Recommended Guidance on Managing COVID-19 in a Residential Aged Care Facility

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Contents

Purpose

This document has been developed to provide Residential Aged Care Facilities (RACFs) with guidance on what to do following a RACF COVID-19 case or outbreak. This document should be read in conjunction with COVID-19, Influenza, Respiratory Syncytial Virus and Other Acute Respiratory Infection Outbreaks in Residential Aged Care Facilities Toolkit and with Commonwealth resources for the prevention, control and public health management of cases and outbreaks in RACFs.

Definitions

Please note: If a staff member was wearing an N95/P2 mask and eye protection without a PPE breach, then no exposure has occurred.

Outbreak

A RACF COVID-19 outbreak is two or more residents of a RACF who have been diagnosed with COVID-19 within 72 hours.

Infectious period

The infectious period begins 48 hours prior to when symptoms start or, where asymptomatic, before the positive test was taken, and continues for up to 10 days after symptoms begin.

Cases are most infectious for the two days before symptoms develop and whilst acute respiratory symptoms (cough, runny nose, sore throat, fever) are present.

Close Contact

Close contacts are those people that live with, or spend a lot of time indoors with, a person diagnosed with COVID-19. They are at higher risk of catching COVID-19 and then passing the virus on to others.

A close contact is defined as:

- a person who has shared a defined area (e.g. a wing of a facility) and/or who has had a household like exposure with a case during their infectious period,
- a person who has spent more than 4 hours in a residential setting with a confirmed case during their infectious period (over a 24-hour period).

People who have recovered from COVID-19 in the last five weeks are not considered to be close contacts and do not need to test for COVID-19 for five weeks from their positive test collection date.

Managing COVID-19 in RACFs

From **Friday 14 October 2022**, the mandatory requirements for isolation following a positive COVID-19 test changed, along with rules relating to the management of contacts. Mandatory isolation under the *Public Health Act 1997* is no longer required but RACFs should consider the following recommendations in developing their workplace policies and in managing cases and outbreaks in their facilities.

Residents
Recommended management of residents who are COVID-19 cases is outlined below.

Residents who are close contacts may leave the facility. It is recommended that resident close contacts:

- do not visit other people at high risk of severe illness, anyone in hospital, or anyone in another aged care facility or disability care setting
    - if they must visit other people, they should do a RAT beforehand
- wear a mask when indoors or on public transport

Staff
Workplaces should have a policy in place to manage staff who have tested positive to COVID-19 or who are close contacts. Staff who test positive to COVID-19 should check their workplace policy before returning to work. It is recommended that staff who test positive stay at home while they have acute respiratory symptoms or fever and should not return to work for 7 days from their positive test.

It is recommended that staff who are close contacts should also check their workplace policy before entering the workplace. It is recommended that close contacts wear a mask and return a negative COVID-19 test daily before attending work for 7 days following their last contact with a case.

Visitors
Visitors should be screened before entering an RACF. Anyone with symptoms should be advised not to attend or be required to return a negative RAT and wear a mask before entering.

Visitors who have tested positive for COVID-19 should not attend a high-risk setting, including RACFs, for at least 7 days following their positive test.

Visitors who have tested positive for COVID-19 in the last 7 days, or who are a close contact of a case, who wish to enter a RACF, should notify the facility in advance and seek permission to enter.

The RACF should have a process in place to assess the request and, if approved, arrange for measures to minimise the risk to staff and residents, such as mask wearing, avoiding shared spaces etc. Advice can be sought from Public Health as required.

Recommendations for COVID-19 Case and Outbreak Management

These recommendations should be implemented as soon as possible to mitigate or control the risk of spread within the facility.

Recommended actions following identification of COVID-19 case/s

Action	Further instructions
Identification and Management of a case	
Symptomatic staff member	• Staff members who are symptomatic should leave the facility and undertake testing. • Ensure RAT result, if positive, is registered with Public Health – Rapid Antigen Test (RAT) - Positive Result Declaration.
Staff member exposure to case	• If the staff member was wearing an N95/P2 mask and eye protection without a PPE breach, then no exposure has occurred. No contact tracing is required. • If the staff member was only wearing a surgical mask, undertake contact tracing to identify possible contacts (see Appendix 1) and manage accordingly
Positive resident	• Isolate resident away from other residents and position PPE • If diagnosed using a RAT and a PCR is not being performed, ensure the result is registered with Public Health – Rapid Antigen Test (RAT) - Positive Result Declaration • Undertake contact tracing to identify close contacts (see Appendix 1) and manage accordingly • Initiate anti-viral treatment as soon as possible • Residents sharing the same wing/area should be managed as close contacts • If a case is in a shared room, transfer the other resident(s) into a different single room(s) where possible if they are a not a case • If the case shares a bathroom, consider using a commode for the positive resident until other arrangements can be made • All resident cases should be recommended to isolate from other residents for 7 days, regardless of symptoms, following the COVID-19 test date of their first positive specimen (that is, until the same day the following week as the day they tested positive). • If the resident remains symptomatic on day 7, they should be recommended to stay in isolation away from others until their symptoms have significantly resolved and they have not had a fever (or signs of fever such as chills or night sweats) for at least 24 hours. • If more than one resident is positive, move to outbreak management.
Activation of Case or Outbreak Management Plan for a single case or outbreak	
Activate RACF Outbreak Management Plan	• Ensure staff are briefed regarding the current situation • Contact ACEOC aceoc@health.tas.gov.au and Public Health at respiratory.outbreaks@health.tas.gov.au if advice required for a single resident case
Advise ACEOC, Public Health and	Notify all resident and staff cases to:

Commonwealth Department of Health	• the Commonwealth Department of Health using the My Aged Care service provider portal | Australian Government Department of Health and Aged Care When in outbreak, notify all resident and staff cases to: • Tasmanian Department of Health (ACEOC and Public Health) by email to aceoc@health.tas.gov.au and respiratory.outbreaks@health.tas.gov.au
Compile a line list	When in outbreak: • Compile a line list of cases who have been at the RACF when infectious – residents and staff. • Email the line list daily to aceoc@health.tas.gov.au and respiratory.outbreaks@health.tas.gov.au by 3.00pm.
OMT Meeting	• For an outbreak, the ACEOC may arrange a multi-stakeholder meeting including the RACF, PHEOC, Commonwealth Department of Health, ACQSC, and TIPCU. • Meetings should occur when an outbreak is identified and can occur as needed throughout the outbreak.
Risk assessment	

Identify affected areas	• Refer to the steps in the First 24 Hours Checklist First 24 hours Checklist.
	• Identify the areas of the facility that are at risk.
	  ○ Where the whole facility is affected, whole-of-facility actions should be taken to restrict access to and within the facility.
	  ○ Where only a wing or floor of the facility is affected, only that area should be managed as an affected area.
	  ○ Risk of transmission is higher where:
	  ▪ a facility has shared bathrooms,
	  ▪ the positive case is socially active within the facility (i.e. attended group activities or outings),
	  ▪ vaccination level is low amongst residents,
	  ▪ the facility has a high level of immunocompromised residents,
	  ▪ the source of infection is unknown.

Contact tracing	• Use Appendix I to assist risk assessment, contact identification and subsequent management. • Notify all affected residents of their potential contact status and encourage them to remain in their rooms until an initial round of testing is complete • Notify affected staff and visitors. • If residents are sharing the same wing/area, these residents should remain in the affected wing/area as close contacts.

Minimising risk	• Ideally, there should be no mixing between:
	  ○ cases and staff who care for cases and those exposed OR not exposed,
	  ○ persons who are exposed but who have not yet developed COVID-19 and those who are cases or not exposed
	  ○ persons at low or no risk of exposure and the other groups
	• At all times, residents with low-risk exposure or no exposure are recommended to be kept separate from cases or those with greater exposures

Testing recommendations	
Symptomatic resident or staff	• Any staff or resident with symptoms consistent with an acute respiratory infection should be tested for COVID-19 unless they have been diagnosed with a COVID-19 infection in the last five weeks (from the collection date of their positive test result). • Staff or residents who are symptomatic but have had a recent COVID-19 infection may have another respiratory infection and GP-review and testing for other respiratory pathogens should be considered.

Initial testing	• Where there is one positive resident, complete a round of surveillance RAT for residents sharing the same wing/area.
	• Where there is an outbreak:
	  ○ undertake an initial PCR test of all residents in the facility and,
	  ○ staff are recommended to perform a RAT daily pre-shift until outbreak stood down (if staff not rostered during this period, RAT on return to work).
	• PCR testing is preferred however RAT accepted where PCR is unavailable.

Ongoing testing	• Where there is one positive resident, continue to test by PCR or RAT on days 3 and 6 for residents sharing the same wing/area. • Where there is an outbreak, after initial testing of all residents, residents sharing the same wing/area as cases require repeat testing every 3 days. • Once a full round of testing of the affected area(s) with all negative results is returned, continue to test residents in the affected wing/s or area/s, every 3 days, prior to the outbreak being stood down. • Where a subsequent resident case is identified in a different wing/area of facility, consider wider testing
Testing refusal	• If a resident who has been identified as a close contact refuses testing, undertake a risk assessment and consider additional precautions. • Other asymptomatic residents not residing in the affected wing/area who refuse testing would not generally have any restrictions. • Discuss specific concerns with Public Health e.g. multiple residents refusing testing
Resident care	

Care and cohorting of residents	• Cases should be recommended to isolate in their rooms
	• Cohorting enables other residents with similar exposure or risk level to be grouped together in an area of the facility away from other residents
	• The RACF should discuss actions with residents and resident families. This should include discussion of:
	  ○ desire to be isolated to prevent infection – residents may choose to stay in their room if there is a concern regarding a potential outbreak, or choose to leave their rooms where this is considered appropriate and proportionate to the risk,
	  ○ desire to be visited and willingness of those visitors to adhere to any guidance put in place by the facility,
	  ○ the acceptability of additional precautions applied to prevent infection in those residents who are higher risk e.g., unvaccinated, not fully vaccinated, or immunocompromised,
	  ○ risks and concerns if families wish to take care of a resident by removing them from the facility.

Access to communal spaces and communal activities in affected areas	• Generally, residents (who are not cases) should be given the choice to remain in their rooms or to mix with people with similar exposure.
	• Residents from the affected wing/area:
	  ○ may choose to leave their rooms to eat in shared dining rooms and participate in social activities with other residents from the affected area – additional precautions may be considered e.g., mask wearing.
	  ○ should be recommended to not enter other parts of the facility
	  ○ should be recommended to not socialise with residents from unaffected areas
	  ○ can leave the facility and should do a RAT before leaving and wear a mask in indoor spaces outside the facility.
	• Where it is practical, cases can be allowed to engage in social activities together if they are well enough to do so and can be kept separated from residents who do not have COVID-19.
	• Resident cases can use private (i.e., not shared) courtyards or balconies adjoining their room.

New and returning residents from the community or hospital	• The presence of an outbreak should not prevent new and returning residents from being admitted/re-admitted to the facility with appropriate IPC measures in place. Decisions should be based on advice from consultation with primary care provider, resident and the residents' representatives. • Residents and families entering the facility during an outbreak should be informed of the current situation and associated restrictions.

Provision of health care to residents	• All residents should continue to receive ongoing routine and required health care on-site.
	• Essential off-site appointments should also continue (e.g. dialysis), with negotiation with the service provider if the resident has COVID-19 or has been exposed to COVID-19.
	• Resident GPs should continue to provide their routine primary care as needed either onsite and/or by telehealth.
	• Ensure GPs are aware of the resident's COVID-19 positive status.
	• Request GPs to:
	  ○ assess pre-diagnosis for eligibility of antivirals, and
	  ○ monitor cases.
	• For further information on antivirals, see: Oral treatments for COVID-19
	• Residents in unaffected areas should be able to attend external appointments

Relocation of residents	• Residents who have not been exposed to COVID-19 may choose to relocate to other settings e.g., to family. Decisions to move residents should be made quickly to minimise ongoing risk of exposure.

Visitors	
Visitors	• RACFs are encouraged to identify visitors who will be recognised as an essential visitor/carer (partner-in-care) for residents, allowing them to visit the affected wing/area. • Essential visitors should comply with any RACF required risk mitigations (e.g. vaccination, screening, wearing appropriate PPE, taking a RAT, following directions from facility IPC lead/s, etc). • Essential visitors should not move between affected and unaffected areas. • It is recommended that non-essential visitors should not attend residents who are cases. • The facility may choose to offer virtual (e.g., iPad) or contactless visits for visitors. • Visitors to cases should be managed using a risk-based approach, especially in circumstances requiring a compassionate approach, such as end-of-life care. • Visitors to unaffected parts of the facility only, can enter if they are willing to comply with RACF required risk mitigations. They should be advised not to enter the affected parts of the facility. • Visitors who have tested positive for COVID-19 in the last 7 days, or who are a close contact of a case, and who wish to enter a RACF, should notify the facility in advance and seek permission to enter. • The RACF should have a process in place to assess the request and, if approved, arrange for measures to minimise the risk to staff and residents, such as through mask wearing, avoiding shared spaces etc. Advice can be sought from Public Health as required.
PPE Requirements	
Staff	• The level of PPE required by staff in RACFs is dependent on the area/zone worked within the facility and the activity being undertaken • Refer to *Appendix 2 - Guidance on the use of personal protective equipment (PPE) with a case or outbreak of COVID-19 in residential aged care facilities (RACF)* for further details
Visitors	• The level of PPE required for visitors to wear is dependent on the COVID-19 status of the resident and whether the visit is indoors or outdoors • Refer to *Appendix 2 - Guidance on the use of personal protective equipment (PPE) with a case or outbreak of COVID-19 in residential aged care facilities (RACF)* outlines when staff and visitors should wear PPE depending on activity
Further guidance	• Refer to ICEG guidelines: ICEG guidance on infection prevention and control for residential care facilities (health.gov.au)
Staffing	
Cohort staff to work if possible	• If staffing numbers allow, staff should be cohorted to only work within one area (e.g. wing, level) of the facility and with either only COVID-19 positive residents, exposed residents or negative residents.

Returning to Business as Usual

Where there has been a single case, facilities can return to usual function where no further cases have been detected and the RACF has received negative test results on at least day 6 for all close contact residents. Note that for a single case, returning to usual functions does not require stand down approval from the ACEOC.

Standing Down an Outbreak

An outbreak may be stood down, along with outbreak IPC precautions, once:

- 7 days have passed with no new resident cases identified (where day zero is the day of the positive test date)
- The advised testing regime of residents in affected areas has been completed
- A full round of negative testing of residents in affected areas has occurred no earlier than day 6

New staff cases where appropriate PPE has been worn and where there were no breaches, should not delay the standing down of an outbreak where the above criteria are otherwise met.

Further Resources

Tasmanian Department of Health
Toolkit to support planning, preparedness, and response to COVID-19 and other acute respiratory infection outbreaks in RACF.
COVID-19, Influenza, Respiratory Syncytial Virus, and other Acute Respiratory Infection Outbreaks in Residential Aged Care Facilities: Toolkit to support, planning, preparedness, and response

Australian Government Department of Health
Measures RACFs should always have in place to prevent and prepare for an outbreak.
Prevent and prepare for COVID-19 in residential aged care

Australian Government Department of Health to report cases and outbreaks and request PPE, refer to the COVID-19 Support Portal
My Aged Care service provider portal | Australian Government Department of Health and Aged Care.

Communicable Diseases Network Australia (CDNA) national guidelines for the prevention, control and public health management of Acute Respiratory Infection (including COVID-19 and influenza) in residential care facilities in Australia

CDNA national guidelines for the prevention, control and public health management of Acute Respiratory Infection (including COVID-19 and influenza) in residential care facilities in Australia

Communicable Diseases Network Australia (CDNA) national guidelines for the prevention, control, and public health management of COVID-19 outbreaks in residential care facilities in Australia.
CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia

Find up to date information and advice on COVID-19 for aged care providers, aged care workers and people who receive residential or home care.
Advice on aged care during COVID-19

Aged Care Quality and Safety Commission
Practical guidance to support COVID-19 outbreak management planning and preparation in residential aged care facilities.
COVID-19 provider resources Aged Care Quality and Safety Commission

IPC Resources

Communicable Diseases Network Australia (CDNA)
COVID-19-SoNG v6.4.pdf (health.gov.au) www.health.gov.au/resources/publications/cdna-national-guidelines-for-the-prevention-control-and-public-health-management-of-covid-19-outbreaks-in-residential-care-facilities-in-australia

Infection Control Expert Group (ICEG) – endorsed infection prevention and control guidance
Revised guidance on the use of personal protective equipment (PPE) for health care workers in the context of COVID-19 www.health.gov.au/resources/publications/guidance-on-the-use-of-personal-protective-equipment-ppe-for-health-care-work

Statement on revised guidance www.health.gov.au/news/infection-control-expert-group-iceg-statement-updated-recommendations-to-protect-healthcare-workers-from-covid-19-infection

Minimising the risk of infectious respiratory disease transmission in the context of COVID-19: the hierarchy of controls www.health.gov.au/resources/publications/minimising-the-risk-of-infectious-respiratory-disease-transmission-in-the-context-of-covid-19-the-hierarchy-of-controls

Guidelines on cleaning and disinfection of protective eyewear in health and residential care facilities www.health.gov.au/resources/publications/iceg-guidelines-on-cleaning-and-disinfection-of-protective-eyewear-in-health-and-residential-care-facilities

Guidelines for infection prevention and control in residential care facilities www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-infection-prevention-and-control-in-residential-care-facilities

Environmental cleaning and disinfection principles for health and residential care facilities www.health.gov.au/resources/publications/coronavirus-covid-19-environmental-cleaning-and-disinfection-principles-for-health-and-residential-care-facilities

Tasmanian Infection Prevention and Control Unit (TIPCU) PPE video series
Personal Protective Equipment demonstration videos | Tasmanian Department of Health www.health.tas.gov.au/health-topics/infection-prevention-and-control/healthcare-worker-education/personal-protective-equipment-demonstration-videos

Appendix 1 – COVID-19 Contact tracing and management guidelines

Contact definitions and identification	*Close contact* • A person who has shared a defined area (e.g. a wing of a facility) and/or who has had a household like exposure with a case during their infectious period • A person who has spent more than 4 hours in a residential setting with a confirmed case during their infectious period (over a 24-hour period) Where a staff or resident has been exposed to a COVID-19 case, and the close contact definition is not met, the following criteria may be used to assist identifying staff and residents who may be at higher risk of contracting COVID-19: *RACF residents* • A resident who has had at least 15 minutes face to face contact with a COVID-19 case during their infectious period. • A resident who has had greater than 2 hours within the same room as a COVID-19 case during their infectious period. Note: if the resident is exposed to a positive staff member who was wearing an N95/P2 mask and eye protection and there was no PPE breach, then no exposure has occurred. *RACF staff* • Staff who have had at least 15 minutes face to face contact with a COVID-19 case during their infectious period and where both mask and eyewear were not worn by the exposed staff member and the case was without a mask. Staff who have spent greater than 2 hours within the same room as a COVID-19 case during their infectious period, where masks have been removed for this period. • Staff who were not wearing adequate PPE (N95/P2 mask and eye protection) where aerosol generating behaviours or procedures were involved.
Contact management recommendations	*RACF resident close contacts* • Remain in their room and/or can socialise within their wing/area with other residents with the same level of exposure. • PCR or RAT test on days 1, 3 and 6 following the exposure to COVID-19. *RACF staff close contacts* • RACF staff who have been in close contact with a case of COVID-19 should follow Public Health recommendations for close contacts and inform their employer (see Advice for contacts | Coronavirus disease (COVID-19).

	• Workplaces should have policies in place to manage close contacts which may include testing negative on a daily RAT and wearing a mask in the workplace. If able, staff may be encouraged to work from home. Where a staff or resident has been exposed to a COVID-19 case, and the close contact definition is not met, the following advice is recommended: *RACF residents* • Consider performing a PCR or RAT on day 1, 3 and 6 following exposure. • Monitor closely for symptoms. • Contacts in a defined area may be managed as group. *RACF staff* • Monitor closely for symptoms • Stay at home and test immediately if they develop any symptoms, even mild. • Consider performing a RAT prior to work shifts for 7 days following exposure. • Consider working in N95/P2 and eye protection. • Where practicable, work in a specific wing/area of the facility. • Where practicable, avoid shared break areas.

Appendix 2 - Guidance on the use of personal protective equipment (PPE) for COVID-19 in residential aged care facilities (RACF)

An increased level and use of PPE for a COVID-19 case or outbreak is required to protect staff, visitors, and residents from both known and unknown sources of infection.

The level of PPE required by staff and visitors in RACFs is dependent on the area/zone worked within the facility and the activity being undertaken.

Undertake all PPE putting on (donning) and taking off (doffing) of PPE with a PPE buddy wherever possible to ensure PPE is worn correctly and a fit check of the P2/N95 has been performed.

Display the approved signs outlining the appropriate PPE for various roles and circumstances at PPE donning and doffing stations.

Display posters for the correct sequence of donning and doffing PPE at PPE donning and doffing stations.

PPE used in RACFs are:

- Surgical mask – single use
- P2/N95 mask – single use
- Protective eyewear – single use or reusable
- Face shield – single use or reusable
- Gown – single use
- Gloves – single use

The PPE required is task specific and are outlined in Table 1.

The sequence for putting on and taking off PPE is outlined in Table 2.

Replace masks if they become damp, visibly soiled, accidently dislodged or have been in place for four hours. Do not touch the outside of the mask or leave the mask under the chin.

Staff who wear P2/N95 masks should ideally complete an initial fit test and must perform a fit check each and every time they don a P2/N95 mask. Where fit testing has not been performed and a P2/N95 mask is recommended for use, a fit-checked P2/N95 mask is preferred to a surgical mask.

To watch a fit check see Personal Protective Equipment demonstration videos | Tasmanian Department of Health <https://www.health.tas.gov.au/health-topics/infection-prevention-and-control/healthcare-worker-education/personal-protective-equipment-demonstration-videos#airborne-precautions>

The level of PPE required for visitors to wear is dependent on the COVID-19 status of the resident and whether the visit is indoors or outdoors (Table 1).

Visitors must be made aware of the risks of visiting during a declared outbreak and must be instructed and observed on the use of PPE and how to perform hand hygiene.

Residents should wear a surgical mask when possible, during face to face visiting.

Definitions

Direct care – where the resident is being physically touched by the carer. Most often occurs during assistance with activities of daily living.

- Examples – assisting with bathing, dressing, toileting, ambulation; performing a procedure such as a wound dressing or catheterisation

Indirect care – where care is provided but there is no physical touching of the resident by the carer

- Examples – dispensing medication, putting a meal tray down in the resident's room, giving the resident an electronic device such as an iPad.

Direct contact with the physical environment

- Example – cleaning a resident's room, cleaning high touch areas in common areas, cleaning bathrooms, waste removal

No direct or indirect care or contact with the physical environment

- Example – preparing food in the kitchen, office work, administrative work.

Visiting/Visitors

- Example – people not employed by the RACF such as friends or relatives or pastoral care

Table 1 - PPE requirements for different activities

Activity (work task or duty)	COVID-19 positive resident	COVID-19 close contacts	COVID-19 negative residents
Direct care	P2/N95 mask Eye protection or face shield Gown Gloves	P2/N95 mask Eye protection or face shield Other PPE as required as per Standard Precautions	Wear PPE as required as per Standard Precautions
Indirect care	P2/N95 mask Eye protection or face shield	P2/N95 mask Eye protection or face shield Other PPE as required as per Standard Precautions	Wear PPE as required as per Standard Precautions
Direct contact with the physical environment	P2/N95 mask Eye protection or face shield Gown Gloves	P2/N95 mask Eye protection or face shield Other PPE as required as per Standard Precautions	Wear PPE as required as per Standard Precautions
Visiting – face to face visits indoors (e.g. end of life)	Resident - Surgical mask if able to be worn Visitor – N95/P2 mask and eyewear. Gloves not required but hand hygiene must be performed	Resident - Surgical mask if able to be worn Visitor – N95/P2 mask and eyewear. Gloves not required but hand hygiene must be performed	Resident – no PPE required Visitor – no PPE required
Visiting - face to face outside	Resident – surgical mask if able to be worn Visitor – P2/N95 mask and protective eyewear	Resident – surgical mask if able to be worn Visitor – P2/N95 mask and protective eyewear	Resident – no PPE required Visitor – no PPE required
Visitors – window visiting with window closed	No PPE required	No PPE required	No PPE required

Table 2 - Sequence for putting on and taking off PPE

PPE	Putting on (donning) sequence	Taking off (doffing) sequence
Mask + protective eyewear/face shield	1. Hand hygiene using ABHR 2. Put on mask 3. Hand hygiene using ABHR 4. Put on protective eyewear/face shield 5. Hand hygiene using ABHR	1. Hand hygiene using ABHR 2. Take off protective eyewear Dispose of disposable eyewear/face shield **OR** Clean reusable eyewear 3. Hand hygiene using ABHR 4. Take off mask 5. Hand hygiene using ABHR
Mask + protective eyewear/face shield + gown	1. Hand hygiene using ABHR 2. Put on mask 3. Hand hygiene using ABHR 4. Put on protective eyewear/face shield 5. Hand hygiene using ABHR 6. Put on gown	1. Hand hygiene using ABHR 2. Take off gown 3. Hand hygiene using ABHR 4. Take off protective eyewear/face shield Dispose of disposable eyewear/face shield **OR** Clean reusable eyewear 5. Hand hygiene using ABHR 6. Take off mask 7. Hand hygiene using ABHR
Mask + protective eyewear + gloves + gown/apron	1. Hand hygiene using ABHR 2. Put on mask 3. Hand hygiene using ABHR 4. Put on protective eyewear/face shield 5. Hand hygiene using ABHR 6. Put on gown 7. Hand hygiene using ABHR 8. Put on gloves	1. Take off gloves 2. Hand hygiene using ABHR 3. Take off gown 4. Hand hygiene using ABHR 5. Take off protective eyewear/face shield Dispose of disposable eyewear/face shield **OR** Clean reusable eyewear 6. Hand hygiene using ABHR 7. Take off mask 8. Hand hygiene using ABHR

Table 3 - Sequence for changing PPE

PPE	Sequence
Change gown and gloves with mask and protective eyewear remaining on	1. Take off gloves 2. Hand hygiene using ABHR 3. Take off gown 4. Hand hygiene using ABHR 5. Put on new gown 6. Hand hygiene using ABHR 7. Put on new gloves