combined cleaning and disinfection product i.e. a two-step clean or a 2 in 1 product.
- Carpets should be regularly vacuumed using a vacuum cleaner with a HEPA filter. It is important to follow the manufacturer's schedule on filter replacement to ensure the filter remains effective
- Steam cleaning or dry cleaning are acceptable processes for soft furnishings if they become visibly soiled. RCF should have a schedule for routine cleaning of all soft furnishings.
- All products should be used in line with the manufacturer's instructions. The product SDS should be readily available, and OSH procedures should always be followed.
- Increase the number of cleaning staff to support enhanced cleaning schedules, provide daily cleaning and disinfection of individual rooms and communal areas. As well as more frequent cleaning and disinfection of frequently touched surfaces in **Red** and **Amber** zones based on number of staff and movements of residents. Rooms must be cleaned and disinfected when a resident is moved.

Emerging disinfection technologies

- When considering emerging disinfection technologies as an adjunct to traditional surface cleaning and disinfection programs, staff should consider the objectives of their use and current evidence for their effectiveness.
- It is advisable that manual cleaning with neutral detergent is completed prior to using novel disinfection technologies; and until evidence changes, novel technologies should not replace manual surface cleaning and disinfection methods.
- For more information see [ICEG guidelines on cleaning and disinfection of protective eyewear in health and residential care facilities | Australian Government Department of Health and Aged Care](#)

Shared equipment

- Any shared equipment must be cleaned and disinfected between every resident use according to manufacturers' instructions.
- In **Red** zones, equipment should be allocated to each resident and not shared, however if this is unavoidable it requires cleaning and disinfection according to the manufactures' instructions before use on the next resident.

Personal resident care

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

Linen handling

- Standard precautions apply when handling soiled and/or contaminated linen including linen from residents in isolation or quarantine.
- Laundry services must comply with Australian Standard AS 4146:2000 Laundry Practice.
- Clean linen and used linen must have segregated storage areas.
- Used linen is to be placed directly into the linen skip. Linen that is heavily soiled should be placed in a plastic or soluble bag as per requirements of the RCFs linen provider.
- Do not overfill linen skips.
- Avoid contact with used linen by holding items away from the body. Avoid agitating the linen which can cause aerosolisation of any infectious particles.
- Hand hygiene must be performed following the handling of used linen and before handling clean linen.

Food service and utensils

- The principles of safe food handling are to be followed in food preparation and service.
- Hand hygiene must be performed before preparing or serving food to residents and after collecting or handling used crockery and cutlery. Crockery and trays can become contaminated with saliva or respiratory droplets.
- Disposable crockery and cutlery are not needed.
- Wash crockery and cutlery in a dishwasher, if available. Otherwise wash with hot water and detergent, rinse in hot water and leave to dry. Items from suspect or confirmed COVID-19 residents do not need to be washed separately.
- Food trays should be processed through the dishwasher or hot washed after each use.
- All trolleys used for food delivery are to be cleaned and disinfected after use.




Waste management

- Standard precautions apply when managing waste.
- RCFs should have a facility wide waste management policy that clearly defines designated waste streams, inclusive of clinical and sharps waste disposal. This policy should be aligned with the [WA Department of Health Code of practice for clinical and related waste management](#).
- Most of the waste generated in RCFs, COVID-19 related or otherwise, including PPE and RATs can be classified as general waste. Waste that is heavily contaminated with blood and/or body fluids is classified as clinical waste.
- All waste should be bagged, ensuring bags are no more than $\frac{3}{4}$ full and securely tied / sealed prior to exiting resident room. Waste segregation should occur at the point of generation.
- Facilities must have contingency plans for increased waste production generated from PPE disposal, including increasing the number and size of waste disposal bins and the need for increased storage and frequency of collection by their waste contractor.

Waste labelling

- Ensure the correct colour coded and labelled containers are used (See Figure 2).
- Similar coloured bin liners should be matched and used with each container e.g. yellow bin liner with the yellow clinical waste bin, black bin liner with the general waste bin.

Figure 2: Waste management stream

	 general waste	
Clinical Waste	General Waste	Recyclable
<p><i>The potential to cause disease, sharps injury or public offence</i></p> <ul style="list-style-type: none"> • heavily soiled dressings/bandages • syringes & needles • any sharps 	<p><i>Presents no significant risk to staff/public</i></p> <ul style="list-style-type: none"> • PPE - gowns, gloves, masks, disposable protective eyewear - face shields • empty urinary catheter bags • incontinence pads • food waste 	<p><i>Reduces volumes to land fill</i></p> <ul style="list-style-type: none"> • cardboard • unbroken glass • newspaper • plastics

Visitors

Ensure all visitors are aware of the following requirements:

- Visitors must be aware of any current visiting restrictions in place
- Go directly to the resident's room or designated area and avoid shared areas.
- Maintain physical distancing, if possible.
- Use ABHR or wash their hands before entering and on leaving the RCF and the resident's room.
- Use of appropriate PPE, as advised and directed by the staff.

Resident transfers

- If transfer to a hospital is required for medical management, the inter-hospital resident transport provider and receiving facility must be advised of the resident's status and condition prior to transport.
- Residents are to wear a surgical mask, and if on oxygen therapy transitioned to nasal prongs if their condition allows, when transported via ambulance.
- If the resident is unable to transition to nasal prongs a surgical mask should be placed over the Hudson mask prior to transport.







Management of the deceased

- While the risk of transmission of COVID-19 from the deceased is low, there is likely to be a continuing risk of infection from handling body fluids and tissues of people confirmed as COVID-19 positive.
- RCWs should follow standard precautions when managing the body which include:
 - performing hand hygiene before and after contact with the deceased body
 - avoiding unnecessary handling of the deceased body that may expel air from the lungs
 - wearing appropriate PPE while handling the deceased body
- A surgical mask is to be placed on the deceased prior to movement of the body and for duration of care until the body is placed in a shroud, to minimise contamination by respiratory secretions.
- Avoid unnecessary handling of the deceased body that may expel air from the lungs
- Family members can view the deceased. After the viewing, bereaved should immediately wash their hands or use an alcohol-based hand rub.
- Deceased persons must be placed in a leak proof body bag for transport
- Refer to [Advice for funeral directors](#)
- Personal belongings can be returned to the family

Appendix 1: Use of appropriate PPE

Standard and transmission-based precautions must be applied to all residents at all times with or suspected to have infections including COVID-19.

Table 1 Recommended PPE for zones

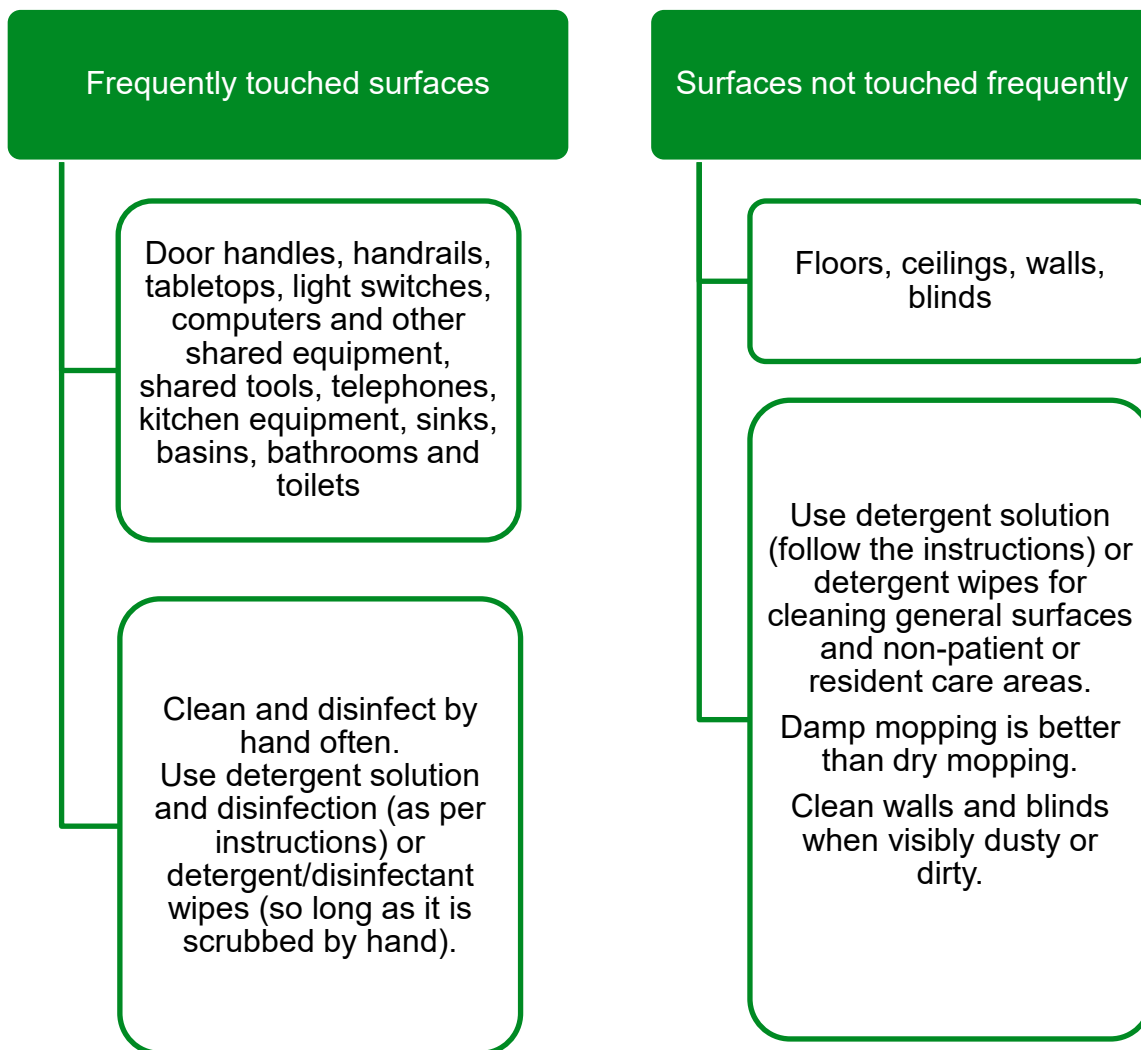
Resident scenario	 Hand hygiene	 Particulate Filter Respirator	 Surgical mask	 Protective eyewear	 Gloves	 Fluid resistant gown or apron
Blue Zone	✓	X	✓	X	X	X
Green Zone	✓	As per standard precautions	As per standard precautions	As per standard precautions	As per standard precautions	As per standard precautions*
Amber Zone	✓	✓	X	✓	As per standard precautions	As per standard precautions
Red Zone	✓	✓	X	✓	✓	✓

*PPE requirements may differ as per public health directives

PPE guidance



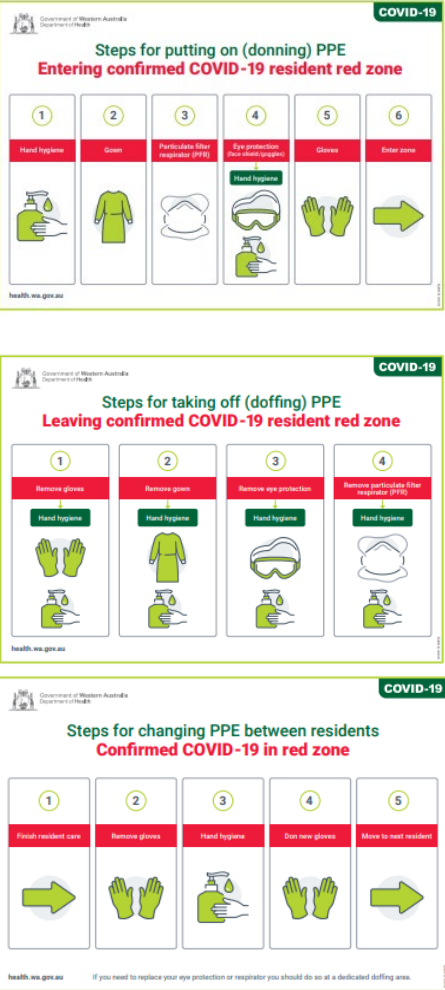
- Masks and eye protection may be worn for up to 4 hours if not damp, damaged or contaminated. Masks should be replaced following any shift or meal breaks and at least every four hours or more frequently as required to relieve pressure. Gloves must be changed between residents and tasks, and hand hygiene performed.
- Aprons or long-sleeve fluid resistant gowns are to be used in situations when there is a risk of exposure to blood, body substances, and other potentially infectious material.
- In **Red** zones, long-sleeve fluid resistant gowns must be used with confirmed or suspect COVID-19 residents.
- Staff may continue to wear the same gown in communal areas of affected zones that are created for residents who are unable to stay in their rooms due to cognitive impairment or mental health conditions. If there is extensive contact with the resident, in addition to the apron and gloves, the gown must be changed at the end of the procedure or episode of care and hand hygiene performed. Examples of extensive contact are providing care such as dressing large or complex wounds, hygiene care for incontinent residents, attending pressure area care, showering fully dependent residents, or urinary catheter care.

Appendix 2: Routine environmental cleaning



Appendix 3: Outbreak IPC resources

<p>Hand Hygiene</p>	<p>Hand Hygiene</p>	
<p>5 moments for Hand Hygiene</p>	<p>Hand hygiene poster</p>	
<p>Keep that cough under cover</p>	<p>Cover Cough</p>	
<p>Protect yourself</p>	<p>Protect yourself and others</p>	

<p>Outbreak tools</p>	<p>Stop Sign Poster – No entry beyond this point</p>	
	<p>Stop Sign Poster – Authorised access only</p>	
	<p>PPE for Red Zone</p>	

PPE for Amber Zone

(Scroll down for Amber posters)

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COVID-19

Steps for putting on (donning) PPE
Entering suspected COVID-19 or close contact resident amber zone

1	2	3	4	5	6
Hand hygiene	Gown	Particulate filter respirator (PFR)	Eye protection (face shield/goggles)	Gloves	Enter zone

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COVID-19

Steps for taking off (doffing) PPE
Leaving suspected COVID-19 or close contact resident amber zone

1	2	3	4
Remove gloves	Remove gown	Remove eye protection	Remove particulate filter respirator (PFR)
Hand hygiene	Hand hygiene	Hand hygiene	Hand hygiene

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Government of Western Australia
Department of Health

COVID-19

Steps for changing PPE between residents
Suspected COVID-19 or close contacts in amber zone

1	2	3	4	5	6
Finish resident care	Remove gloves	Remove gown	Don new gown	Don new gloves	Move to next resident
	Hand hygiene	Hand hygiene			

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If you need to replace your eye protection or respirator you should do so at a dedicated doffing area.

PPE for Green Zone

(Scroll down for green posters)

Government of Western Australia
Department of Health

COVID-19

Steps for putting on (donning) PPE
Entering non-COVID-19 resident green zone

1	2	3	4
Hand hygiene	Surgical mask	Eye protection (face shield/goggles)	Enter zone
			Don gowns, perform hand hygiene and put gloves on if anticipating potential exposure to blood or body fluids as per standard precautions.

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COVID-19

Steps for taking off (doffing) PPE
Leaving non-COVID-19 resident green zone

1	2	3	4
Remove gloves (if worn)	Remove gown (if worn)	Remove eye protection	Remove surgical mask
Hand hygiene	Hand hygiene	Hand hygiene	Hand hygiene

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<p>PPE</p>	<p><u>PPE: Donning and doffing in the healthcare settings</u></p>	 <p>Donning PPE</p> <ol style="list-style-type: none"> Hand hygiene - Wash hands with soap and water for 20 seconds or use hand sanitizer. Fit testing - Perform fit testing for all respirators. Apply and fit check - medical mask or surgical gown - Apply mask or gown and perform fit check. PPE for entrance to patient care area - Apply PPE for patient care area. Fit testing - Perform fit testing for all respirators. Fit glasses over end of gown - Fit glasses over end of gown. <p>Doffing PPE</p> <ol style="list-style-type: none"> Remove and dispose of gown - Remove and dispose of gown. Remove the face shield - Remove the face shield. Remove and dispose of goggles or face shield - Remove and dispose of goggles or face shield. Remove and dispose of mask - Remove and dispose of mask.
<p>Fit checking PFR</p>	<p><u>Flat style PFR</u></p>	 <p>Wearing a flat style respirator*</p> <p>A correctly fitted P2 or N95 respirator will offer protection from airborne infections. A fit check must be performed each time a P2 or N95 respirator is worn.</p> <ol style="list-style-type: none"> 1. Hold the respirator by the top edge. Do not touch the front or sides. 2. Place the respirator over your nose and mouth. Adjust the top strap over your head. 3. Pull the bottom strap over your head. Adjust the bottom strap so it is centered behind your head. 4. Press the respirator against your face. Press the top strap against your forehead. 5. Pull the bottom strap over your head. Adjust the bottom strap so it is centered behind your head. <p>Fit check</p> <ol style="list-style-type: none"> 1. Inhale and exhale. Make sure you can breathe. Do not feel any air leaking around the face seal or through the filter. 2. While wearing the mask, breathe in and out. If you feel any air leaking around the face seal or through the filter, the mask does not fit. Do not use the mask until you have a proper fit. 3. Continue wearing the mask until you are ready to remove it. Do not touch the mask while wearing it.
<p>Fit checking PFR</p>	<p><u>Cup style PFR</u></p>	 <p>Wearing a cup style respirator*</p> <p>A correctly fitted P2 or N95 respirator will offer protection from airborne infections. A fit check must be performed each time a P2 or N95 respirator is worn.</p> <ol style="list-style-type: none"> 1. Hold the respirator by the top edge. Do not touch the front or sides. 2. Place the respirator over your nose and mouth. Adjust the top strap over your head. 3. Pull the bottom strap over your head. Adjust the bottom strap so it is centered behind your head. 4. Press the respirator against your face. Press the top strap against your forehead. 5. Pull the bottom strap over your head. Adjust the bottom strap so it is centered behind your head. <p>Fit check</p> <ol style="list-style-type: none"> 1. Cover the top of the respirator with both hands. Breathe in and out. Do not feel any air leaking around the face seal or through the filter. 2. Breathe in and out. Make sure you can breathe. Do not feel any air leaking around the face seal or through the filter. 3. While wearing the mask, breathe in and out. If you feel any air leaking around the face seal or through the filter, the mask does not fit. Do not use the mask until you have a proper fit. 4. Continue wearing the mask until you are ready to remove it. Do not touch the mask while wearing it.

Version Control

Version	Date	Author	Approved by	Comments on revision
3.0	November 2022	IPC team, Planning Cell, SHICC		Updated contact information as document handed over from SHICC to IPPSU Removed information on Directions as State of Emergency stood down
2.1	23 March 2022	IPC Team, Planning Cell, SHICC		Pending attachment links added
2.0	18 March 2022	IPC Team, Planning Cell, SHICC	Kylie Mulcahy Planning Cell Lead Gail Milner, Subject Matter Expert	Detail of outbreak management. Inclusion of details on zoning and cohorting. Detailed PPE guidance, donning and doffing. Management of deceased. Highlighted sections in the document refer to new content from previous version.
1.0	13 December 2021	IPC Team, Planning Cell, SHICC	Dr Revle Bangor-Jones, Deputy Incident Controller, Public Health, SHICC	Nil - Original Document

Last updated November 2022 - SHICC IPC Version 3.0

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