# COVID-19 Policy Review

Guidance Paper

October 2023

**OFFICIAL**

## Purpose

This document provides updated enduring COVID-19 guidance to Victorian health services in the context of an evolving COVID-19 risk environment. The updated guidance will establish sector consistency, efficiency and sustainability whilst continuing to protect the health and wellbeing of patient, visitors and healthcare workers.

The updated guidance has been informed by extensive consultation with health service infectious disease specialists, Infection Prevention and Control experts, health service operational executives, Ambulance Victoria and relevant health sector unions.

Many of the guidance referred to in this document will be detailed in the Department of Health's updated COVID-19 Blue Book and Infection Prevention and Control (IPC) Guidelines.

## COVID-19 related guidance, policy and measures for continued implementation

The following COVID-19 management guidance, policy and measures are deemed necessary for the ongoing protection of patients, visitors and healthcare workers and are recommended to be retained by health services with adjustments to reflect the current COVID-19 landscape and in consideration of your local risk environment.

Where relevant, health services are encouraged to develop local policies and practices that are relevant to their operational framework and local risk environment.

# Department of Health updated guidance

**Table 1** provides a summary of the existing COVID-19 policy settings to be retained including proposed amendments.

Table 1. Measures to be retained with amendments to be made to reflect the current COVID-19 risk environment.

| Measure name | Previous policies/guidance | Updated guidance |
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| **Data reporting- COVID-19 hospitalisations** | The Department of Health requires regular and up-to-date data from all Victorian health services and facilities, including public, private and specialty hospitals, and day procedure centres collected through the Agency Information Management system (AIMS) online reporting system.<br><br>From April 2020, the Daily Capacity and Occupancy Register was added as an AIMS form to monitor the availability of bed stock across the Victorian health system in the event of unprecedented demand due to COVID-19. This included reporting of beds, Hospital in the Home (HITH) and Subacute in the home with confirmed COVID-19 patients to determine the impact of COVID-19 on staff capacity.<br><br>VICNISS also requires all confirmed COVID-19 cases admitted to hospital be reported and their location updated every day until discharge or recovery (i.e., no longer require additional precautions). This includes those patients with confirmed COVID-19 before admission and still infectious on admission, as well as those confirmed positive during their hospital stay. | Continued identification and reporting of patients admitted to Victorian public hospitals with COVID-19, including hospital acquired infections in line with any VICNISS and AIMS requirements. This data is required as part of routine hospital activity reporting and will support COVID-19 surveillance to ensure timely response as COVID-19 transmission risk evolves. |
| **Data reporting - healthcare worker unplanned** | AIMs reporting monitors workforce vacancy and other workforce pressures across the Victorian public health system as a result of the COVID-19 pandemic, including staff capacity impacted by COVID-19. | This reporting has ceased as of 30 September 2023.<br><br>Health services are encouraged to retain records in instances where a staff member requires access to special leave where sick leave has been exhausted and where the individual cannot work |

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| **absence due to COVID-19** | | from home (refer to Department of Health Guidance Note *Advice to Victorian Public Health Services – Managing COVID-19 positive healthcare workers,* issued on 28 September 2023, which came into effect from 1 October 2023. |
| **Data reporting – COVID-19 ICU data including demographics, admissions and mortality** | The CHRIS (Critical Health Resource Information System) is a real time, web-based bed occupancy reporting tool used by health services nationally to provide a national view of Intensive Care Resources across the country, to ensure all Australians have optimal access to Intensive Care Services no matter where they live.<br><br>CHRIS is intended to be a near "real time" register of ICU resources. Hospitals are required to submit updates at a minimum of twice per day (between 0800-1400 & 1700-0000).<br><br>Demographic and COVID-19 mortality information can be derived from the Victorian Admitted Episode Dataset (VAED). | Reporting of COVID-19 ICU data should continue to support critical care capacity management and surveillance information. |
| **Data reporting – staff vaccination status** | The *Pandemic COVID-19 Mandatory Vaccination Specified Facilities Order 2021 (No.1)* requires operators of healthcare facilities to manage vaccination status of workers, including to collect, record and hold vaccination information of workers and inform workers it is doing so.<br><br>Victorian public health services, as defined under the *Health Services Act 1988* are requested to provide weekly data on the COVID-19 vaccination status of their workforce.<br><br>Reporting was amended from 10 January 2022 to also report the number of health service employees who have received their third dose of vaccinations. | Retain current reporting requirements until Secretary Directions are amended, at which point this may be reviewed. |

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| **Unplanned staff absence due to COVID-19 including:**<br>• **Length of time**<br>• **Close contact and confirmed case guidance** | As per the Blue Book and IPC Guidelines, healthcare workers should monitor personal health and not present for work when unwell with acute respiratory infection symptoms. Anyone who has COVID-19 or symptoms of COVID-19 or is a close contact of someone with COVID-19, should avoid working in sensitive settings for at least 7 days and until acute symptoms have resolved.<br><br>**Close contacts:**<br>If they are workers and required to work in healthcare or residential care facilities, including providing in home care to people at high risk of severe health outcomes from COVID-19, they should be asymptomatic and should undertake rapid antigen testing (RAT) 24 hours apart, for 5 days out of 7 days, after being identified as a close contact.<br><br>**Confirmed cases:**<br>Workers who are cases should have a negative PCR or RAT prior to returning to work in sensitive settings. Return to work is not recommended for at least 7 days and after resolution of acute symptoms. If positive, the case should stay home and seek advice. If it is essential that a case or close contact visits a sensitive setting, they should undertake a COVID-19 test prior to their visit. | As per Department of Health Guidance Note *Advice to Victorian Public Health Services – Managing COVID-19 positive healthcare workers* issued on 28 September 2023, which came into effect from 1 October 2023<br><br>**Close contacts**<br><br>Routine isolation of staff (or patients) who are close contacts is not required, with household/close contacts recommended to wear a P2/N95 respirator for 7 days after the exposure. COVID-19 testing requirements for staff and patients who are close contacts should be based on health service discretion.<br><br>**Confirmed cases**<br>It is recommended that staff not attend the workplace for a minimum of 5 days (return on day 6) following the onset of symptoms or positive RAT/PCR and until resolution of acute symptoms. Additional mitigations should be in place to support staff return on day 6, such as requiring use of P2/N95 respirator, returning a negative RAT, separate breakout areas where possible until 10 days following the onset of symptoms.<br><br>Health services can consider earlier return to work in circumstances where staff attendance at work is required to prevent significant risk to safe service delivery. In these situations, local risk assessment should be undertaken and additional mitigations should be in place - such as requiring P2/N95 respirator, the case being asymptomatic (or acute symptoms having resolved) and returning a negative COVID-19 RAT, separate breakout areas etc.<br><br>Healthcare workers should under no circumstances be compelled to return to work (e.g., if they are too sick). |

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| **PPE fit testing requirements and frequency** | As per the IPC Guidelines, all employees who wear a respirator should undergo fit testing to ensure that an effective face seal is achieved and to comply with the Australian and New Zealand Standard AS/NZS 1715:2009.<br><br>Students on placement who are required to wear a P2/N95 respirator should be fit-tested, either prior to commencement, as part of their onboarding process.<br><br>*Repeat fit testing guidance for health service organisations* guidance notes that whilst annual fit testing is recommended in both the international standard, *ISO 16975-3:2017,* and the Australian and New Zealand standard, *AS/NZS 1715:2009*, the significant volume of healthcare workers (HCW) requiring fit testing must be acknowledged.<br><br>*AS/NZS 1715:2009* recommends that fit testing should be performed at appropriate intervals, however the ability of each health service to implement repeat fit-testing annually for all HCWs required to wear PPE will be dependent on the size of the organisation, the risk profile of their HCWs and the fit testing resources available.<br>Health services will need to employ a pragmatic approach to their fit testing and re-testing programs with a focus on practical risk reduction. Health services must detail fit testing requirements in their Respiratory Protection Plan that is informed by the Victorian Respiratory Protection Plan Guidelines.<br>Health service organisations may choose to implement more rigorous re-testing policies for their HCWs than what is recommended within the guideline. | Fit testing of P2/N95 respirators for staff should be implemented as per health service's Respiratory Protection Plan that is informed by the Victorian Respiratory Protection Program Guidelines. |

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| **Use of reusable PPE** | IPC Guidelines suggest that PPE labelled and marketed as reusable may be reused following cleaning and disinfection between each use.<br><br>Reusable PPE should be inspected before each use to confirm that it is undamaged and still fit for purpose.<br><br>Reusable eye protection should be cleaned and disinfected according to the manufacturer's instructions and stored clean, dry, and protected from contamination. | Appropriate use of reusable PPE is supported. |
| **Visitor PPE requirements** | As per the Blue Book, masks should be worn by all visitors in sensitive settings.<br><br>IPC Guidelines – visitors must use the same level of PPE protection as HCWs when visiting COVID/SCOVID patients. | As per existing IPC Guidelines and ensuring that visitors have access to PPE.<br><br>Surgical masks may be adequate for most clinical areas however health services may consider P2/N95 respirators for visitors in high risk areas (i.e. wards with high numbers of immunocompromised patients) as determined by health service or during periods of increased transmission risks. |
| **Patient PPE requirement** | As per the Blue Book, in clinical areas, communal waiting areas, public access areas, and during transportation, it is recommended that patients suspected or confirmed to have COVID-19 wear a face mask, noting that respirators provide higher level protection than surgical masks.<br><br>A face mask is not recommended when patient's breathing or clinical care may be compromised.<br><br>It is recommended that children two years old and under never wear a face covering or mask due to choking and strangulation risks. | In line with the guidance published in the Blue Book, patients with COVID-19 should wear a P2/N95 respirator (where safe to do so) when required to be outside their room for the purposes of clinical care or sharing areas with non-COVID-19 patients.<br><br>Non-COVID-19 patients should have access to PPE, wear a mask if tolerated and be offered either a surgical mask or P2/N95 respirator. |

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| **Staff utilisation of PPE for suspected or confirmed COVID-19 patients** | The following are recommended for the care of COVID-19 patients (including suspected or confirmed cases) as per the IPC Guidelines.<br>• P2/N95 respirator<br>• Eye protection<br>Disposable or reusable gown and gloves as per standard precautions when a risk assessment indicates a potential exposure to blood or body fluids (i.e., respiratory secretions) | Retain the transmission-based precautions for the care of COVID-19 patients (including suspected cases) as per the department's IPC Guidelines |
| **Staff utilisation of PPE in non-patient facing areas** | As per the Blue Book, masks should be worn by all staff and visitors in sensitive settings. | Health services should employ risk assessment in determining masks requirements in public facing areas (e.g., visitors enquiry desk). Health services may consider not employing mask requirements during periods of low community COVID-19 transmission risk. In periods of high community COVID-19 transmission risk[1], health services should require public facing staff to wear masks, with the choice of mask at the individual's or service's discretion and in accordance with their fit test profile.<br><br>Individual staff choice to wear a mask should be maintained in other non-patient, non-public facing areas e.g., corporate support offices. Masks (both surgical masks and P2/N95 respirators) should be made available to all staff to support staff choice and risk (e.g. contacts attending the workplace) |
| **Staff utilisation of PPE for clinical and other patient facing areas** | As per the Blue Book, masks should be worn by all staff and visitors in sensitive settings.<br><br>IPC Guidelines advise that where a lower risk of COVID-19 has been identified, organisational guidelines on the use of PPE should be | The use of PPE in patient facing areas is in accordance with the IPC Guidance and health facility risk assessment.<br><br>P2/N95 respirators should be worn by staff in all patient facing areas (including nurse's stations or admin areas on wards) when |

[1] Informed by local epidemiology, COVID-19 hospitalisation numbers or in areas with high levels of immunocompromised patients

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| | consistent with current jurisdictional and national guidance, which may include government directions, Victorian Department of Health or Commonwealth Department of Health and Aged Care guidance. | COVID-19 transmission risk is high and optional choice of mask type (surgical or P2/N95) when the COVID-19 transmission risk is low (informed by local epidemiology, COVID-19 hospitalisation numbers or in areas with high levels of immunocompromised patients).<br><br>Health services are supported to recommend P2/N95 respirators for specific groups in high risk areas as determined by the health service.<br><br>Health services should ensure (subject to availability) that P2/N95 respirators and surgical masks are made available for staff based on their preference and fit test/fit check profile. |
| **COVID-19 testing for non-admitted (including in EDs, outpatients) or admitted ambulatory patients** | No current guidance | Retain RAT or PCR testing for non-admitted patients with symptoms/as clinically indicated; routine asymptomatic testing of non-admitted patients is not required. Health services may develop their own policies for testing asymptomatic non admitted patients in specific circumstances such as during periods of high community COVID-19 transmission risk or in settings of elevated clinical risk (e.g. day oncology) |
| **COVID-19 testing for admitted overnight patients** | No current guidance | Retain RAT or PCR (if available) testing for symptomatic patients.<br><br>Asymptomatic patient testing has been informed by cost effectiveness modelling and the broader budget constraints and system efficiencies. Department of Health recommends RA testing of admitted overnight patients during periods of high transmission risk.<br><br>RAT testing of asymptomatic admitted patients is not required during low transmission risk periods, unless clinically appropriate. |

**Table 2** provides a summary of the existing COVID-19 measures to be retained with additional policy guidance for health services

Table 2. Measures to be retained with the department providing guidance for health services to develop local policies

| Measure name | Previous policies/guidance | Updated guidance |
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| Visitor screening requirements: Restriction on visitor numbers | No current guidance. | Health services should employ local risk assessments to determine any restriction to visitor numbers or testing requirements, noting that there may be areas of a health service where visitor restrictions may need to be applied.<br><br>The department acknowledges the challenges in health service's monitoring any such restrictions, and issues that may arise from policy inconsistency across the sector.<br><br>The department will provide guiding principles and risk considerations, embedded in the Bluebook, to support health services in developing their policies and assist decision making, whilst optimising sector consistency. |
| Routine COVID-19 surveillance testing of staff (including frequency) | No current guidance | Routine asymptomatic testing of staff is not supported when COVID-19 transmission risk is low. It's recommended that individual health service consider implementing staff surveillance testing in specific circumstances, such as during an outbreak as determined by health services.<br><br>The department will provide guiding principles and advice, embedded in the Bluebook, on the circumstances when staff surveillance may be useful or indicated to support local health service policy development. |
| Cohorting and zoning, specialty cohort | IPC Guidelines provide recommendations on how isolation, cohorting and zoning may be performed. | Patients with COVID-19 should be cared for in the safest area possible, physically separated from patients without COVID-19 in order to reduce transmission risk, noting |

| Measure name | Previous policies/guidance | Updated guidance |
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| considerations (e.g., Mental Health) | **Isolation**<br>Single room isolation (ideally with ensuite and negative pressure air handling) is recommended for the treatment and care of patients with confirmed and suspected COVID-19.<br><br>The priority room allocation for single room isolation of confirmed or suspected COVID-19 patients should consider the following, according to facility resources:<br><br>1. Single room with ensuite facilities, negative pressure air handling, with or without a dedicated anteroom.<br>2. Single room with ensuite facilities without negative pressure air handling.<br>3. Single room without ensuite facilities and without negative pressure air handling<br>4. Cohorted room.<br><br>Special arrangements may be required for patients or residents with cognitive impairment.<br><br>If ensuite facilities are not available, a dedicated toilet or commode should be allocated. Bathroom exhaust fans should always be turned on.<br><br>Healthcare and residential care settings are also strongly recommended to manage resident/inpatient cases under appropriate precautions for at least 7 days.<br><br>**Cohorting**<br>The goal of cohorting patients and the staff that attend to them is to | physical environment is one of the hierarchy of controls and that some health services will be required to make a decision that balances risk with operational constraints.<br><br>Noting that not all health services will be able to achieve complete separation of infectious patients without compromising some other aspect of safe patient care delivery, or simply because there may not be the existing physical infrastructure to support isolated points of care.<br><br>Risk based assessments should be undertaken in determining the appropriate location for patient care. This should include consideration of clinical risks and benefits, for example, locating a patient in a single room versus a shared room (as is the case for mental health inpatients). Where the safest option is not available or appropriate then a risk-based decision should be made by senior admitting staff in consultation with service leaders and local IPC teams where available particularly if there is uncertainty or division regarding the balance of risk or other contextual information that may be required for an appropriate decision to be made (e.g. hospital occupancy).<br><br>The following levels of accommodation type for the care of COVID-19 patients is proposed:<br><br>**First Line:**<br>• Class N negative pressure rooms are the first choice, where available<br>• Single rooms with negative pressure/high flow specialised |

| Measure name | Previous policies/guidance | Updated guidance |
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| | minimise opportunities for infection transmission. Cohorting minimises interactions between those who are infectious and those who are not.<br><br><u>Cohorting uses three risk categories:</u><br>• Confirmed infection – patients with the same confirmed pathogen are grouped together during the infectious period.<br>• Suspected infection – patients suspected to have an infection caused by the same pathogen are cohorted separately from those confirmed to have the infection and separately to those not suspected of having the infection.<br>• No identified infection risk – patients not suspected of having the infection, or those deemed to be cleared of a previous infection, are grouped together.<br><br>**Zoning**<br>To remain prepared for COVID-19 outbreaks, health services must have an Outbreak Management Plan that includes:<br>• identified areas that are suitable for use as COVID-19 clinical care zone<br>• colour coded or labelled floor maps outlining each zone<br>• instructions on how to implement and manage each zone. | bespoke airflow adaptations<br>• Dedicated COVID-19 wards/wings of wards physically separated from other patient areas.<br><br>**<u>Second Line</u>:**<br>• Single rooms physically separated from other areas with doors closed and portable air cleaners used, where appropriate.<br><br>**<u>Third line:</u>**<br>• In these cases careful risk assessment, consultation with IPC staff, Occupational Health and Safety staff and service leadership (e.g., executive staff responsible for hospital operations) can support decision making in instances where there are complex circumstances/considerations.<br>• Co-location of COVID-19 and non-COVID-19 patients in shared spaces should only be used in exceptional circumstances as a last resort. In such circumstances services should maximise the use of other mitigations such as personal ventilation hoods, stringent PPE measures and portable air cleaners where possible. Where these mitigations are unavailable, services need to make a decision based on their local system capacity and risk assessment. |

**Table 3** provides a summary of all measures that the department recommends should be ceased from current guidance or not implemented routinely by health services.

Table 3. Measures to be ceased

| Measure name | Previous policies/guidance | Updated Guidance |
|---|---|---|
| Visitor screening requirements: Temperature testing | No current guidance. | This measure should be ceased |
| Visitor screening requirements: Routine COVID-19 surveillance testing for visitors (RATs) | IPC Guidelines suggest referring to the current Department guidance for advice on entry point screening and restrictions. Visitors should undertake a COVID-19 test before attending a sensitive setting. | This measure should be ceased |
| Visitor screening requirements: Screening questions | No current guidance. | This measure should be ceased |
| PPE spotter | Although current IPC Guidelines provides detail on how to implement a PPE spotter, it does not provide a recommendation as to when for/against use of a PPE spotter. | This measure should be ceased |
| COVID-19 related cleaning advice including linen and waste management | IPC Guidelines provide detailed advice on cleaning, linen and waste management standards in healthcare settings. | Health services should return to business as usual, i.e., standard cleaning, linen and waste management protocols apply. |

| Measure name | Previous policies/guidance | Updated Guidance |
|---|---|---|
| Special dispensation for non-Medicare patients presenting with COVID-19 | Department of Health Policy and Funding Guidelines on special dispensation for COVID-19 costs for Medicare-Ineligible Patients have now lapsed. | Support for health services to return to business as usual, i.e., usual process for assessing applications to revoke or reduce fees for Medicare ineligible patients. |

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