

GUIDANCE
for health service
organisations

COVID-19: Infection prevention and control risk management

This guidance supports health service organisations with risk assessment and management activities in relation to SARS-CoV-2 (COVID-19).

The risk of COVID-19 in Australia remains current. Health service organisations, including community and Aboriginal health services, and residential aged care facilities, need to manage the risk of transmission of COVID-19. To help mitigate risk, organisations should:

- Maintain an up-to-date and comprehensive organisation-wide Risk Management Plan that incorporates the response to COVID-19
- Identify and manage risks associated with infections using the hierarchy of controls in conjunction with infection prevention and control systems
- Ensure compliance with standard and transmission-based precautions in accordance with the current [Australian Guidelines for the Prevention and Control of Infection in Healthcare](#) and other relevant national and state and territory guidance
- Use protocols to screen the workforce and patients for COVID-19 and other acute transmissible infections
- Establish processes for reducing non-essential activity and non-essential access
- Prevent and manage infections in the workforce
- Promote uptake of COVID-19 vaccination in the workforce and by patients and visitors
- Support compliance with physical distancing requirements where possible
- Promote observance of cough etiquette and respiratory hygiene by the workforce, patients and visitors at all times.

This guidance should be read in conjunction with guidance developed by each state and territory health department and the [Australian Government Infection Control Expert Group \(ICEG\)](#).

Health service organisations should continue to ensure that there is equitable access for all patients, determined by clinical urgency and safety, and that

a culture that prioritises patient safety is maintained whilst also protecting the health and safety of the workforce.

The Australian Commission on Safety and Quality in Health Care (the Commission) developed the National Safety and Quality Health Service (NSQHS) [Preventing and Controlling Infections Standard](#) to further support health service organisations to prevent, control and respond to infections that cause outbreaks, epidemics or pandemics, including novel and emerging infections. From May 2021, this Standard, which addressed any gaps and uncertainties that arose during the response to COVID-19, replaced the 2017 Preventing and Controlling Healthcare-Associated Infections Standard. A [mapping factsheet](#) was developed to provide information on alignment of the actions and criteria from the 2017 Standard to the 2021 Preventing and Controlling Infections Standard.

The Commission has also developed [resources](#) to support implementation of infection prevention and control practices that reduce the risk of COVID-19 exposure, transmission and infection.

For immediate action

Health service organisations implementing the NSQHS Standards need to have in place additional measures to reduce the risk of spread of COVID-19. In particular, these measures should address Action 1.10 of the [Clinical Governance Standard](#); and Actions 3.01, 3.02, 3.05 to 3.10, and 3.13 to 3.16 of the [Preventing and Controlling Infections Standard](#).

Organisation-wide Risk Management Plan

Health service organisations are required to prepare and implement an organisation-wide Risk Management Plan to manage and reduce the risk related to the transmission of COVID-19 (see Appendix 1 for examples of how to identify risks and assess level of risk).

An effective Risk Management Plan involves the identification of hazards, and assessment and control of risks for patients, visitors and members of the workforce, so far as is reasonably practicable (i.e. what can be done and what is possible in the circumstances for ensuring health and safety and continuity of health service delivery).

The Risk Management Plan should be informed by a risk assessment that takes into account the current context of the epidemiology and local transmission of COVID-19 as well as other factors that may influence the organisation's ability to provide safe and quality patient care. These factors may include but are not limited to workforce availability, availability of telehealth and virtual services, bed capacity, physical building structures and relationships with other services.

The hierarchy of controls should be used by health service organisations to formulate and document in the Risk Management Plan the organisation's infection prevention and control response to increasing levels of identified risk. If it is not reasonably practical to eliminate risks, then risks must be minimised as far as is reasonably practicable by using one or a combination of substitution, isolation or engineering controls. Administrative controls and PPE should then be considered.

In the context of COVID-19, mitigation strategies include:

- Protocols for screening of the workforce and patients for COVID-19
- Reduced non-essential surgery
- Visitor restrictions
- Vaccination of the workforce
- Implementing standard and transmission-based infection prevention and control precautions
- Use of PPE that is consistent with the current [Australian Guidelines for the Prevention and Control of Infection in Healthcare](#) and with [guidance](#) published by the Commission, relevant state or territory health department guidance and [ICEG guidance](#)
- [Environmental cleaning](#)
- Engineering controls
- Complying with physical distancing requirements, except when unavoidable during physical examinations and providing care; in these circumstances standard precautions and transmission-based precautions should be employed, as appropriate
- Support for cough etiquette and respiratory hygiene
- [Management of people with cognitive impairment.](#)

More detailed information on potential risk minimisation strategies for COVID-19 is available in the ICEG Statement [Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: The hierarchy of controls.](#)

Workforce, patient and visitor screening

The screening frequency and protocols for screening and monitoring should be determined by current national and state and territory public health advice. Other considerations include local epidemiology and community transmission of COVID-19, vaccination coverage of the workforce and the community, best available evidence and level of organisational risk. Screening may involve use of questions relating to [epidemiological and clinical risk factors for COVID-19](#) in combination with temperature and/or laboratory screening, as required.

Protocols for screening processes should take account of variable working times and schedules, location of entry points, clinical and other areas at risk, admission processes and visiting arrangements for each facility and/or service.

Members of the workforce and visitors who, on screening, require further investigation for COVID-19 risk should be referred to an appropriate health service. Patients who require further investigation should only be considered for emergency surgery, procedures or investigations.

In the case of a confirmed COVID-19 infection or positive screening results in the workforce, patient population or visitors, the organisation is required to make immediate contact with their local public health unit and follow their directions for the management of risks and operation of the health service organisation.

Healthcare workers with any illness should remain at home until their symptoms have resolved. Visitors with respiratory symptoms should not be permitted to enter the health service organisation.

Depending on local rates of community transmission, individual states and territories may recommend testing and quarantine of patients for elective surgery, procedures or investigations to manage risks for patients, healthcare workers and health service organisations.

Vaccination

Members of the workforce should be encouraged to be vaccinated against COVID-19. Vaccination is a requirement in some states and territories.

Health service organisations should also promote COVID-19 vaccination to their patient population and other consumers.

Implementing standard and transmission-based infection prevention and control precautions

A precautionary approach to transmission-based precautions is required, aligned with the relevant clinical procedure and based on a risk assessment and consideration of the status of scientific evidence. For example, in relation to COVID-19, infection is transmitted by aerosols in specific circumstances, and evidence continues to evolve.

Each state and territory and [ICEG](#) have guidance in place in relation to transmission-based precautions for COVID-19.

The Commission has also developed [COVID-19 specific signage](#) that incorporates the principles of standard and transmission-based infection prevention and control precautions.

Standard precautions

Standard precautions are required for all patients, regardless of infection status. Standard precautions include hand hygiene; risk assessment to determine PPE (mask, particulate respirator, gown, apron, gloves, and eye protection) requirements, if any; correct use of PPE and environmental cleaning.

Transmission-based precautions

Combined contact and droplet precautions, in addition to standard precautions, should be adopted for patients with acute respiratory tract infection, with unknown aetiology (i.e. low risk of transmission of COVID-19).

Combined airborne and contact precautions, in addition to standard precautions, should be used to care for patients who have or are suspected of having COVID-19. This means that healthcare workers would use a P2/N95 respirator, in addition to other personal protective equipment that may be required as part of standard precautions, to care for these patients.

Performing aerosol-generating procedures

Each state and territory and [ICEG](#) have developed guidance that includes examples and other information regarding aerosol-generating procedures.

Environmental cleaning

The virus that causes COVID-19 can survive on surfaces for many hours, but is readily inactivated by routine cleaning and disinfection. Environmental cleaning should be consistent with the current [Australian Guidelines for the Prevention and Control of Infection in Healthcare 2019](#). Routine [environmental cleaning processes](#) should be followed for all settings (including operating theatres, day procedure areas, medical imaging procedural areas, labour and delivery wards, and general wards).

In addition to routine cleaning of surfaces and equipment in all care settings, frequently touched surfaces should be cleaned more frequently with detergent solution followed by a disinfectant wipe or solution, or use of a combined detergent/disinfectant product. The Commission has produced resources regarding [product selection](#), [principles for auditing environmental cleaning](#) and [cleaning processes](#).

All state and territory health departments and [ICEG](#) have also developed guidance on environmental cleaning.

Disinfection should always be undertaken following, and in addition to, cleaning with detergent. Use of a disinfectant is necessary:

- For cleaning surfaces (including floors) suspected or known to have been contaminated by a multidrug resistant organism; an organism with outbreak potential such as COVID-19; and/or, other potentially infectious material including blood and other body fluids
- In high or extreme risk settings (according to local risk assessment)
- For discharge cleaning following a patient with multidrug resistant organisms or other infections, including COVID-19.

Engineering controls

Where elimination or substitution is not possible, health service organisations should consider engineering controls to reduce hazards. For example, reviewing and optimising ventilation and air quality including raising ceilings, increasing air exchange

rates, installing or upgrading air flow and air filtration systems, and controlling temperature and ambient humidity. Where available, negative pressure rooms with an anteroom should be used to care for COVID-19 cases. If a negative pressure room is not available, a standard isolation room or single room with negative airflow should be used. Rooms with positive pressure airflow should be avoided.

Other examples of engineering controls include grouping COVID-19 positive patients in dedicated wards or zones separate to uninfected patients and patients whose status is uncertain.

Each state and territory and [ICEG](#) have developed guidance that includes examples and other information regarding engineering control strategies for COVID-19.

Physical distancing requirements

Health service organisations should ensure that arrangements are in place to enable the workforce, patients and visitors to comply with physical distancing requirements of 1.5 metres during planning, preparation and post treatment, and in all clinical and non-clinical areas.

The exception is during physical examination and provision of one-to-one care, when standard precautions are required for all patients, regardless of known COVID-19 status; and transmission-based precautions should be employed, as appropriate.

Cough etiquette and respiratory hygiene

As part of standard precautions, the health service organisation should promote cough etiquette and respiratory hygiene for the workforce, patients and visitors. Cough etiquette involves covering the mouth and nose with a tissue during coughing and sneezing and disposing of the tissue immediately, coughing or sneezing into the elbow if a tissue is not available, and hand hygiene.

Patients with respiratory symptoms should wear a surgical mask, if tolerated.

Management of people with cognitive impairment

Cognitive impairment is a temporary or permanent condition that affects a person's memory, communication, attention, thinking and judgement. It can affect a person's ability to carry out daily tasks or follow instructions. COVID-19 can cause delirium. While dementia and delirium are common causes of cognitive impairment in hospital, cognitive impairment can be the result of a range of conditions such as intellectual disability, acquired brain injury, stroke, psychiatric disorders, or side effects of medications.

The unfamiliar hospital environment may increase the risk of harm for people with cognitive impairment and healthcare workers. People with cognitive impairment may be frightened by staff wearing personal protective equipment, and find infection control instructions hard to follow. Carers may not be physically present due to temporary visitor restrictions, which can affect communication about treatment preferences.

The Commission has a [range of resources](#) to support provision of safe high quality care for people with cognitive impairment, including a [Delirium Clinical Care Standard](#) and a [specific resource on COVID-19](#).

More information

For more information about COVID-19 infection prevention and control please visit:

<https://www.safetyandquality.gov.au/covid-19>

<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert>

<https://www.health.gov.au/committees-and-groups/infection-control-expert-group-iceg>

<https://covid19evidence.net.au/>

Appendix 1

COVID-19 risk management guidance framework

This guidance framework has been developed to provide examples to support organisations prepare an organisation-wide Risk Management Plan to manage and reduce the risk related to the transmission of COVID-19. The National Safety and Quality Health Service (NSQHS) Clinical Governance and Preventing and Controlling Infections standards require health service organisations to identify and act to reduce infection risks.

Controlling exposures to occupational hazards is the main way to protect personnel in a workplace. Organisations should use the hierarchy of controls to achieve practical and effective control of workplace hazards. The hierarchy of controls lists different risk avoidance or mitigation strategies in decreasing order of reliability. Use of multiple control strategies is recommended to either eliminate or effectively minimise hazards. A number of states and territories, and the Australian Government Infection Control Expert Group (ICEG) have developed **guidance** on minimising the risk of transmission of COVID-19 using the hierarchy of controls.

Work-related risk is managed under the Work Health and Safety Act (2011), Regulations and the approved code of practice, 'How to Manage Work Health and Safety Risks' (2011). These require all Australian workplaces to assess and manage risk 'so far as is reasonably practicable.'

Health service organisations are required to apply standard and transmission-based precautions that are consistent with the current **Australian Guidelines for the Prevention and Control of Infections in Healthcare**, guidance issued by their state or territory health department and **guidance** developed by ICEG.

The processes described in this guidance are consistent with AS/NZO ISO 31000:2019 Risk Management Principles and Guidelines.

This risk assessment process can be applied at the individual service level (e.g. for a clinic or a ward) or at organisational level, but should be integrated with the organisation's routine corporate and clinical risk processes, and informed by monitoring emerging evidence. Reporting on COVID-19 risks and mitigation strategies should be incorporated into the organisation's clinical governance monitoring and reporting processes.

1. Establish the context

Organisations need to self-assess what measures are currently in place to respond to operational and infection risks, and the issues arising from the continuation or resumption of services while COVID-19 remains an infection risk. The outcome of the following steps must be documented as part of the Risk Management Plan.

1.1 Table 1: External parameters and considerations

External parameters and considerations	Sample questions for consideration	Notes
Local epidemiology and rates of community transmission of COVID-19	<ul style="list-style-type: none"> a. Are there geographic clusters? b. What is the rate of local community transmission? c. Are there any other possible sources for infection? d. What is the likelihood of the organisation being exposed to these sources? 	Review relevant state, territory and national data on cases and location of cases, including hot spots and international travellers
Local community vaccination status	<ul style="list-style-type: none"> a. What is the rate of local community vaccination? b. Are there specific groups of low-vaccination coverage in the local community? 	Review relevant state, territory and national data on community vaccination status
Community expectations/ behaviours	<ul style="list-style-type: none"> a. How has COVID-19 affected community expectations of service provision? b. Are any additional practices or resources required to meet these changed expectations? c. Does the community have concerns about accessing healthcare due to COVID-19? 	<p>Consider the higher levels of awareness in the community about vaccination, physical distancing and hand hygiene, and how this impacts on local operational policies, access to hand hygiene product, physical layout of facilities where care is provided and information for patients</p> <p>Consider the level of awareness in the community about protecting vulnerable populations, and how this impacts on local operational policies and information for patients</p> <p>Consider whether increased access to technology and digital literacy in the community can be used as part of service delivery, e.g. enable uptake of telehealth services</p> <p>Consider whether engagement with local community leaders or other health promotion strategies may be needed to address concerns about accessing healthcare during the pandemic</p>

External parameters and considerations	Sample questions for consideration	Notes
Legal, regulatory and policy requirements	<ul style="list-style-type: none"> a. Have any new legal, regulatory or policy requirements emerged in response to COVID-19 that have implications for local service provision? b. Are any additional practices or resources required to meet these new requirements? 	<p>Consider current vaccination requirements for the health workforce that may affect staffing and ready access to external services (e.g. equipment, maintenance, personnel).</p> <p>Consider impact of physical distancing and workforce self-isolation/quarantine requirements on organisation's ability to maintain business as usual</p>
Financial/economic	<ul style="list-style-type: none"> a. Has COVID-19 affected access to supplies or services needed to continue or resume service provision? b. Are alternative providers available? c. How is business continuity being managed? d. Are there waste management and sustainability implications? 	<p>Consider procedural supplies, medicines and PPE supplies and cleaning supplies</p> <p>Consider the need to increase linen and waste services, including waste management and sustainability</p> <p>Consider access to maintenance services, particularly if there is any equipment that requires servicing by interstate/international agents</p>
Current drivers and trends	<ul style="list-style-type: none"> a. How has COVID-19 affected demand for service provision? b. Are any additional practices or resources required to meet these changes in the volume or nature of service demand? 	<p>Consider potential for reduced demand due to fear of COVID-19 transmission, and how these fears could be managed to ensure that necessary clinical care is delivered</p> <p>Consider potential for subsequent high demand due to temporary cessation of services</p>

Depending on the organisation governance and business structure, and its catchment population, other external parameters, such as technological, natural environment and competition, may also need to be considered.

1.2 Table 2: Examples: internal parameters and considerations

Internal parameters for consideration	Sample questions for consideration	Notes
Governance, organisational structure, roles and accountabilities	<ul style="list-style-type: none"> a. What existing structures, roles and accountabilities are in place in the organisation to manage risks associated with COVID-19? b. Are any new structures, roles and accountabilities required to manage risks associated with COVID-19? 	<p>Consider who currently has accountability for business continuity planning, infection control, outbreak management, workforce management and vaccination and incident control in the organisation</p> <p>Ensure business continuity plan is updated appropriately</p>
Policies, protocol and procedures	<ul style="list-style-type: none"> a. What policies, protocol and procedures are in place in the organisation to manage risks associated with COVID-19? b. Do any of the existing policies need to be updated to address risks associated with COVID-19? c. Are any new policies, protocol and procedures required to manage risks associated with COVID-19? 	<p>Consider the current risk management policy – does this resource address infection risk?</p> <p>Consider the content of existing business continuity planning, infection prevention and control, outbreak management, workforce management, workforce screening, workforce vaccination and incident control policies, protocol and procedures. Are sufficient resources available to meet requirements?</p>

Internal parameters for consideration	Sample questions for consideration	Notes
Capability and capacity	<ul style="list-style-type: none"> a. Is there a sufficient number of appropriately vaccinated skilled staff available to resume or continue service provision? b. What existing contingency measures does the organisation have in place to manage high staff absenteeism or fluctuating availability of staff? c. How might areas where care is provided need to be re-arranged? d. Is there sufficient physical building and equipment capacity available to safely resume or continue service provision? 	<p>Consider potential for absenteeism due to illness, positive COVID-19 tests, carer responsibilities, physical distancing/ self-isolation/quarantine requirements and personal concerns</p> <p>Consider capacity to redeploy staff if required within and between health service organisations, if required</p> <p>Consider re-arrangement of spaces and furniture and changes to workflows to meet physical distancing requirements, and protocols for situations where physical distancing may not be possible, including PPE use</p> <p>Consider temporary utilisation of outdoor space for vaccine clinics and COVID-19 assessment areas</p> <p>Increase access to and delivery of non-hospital based services, such as telehealth, virtual hospitals, hospital-in-the-home, home-based care, community nursing models</p> <p>Consider temporarily decanting clinical services and/or patient cohorts to other health service organisations, if required</p>
Information and communication processes	<ul style="list-style-type: none"> a. What processes are currently in place to communicate infection risk to patients, their families and their visitors and staff? b. What processes are currently in place to support rapid identification of at risk staff, in the event of contact with a confirmed COVID-19 case in the organisation? c. What processes are currently in place to communicate infection events to public health units, general practitioners and organisations such as aged care facilities and hostels? 	<p>Consider all forms of communication – clinical communication via healthcare records, patient correspondence, signage, staff communication</p> <p>Consider privacy and confidentiality requirements around the disclosure of infectious disease status</p> <p>Consider availability and surge capacity of translation services and availability of translated resources</p> <p>Consider any additional information that is required to be captured in organisation’s visitor registry</p> <p>Consider the inclusion of community-based leaders in the development and delivery of health promotion strategies</p>

Internal parameters for consideration	Sample questions for consideration	Notes
Internal stakeholders	<ul style="list-style-type: none"> a. What is currently being done to ensure that staff/on-site contractors understand the vaccination requirements, infection risks associated with COVID-19, and can respond to these risks? b. Is additional training required to educate staff/on-site contractors on the infection risks associated with COVID-19? 	<p>Consider existing orientation and/or infection prevention and control training programs. Refer to the Commission's online learning modules for hand hygiene and infection prevention and control</p> <p>Consider the effectiveness of staff communication and communication with contracted organisations and whether alternative communication modalities are required</p>
Standards, guidelines and other resources	<ul style="list-style-type: none"> a. What standards, guidelines and other resources are available to assist the organisation in managing risks associated with COVID-19? b. Are any additional practices or resources required to meet these standards and guidelines and resources? 	<p>Refer to the Australian Government Department of Health COVID-19 resource page and Australian Government Infection Control Expert Group</p> <p>Refer to state/territory health department COVID-19 resource page</p> <p>Refer to the Australian Commission on Safety and Quality in Health Care resource pages</p>
Contractual relationships	<ul style="list-style-type: none"> a. Is there provision in current contracts with on-site service providers that have direct or indirect patient care involvement for vaccination, infection control training and competency for these individuals? b. Is there provision in the current contracts with linen, waste and cleaning services for additional services related to enhanced infection control management? 	<p>Review contracts and enact or make provision for ensuring vaccination requirements are met, and infection control competency and/or training is attained</p> <p>Review contracts and enact or make provision to address the additional risks associated with COVID-19</p>

2. Risk assessment

This step combines the processes of hazard identification, risk analysis and risk evaluation.

2.1 Hazard identification

As part of step one, the organisation has identified processes in place for identifying and managing risk. Where processes are not up to date or are absent, there is a risk. There may be other risks that emerge that are independent of the context. These risks should also be re-considered and updated in the Risk Management Plan.

2.2 Risk analysis

For the purposes of this Risk Management Plan, the focus is on minimising the risk of COVID-19 transmission.

The [Communicable Diseases Network of Australia](#), [ICEG](#) and state and territory health departments provide guidance regarding analyses and determination of the risk of exposure to infectious material in healthcare settings, based on the level of contact with that material and the level of background COVID-19 transmission in the community. The risk of infection from COVID-19 exposure in healthcare settings can be mitigated if staff are fully vaccinated and fully compliant with standard, contact and droplet precautions (for low risk of transmission of COVID-19) or standard,

airborne and contact precautions (for high or very high risk of COVID-19 transmission or aerosol-generating procedures) and other elimination, substitution, isolation and engineering controls that have been put in place to prevent the spread of disease.

Emerging evidence regarding the circumstances in which COVID-19 is transmitted and vaccine efficacy over time may also require consideration in relation to risk assessment and mitigation.

2.3 Risk evaluation

Risk evaluation is about comparing the level of risk and prioritising which risks require treatment.

3. Risk mitigation and response

For those risks that were deemed in Step 2 as necessary to act upon, this step supports local consideration and documentation of individual risks and the strategies to be developed to eliminate the risk, or if that is not possible, to minimise the level of risk.

4. Ongoing monitoring

Organisations should monitor the control of any identified risks identified in Steps 2 and 3 above, as well as the evidence regarding prevention and control of COVID-19. If monitoring identifies emerging risks, Steps 2 and 3 above should be repeated.

Risk identification	Risk analysis	Impact of Risk	Risk evaluation	Risk treatment
Risk 1	What is the level of risk? LOW, MODERATE, HIGH, VERY HIGH	LOW, MODERATE, HIGH, VERY HIGH	Is there is a need to treat this risk? YES/NO	What needs to be done to eliminate or reduce this risk?
Risk 2 etc				