



Guidance on the minimum recommendations for the use of personal protective equipment (PPE) in hospitals during the COVID-19 outbreak

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Background

This document was developed by the Infection Control Expert Group (ICEG) and endorsed by the Australian Health Protection Principal Committee. It provides guidance on the use of personal protective equipment (PPE) in hospital settings, including the birth suite, during the COVID-19 pandemic. For additional guidance on infection prevention and control during the COVID-19 pandemic, see the [Department of Health website](#).

As a national document, the guidance on PPE contained in this document, should be considered as the **minimum**. This advice is continually reviewed as the situation changes and new evidence about COVID-19 becomes available. Check with your state or territory health department for additional specific advice for your jurisdiction.

In geographical areas with significant community transmission of COVID-19 (as defined by jurisdictional public health units) or, in specified clinical settings, health care workers and others deemed potentially at risk of transmission, may need to take extra precautions. This may include precautions *above those usually indicated for standard and transmission-based precautions*. See [ICEG guidelines on PPE in areas with significant community transmission](#) for more information.

All PPE should be used in line with the principles in the [Australian Guidelines for the Prevention and Control of Infection in Healthcare \(2019\)](#), whilst acknowledging the unique circumstance of COVID-19 and requirements for additional PPE in some circumstances.

For current COVID-19 case definitions and testing criteria see the [Communicable Diseases Network Australia National Guidelines for Public Health Units](#).

[Guidance on the use of PPE in non-inpatient health care settings during the COVID-19 outbreak](#) and further supporting information on the [use of masks and respirators in the context of COVID-19](#) are also available.

In areas with no or low community transmission: for clinical care of patients who are NOT suspected or confirmed COVID-19 cases*, standard infection prevention and control precautions — including use of PPE, if required — should be observed as usual.

In areas with significant community transmission: surgical masks should be used for all routine clinical encounters (not just for suspected or confirmed cases); and particulate filter respirators (PFRs) should be used in some settings or scenarios. See [here](#) for details.**

*Case definitions are outlined in the [Communicable Diseases Network Australia \(CDNA\) National Guidelines for Public Health Units](#).

**Health care workers who use PFRs, such as P2 or N95 respirators, must be trained in their correct use, including how to perform fit-checking at donning, and safe removal. Men must be clean shaven to achieve a good seal on the face. Unless PFRs are used correctly, their effectiveness will be compromised and the risk of infection (to the wearer) increased.

1.1 Current evidence

Extensive evidence, particularly from China, Canada, Taiwan, Singapore, and Hong Kong, indicates that the application of recommended infection prevention and control measures including administrative, engineering, environmental controls, and protective measures during patient care, have almost completely prevented occupational acquisition of COVID-19 (1-7).

The following advice is based on evidence-informed literature and expert opinion.

- **Asymptomatic COVID-19 infection** is estimated to occur in 20% of people who become infected with SARS-CoV-2 (95% CI 17-25, systematic review of 79 studies) (8). Although transmission is well described, it is likely to be significantly less than from a person with symptomatic infection (9). It can occur at any age. However, the prevalence of asymptomatic vs presymptomatic transmission may be overestimated because of limited or no follow-up in some studies.
- **Presymptomatic transmission** is well documented. The duration of infectivity before the onset of symptoms is uncertain but evidence suggests viral load may be highest around the day of symptom onset (9).
- Viral RNA load declines in the second week of illness. Viable (cultivable) virus can rarely be recovered from the respiratory tract for more than 8 days after symptom onset. Viral RNA may be detected by PCR for much longer but is unlikely to represent viable virus as specimens are rarely culture positive and secondary transmission from late PCR-positive cases is rarely observed.
- A large range of epidemiological evidence confirms that, like most respiratory viral infections, **COVID-19 is predominantly transmitted by large droplets** (>10 µm).
- Activities such as shouting singing and coughing, especially in an enclosed, poorly ventilated space, can increase the amount of droplet production and range of droplet dispersal. Therefore the risk of transmission may be increased due to incorrect use of PPE and/or environmental contamination.
- Airborne transmission (via aerosols of small particles) is believed, by most authorities, to be rare, except possibly in association with aerosol-generating behaviours and some high-risk aerosol-generating procedures.

For a more extensive review of the evidence, see the ICEG review, [Use of masks and respirators in the context of COVID-19](#).

1.2 Current status of COVID-19 in Australia (August, 2020)

- There has been a recent resurgence of COVID-19 in Australia, primarily driven by outbreaks in Victoria and New South Wales.
- The majority of states and territories in Australia continue to have low or no community transmission due in part to the correct implementation of infection prevention and control practices.
- Some geographical areas have significant community transmission of COVID-19 (as defined by jurisdictional public health units). Other areas of outbreaks have also been reported in relation to certain workplaces (e.g. RACFs) and industries (e.g. abattoirs/meat works).

- The case fatality rate in Australia, overall, is relatively low, however this does not lessen the significance the impact of COVID-19 on individuals, families and the community.
- While limited data are available on the sources of COVID-19 infection in health care workers, the majority of infections have occurred among nurses working in acute and aged care. There is also evidence of acquisition of infection in occupational settings not associated with patient contact (e.g. from another health care worker in non-clinical areas), and also acquisition of infection in the community.¹

General guidance on minimum PPE for the care of patients who ARE suspected or confirmed COVID-19 cases

2.1 Care of patients with acute respiratory symptoms or suspected or confirmed COVID-19

- Standard precautions, respiratory hygiene, cough etiquette and physical distancing apply, as for all patients.
- Patients with acute respiratory symptoms and/or who are suspected cases of COVID-19 should be asked to wear a surgical mask upon presentation to hospital or other healthcare setting e.g. clinic.
- Patients should be placed in a single room with the door closed, or, if this is not available place in a physically separated, designated isolation area that is separate from other patient areas and is not used as a thoroughfare.
- The minimum requirement for an aerosol generating procedure (AGP) on a patient with suspected or confirmed COVID-19, is a single room with the door closed.
- However, if possible, a high-risk AGP (see page 8) should be performed in a negative pressure room or well-ventilated operating or procedure room.

If transfer outside of the room or designated isolation area is necessary, the patient should wear a surgical mask during transfer, if their condition allows. Patients should be reminded of the importance of respiratory hygiene and cough etiquette at all times. Patients requiring oxygen therapy should be transitioned to nasal prongs where medically possible and wear a surgical mask.

2.2 Environmental hygiene

In addition to routine cleaning, frequently touched surfaces and equipment should be cleaned frequently, preferably after each use, or whenever visibly soiled. Use a detergent/disinfectant wipe or a detergent product, with disposable or laundry-safe cloth. Refer to the manufacturer's instructions regarding the disinfectant used.

Advice on environmental cleaning and disinfection for health and residential care facilities is available on the [Department of Health website](#).

¹ See <https://www.dhhs.vic.gov.au/victorian-healthcare-worker-covid-19-data>

2.3 Transmission-based precautions

- **Contact² and droplet³ precautions** should be used for the routine care of suspected or confirmed cases of COVID-19.
- **Contact and airborne⁴ precautions** should be used for the care of suspected or confirmed cases of COVID-19 in specified circumstances:
 - When performing AGPs (see 2.4 Aerosol-generating procedures).
 - In other specified clinical circumstances (see Contact and airborne precautions: Use of PPE in specific patient groups with suspected or confirmed COVID-19, and 3.4 Birth suite below).

There is strong clinical and epidemiological evidence that the predominant mode of spread of COVID-19 is via **respiratory droplets** (produced during speaking, coughing, sneezing etc.):

- **Directly** during close face-to-face contact (within ~1.5 m) by exposure of the face (and then mucosae of mouth, nose or eyes) OR
- **Indirectly** by touching surfaces or fomites contaminated by respiratory droplets and then touching the face.

Contact and droplet precautions: PPE for use in routine care of patients with suspected or confirmed COVID-19

The following PPE should be put on (donned) before entering the patient's room:

- **Gown / Aprons**
 - Long-sleeved, preferably fluid-resistant, **gown or apron**.
 - A launderable cloth gown or apron is adequate when direct physical contact is minimal and/or the risk of blood or body fluid splash is low (e.g. observations, medication delivery).
- **Surgical mask**
 - Varying levels of fluid resistant surgical masks are available.
 - When the likelihood of exposure to blood or body fluid is low, in routine care, a level 1 surgical mask is acceptable. Level 2 or 3 masks should be used when there is a risk of blood or body fluid exposure and in the operating theatre.⁵
- **Eye protection**
 - Face shield, wrap-around safety glasses, visor or goggles. Note prescription glasses do not represent safety eye wear and additional eye protection is recommended.
- **Gloves**

² See <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approach-1-contact-standard-precautions-photo>

³ See <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approach-2-droplet-standard-precautions-icon>

⁴ See <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/approach-1-airborne-standard-precautions-photo>

⁵ See ICEG guidance on the use of face masks and respirators in the context of COVID-19.

- Disposable non-sterile **gloves** when in direct contact with patients (use hand hygiene before donning and after removing gloves).
- **Boot/Shoe Covers**

Use of boots or shoe covers is not recommended unless gross contamination is anticipated or they are required as standard attire in operating theatre or trauma room.

- **Head Covers**
 - Long hair should be securely tied back.
 - Head covering is not required except as part of standard operating theatre attire or when performing a sterile/aseptic procedure (e.g. central line insertion). A head covering may be used to contain hair or for comfort reasons (e.g. to form a barrier for straps from masks or face shields).

NOTE: As per Australasian Institute of Clinical Governance (AICG) artificial nails and jewellery that interferes with the safe use and correct donning and doffing PPE should be removed.

Care should be taken to avoid self-contamination when removing (doffing) PPE.

The **principle** is to avoid contamination of clothing, skin or mucous membranes (including the eyes) with potentially contaminated PPE. Do not touch the front of the gown, eye protection or mask and perform hand hygiene between steps.

The following sequence is recommended but alternative sequences can be performed safely.

- Remove gloves without touching the outside of the glove and perform hand hygiene.
- Remove gown/apron, without touching the front of the gown, by folding it so that the external (exposed) side is inside; perform hand hygiene.
- Remove eye protection, perform hand hygiene and then remove your mask by the ties or ear loops, and perform hand hygiene.

Eye protection and mask should be removed outside, of the patient's room. Local jurisdictional regulations for waste disposal should be followed.

Only PPE marked as reusable should be reused and then only after decontamination and reprocessing according to the manufacturer's instructions. All other PPE must be disposed of appropriately after use.

Contact and airborne precautions: Use of PPE in specific patient groups with suspected or confirmed COVID-19

The only modification for **airborne precautions**, is the requirement for use of a particle filter respirator (PFR), such as a P2 or N95 respirator, instead of a surgical mask. All other components of standard, contact precautions, remain the same.

Principles for use of PFRs in COVID-19

- PFRs are required in the context of AGPs and AGBs and other specified circumstances (see sections 2.3, 2.4, 3.1, 3.2, 3.3 and 3.4).

- Health care workers who use PFRs should be trained in their correct use, including how to perform fit-checking and safe removal. Note some jurisdictions have fit testing requirements and programs, refer to local policies Australian standards.
- Unless PFRs are used correctly, protection against airborne pathogen transmission will be compromised (refer to information about correct use as below).

Fit-checking is the minimum standard for each occasion of use of a PFR.

- Fit-checking ensures the respirator fits the user's face snugly (i.e. creates a seal) to minimise the number of particles that can bypass the filter through gaps between the user's skin and the respirator seal.
- An airtight protective seal is difficult to achieve in the presence of facial hair that underlies the edge of the PFR. The face must be smooth and/or clean-shaven to achieve a good airtight seal. Facial hair should be removed or an alternative type of PFR, such as a powered air-purifying respirator (PAPR) considered (see below).
- A range of types and sizes of PFR may need to be fit-checked to find one that achieves a protective seal (i.e. passes fit-check). If a suitable PFR cannot be found an alternative (e.g. PAPR) should be considered.
- For further information on fit-testing, see the ICEG guidance on [the use of face masks and respirators in the context of COVID-19](#).

Fit-testing, as defined in the Australian/New Zealand Standard 1715: 2009, is a validated method for matching PFRs with an individual's facial shape, but has not been widely applied in Australia. Despite increased awareness and demand, in the context of COVID-19, it is acknowledged that fit-testing of all health care workers who may need to use a PFR, will be difficult to accomplish due to limited supplies and range of types/sizes available.

Note: Fit-testing does not guarantee a respirator will not leak, particularly if a different type or size is used to one previously fit-tested. A repeat fit test is required if a different PFR is utilised. This reinforces the need to fit-check each time a respirator is used.

Transmission-based precautions, as outlined — including appropriate use of PFRs — will provide high-level protection of health care workers caring for patients with suspected or confirmed COVID-19.

Powered Air Purifying Respirators (PAPRs)

- PAPRs are an alternative to PFRs that may be considered in selected circumstances e.g. when the fit of a PFR is compromised or when extended use of a PFR is required see below*.
- A number of different types of relatively lightweight, comfortable PAPRs are available.
- The use of a PAPR does not provide any additional protection compared to a well-sealed PFR.
- PAPRs should only be used by health care workers trained in their use, including safe application and removal using the correct sequence; the respirator is last item of PPE to be removed.
- PAPRs should be used according to the manufacturer's instructions including battery use, filter position, reprocessing of re-usable components etc.

- If a health care worker is required to remain in the patient's room continuously for a long period to perform multiple AGPs (e.g. for more than one hour), the use of a PAPR may be considered for additional comfort and visibility.
- PAPRs used during sterile procedures should be suitable for use to maintain sterile field.
- PAPRs designed for use in settings outside of health care are not recommended.
- Manufacturer's instructions for reprocessing of reusable PAPR components and management of filters, should strictly be followed.

Training and care is required with removal of a PAPR, incorrect removal can be associated with an increased risk of self-contamination. In some situations the use of an additional person (wearing appropriate PPE) can assist in the guidance and supervision during the doffing sequence.

2.4 Aerosol-generating procedures

Some AGPs performed during the care of patients with suspected or confirmed COVID-19, may be associated with an increased risk of transmission. The following **examples** are illustrative of a range of high-risk AGPs.

Instrumentation or surgical procedures on the respiratory tract

- Insertion or removal of an endotracheal tube and related procedures (e.g. manual ventilation and open suctioning of the respiratory tract).
- Bronchoscopy and upper airway procedures that involve open suctioning.
- Tracheotomy/tracheostomy (insertion, removal, open suctioning).
- Ear-nose-throat, faciomaxillary or trans-sphenoidal surgery; thoracic surgery involving the lung.
- Post-mortem procedures involving high speed devices on the respiratory tract.
- Intentional or inadvertent disconnection/reconnection of closed ventilator circuit and/or suctioning.

Other procedures that generate respiratory aerosols

- Manual or non-invasive ventilation (NIV): bi-level positive airway pressure ventilation (BiPAP); continuous positive airway pressure ventilation (CPAP).
- Collection of induced sputum.
- High flow nasal oxygen.
- Upper gastrointestinal instrumentation that involves open suctioning of upper respiratory tract.
- Some dental procedures (e.g. involving high speed drilling).

Cardiopulmonary resuscitation is a special circumstance:

- Because it is an emergency, life-saving procedure, special consideration is warranted for cardiopulmonary resuscitation (CPR).
 - A systematic review⁶ of AGPs showed that CPR was a high-risk procedure, associated with an increased risk of transmission of SARS.

⁶ Tran K, Cimon K, Severn M, Pessoa-Silva CL, Conly J. Aerosol generating procedures and risk of transmission of acute respiratory infections to healthcare workers: a systematic review. PLoS One. 2012;7(4):e35797.

- **However, neither chest compression nor defibrillation, alone, was associated with increased risk of transmission unless accompanied by intubation.**
- Contact and droplet precautions are the minimum protection required in the context of CPR of a patient with suspected or confirmed COVID-19. A health care worker using contact and droplet precautions can commence defibrillation or chest compressions. However, some hospitals may recommend airborne precautions prior to commencement of chest compressions, if feasible.
- **Delay in the commencement of chest compressions should be avoided.**
- **A PFR should be used for active airway management procedures.**

In the context of low or no community transmission of COVID-19, chest compression and defibrillation are unlikely to pose a risk to first responders or bystanders who commence CPR without knowledge of the subject's COVID-19 status. **Other specified settings in which a PFR should be used**

- **PFRs** should be considered in preference to a surgical mask for the care of *suspected or confirmed cases*, in emergency departments, residential care facilities, or *in-patient settings where one or more of the following apply*:
 - For the clinical care of *patients with suspected or confirmed COVID-19 who have cognitive impairment, are unable to cooperate or exhibiting challenging behaviours*.⁷
 - Where there are *high numbers of suspected or confirmed COVID-19 patients AND a risk of challenging behaviours and/or unplanned aerosol-generating procedures*.
 - Settings where there are a high density of COVID-infected patients, particularly in wards or cohorted areas without optimal ventilation and where prolonged episodes of care are required.
- See [here](#) for further detail.

Use of PPE for the care of suspected or confirmed cases in specific hospital settings

3.1 Intensive care unit (ICU)

- **Contact and droplet** precautions are the minimum protection required for routine care of patients in ICU, who are suspected or confirmed cases of COVID-19, and who:
 - are not ventilated (either invasive or non-invasive), nor on CPAP nor requiring High Flow Nasal Prong (HFNP) regular nebulisers
 - are intubated with a closed ventilator circuit, from which the risk of airborne transmission is minimal. However, during routine care when the circuit is opened (e.g. to change a heat-moisture exchanger) or if risk assessment indicates that

⁷ There is an increased risk associated with challenging behaviours, such as shouting, by patients who find instructions – to wear a mask or practice respiratory/cough etiquette – hard to follow (e.g. secondary to cognitive impairment or mental illness), especially in the first week of infection, when viral load may be high.

inadvertent disconnection of the ventilator circuit may occur, use of a PFR should be considered.

- Contact and **airborne** precautions, including a PFR, should be used for care of COVID-19 patients in ICU requiring or at risk of AGPs.
- If a health care worker is required to remain in an ICU patient's room for a long period (e.g. more than one hour) to perform multiple AGPs, the use of a PAPR may be considered, as an alternative, for greater comfort and visibility.

ICU staff caring for patients with COVID-19 (or any potentially serious infectious disease) should be trained in the correct use of PPE, including the use of a PFR and PAPR, by an infection prevention and control professional or other suitably qualified educator.

3.2 Wards, including care of critically ill patients outside of the ICU setting, e.g. general wards, COVID wards and emergency departments

- At a minimum contact and **droplet** precautions (including the use of a PFR) should be used for the care of patients with suspected or confirmed COVID-19 in general wards, dedicated COVID-19 wards, other in-patient settings, and emergency departments.
- Contact and **airborne** precautions should be considered for the care of patients with suspected or confirmed COVID-19 when one or more of the following apply:
 - When performing an AGP.
 - AGPs should be performed in a negative pressure room (or a standard isolation room with door closed).
 - The number of persons present in the room should be minimised.
 - For the clinical care of patients who have cognitive impairment, are unable to cooperate, or exhibit challenging behaviours (such as shouting).
 - Where there are high numbers of COVID-19 patients AND a risk of challenging behaviours and/or unplanned aerosol-generating procedures.

3.3 Operating suite

NOTE: For procedures performed on patients in an operating suite who are NOT suspected or confirmed cases of COVID-19, the usual surgical PPE for the clinical circumstances should be used i.e., surgical mask, theatre cap, gown, gloves, eye protection.

Routine infection prevention and control principles should be strictly adhered to during surgery, including avoidance of unnecessary entry and exit from the operating theatre during surgery.

The number of people in the theatre should be limited to those required for clinical or educational purposes.

- Surgical procedures for patients with suspected or confirmed COVID-19 should be performed only in an emergency or deemed medically essential.

Separate guidelines are available for use of PPE by anaesthetic and surgical staff during elective surgery for patients with suspected or confirmed COVID-19.⁸

The same general principles apply as outlined above:

- **Standard precautions** apply to the care of all patients, including use of PPE based on risk assessment.
- **Contact and droplet** precautions for anaesthetic or surgical procedures not involving AGPs in patients with suspected or confirmed COVID-19.
- **Contact and airborne** precautions for anaesthetic or surgical procedures involving AGPs in patients with suspected or confirmed COVID-19.

NOTE: Intubation is considered an AGP – refer to section 2.4.

3.4 Birth suite

For the care of a pregnant woman with suspected or confirmed COVID-19, during labour:

- The woman should be asked to wear a surgical mask, if tolerated.
- The number of staff in attendance should be reduced to a minimum.

For clinical staff caring for a woman with suspected or confirmed COVID-19 during labour:

- **Contact and droplet precautions**, including a surgical mask and eye protection, should be observed by all labour ward staff, in addition to standard precautions.

PFR use in specified clinical settings:

- **A PFR** should be worn by staff who have prolonged, close contact with a woman who is a confirmed case of COVID-19, during established labour and vaginal delivery.
- There is anecdotal evidence of a link between health care worker infection and challenging behaviour, such as shouting, by patients who are agitated or find instructions hard to follow, especially during the first week of infection, when viral load may be high.
- The risk of health care worker infection seems to increase when there is prolonged patient contact.
- However, it is not clear whether any increased risk reflects enhanced infection potential from greater dispersal of droplets and/or heavy environmental contamination or aerosolisation due to increased vocal/respiratory activity such as shouting.
- It is also not clear that the use of a PFR will reduce the risk.

The woman's partner **or** other support person (one only) may attend the delivery even if s/he is in quarantine.⁹ Precautions required to protect labour ward staff include:

- Communication should occur between the birthing mother, birth partner and hospital to assess risk and provide risk mitigation strategies.
- On entering the hospital, the partner/support person should: perform hand hygiene and put on a surgical mask (to protect others); in the labour ward put on a gown and other PPE as required (to protect clothes from blood/liquor).

⁸ See <https://www.safetyandquality.gov.au/publications-and-resources/resource-library/covid-19-elective-surgery-and-infection-prevention-and-control-precautions>

⁹ Quarantine requirements are outlined in the [CDNA National Guidelines for Public Health Units](#).

- During the delivery, it is likely to be safer if the partner/support person moves to stand to the side of the woman and out of direct line of the mouth.
- On leaving the labour ward, the partner/support person should remove gown and perform hand hygiene; perform hand hygiene and remove mask (if not in quarantine) when leaving the premises.
- If the partner is in quarantine as a close contact, s/he should observe precautions as instructed by the public health unit and wear a mask until reaching home.
- **A birth support person with acute respiratory or other symptoms consistent with COVID-19 should not attend the delivery.**

For patients with suspected COVID-19, a risk assessment should be undertaken to determine the appropriate level of PPE required during labour and delivery.

General guidance on care of patients who are NOT suspected or confirmed COVID-19 cases in areas with LOW or NO community transmission

In areas with low or no community transmission, PPE for the care of inpatients who are NOT suspected or confirmed cases of COVID-19, should be used in accordance with the *Australian Guidelines for the Prevention and Control of Infection in Healthcare (2019)*.¹⁰

Standard precautions are required for all patients regardless of known COVID-19 status, including hand hygiene and risk assessment, to determine the level of PPE required, if any.

Respiratory hygiene and cough etiquette must be observed at all times.

Physical distancing during the COVID-19 outbreak: health care staff should stay at least 1.5 m away from other people including:

- patients (except when unavoidable, e.g. during physical examination/care), AND
- members of the public, hospital visitors and other staff (e.g. in wards, clinics and nonclinical areas such as during meetings, in offices and shared workplaces and during tea breaks etc.).

AGPs performed on non-COVID-19 patients

In areas with low or no community transmission, standard precautions, in addition to PPE appropriate for the procedure and setting (e.g. operating theatre), are adequate for the performance of AGPs on patients who are not suspected or confirmed cases of COVID-19, unless another infection that is known to be airborne, such as tuberculosis, is suspected. A gown, surgical mask, eye protection gloves (and head covering if required as regular theatre attire) would typically be worn.

¹⁰ <https://www.nhmrc.gov.au/about-us/publications/australian-guidelines-prevention-and-control-infection-healthcare-2019#block-views-block-file-attachments-content-block-1>

Where can I get more information?

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

Call the National Coronavirus Health Information Line on 1800 020 080. The line operates 24 hours a day, seven days a week. If you require translating or interpreting services, call 131 450. The telephone number of your state or territory public health authority is available on the coronavirus page at www.health.gov.au/state-territory-contacts

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