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COVID-19 Personal Protective Equipment (PPE)

Directions for UnitingCare Hospitals Staff

As at 7 April 2020

As the COVID-19 situation evolves, it has become apparent Personal Protective Equipment (PPE) levels are very low – based on our current usage. UnitingCare is currently working with our existing and new suppliers to ensure we continue to have adequate stocks.

It is vital and now necessary that we take appropriate action to ensure frontline staff and practitioners continue to have access to PPE throughout the entirety of the COVID-19 response.

We ask that every single staff member and practitioner considers the following actions to help preserve existing stocks of PPE.

We ask that you:

- Immediately limit the number of people involved in all clinical or care procedures only to essential operators.
- Carefully consider who is required in a room during all clinical or care procedures to limit the use of PPE. This will depend on the specific procedure and infection control requirements but should be kept to the absolute minimum.
- Staff and practitioners should only wear PPE required for the situation based on Infection Control principles.

We are in an unprecedented situation. What we would do in optimal circumstances is no longer sustainable or fit for purpose. We are all required to think innovatively as we respond to this challenge. We are taking advice from Infection Control experts from our hospital services.

Re-use of PPE in low risk situations for instance may be a better alternative than no PPE at all, allowing us to conserve PPE stocks to respond appropriately to known risk-situations. Remember soap and water effectively and efficiently kills this virus and in most circumstances is the best PPE we have.

It is important that we all work together and do what we can at an individual and team service level to ensure that our frontline staff members and practitioners have access to adequate PPE over the coming months with COVID-19 and other highly infectious diseases.

We have seen from the experience of our service counterparts responding to COVID-19 in countries overseas that PPE stocks deplete rapidly. It is essential that we learn from that and act now.

If you have any questions or further suggestions as to how we can continue to preserve PPE for our frontline staff members and practitioners please email businesscontinuity@ucareqld.com.au

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Guide for Personal Protective Equipment (PPE) Matrix

- Careful management of the supply chain is required at all times, and monitoring and securely storing PPE stock is critical. PPE should be supervised by care workers and only used for clients under care worker direction.
- Strategies to reduce the use of PPE should not reduce the safety of care workers, and PPE should always be available to be used by those who require it.
- Unnecessary use of PPE should be avoided and training on use of PPE should only be used with expired stock.
- Consideration can be given to using alternative products and reuse of gowns may be considered for use in areas that currently use single use items.
- The use of plastic aprons can be used instead of long-sleeved disposable gowns where appropriate (care workers need to ensure they wash all exposed areas of hands and arms).
- Extended use is the practice of wearing the same PPE for repeated client interactions without removing and replacing the PPE. This may be considered where a local risk assessment of the situation is undertaken and staff have been trained in the appropriateness of extended use. This could be appropriate in a care setting where COVID-19 clients are cohort area.
- Surgical masks should be discarded if contaminated with blood or body fluids, not worn outside care area, removed before proceeding to care for clients other than those who are isolated for COVID-19 and removed when wet or damp. Surgical masks are designed to be worn for extended periods of time, expect care workers to remove or change mask for reasons such as taking toilet break or leaving care area. Masks should not be pulled down around the chin and neck and then re-worn. Hand hygiene must adhered to before, and after removing a mask.
- P2 / N95 masks should only be used in care scenarios where there are aerosol procedures being undertaken e.g. suctioning a tracheostomy, administering a Ventolin nebuliser, treatment of a client with acute tuberculosis, cardio-pulmonary resuscitation and intubation of a client. There is no recommended maximum length of time that a P2/ N95 mask can be worn, however should be removed for reasons such as taking a toilet break or leaving the care area. Education and training on the use and changing of this type of mask must be provided to care workers if used extended. Hand hygiene must be adhered to before, and after removing a mask.
- Eye protection can consist of items that protect the wearer's eyes from sprays and splashes. This may be reusable safety goggles, these must be cleaned and disinfected before being re-used. Eye protection should not be worn outside the care area, be discarded or cleaned if visibly contaminated with blood or body fluids.

Source: Adapted from Queensland Health COVID19 general considerations for conserving personal protective equipment 7 March 2020.

Summary of Personal Protective Equipment (PPE) Required for Patient Care

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Protection level	Personal Protective Equipment	Scope of Application	Additional
Level 1	• Standard Precautions • Transmission-Based Precautions for other non-COVID-19 reasons	• General wards (non COVID-19)	• Business as usual • If patients develop fever and respiratory illness place surgical mask on patients and initiate droplet precautions in ward • Proceed to moving patient to COVID-19 clinical area
Level 2	• Surgical mask	• Pre-examination triage where patients with potential COVID-19 are presenting from community, e.g. Emergency Centre	• Work uniform • Social distancing • Patients triaged and moved to appropriate assessment area
Level 3	• Surgical mask for droplet precautions • N95 for aerosol generating procedures • Long sleeve gown • Goggles/face shield • Gloves	• Patients in single rooms • Mild cases in open bed wards, e.g. 4 bed bay • Suspected cases of COVID-19	• Work uniform/scrubs as determined by facility • In an open 2 or 4 bed bay a surgical mask only is worn outside of direct patient bed areas
Level 4	• Surgical mask or N95 depending on patient acuity • Long sleeve gown • Surgical cap (optional) • Goggles/face shield • Gloves (Long cuff) - Change between patients with hand hygiene in between • Plastic apron – change between patients (caution if wearing a face shield as changing apron may dislodge)	• Isolation ward area including isolated ICU, emergency department respiratory acute, designated wards • Imaging examination • When moderate cases can't be accommodated in single rooms in open wards	• Work uniform/scrubs • Consider work shoes only • Prepare before entering area (drink, eat, bathroom) • Apply in donning area and keep on for whole time in area as tolerated • Group work together and be prepared to be in the area for up to 4 hours but be aware of PPE fatigue • Must have spotter for donning and doffing in designated areas
Level 5	• N95 mask • Long sleeve gown/coveralls • Surgical cap • Face shield over goggles • Gloves x 2 (Long cuff) - remove second set of gloves immediately after procedure • Plastic apron over gown - remove immediately after procedure by breaking neck and waist tie • TOGA for Anaesthetist and intubation team ONLY	• Procedures in which there is potential of spray/ splash of respiratory secretions and other bodily fluids such as tracheal intubation, tracheotomy, bronchoscopy, endoscopy • Applies to staff directly within 1.8m of the aerosolising procedure • Performing surgery • Performing autopsy	• Work uniform/scrubs • Consider work shoes only • Must have spotter for donning and doffing in designated areas • After performing high contamination procedure leave COVID-19 area to change PPE
Additional	• Balaclava • Shoe covers	• Operating Theatre COVID-19 Confirmed	• Consider additional measures for confirmed COVID-19 cases

Clinical Classification	Definition	Protection level
Mild Cases	No evidence of lower respiratory disease or other features of systemic compromise	Level 3
Moderate Cases	Lower respiratory tract symptoms – dyspnoea, cough, hypoxia corrected with low flow oxygen (Sp02>94%, unless normal for that patient)	Level 3 Level 4 when moderate cases are not in single rooms
Severe Cases	Requirement for high flow oxygen or other organ support	Level 4 Level 5
Critical Cases	Respiratory failure, shock or multi-organ dysfunction	Level 4 Level 5