Background

The recommendations on the escalation of personal protective equipment (PPE) contained in this guidance are based on currently available information about COVID-19 and apply to residential aged care and disability accommodation services.

The decision to escalate PPE use, outside of caring for a confirmed, probable or suspected case of COVID-19, is based on an assessment of the risk of unexpected COVID-19 infection in residents/clients or workers\(^1\) 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 workers\(^1\), residents/clients, and visitors. In addition to infected residents/clients, workers\(^1\) are at risk for the acquisition of SARS-CoV-2 from infected co-workers and visitors.

This guidance is to be read in conjunction with relevant Chief Health Officer Public Health Directions, and other related government directions and guidance documents (see below).

Scope

This guidance applies to residential aged care and disability accommodation services in Queensland.

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 for infection prevention and control in residential care facilities
- Infection Control Expert Group Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: the hierarchy of controls
- The Communicable Disease Network of Australia National guidelines for Public Health Units
- Other advice provided by Queensland Health as part of the COVID-19 response.

\(^1\) Workers: includes employees, contractors, volunteers and students
To avoid doubt, a current public health directive/s prevails should there be any conflict between these guidelines and that directive.

### Decision for escalation of PPE

This guidance refers to three PPE escalation levels: low risk, moderate risk and high risk. The PPE escalation levels outline the recommended PPE corresponding with the COVID-19 community levels and consequent unexpected exposure to COVID-19 infection in residents/clients or workers (refer to table 1).

A change in escalation level should be triggered by a change in the level of COVID-19 infection and COVID-19-related illness in the community. It is recommended that Hospital and Health Service (HHS)-level data be used to assess the local COVID-19 community level regularly and that this information is shared with RACF and Disability Accommodation Service providers so that they may also implement the recommended approach.

See the Appendix for information on the indicators that are suggested to be used to contribute to an HHS-level determination of the COVID-19 community level.

RACF and disability care providers are responsible for initiating the PPE requirements listed for the corresponding HHS COVID-19 community level as advised by Queensland Health.

These risk determinations can be localised (for example, in the event of a local outbreak or cluster of COVID-19), regional or state-wide. RACF and disability care providers may also escalate to a higher risk determination in the event of a facility outbreak.

### Performing a risk assessment when selecting PPE

#### General considerations

Ongoing risk assessment of individual residents/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*, and *Guidance on infection prevention and control for residential care facilities in the context of COVID-19* an assessment of the risk of transmission of COVID-19 to workers’ should be undertaken when providing direct care to resident/clients. The assessment of the risk of transmission should consider the following:

- the individual resident/client’s pre-existing likelihood of COVID-19
- resident/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

Refer to *Guidance on infection prevention and control for residential care facilities in the context of COVID-19* for further guidance.

**Resident/client risk categories**

The below criteria should be used to decide the risk category for transmission of COVID-19 for an individual resident/client. Refer to Table 1 for recommendations on PPE for each risk category.

**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.

For further information about recognising COVID-19 in elderly people, refer to the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia.

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).
Confirmed and probable COVID-19 cases and suspect COVID-19 residents/clients

- All residents/clients with confirmed COVID-19
- All resident/clients with probable COVID-19 (individuals who have a positive rapid antigen test for SARS-CoV-2)
- All residents/clients with suspected COVID-19 (symptoms of COVID-19 and awaiting test results)
- All residents/clients identified as a close contact (with or without symptoms of COVID-19)

Non-COVID-19 resident/clients

Resident/clients with NO acute respiratory illness or other symptoms of COVID-19 (in the past 14 days) AND

- Not a close contact AND
- No other indication for transmission-based precautions

Remaining resident/clients

Resident/clients with symptoms of respiratory infection or other symptoms of COVID-19:

- NOT a close contact AND,
- COVID-19 is not suspected or has been ruled out

Infection prevention and control

Standard precautions:

Standard precautions are required for all interactions with residents/clients regardless of their known or presumed infectious status. Standard precautions are the primary strategy for minimising the risk of infection and must be used as part of day-to-day practice when providing care to residents/clients.

Standard precautions consist of:

- Hand hygiene consistent with the 5 moments for hand hygiene,
- The use of appropriate personal protective equipment,
- The safe use and disposal of sharps,
- Routine environmental cleaning,
- Reprocessing of reusable medical equipment and instruments,
- Respiratory hygiene and cough etiquette,
- Aseptic technique where indicated,
- Waste management, and
- Appropriate handling of linen.
For further information on standard precautions refer to section 3.1 of *The Australian Guidelines for the Prevention and Control of Infection in Healthcare*.

**Transmission-based precautions:**

Transmission-based precautions are applied in addition to standard precautions when residents/clients are suspected or confirmed to be infected with agents transmitted by the contact, droplet or airborne route. For further information about transmission-based precautions refer to section 3.2 of *The Australian Guidelines for the Prevention and Control of Infection in Healthcare*.

A risk assessment is required to determine the required transmission-based precautions (i.e., contact +/- droplet +/- airborne precautions). Risk assessment involves the evaluation of:

1. The level of community transmission (see risk level definitions above)
2. The presence of clinical and/or epidemiological risks of individual residents/clients
3. The type of care being provided to the resident/client

Table 1 outlines the recommended escalation of PPE for use as part of transmission-based precautions in residential aged care and disability accommodation services.

**Continuous surgical mask use**

Continuous surgical mask use is required for workers\(^1\) in residential aged care and disability accommodation services, during periods of moderate and high community transmission of COVID-19, to reduce the risk of transmission of COVID-19 between workers\(^1\) and residents/clients and amongst workers\(^1\) (who may be asymptomatic but infectious, especially early in the course of illness).

This will require workers\(^1\) who work with residents/clients and in common workspaces to continuously wear a surgical mask during their routine activities throughout the entire shift. Workers\(^1\) who generally work alone in their own office will be required to wear a mask when outside their office and/or in accordance with relevant Public Health Directions.

Refer to Queensland Health PPE and infection control guidance for the latest information regarding level of risk assigned to a particular Hospital and Health Service and local government area (LGA), and PPE recommendations.

**Use of particulate filter respirators (PFR)**

For the care of residents/clients with confirmed/probable COVID-19 and suspect COVID-19 residents/clients, the use of a particulate filter respirator (PFR) (such as a P2/N95 respirator) in addition to PPE for droplet and contact precautions is required.

All workplaces that use respiratory protection equipment (PFR e.g., P2/N95 respirators) are required to implement a respiratory protection program. This requirement is achieved through the Work, Health and Safety Act 2011 (Queensland), the Work Health and Safety Regulation 2011 (Queensland), and Australian/New Zealand Standard 1715:2009 – Selection, use and maintenance of respiratory protective equipment.

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 PFRs.
Additional considerations around use of face masks and respirators

Staff wearing masks or respirators

The use of surgical masks or respirators when providing care to some residents/clients in residential aged care and those with disability can sometimes cause additional problems. If the resident/client gets, or is likely to get distressed, alarmed, or violent because staff are wearing a surgical mask or respirator, or has communication difficulties such as reliance on lip reading, staff should consider alternative options after discussion with the resident/client and employer. For example, discussing with the resident/client 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.

For very limited and rare circumstances, such as when communicating to the resident/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 resident/client has not tested COVID-19 positive,
- the resident/client displays no symptoms of COVID-19,
- there is not an outbreak at the facility, and
- the resident/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 public health directions. In addition, staff should be aware that data is lacking 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.

Residents/clients wearing masks

Residents or clients 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
- It is important to be able to see their mouth for communication

Safety considerations

The following recommendations are to be followed in relation to respirator or surgical mask use:

- Respirators and masks must be worn to cover the mouth and nose fully to be effective.
- 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 or loosely from one ear.
- 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 practice physical distancing when on meal breaks when the mask is not in place.

- Staff must dispose of used respirators and masks in waste receptacles as soon as they are removed.

Refer to the Queensland Health document Optimising the supply of personal protective equipment for further information about extended use of PPE.
Table 1. 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>Community-level risk →</th>
<th>Low</th>
<th>Moderate</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident/client category ↓</td>
<td>Staff who work only in a single facility</td>
<td>Staff who work across multiple facilities*</td>
<td>Staff who work only in a single facility</td>
</tr>
</tbody>
</table>

Care of non-COVID-19 residents/clients: No symptoms of COVID-19 AND not a close contact AND no other indication for transmission-based precautions

Care of residents/clients with:
Symptoms of COVID-19 AND NOT a close contact AND COVID-19 is not suspected or has been ruled out

Care of clients: Confirmed/Probable COVID-19 OR Suspected COVID-19 (symptoms of COVID-19 AND a close contact) OR Close contacts

PPE for staff* doing activities other than direct resident/client care

PPE for residents/clients with symptoms of COVID-19 OR close contact OR Suspected or Confirmed/Probable COVID-19 cases

PPE for visitors

* includes health professionals, employees, contractors, volunteers, and students on placements

*Work across multiple facilities: working across more than one RACF, disability or other healthcare facility

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* See over for footnotes

PPE for staff* doing activities other than direct resident/client care: As indicated by usual requirements of activities

PPE for visitors: Nil
Table 1 footnotes

1 Staff who reside in an area that is designated a different risk level to the residential aged care facility they work in are to comply with their workplace facility risk PPE requirements.

2 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).

3 Please refer to applicable Chief Health Officer public health directions for information regarding visitor restrictions to residential care and disability accommodation services.

4 Protective eyewear is defined as a face-shield, goggles or dedicated safety glasses. Note that prescription glasses alone are not considered adequate eye protection.

5 PFR stands for particulate filter respirator (e.g., P2 or N95).

6 Aerosol generating procedures (AGP), aerosol-generating behaviours (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. Aerosol generating behaviours (AGBs) may include:
   - shouting, screaming.
   - Also consider high-risk behaviours with potential for AGB: residents/clients who find instructions to wear a mask or practice respiratory hygiene hard to follow or are unable to co-operate (e.g., cognitive impairment or mental illness).

7 Vinyl gloves are not recommended for the clinical care of residents in the context of COVID-19. Powder-free latex or nitrile gloves are accepted as superior in clinical care and are less likely to be breached compared with vinyl gloves. (Refer to Infection Control Expert Group COVID-19 Infection Prevention and Control for Residential Care Facilities [https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-infection-prevention-and-control-in-residential-care-facilities].

8 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.

9 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.
Appendix – Community COVID-19 levels

Change of escalation level is triggered by a review of epidemiological data on levels of 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.²

Community COVID-19 levels will be communicated to RACF and Disability Accommodation Service providers.

<table>
<thead>
<tr>
<th>New COVID Cases per 100,000 people in the 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>

² Centers for Disease Control CDC COVID-19 community levels, found here: https://www.cdc.gov/coronavirus/2019-ncov/science/community-levels.html
## Definition of terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
</table>
| **Symptoms of COVID-19** | The Communicable Disease Network of Australia [National guidelines for Public Health Units](https://www.health.gov.au) provides information about COVID-19 and is regularly updated. Please refer to the most recent version of this guideline for the most up-to-date description of COVID-19 disease.  
The [CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia](https://www.aihw.gov.au) provides a more expansive list of symptoms that may be experienced by the elderly. Please refer to the most recent version of this guideline for up-to-date information. |
| **Non-COVID-19 clients** | Resident/clients with NO acute respiratory illness or other symptoms of COVID-19 (in the past 14 days)  
AND  
**Not a close contact**  
AND  
no other indication for transmission-based precautions |
| **Confirmed COVID-19 cases/clients** | Please refer to the Communicable Disease Network of Australia [National guidelines for Public Health Units](https://www.health.gov.au) confirmed case definition. |
| **Probable COVID-19 cases/clients** | A probable case includes individuals who have a positive rapid antigen test for SARS-CoV-2. Refer to the latest version of the CDNA [National Guidelines for Public Health Units](https://www.aihw.gov.au) for updates to this definition. |
| **Suspected COVID-19 cases/clients** | The Communicable Disease Network of Australia [National guidelines for Public Health Units](https://www.health.gov.au) defines suspect COVID-19 cases and is regularly updated. Please refer to the most recent version guideline for the most up-to-date definition. |
| **Particulate filter respirator (PFR)** | Respirators, such as P2 or N95, that are designed to protect the wearer from respiratory exposure to small airborne particles. |
| **Transmission-based precautions** | Transmission-based precautions are used in addition to standard precautions for patients who may be infected or colonised with certain infectious agents for which additional precautions are needed to prevent infection transmission. |

## Document approval details:

### 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 control and endorsement history:

<table>
<thead>
<tr>
<th>Version number</th>
<th>Summary of changes</th>
<th>Endorsing entities</th>
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<tr>
<td>v 0.1</td>
<td>New Document</td>
<td>RCAG, DCAG and CRG 2020</td>
</tr>
<tr>
<td>v1.2</td>
<td>Updated to include P2/N95 use for care of confirmed/suspected COVID-19; standard precautions for routine care non-COVID residents / clients; section on mask/respirator use; updated link to ICEG RACF guidelines</td>
<td>out of session CHO/DDGCEFQ 29 June 2021</td>
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<tr>
<td>v1.3</td>
<td>New sections added: Scope; Related directions and guidance; Decisions for escalation of PPE; Recommendations for assessing resident/client risk; Use of P2/N95 respirators and masks; Definition of terms Revisions made to Table 1.</td>
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</tbody>
</table>
| v1.4           | Alignment with other PPE and Infection Control documents; | CRG 5 August 2021  
CSLF 12 August 2021 |
| v1.5-2.0       | Update following changes to border restrictions as per Border Restrictions Direction no. 57. Revision of definition for epidemiological evidence. Changes from last version highlighted in yellow. | PPE Working Group 21 December 2021 (OOS)  
CRG Advisory 21 December 2021 |
| v2.1 – 3.0     | February/March 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. | PPE Working Group 23 February 2022  
COVID-19 System Response Group 14 March 2022 |
Further revision including addition of "probable case", revision of definition of epidemiological evidence, addition of further context for assessing risk, general editorial review.

V3.1-4.0 6 May – 28 June 2022. Change to definition of epidemiological evidence (now close contact) to align with changes to broader policy settings. Terminology change: P2/N95 to particulate filter respirator (PFR) Addition of data-driven framework for deciding Community COVID-19 level.

Contact area

PPE Working Group PPEWorkingGroup@health.qld.gov.au