Background

The recommendations on the escalation of personal protective equipment (PPE) contained in this guidance are based on currently available information about COVID-19. The decision to escalate PPE use, outside of caring for a confirmed, probable or suspected case, is based on an assessment of the risk of unexpected COVID-19 infection in clients/patients¹, or workers because of the current level of COVID-19 community risk. The escalation of PPE aims to minimise the risk of acquisition of COVID-19 infection by workers², clients, and visitors. In addition to infected clients, workers are at risk for the acquisition of SARS-CoV-2 from infected co-workers and visitors.

Scope

This guidance applies to healthcare settings, community health and care services, in-home care settings, and healthcare delivery in correctional services.

General practices are encouraged to apply the PPE recommendations in accordance with Table 3 Healthcare settings.

Related directions and guidance

This document should be read in conjunction with:

- Chief Health Officer Public Health Directions.
- Queensland Health infection prevention and control guidelines for the management of COVID-19 in healthcare settings.
- Queensland Health: Optimising the supply of personal protective equipment
- Infection Control Expert Group Guidance on the use of personal protective equipment (PPE) for health care workers in the context of COVID-19
- The Communicable Disease Network of Australia Coronavirus Disease 2019 (COVID-19) CDNA National guidelines for public health units, and
- Other advice provided by Queensland Health as part of the COVID-19 response.

To avoid doubt, a current public health directive/s prevails should there be any conflict between these guidelines and that directive.

¹ Clients. As this guidance applies broadly across a number of settings, the term “clients” has been chosen to indicate clients, patients, inmates of correctional centres, clients of community corrections

² Workers: includes employees, contractors, volunteers and students

Pandemic response guidance - Escalation of personal protective equipment usage in healthcare delivery, community health and care services, in-home care settings, and for healthcare delivery in correctional services version 4.0 28 June 2022
Decision for escalation or de-escalation of PPE

This guidance refers to three PPE escalation levels: low, moderate and high. The PPE escalation levels outline the recommended PPE corresponding with the COVID-19 community level and consequent unexpected exposure to COVID-19 infection in clients or workers.

Change of escalation level should be triggered by a review of Hospital and Health Service (HHS)-level data on COVID-19 infection and COVID-19-related illness in the community.

The below indicators are suggested to be used to contribute to an HHS-level determination of the COVID-19 community level. These indicators are based on the framework used by the US CDC to calculate COVID-19 community levels. The COVID-19 community level is based on the current level of active cases combined with measures of new COVID-19 admissions and the percentage of staffed inpatient beds occupied by COVID-19 patients. If the measures for new COVID-19 admissions and percentage of staffed inpatient beds occupied by COVID-19 patients are discordant, it is suggested to use the higher COVID-19 community level.

The recommended measures may not be reliable in HHS with smaller populations. These HHS may take unexpected occasions of care into account as an additional measure. Where unexpected occasions of care occur, this may be used as an indicator of a higher COVID-19 community level.

It is recommended that assessment of a decreased COVID-19 community level triggers a staged approach, with de-escalation of COVID-19 screening testing for a period of time sufficient to assess the impact on hospital COVID-19 transmission prior to de-escalation of PPE. Refer to the COVID-19 Testing Framework Implementation Plan for further information about the testing strategy.

### Indicators of COVID-19 community levels

<table>
<thead>
<tr>
<th>New COVID Cases per 100,000 people in prior 7 days</th>
<th>Indicator</th>
<th>Low levels</th>
<th>Moderate levels</th>
<th>High levels</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 200</td>
<td>New COVID-19 inpatient admissions per 100,000 population (7-day total) – including Hospital in the Home (HITH) admissions</td>
<td>&lt; 10</td>
<td>10-19.9</td>
<td>&gt;/= 20</td>
</tr>
<tr>
<td></td>
<td>Percent of staffed inpatient beds occupied by COVID-19 patients (7-day average)</td>
<td>&lt; 10%</td>
<td>10 – 14.9%</td>
<td>&gt;/= 15%</td>
</tr>
<tr>
<td>&gt;/= 200</td>
<td>New COVID-19 inpatient admissions per 100,000 population (7-day total) – including HITH admissions</td>
<td>N/A</td>
<td>&lt; 10</td>
<td>&gt;/= 10</td>
</tr>
<tr>
<td></td>
<td>Percent of staffed inpatient beds occupied by COVID-19 patients (7-day average)</td>
<td>N/A</td>
<td>&lt;10%</td>
<td>&gt;/= 10%</td>
</tr>
</tbody>
</table>

---

Within Queensland Health, Hospital and Health Services are responsible for initiating the PPE requirements based on local COVID-19 community levels.

It is recommended that Hospital and Health Service (HHS)-level data be used to assess the local COVID-19 community level regularly and this information is shared with Primary Health Networks, Aboriginal Community Controlled Health Organisations (ACCHO), RACF and Disability Accommodation Service providers so that they may also implement the recommended approach.

Tables 1, 2 and 3 outline the recommended use of PPE for each escalation level:
- Table 1 provides recommendations for PPE escalation in community health services and in-home care settings
- Table 2 provides recommendations for PPE escalation in healthcare delivery in correctional services
- Table 3 provides recommendations for PPE escalation in healthcare settings

**Recommendations for assessing client risk**

**General considerations**

Ongoing risk assessment of individual clients should occur in all care settings in order to inform the most appropriate PPE required for specific clinical and non-clinical interactions.

In accordance with the Infection Control Expert Group *Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: the hierarchy of controls* and the Infection Control Expert Group *Guidance on the use of personal protective equipment for healthcare workers in the context of COVID-19* an assessment of the risk of COVID-19 transmission to workers should be undertaken when providing direct care to clients. The assessment of the risk of transmission should consider the following:
- the individual client’s pre-existing likelihood of COVID-19
- client factors
  - behaviours that increase the risk of transmission, for example, inability to cooperate, challenging behaviours, coughing, increased work of breathing
  - whether the resident/client is able to wear a surgical mask
- physical location of care.
  - ventilation in the location
  - cohorting
  - less controlled or more complex care settings, for example, during transport, units specific to dementia care
- nature of the care episode
  - proximity and duration of contact
  - aerosol-generating procedures

When the risk is unknown, is yet to be assessed, or is unable to be assessed, a patient should be managed as a suspected COVID-19 case.

Workers in less controlled settings such as fever/testing clinics and triage settings in Emergency Departments should consider the use of particulate filter respirators (PFR) in addition to other
PPE when having face-to-face contact or providing direct patient care. This should particularly apply when the risk of unexpected COVID-19 infections in the community is increased. This is because the ability to conduct an individual risk assessment prior to having contact with patients may be constrained in these settings. Such environments may be less controlled with multiple patients with symptoms consistent with COVID-19 requiring review and testing concurrently.

Client risk categories

Client/patient risk categories in tables 1, 2, and 3 are based on the combination of the presence/absence of signs/symptoms of COVID-19 and whether the client is a close contact.

**Symptoms** of COVID-19

All people with symptoms of an acute respiratory infection (ARI) should be considered to have “Symptoms of COVID-19” (previously known as Clinical Evidence in this and other QH documents) until an alternative diagnosis is determined, if in the last 14 days they have experienced:

- recent onset of new, or worsening symptoms, of ARI (e.g., cough, breathing difficulty, sore throat, runny nose/nasal congestion), with or without other symptoms
- other symptoms may include:
  - headache, myalgia, fatigue, diarrhoea, nausea/vomiting, loss of appetite, loss of smell or loss of taste (less common with new VOC),
  - fever (≥37.5°C) or history of fever (e.g., night sweats, chills), less common in elderly
  - in the elderly consider, new or increased confusion, change in baseline behaviour, falling, exacerbation of underlying chronic illness [1].

Clinical judgement should be applied where there are alternative clinical explanations for symptoms or non-specific symptoms are present.

For consistency, throughout this Guideline, the term “Symptoms of COVID-19” will be used, acknowledging that the CDNA SoNG uses the term “Symptoms of Acute Respiratory Infection”.

**Close contact**

The client has been identified as a close contact of a case of COVID-19 in the last 7 days, according to Queensland Health CHO Direction AND/OR the current version of the Communicable Diseases Network Australia COVID-19 National Guidelines for Public Health Units (The CDNA COVID-19 SoNG).

**Use of particulate filter respirators (PFR) and surgical masks**

In accordance with the recommendations in the Queensland Health Infection prevention and control guidelines for the management of COVID-19 in healthcare settings the following recommendations are to be followed:

- Respirators and masks should be changed when they become damaged, soiled or wet.
- Respirators and masks should never be reapplied after they have been removed.
- Respirators and masks should not be left dangling around the neck.
- Avoid touching/adjusting the front of the respirator or mask while wearing it.
- Hand hygiene should be performed upon touching or discarding a used respirator or mask.
• Respirators and masks need to be removed for eating and drinking and this is permitted, necessary and safe. It is important to limit the duration that the mask is removed to help minimise any potential risk of exposure. Staff must maintain physical distancing when on meal breaks.
• Staff must dispose of used respirators and masks in waste receptacles as soon as they are removed.
• Plan for the need to replace the discarded mask and have a new mask ready to apply.

Please refer to the Queensland Health guidance document **Fit testing of P2/N95 respirators in respiratory protection programs** for detailed information regarding fit testing requirements for PFR.

**Powered Air Purifying Respirators (PAPRs)**

There are circumstances where the use of a PAPR may be considered in place of a PFR e.g.:
• when prolonged use of airborne PPE is indicated e.g., prolonged bedside care in ICU or care of cohorted patients on a ward or in the emergency department,
• staff who have failed fit tests on available disposable Particulate Filtration Respirators (PFR) e.g., P2/N95s.

Please refer to relevant local guidelines and the **Queensland Health CleanSpace HALO guidance** for detailed information on the use, reprocessing and maintenance of these devices. The decision to use PAPRs is made at a local level following a risk-based assessment.

**Continuous surgical mask use**

Continuous surgical mask use is **recommended for workers during periods of moderate and high community COVID-19 levels**, to reduce the risk of transmission of COVID-19 between workers and clients, and amongst workers (who may be asymptomatic but infectious, especially early in the course of illness).

Workers who directly work with clients and/or in common workspaces are **recommended** to continuously wear a surgical mask in client care areas and common areas throughout the entire shift during periods when there is a moderate or high COVID-19 community level. Workers who generally work alone in their own office will be **recommended** to wear a mask when outside of their office.

Surgical masks are designed to be worn for extended periods of time. They are generally well tolerated on the face. A worker will likely remove or change a mask for reasons such as eating or drinking, taking a toilet break, or leaving the client care area before the integrity/effectiveness of the mask is compromised.

**Additional considerations for community health services and in-home care settings**

Community health service: A facility-based service that delivers care but does not provide overnight support.

In-home care setting: Care that is delivered within a client’s permanent or temporary residence.
Safe fitting and removal of PPE for home visiting services

Strict adherence to safe fitting and removal of PPE is crucial.

For home visiting services, fitting (donning) should occur prior to entry of the premises and removal (doffing) should occur immediately after leaving the premises/residence with all equipment placed in a sealed bag for transport and disposal (also see Correct use of PPE).

Ensure that hand hygiene is performed before fitting PPE and upon removal of each item of PPE as per safe fitting and removal of PPE.

Staff wearing masks

The use of surgical masks when providing care to people at increased risk of severe illness/adverse outcomes and those with disabilities can sometimes cause additional problems. If the client gets or is likely to get distressed, alarmed or violent because the staff member is wearing a surgical mask or has communication difficulties such as reliance on lip reading, staff may need to consider alternative options after discussion with the client and/or carer/appointed substitute decision-makers. A risk assessment must be conducted prior to considering/implementing alternative options (refer to risk assessment in the Infection Control Expert Group Guidance on the use of personal protective equipment for healthcare workers in the context of COVID-19). Alternative options may include, for example, discussing with the client/resident first from a distance greater than 1.5 metres, or using social stories to explain and reassure them, prior to putting on the surgical mask to assist them. Employing strategies to socialise surgical mask use now is essential so clients are familiar with them in the event of an outbreak where masks will be essential for the safety of both clients and staff.

For very limited and rare circumstances where essential care/support is required and communicating to the client without a surgical mask from a distance of greater than 1.5 metres is not a viable alternative strategy the option of a face shield instead of a surgical mask may be considered but only where:

- the client has not tested COVID-19 positive,
- the client displays no symptoms of COVID-19,
- there is not a person in the home/care setting that is confirmed/probable or awaiting COVID-19 results, and
- the client is not identified as a close contact of a case of COVID-19.

Such an approach should only be considered where it does not conflict with current Chief Health Officer Public Health Directions. In addition, staff should be aware of the lack of data showing that face shields alone prevent transmission of COVID-19 and they may not offer the same level of protection as a surgical mask.

A person’s use of PPE should not create any serious risk to that person’s life or health and safety, including if determined through work Occupational Health and Safety guidelines.

Clients wearing masks

Clients at increased risk of severe illness and adverse outcomes should not be required to wear a mask if:

- they are affected by a medical condition, mental health condition or disability that may be exacerbated or made worse in any way by wearing a mask, and/or
- it is important to be able to see their mouth for communication.
Where this is applicable, PPE should be worn by the healthcare/support worker and by other people in the vicinity of the person at increased risk of severe illness and adverse outcomes. Hand hygiene and environmental cleaning should also be conducted to reduce the transmission risk for the person unable to wear a mask.

**Considerations for correctional centres – primary protection measures**

In response to the COVID-19 pandemic, several protection measures have been put in place in correctional centres to reduce the risk of COVID-19 being present in a correctional centre. These measures include:

- Screening of all visitors, staff each time they enter a correctional facility. (staff or visitors are refused entry if it is not safe for them to enter)
- Screening of all clients on reception to a correctional centre.
- Polymerase chain reaction (PCR) testing and isolating of clients in a correctional centre as per the testing and isolation advice of Queensland Health.
- Temporary restriction or suspension of personal visits in correctional centres in response to community and/or centre-based transmission.
- Management of new receptions under the Queensland Corrective Services *Managing new admission receptions prisoners and COVID-19 policies for standard response and restricted operations*. 


<table>
<thead>
<tr>
<th>COVID-19 community level</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client category ↓</td>
<td>Staff who work only in a single community facility/home¹</td>
<td>Staff who work across multiple community facilities/homes¹</td>
<td>Staff who work only in a single community facility/home¹</td>
</tr>
<tr>
<td>NO symptoms of COVID-19 and NOT a close contact²</td>
<td>Standard precautions</td>
<td>Surgical mask¹</td>
<td>Surgical mask¹</td>
</tr>
<tr>
<td>Symptoms³ of COVID-19 and NOT a close contact⁴</td>
<td>Surgical mask¹</td>
<td>Protective eyewear² (within 1.5m)</td>
<td>Surgical mask¹</td>
</tr>
<tr>
<td>Confirmed/Probable⁵ COVID-19 OR Suspected COVID-19⁶ (symptoms of COVID-19 and awaiting test results) OR Close contact⁷</td>
<td>PFR</td>
<td>Protective eyewear²</td>
<td>PFR</td>
</tr>
<tr>
<td>PPE for staff doing activities other than direct client care</td>
<td>Surgical mask</td>
<td>Surgical mask</td>
<td>Surgical mask</td>
</tr>
<tr>
<td>PPE for clients – Symptoms of COVID-19 OR close contact⁷ (excluding children under 12)</td>
<td>Clients to wear surgical mask where tolerated (excluding children under 12)</td>
<td>Clients to wear surgical mask where tolerated (excluding children under 12)</td>
<td>Clients to wear surgical mask where tolerated (excluding children under 12)</td>
</tr>
<tr>
<td>PPE for Support persons or other household members during healthcare interaction for non-COVID-19 clients</td>
<td>Nil additional</td>
<td>Surgical mask</td>
<td>Surgical mask</td>
</tr>
</tbody>
</table>

Table 1 footnotes

²Close contact: a client who has been identified as a close contact of a case of COVID-19 in the last 7 days, according to Queensland Health CHO Direction AND/OR the current version of the Communicable Diseases Network Australia COVID-19 National Guidelines for Public Health Units [The CDNA COVID-19 SoNG](https://www.childrens.health.qld.gov.au/wp-content/uploads/PDF/covid-19-extranet/ppe-requirements-HVP.pdf).
³Protective eyewear is defined as a face shield, goggles, or dedicated safety glasses – note that prescription glasses alone are not considered adequate eye protection.
⁵In these situations a particulate filter respirator (PFR) should be worn for Aerosol generating procedures (AGP), aerosol-generating behaviours (AGB), and upon entering a room within 30 min of an AGP where there have been no other risk mitigating strategies to reduce that time. AGP, AGB and other factors increasing the risk of transmission are outlined in Appendix 7 of the Queensland Health infection prevention and control guidelines for the management of COVID-19 in healthcare settings.
⁶A long-sleeved, preferably fluid-resistant gown. An apron or a non-fluid-resistant gown may be used in situations where physical contact is minimal and there is little chance of body fluid splash. Healthcare staff who reside in an area that is designated a different risk level to the healthcare facility they work in are to comply with their workplace facility risk PPE requirements.
⁷A probable case includes individuals who have a positive rapid antigen test for SARS-CoV-2. Refer to the latest version of the CDNA COVID-19 SoNG for updates to this definition.
### Table 2. Healthcare delivery in correctional services: Recommended PPE escalation according to COVID-19 community levels (in addition to standard precautions +/- transmission-based precautions if indicated for another reason)

<table>
<thead>
<tr>
<th>COVID-19 community level</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client category</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NO symptoms of COVID-19 and NOT a close contact</td>
<td>Standard precautions</td>
<td>Surgical mask(^1)</td>
<td>Surgical mask(^1)</td>
</tr>
<tr>
<td>Symptoms of COVID-19 and NOT a close contact(^4)</td>
<td>Surgical mask(^1)</td>
<td>PFR(^4)</td>
<td>PFR(^4)</td>
</tr>
<tr>
<td>Confirmed/Probable(^4) COVID-19 OR Suspected COVID-19 (symptoms, and awaiting test results) OR Close contact(^6)</td>
<td>PFR(^4)</td>
<td>PFR(^4)</td>
<td>PFR(^4)</td>
</tr>
<tr>
<td>PPE for staff doing activities other than direct client care</td>
<td>Not applicable</td>
<td>Surgical mask</td>
<td>Surgical mask</td>
</tr>
<tr>
<td>PPE for clients(^5) with symptoms of COVID-19 OR close contact(^6) (excluding children under 12)</td>
<td>Client to wear surgical mask where tolerated when outside of single room</td>
<td>Client to wear surgical mask where tolerated when outside of single room</td>
<td>Client to wear surgical mask where tolerated when outside of single room</td>
</tr>
<tr>
<td>PPE for visitors(^3)</td>
<td>Nil additional</td>
<td>Surgical mask</td>
<td>Surgical mask</td>
</tr>
</tbody>
</table>

**Table 2 footnotes**

1. Healthcare staff who reside in an area that is designated a different risk level to the correctional facility they work are to comply with their workplace facility risk PPE requirements.
2. Please refer to the applicable Determination by the Commissioner of Queensland Corrective Services.
3. Fit testing of particulate filter respirators (PFR) is required of staff on at least a 12-monthly basis.
4. In these situations a PFR should be worn for Aerosol generating procedures (AGP), aerosol-generating behaviours (AGB), and upon entering a room within 30 min of an AGP where there have been no other risk mitigating strategies to reduce that time. AGP, AGB and other factors increasing the risk of transmission are outlined in Appendix 7 of the Queensland Health infection prevention and control guidelines for the management of COVID-19 in healthcare settings.
5. A probable case includes individuals who have a positive rapid antigen test for SARS-CoV-2. Refer to the latest version of the CDNA COVID-19 SoNG for updates to this definition.
6. Close contact: a client who has been identified as a close contact of a case of COVID-19 in the last 7 days, according to Queensland Health CHO Direction AND/OR the current version of the Communicable Diseases Network Australia COVID-19 National Guidelines for Public Health Units (The CDNA COVID-19 SoNG).
7. A long-sleeved, preferably fluid-resistant gown. An apron or a non-fluid-resistant gown may be used in situations where physical contact is minimal and there is little chance of body fluid splash.
### Table 3. **Healthcare settings** Recommended PPE escalation according to **COVID-19 community levels** (in addition to standard precautions +/- transmission-based precautions if indicated for another reason)

<table>
<thead>
<tr>
<th>COVID-19 community level</th>
<th>Client category</th>
<th>Low: Standard and Transmission-Based Precautions</th>
<th>Moderate: Standard and Transmission-Based Precautions, Plus measures to counter moderate risk of unexpected COVID-19 infection, including source control</th>
<th>High: Standard and Transmission-Based Precautions, Plus measures to counter high risk of unexpected COVID-19 infection, including source control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low</td>
<td>NO signs/symptoms of COVID-19 and NOT a close contact</td>
<td>Standard precautions</td>
<td>Surgical mask&lt;sup&gt;1&lt;/sup&gt; Protective eyewear</td>
<td>Surgical mask&lt;sup&gt;1&lt;/sup&gt; Surgical mask&lt;sup&gt;9&lt;/sup&gt; PFR in high-risk clinical areas&lt;sup&gt;6&lt;/sup&gt; Protective eyewear</td>
</tr>
<tr>
<td>Low</td>
<td>Symptoms of COVID-19 and NOT a close contact</td>
<td>Surgical mask&lt;sup&gt;1&lt;/sup&gt; Protective eyewear Gown or apron&lt;sup&gt;1&lt;/sup&gt; Gloves</td>
<td>PFR&lt;sup&gt;6&lt;/sup&gt; Protective eyewear Gown or apron&lt;sup&gt;7&lt;/sup&gt; Gloves</td>
<td>PFR&lt;sup&gt;6&lt;/sup&gt; Protective eyewear Gown or apron&lt;sup&gt;7&lt;/sup&gt; Gloves</td>
</tr>
<tr>
<td>Low</td>
<td>Confirmed/Probable&lt;sup&gt;8&lt;/sup&gt; COVID-19 OR Suspected COVID-19 (symptoms and awaiting test results) OR Close contact</td>
<td>PFR&lt;sup&gt;6&lt;/sup&gt; Protective eyewear Gown or apron&lt;sup&gt;1&lt;/sup&gt; Gloves</td>
<td>PFR&lt;sup&gt;6&lt;/sup&gt; Protective eyewear Gown or apron&lt;sup&gt;7&lt;/sup&gt; Gloves</td>
<td>PFR&lt;sup&gt;6&lt;/sup&gt; Protective eyewear Gown or apron&lt;sup&gt;7&lt;/sup&gt; Gloves</td>
</tr>
<tr>
<td>Low</td>
<td>PPE for staff during activities other than direct patient care</td>
<td>Not Applicable</td>
<td>Surgical mask unless working alone in their own office&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Surgical mask unless working alone in their own office&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>Low</td>
<td>PPE for patient use - symptoms of COVID-19 OR close contact (excluding children under 12)</td>
<td>Surgical mask where tolerated, unless inpatient in own bed</td>
<td>Surgical mask where tolerated, unless inpatient in own bed</td>
<td>Surgical mask where tolerated, unless inpatient in own bed</td>
</tr>
<tr>
<td>Low</td>
<td>PPE for patient use - non-COVID-19 (excluding children under 12)</td>
<td>Nil</td>
<td>Surgical mask where tolerated, unless inpatient in own bed</td>
<td>Surgical mask where tolerated, unless inpatient in own bed</td>
</tr>
<tr>
<td>Low</td>
<td>PPE for visitors</td>
<td>Nil</td>
<td>Surgical mask OR Own mask if adequate&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Surgical mask OR Own mask if adequate&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

**Table 3 footnotes**

<sup>1</sup>High-risk clinical areas are emergency departments, inpatient wards accommodating patients with confirmed COVID-19 and facilities/inpatient units with high rates of internal COVID transmission. Health Services may also designate additional high-risk clinical areas locally based on a risk assessment. Health Services may also consider universal particulate filter respirator (PFR) use during periods of sustained high community transmission.

<sup>2</sup>Close contact: a client who has been identified as a close contact of a case of COVID-19 in the last 7 days, according to Queensland Health CHO Direction AND/OR the current version of the Communicable Diseases Network Australia COVID-19 National Guidelines for Public Health Units (The CDNA COVID-19 SoNG).

<sup>3</sup>Restricted Hospital as per Chief Health Officer Public Health Directions.

<sup>4</sup>In these situations a PFR should be worn for Aerosol generating procedures (AGP), aerosol-generating behaviours (AGB), and upon entering a room within 30 min of an AGP where there have been no other risk mitigating strategies to reduce that time. AGP, AGB and other factors increasing the risk of transmission are outlined in Appendix 7 of the Queensland Health infection prevention and control guidelines for the management of COVID-19 in healthcare settings.

<sup>5</sup>Powered Air Purifying Respirators (PAPRs) may be used in certain circumstances as an alternative to P2/N95 respirators. The decision to use these devices is made at a local level following a risk-based assessment.

<sup>6</sup>A long-sleeved, preferably fluid-resistant gown. An apron or a non-fluid-resistant gown may be used in situations where physical contact is minimal and there is little chance of body fluid splash.

<sup>7</sup>A probable case includes individuals who have a positive rapid antigen test for SARS-CoV-2. Refer to the latest version of the CDNA COVID-19 SoNG for updates to this definition.

<sup>8</sup>A PFR may be chosen by staff according to an individual risk assessment. PFR should remain available to all staff as a choice during high community COVID-19 level escalations.
Definition of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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</thead>
<tbody>
<tr>
<td>Community health service</td>
<td>A facility-based service that delivers care but does not provide overnight support.</td>
</tr>
<tr>
<td>In-home care setting</td>
<td>Care that is delivered within a client's permanent or temporary residence.</td>
</tr>
<tr>
<td>Particulate filter respirator (PFR)</td>
<td>Respirators, such as P2 or N95, that are designed to protect the wearer from respiratory exposure to small airborne particles.</td>
</tr>
<tr>
<td>Probable case of COVID-19</td>
<td>A probable case includes individuals who have a positive rapid antigen test for SARS-CoV-2. Refer to the latest version of the Communicable Diseases Network Australia COVID-19 National Guidelines for Public Health Units for updates to this definition.</td>
</tr>
</tbody>
</table>

Review

This guideline will be reviewed as new information becomes available.

Document approval details:

Endorsement

PPE Working Group 17 June 2022
COVID-19 Health System Response Group 28 June 2022

Document custodian


Approval officer

Sean Birgan, COVID-19 Health System Response Lead

Approval date: 28 June 2022

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### Version History

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<tr>
<th>Version</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>V1.1</strong></td>
<td>Inclusion of PAPR devices in body of text and Table 3 footnotes; Addition to Table 2 for PPE use when caring for clients with COVID clinical evidence and no epidemiological evidence; removal of definition of Non-COVID with epidemiological evidence</td>
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<tr>
<td><strong>V1.3-1.4</strong></td>
<td>Updates from previous version are highlighted in yellow. Update following changes to border restrictions as per Border Restrictions Direction no. 57. Those with epidemiological evidence, with or without clinical evidence are to be managed using additional precautions. Those who have been in a hotspot who are vaccinated must be managed using additional precautions until after they have had a test for COVID-19 on day 5 after leaving the hotspot. This update progressed rapidly with endorsement of PPE Working Group Chair and Dr James Smith, DCHO.</td>
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<tr>
<td><strong>V1.5</strong></td>
<td>17 December 2021. Revision of recommendations for those with epidemiological evidence only. Definition of epidemiological evidence has been revised.</td>
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<tr>
<td><strong>V1.6-2.0</strong></td>
<td>14 January 2022. Addition of choice of an apron or a non fluid-resistant gown rather than a long-sleeved fluid resistant gown in situations where physical contact is minimal and there is little chance of body fluid splash. Yellow highlighted text is updated since the last published version.</td>
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<tr>
<td><strong>V2.1-3.0</strong></td>
<td>February-March 2022. Revision of definition of epidemiological evidence. Addition of “Probable case”.</td>
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<tr>
<td><strong>V3.1</strong></td>
<td>18 March 2022. Addition of minor clarification to footnote about aerosol-generating procedures, to allow for risk mitigating strategies to be taken into account. This minor clarification approved by Chair, PPE Working Group 18 March 2022.</td>
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<tr>
<td><strong>V3.2-4.0</strong></td>
<td>6 May – 28 June 2022. Change to definition of epidemiological evidence to align with changes to broader policy settings. Change to the recommended PPE for high setting, for the care of patients without symptoms of COVID-19 who are not a close contact, to remove the recommendation for universal P2/N95 use here. Change to wording - changed “clinical evidence” to “signs/symptoms of COVID-19” and changed “epidemiological evidence” to “close contact”. Addition of data-driven framework for deciding Community COVID-19 level. Change of terminology - P2/N95 to particulate filter respirator (PFR).</td>
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</table>

### Contact area

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Pandemic response guidance - Escalation of personal protective equipment usage in healthcare delivery, community health and care services, in-home care settings, and for healthcare delivery in correctional services version 4.0 28 June 2022