COVID-19

Government of **Western Australia**
Department of **Health**

COVID-19 guidelines for healthcare practices in the community

State Health Incident Coordination Centre (SHICC)
Department of Health, WA

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Version Control and Approval

This document should be considered a 'live document' and will be reviewed and updated regularly 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; or
- Stakeholder engagement and feedback.

Review and update of this document is coordinated by the State Health Incident Coordination Centre (SHICC) Planning Cell which can be contacted with feedback at SHICC.PHAB@health.wa.gov.au.

Version	Date	Author	Approved by	Comments on revision
1.0	18 February 2022		Dr Revle Bangor-Jones Deputy Incident Controller – Public Health	Original version
2.0	21 April 2022	SHICC PHAB	Dr Revle Bangor-Jones Deputy Incident Controller – Public Health	• Removal of references to high and very high caseload environments • Updated close contact definition • Removal of risk assessment of persons exposed to COVID-19 table (in keeping with changes to close contact definition) • Updated furloughing table • Updated case and close contact information • All links reviewed and updated
3.0	3 May 2022	SHICC PHAB	Dr Revle Bangor-Jones Deputy Incident Controller – Public Health	• Updated furloughing guidance • Updated case and close contact information • PPE requirements: face masks

Contents

1. Introduction

This document is intended for use by healthcare practices in the community including general practices, specialist medical, dental, allied health, pharmacy, alternative health practices, chiropractors, optometrists, imaging, psychologists, counsellors, acupuncture, traditional medicine and remedial massage.

Healthcare practices are at high risk of transmission of COVID-19. In addition, they are considered different to general workplace settings due to the potential susceptibility of patients and the duty of care related to providing health services.

When a person with COVID-19 has attended the premises during their infectious period as a staff member, client/patient or carer, further actions may be required. Exposures can occur during individual clinical consultations, in group scenarios and whilst in non-clinical settings such as the waiting room.

Noting that the risk of exposure to COVID-19 cannot be eliminated, a risk managed approach that applies appropriate mitigation strategies will aim to reduce the risk of exposure to COVID-19.

These guidelines are applicable at the time of publication. Stakeholders are urged to check the current status of key publications.

1.1 Objectives

This paper will ensure:

1. Healthcare practices in the community can risk assess COVID-19 exposure and ensure continuity of critical services, particularly in remote and rural WA.
2. Healthcare practitioners are better positioned to support patients in their ongoing health needs.
3. Healthcare practitioners can continue to help reduce the demand on the tertiary system including emergency departments.

1.2 Scope

This document is intended for use by healthcare practices in the community in metropolitan, remote and rural WA.

2. Assessing the risk following a COVID-19 exposure

Work Health and Safety laws require employers to ensure the safety of workers and others in the workplace so far as is reasonably practicable. This includes preventing transmission of COVID-19 and responding to cases of COVID-19 in their workplace. Each workplace is responsible for assessing and applying this guidance when an exposure occurs in a work setting.

Irrespective of definitions, any person who experiences symptoms needs to present for testing immediately and isolate until the result is available.

A **close contact**, is defined as:

- A household member or intimate partner of a person with COVID-19 who has had contact with them during their infectious period, or
- a person who has had close personal interaction with a person with COVID-19 during their infectious period, where they spent 4 hours of cumulative contact with them in a residential setting (including a home, residential care facility, boarding school, maritime vessel or other accommodation facility) in any 24-hour period where masks have been removed by both people during the period of contact, or
- a healthcare worker (HCW) who was not wearing appropriate PPE (fit-tested N95/P2 mask, eye protection [goggles, safety glasses or face shields], gowns and gloves) where aerosol generating behaviours or procedures have been involved in relation to a person with COVID-19, or
- someone who has been advised by WA Health that they are a close contact.

Where an aerosol generating behaviour or procedure has been performed on a person with COVID-19 during their infectious period, a HCW is considered a close contact if they did not wear appropriate PPE (as detailed above). See Appendix A for examples of aerosol generating behaviours and procedures.

2.1 Furloughing of healthcare workers

COVID Transition (Testing and Isolation) Directions (No 13) outline the legal obligations of asymptomatic close contacts to attend a high-risk setting (which include aged care facilities, residential care facilities, health care settings and correctional facilities) for the purposes of attending work. As per the Directions, relevant workers must:

- advise their employer that they are a close contact, and receive confirmation from their employer that the employer agrees to the person attending work,
- be fully vaccinated,
- return a daily negative RAT prior to leaving home,
- actively monitor for symptoms,
- leave the workplace and return home immediately if they develop symptoms or test positive,
- only remain at the high-risk setting for the purpose of their work duties,
- wear a surgical mask at minimum (or another mask as required by workplace),
- not share break areas with any other person at the high-risk setting, and
- use reasonable endeavours to maintain a physical distance of 1.5m from other people in the workplace.

The healthcare setting should determine if asymptomatic HCWs should attend work in a health care setting based on an individual risk assessment.

Symptomatic close contacts must isolate at home and must not attend work (see guidance for close contacts).

3. Guidance for cases and close contacts

Table 1. Case and close contact guidelines

Confirmed COVID-19 case	Isolate for a minimum of seven full days from date of positive test (Day 0) If symptoms still present after seven days, continue isolating until symptoms resolve; if symptoms have resolved after Day 7, leave isolation* No further testing or clearance by Public Health is required
Close contact who is asymptomatic	For a period of seven days from the date of the case's positive test (for household contacts), or from the last date of contact with the positive case (for other close contacts), asymptomatic close contacts must: • wear a face mask when leaving the house • avoid visiting high-risk settings^ unless to attend work (see requirements in *Worker in a high-risk setting who is a close contact*) • return a negative RAT before leaving home on any day (unless under 2 years of age) • take a PCR test on Day 6 or final RAT on Day 7 • work from home, where possible It is strongly recommended that close contacts: • avoid non-essential gatherings and contact with people at risk of severe illness • notify their employer/educational facility of their close contact status If a test is positive at any time – follow confirmed COVID-19 case guidelines If symptoms develop within 7 days of becoming a close contact, follow guidance for close contact who develops symptoms
Close contact who has symptoms	Undertake a PCR or RAT test as soon as possible, and isolate immediately until at least symptoms resolve If test is positive at any time – follow confirmed COVID-19 case guidelines

	If a RAT test is performed in a symptomatic close contact (rather than a PCR) and the result is negative, a person must repeat the RAT in 24 hours If symptoms resolve within seven days of exposure to a COVID-19 case (and test results are negative), follow guidance in *Close contact who is asymptomatic* If symptoms persist, remain isolated and take a PCR on Day 6 or RAT on Day 7. If Day 7 RAT is negative, remain isolated and repeat the RAT in 24 hours. If tests are negative, a person may leave isolation when symptoms have resolved

*In addition to the confirmed COVID-19 case guideline for isolation, in some high-risk clinical settings, confirmed cases who are significantly immunocompromised may be requested to meet additional testing criteria, per the CDNA SoNG for COVID-19. Specific guidance for renal dialysis patients is available in COVID-19 Guidelines for Renal Dialysis.

4. PPE requirements

The WA Health COVID-19 Framework System Alert and Response Framework (the SAR) provides overarching guidance for public hospitals to manage and mitigate the risks associated with COVID-19 transmission; however, health care practices in the community may find the advice helpful when determining their own strategies and responses to mitigating risks to patients and service delivery associated with COVID-19.

Face coverings must be worn by people aged 12 years and over in a health care setting, which includes any health facility where health care is delivered to patients face-to-face, in places where patients have access. This includes hospitals, primary health clinics, specialist outpatient services, allied health services and ambulance and patient transport services. For further information see HealthyWA and the COVID Transition (Face Covering) Directions (No 7) (wa.gov.au).

5. Cleaning and potential closure of premises

SARS-CoV-2, the virus that causes COVID-19, can survive on surfaces for some time, but effective cleaning and disinfection will kill the virus. The length of time the SARS-CoV-2 virus can survive on surfaces varies depending on several factors including the amount of virus expelled onto a surface by respiratory droplets, the type of surface exposed, the temperature and the humidity.

The term ‘deep-cleaning’ has been loosely used by the media to communicate thorough cleaning and disinfection of a public site that has potentially been exposed to the SARS-CoV-2 virus. This terminology is not a quantifiable measure of cleaning and it is not recognised or used by the Department of Health Western Australia.

There is no requirement for a certificate of cleaning and disinfection to be issued for the premises to resume routine operations. Staff undertaking cleaning, including contracted cleaning companies, should have received training on cleaning and disinfection and the correct use of cleaning equipment. This includes training in the correct use of personal protective equipment (PPE).

Cleaning guidance is available in the document infection prevention and control advice on cleaning and disinfection in the workplace.

6. Key companion documents

Useful links:

- COVID-19 information for health professionals (health.wa.gov.au)
- HCW Furloughing: WA COVID-19 Healthcare Worker Furloughing Guidelines (health.wa.gov.au)
- WA COVID-19 Test, Trace, Isolate and Quarantine (TTIQ) Plan (health.wa.gov.au)
- Infection prevention and control:
    - Face masks HealthyWA (healthywa.wa.gov.au)
    - Advice on how to access Personal Protective Equipment (PPE) (health.wa.gov.au)
    - Advice for use of PPE for non-healthcare workers in community settings (health.wa.gov.au)
    - Infection prevention and control advice on cleaning and disinfection in the workplace (health.wa.gov.au)

- Workplace advice: COVID-19 in the workplace – information for employers and employees (health.wa.gov.au)
- Free home monitoring care for COVID-positive people who require it due to having risk factors which put them at greater risk of requiring hospitalisation: WA COVID Care at Home (healthywa.gov.au)
- Renal dialysis patients: COVID-19 Guidelines for Renal Dialysis (health.wa.gov.au)
- Other:
    - Pulmonary function testing during SARS-CoV-2 outbreaks: preliminary guidance from TSANZ/ANZSRS – January 2022
    - WA Primary Health Alliance: HealthPathways
    - Royal Australian College of General Practitioners (RACGP) COVID-19 resources
    - Department of Health Advice for groups at greater risk

Appendix A: Aerosol Generating Procedures Checklist

Aerosol generating procedures

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.

The list below provides examples of AGPs:

Instrumentation or surgical procedures on the respiratory tract including:

- insertion or removal of endotracheal tube
- intentional or inadvertent disconnection/reconnection of closed ventilator circuit
- high frequency oscillatory ventilation (HFOV)
- open oropharyngeal or tracheal suctioning
- upper respiratory instrumentation or surgery e.g. bronchoscopy, tracheotomy, ear nose throat surgery
- surgical or post-mortem procedures on respiratory tract involving high-speed devices
- intercostal catheter insertion for relief of pneumothorax
- thoracic surgery that involves entering the lungs.

Other procedures that can 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 (HFNO)
- diagnostic instrumentation of the upper digestive tract, including transoesophageal echocardiography
- cardiopulmonary resuscitation (CPR).

Aerosol generating behaviours

Aerosol-generating behaviours (AGBs) are behaviours that are more likely to generate higher concentrations of infectious respiratory aerosols such as persistent and/or severe coughing, screaming, shouting, and singing.

This document can be made available in alternative formats on request for a person with disability.