

Infection Prevention and Control

Response and Escalation Framework: Evaluation and Application Beyond a Pandemic

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Infection Prevention & Control / Healthcare Associated Infections | Patient Safety



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Global Context and Rationale for an IPC Escalation Framework

Recent pandemics exposed global variation in infection prevention and control (IPC) escalation

IPC decision-making during emergencies is often **reactive, inconsistent, and variable** across services.

Lack of a shared framework can lead to:

- Delayed escalation
- Over- or under-application of controls
- Confusion around roles, responsibilities, and authority

A formal framework supports proportional, transparent responses with **clarity, consistency, and accountability.**



Clinical Excellence Commission COVID-19 Response

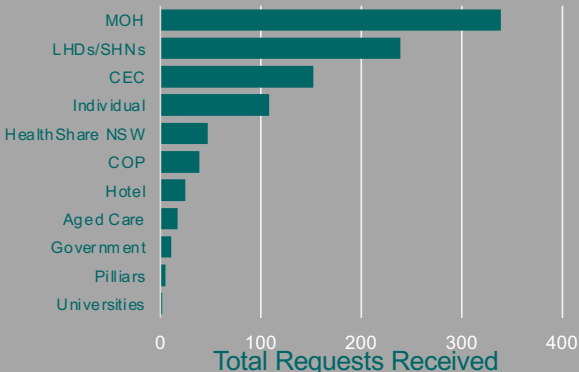
January 2021 – July 2021



Demand



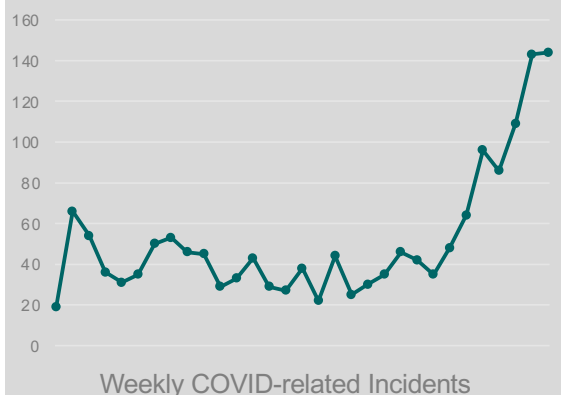
984
Support Requests



22
SAERs



1,603
ims+ Incidents



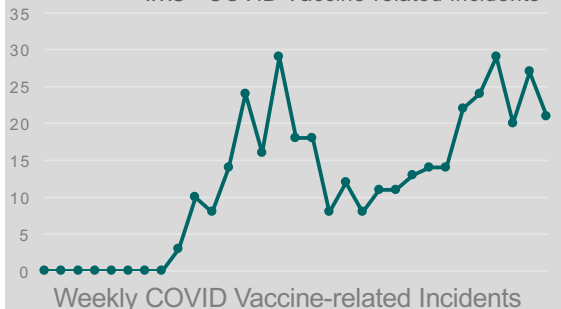
10
QARS PPE Audit Cycles for LHDs



20
Communities of practice



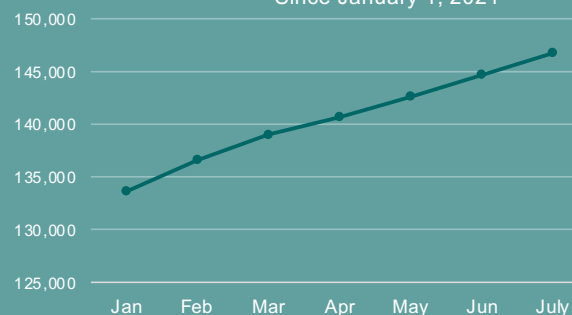
374
ims+ COVID Vaccine-related Incidents



Response



15,826
HETI PPE Modules Completed
Since January 1, 2021



70
Med Safety Investigations

- 50** Supply Issues requiring local mitigation
- 13** Safety Communications Required
- 7** Medication-related SABS



Hotel Quarantine
469 Recommendations

- TOP 5**
- 1 Mask Wearing
 - 2 PPE Use
 - 3 Cleaning
 - 4 Communication
 - 5 Physical Distancing



43
PPE Products Assessed



55
Website Resources



13
PPE Videos

* All data presented as activity from January – July 2021 or as cumulative totals of ongoing work. Infographic data provided from all CEC Directorates

Infection Prevention and Control Novel Coronavirus 2019 (2019-nCoV)

APPENDIX 1: CONTACT PRECAUTIONS

Requirements	Contact Precautions
Single room	Yes, or cohort with patient with same pathogen (in consultation with infection control professional or infectious diseases physician).
Negative pressure*	No
Hand hygiene	Yes
Gloves	Yes, if there is direct contact with the patient or their environment.
Gown/apron	Yes, if there is direct contact with the patient or their environment.
Mask	Standard Precautions
Protective eyewear	Standard Precautions
Special handling of equipment	Single use or if reusable, reprocess before next patient. Avoid contaminating environmental surfaces and equipment with used gloves.
Transport of patients	Surgical mask if coughing/sneezing and other signs and symptoms of an infectious transmissible disease spread by airborne or droplet route. Notify the area receiving patient. Advise transport staff of level of precautions to be maintained.
Alerts	Remove gloves and gown/apron and perform hand hygiene on leaving the room. Patient Medical Records must not be taken into the room. Signage of room.
Room cleaning	Standard cleaning protocol. May require additional cleaning with a disinfectant agent depending on organism. Consult with infection prevention and control professional.

Infection Prevention and Control Novel Coronavirus 2019 (2019-nCoV)

APPENDIX 2: DROPLET PRECAUTIONS

Requirements	Droplet Precautions
Single room	Yes, or cohort with patient with same pathogen (in consultation with infection control professional, or infectious diseases physician), or maintain spatial separation of at least one metre. It is recommended that single patient rooms be fitted with ensuite facilities. In the advent of no ensuite facilities, a toilet and bathroom should be dedicated for individual or cohort patient use.
Negative pressure*	No
Hand hygiene	Yes
Gloves	Standard Precautions
Gown/apron	Standard Precautions
Mask	Yes, Surgical mask. Remove mask after leaving patients room.
Protective eyewear	Yes
Special handling of equipment	Standard Precautions
Transport of patients	Surgical mask if coughing/sneezing and other signs and symptoms of an infectious transmissible disease spread by airborne or droplet route. Surgical mask for patient when they leave the room. Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows). Advise transport staff of level of precautions to be maintained. Notify area receiving the patient.
Alerts	When cohorting patients, they require minimum of one metre of patient separation. Visitors to patient room must wear a fluid resistant surgical mask and protective eyewear and perform hand hygiene. Patient Medical Records must not be taken into the room. Signage of room.
Room cleaning	Cleaning and Disinfection

Infection Prevention and Control Novel Coronavirus 2019 (2019-nCoV)

APPENDIX 3: AIRBORNE PRECAUTIONS

Requirements	Airborne Precautions
Single room	Yes Door closed. It is recommended that single patient rooms be fitted with ensuite facilities. In the advent of no ensuite facilities, a toilet and bathroom should be dedicated for individual patient use.
Negative pressure*	Yes, if available otherwise single room with door closed and window open.
Hand hygiene	Yes
Gloves	Standard Precautions
Gown/apron	Standard Precautions
Mask	Yes, P2/N95 Mask (perform fit check prior to entering room). Remove mask after leaving patient room.
Protective eyewear	Standard Precautions
Special handling of equipment	Standard Precautions Avoid contaminating environmental surfaces and equipment with used gloves.
Transport of patients	Surgical mask for patient when they leave the room ¹⁴ Patients on oxygen therapy must be changed to nasal prongs and have a surgical mask over the top of the nasal prongs for transport (if medical condition allows). Advise transport staff of level of precautions to be maintained. Surgical mask if coughing/sneezing and other signs and symptoms of an infectious transmissible disease spread by airborne or droplet route. Notify area receiving patient.
Alert	Visitors to patient room must also wear P2/N95 mask and perform hand hygiene. Patient Medical Records must not be taken into the room. Signage of room.
Room cleaning	Cleaning and Disinfection

Design and Structure of the Framework

- The framework defines **graduated levels of IPC response**, aligned to:
 - Epidemiological risk
 - Clinical and operational impact
 - Workforce and system capacity
- Each escalation level links to:
 - Clear triggers for activation
 - Defined IPC actions and control measures
 - Governance and communication requirements
- Emphasises the **hierarchy of controls**, ensuring IPC actions are risk-based and proportionate.

Timeline for a Risk Matrix



While internationally COVID-19 alert frameworks varied, they all included the following features:

- a schematic system, usually colors or numbers;
- different risk levels as defined by specific indicators;
- measures that corresponded to the intensity of control needed to maintain the epidemiological situation at each level of community control strategies;
- and indicators, usually updated weekly to trigger moving up or down a level usually based on cases and hospitalizations/health system capacity

Table 3: Mask Utilisation Priority during Pandemic Planning – NSW Health

	Normal Demand		Increased Demand CAUTION		High Demand ALERT
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Complexity of changing environment. Data such as the following to be considered to calculate risk:

- The onset to reporting interval
- Changing case definition (particularly for suspect cases)
- Testing numbers/prevalence
- Estimate of the percentage of undetected cases
- Age specific seroprevalence
- Methods of predicting Prevalence
- 14-day cumulative notification (by state/LHD)
- Sensitivity and specificity of diagnostic tests

COVID-19 RISK STRATIFICATION PPE GUIDANCE

This is to assess the facility risk of COVID-19. It does not replace clinical judgement for other conditions.

FACILITY RISK LEVEL INTERMEDIATE				
RISKS OF COVID-19	Clinical Risk Assessment			Procedural Risk Assessment
	This is the minimal level of PPE required			PPE should be at least the same level as for the clinical risk assessment
	1 Presence of Acute Respiratory Illness			2 Type of AGP
	None Minimal Significant			Low risk Higher Risk
	Very unlikely • No exposure identified or • Clinically unlikely • Alternative Dx or • Negative test	5		
Low Likelihood • No exposure identified or • Alternative diagnosis	5			
Possible • Low risk contact with a confirmed case or • Risk not assessable				
Probable or Confirmed • Known close contact • Consistent clinical picture or • Known cluster or • Positive test				
Level of PPE determined by clinical risk assessment. Check AGP list before proceeding.				
Removal of risk (social isolation) Engineering controls (physical barrier changing elective surgery) Administrative controls (reducing the number of patients/staff in one space, physical distancing, checking anyone who enters the facility for symptoms/fever) Hand hygiene Personal protective equipment (PPE)				
All facilities are expected to comply with engineering and administrative controls, but the use of PPE will vary depending on facility risk. A facility risk needs to be understood and these guidelines help facilities to be placed in one of three risk categories (depending on likelihood of COVID-19 patients presenting to the facility). Facility Risk: LOW Facility Risk: MEDIUM Facility Risk: HIGH				
For Aerosol Generating Procedures (AGPs) performed on non-COVID-19 patients in OT, emergency department, and other procedural suites. Within the risk framework there are two important factors to consider. The risk of a patient having COVID-19 and the risk associated with aerosol-generating-procedures (AGPs). Although there is limited information about the absolute risk of AGPs a number of professional bodies are classifying these as high or lower risk. For example, direct manipulation of the upper and lower airway is classified as high risk, whereas cardiac compression or laparoscopic surgery is classified as lower risk. Given the relatively low prevalence of COVID-19 in Australia, standard precautions, in addition to standard operating theatre attire or personal protective equipment appropriate for the procedure, are adequate for the performance of AGPs on patient who are not suspected or confirmed cases of COVID-19. A surgical mask, theatre gown, gloves, eye protection (and head/shoe covering only if required as regular theatre attire) should typically be worn. A P2/N95 mask, respirator or respiratory circuit is not necessary in this context. The current prevalence of COVID-19 in NSW, the majority of facilities would be considered as LOW RISK				
1 STANDARD PRECAUTIONS	CONTACT	DROPLET	AIRBORNE	
Hand hygiene Aseptic technique Risk assessment for PPE Safe sharps management Respiratory etiquette Waste management Environmental Cleaning	Wear an apron or gown, gloves depending on risk of body fluid contact	Surgical mask Eye protection Impervious apron or gown Disposable gloves	P2/N95 Mask Eye protection Impervious gown Disposable gloves	

1. For acute respiratory illness see definitions on page X
2. Aerosol Generating Procedures can be divided into higher or lower risk. See table on page X
3. This may change over time, this is current as of May 2020
4. Standard precautions apply to all patient encounters on all occasions. Contact, droplet and airborne all include standard precautions.
5. Staff in the ED to wear a surgical mask due to undifferentiated presentations

FACILITY RISK ASSESSMENT MATRIX COVID-19

5

COVID-19 RISK STRATIFICATION PPE GUIDANCE

This is to assess the facility risk of COVID-19. It does not replace clinical judgement for other conditions.

During COVID-19, transmission across New South Wales (NSW) may vary and therefore the risks to individual facilities and Local Health Districts may change. Transmission is currently at low levels, but experience from other countries shows that transmission rates can change and need to be monitored regularly.

The management of COVID-19 requires a strong infection prevention and control framework which includes the following. All of these factors are important and must be included as a whole process.

Removal of risk (social isolation)
Engineering controls (physical barrier changing elective surgery)
Administrative controls (reducing the number of patients/staff in one space, physical distancing, checking anyone who enters the facility for symptoms/fever)
Hand hygiene
Personal protective equipment (PPE)

All facilities are expected to comply with engineering and administrative controls, but the use of PPE will vary depending on facility risk. A facility risk needs to be understood and these guidelines help facilities to be placed in one of three risk categories (depending on likelihood of COVID-19 patients presenting to the facility).

Facility Risk: LOW
Facility Risk: MEDIUM
Facility Risk: HIGH

For Aerosol Generating Procedures (AGPs) performed on non-COVID-19 patients in OT, emergency department, and other procedural suites.

Within the risk framework there are two important factors to consider. The risk of a patient having COVID-19 and the risk associated with aerosol-generating-procedures (AGPs). Although there is limited information about the absolute risk of AGPs a number of professional bodies are classifying these as high or lower risk. For example, direct manipulation of the upper and lower airway is classified as high risk, whereas cardiac compression or laparoscopic surgery is classified as lower risk.

Given the relatively low prevalence of COVID-19 in Australia, standard precautions, in addition to standard operating theatre attire or personal protective equipment appropriate for the procedure, are adequate for the performance of AGPs on patient who are not suspected or confirmed cases of COVID-19. A surgical mask, theatre gown, gloves, eye protection (and head/shoe covering only if required as regular theatre attire) should typically be worn. A P2/N95 mask, respirator or respiratory circuit is not necessary in this context. The current prevalence of COVID-19 in NSW, the majority of facilities would be considered as LOW RISK



Emergency Department – PPE Quick Reference Guide

This is the quick reference guide for Personal Protective Equipment (PPE) use in Emergency Departments.

Any variation to this guidance must be based on local risk assessment and made in conjunction with facility management, local infectious diseases physicians, public health unit, infection prevention and control and advice from the CEC.

Refer to the CEC COVID-19 web pages for more information.

STANDARD PRECAUTIONS Standard precautions for all patient care. PPE use based on risk of anticipated exposure to blood, or body substances. <u>Consider includes social</u> .	• Hand hygiene • Aseptic technique • Cleaning and disinfection	• Respiratory etiquette • PPE based on risk assessment • Safe handling of sharps • Waste disposal
CONTACT If contact with blood or body fluid is anticipated <u>or pathogenic organisms spread by direct or indirect contact</u> .	• Impervious apron or gown	• Disposable gloves <u>when in contact with patient</u>
DROPLET Used when infectious particles are transmitted by droplets. Providing care for patients suspected or confirmed to have COVID-19 within 1.5m. <u>Combine with CONTACT AND DROPLET PRECAUTIONS</u>	• Surgical mask • Eye protection (face shield/safety glasses)	• Disposable gloves <u>when in contact with patient</u> • Plastic apron or impervious isolation gown
AIRBORNE If infectious particles are transmitted by aerosols or when performing AGPs* on patients suspected, probable or confirmed to have COVID-19. Combine with CONTACT and DROPLET PRECAUTIONS	• P2/N95 mask (or higher) • Eye protection (face shield/safety glasses)	• Disposable gloves when in contact with patient • Impervious isolation gown

*AGP includes NIV, intubation, extubation, bag mask ventilation, nebuliser administration and HFNO2

Bare below the elbow, simple, machine washable clothes worn only to work, easily cleanable closed footwear worn only to work, hair short or tied back and risk assessment of facial hair and fit checking of P2/N95 respirator.

COVID-19 Procedural PPE¹ FACILITY RISK ASSESSMENT – LOW

Patient COVID risk ²	Low or very low	Low or very low	Proven or probable
AGP ³	NO	YES	YES
Patient	nil	nil	Surgical mask ⁴
Anaesthetist (+Assistant)	Surgical attire	Droplet	Airborne Optional PAPR
Anaesthetic nurse	Surgical attire	Droplet	Airborne Optional PAPR
Instrument/circulating nurse	Surgical attire	Droplet	Airborne Optional PAPR
Surgical team	Surgical attire	Droplet	Airborne Optional PAPR
OAs ⁵	Surgical attire	Droplet	Droplet
Recovery nurse	Surgical attire	Droplet	Airborne
Medical imaging or allied health ⁶	Surgical attire	Droplet	Airborne
Surgical Reps ⁶	Surgical attire	Droplet	Airborne
Environmental cleaning	Standard clean	2-Stage Clean	Terminal clean after 3 – 5 air exchanges.
Operating Theatres ⁷	Non-COVID theatres	Non-COVID Theatres	COVID Theatres
Patient transportation	Surgical attire	Surgical attire	Droplet
Perioperative Staff Requirements	As per ACORN	As per ACORN	Outside runner for theatre team
Recovery of patients	Recovery unit	Extubate in OT, then recovery	Extubate and recover in OT

1. PPE: All include standard precautions.
2. Droplet includes contact; **airborne** includes droplet and contact
3. COVID Risk is based on current surveillance definitions
4. AGPs – see separate sheet (based on ANZCA April 9) and these may change based on local transmission rates
5. Apply a surgical mask to the at risk COVID-19 patient if they are able to tolerate it (until anaesthetic induced)
6. OAs and staff not involved in the procedure are expected to be outside the OT during an AGP
7. Medical imaging/allied health and surgical reps should be scheduled to be outside the OT during an AGP

Adapted from Nepean Blue Mountains PPE for Surgery and Facility Risk Matrix from Northern Sydney LHD



COVID-19 Procedural PPE¹ FACILITY RISK ASSESSMENT – MEDIUM

Patient COVID risk ²	Low or very low	Low or very low	Proven or probable
AGP ³	NO	YES	YES
Patient	nil	nil	Surgical mask ⁴
Anaesthetist (+Assistant)	Surgical attire	Airborne	Airborne Optional PAPR
Anaesthetic nurse	Surgical attire	Airborne	Airborne Optional PAPR
Instrument /circulating nurse	Surgical attire	Droplet	Airborne Optional PAPR
Surgical team	Surgical attire	Droplet	Airborne Optional PAPR
OAs ⁵	Surgical attire	Droplet	Airborne
Recovery nurse	Surgical attire	Droplet	Airborne
Medical imaging or allied health ⁶	Surgical attire	Droplet	Airborne
Surgical Reps ⁶	Surgical attire	Droplet	Airborne
Environmental cleaning	Standard clean	2-Stage Clean	Terminal clean after 3 – 5 air exchanges.
Operating Theatres ⁷	Non-COVID theatres	Non-COVID Theatres	COVID Theatres
Patient transportation	Surgical attire	Surgical attire	Droplet
Perioperative Staff Requirements	As per ACORN	As per ACORN	Outside runner for theatre team
Recovery of patients	Recovery unit	Extubate in OR, then recovery	Extubate and recover in OR

1. PPE: All include standard precautions. Droplet includes contact; **airborne** includes droplet
2. COVID Risk is based on current surveillance definitions
3. AGPs – see separate sheet (based on ANZCA April 9) and these may change based on local transmission rates
4. Apply a surgical mask to the patient if they are able to tolerate it
5. OAs are expected to be outside the OT during an AGP
6. Medical imaging/allied health and surgical reps should be scheduled to be outside the OT during an AGP
7. If COVID theatres have been identified, they can be added here

Adapted from Nepean Blue Mountains PPE for Surgery and Facility Risk Matrix from Northern Sydney LHD

COVID-19 Procedural PPE¹ FACILITY RISK ASSESSMENT – HIGH

AEROSOL GENERATING PROCEDURES (AGPs)			
Patient COVID risk ²	Low or very low	Low or very low	Proven or probable
AGP ³	NO	YES	YES
Patient	nil	nil	Surgical mask ⁴
Anaesthetist (+Assistant)	Droplet	Airborne	Airborne Optional PAPR
Anaesthetic nurse	Droplet	Airborne	Airborne Optional PAPR
Instrument/circulating nurse	Droplet	Airborne	Airborne Optional PAPR
Surgical team	Droplet	Airborne	Airborne Optional PAPR
OAs ⁵	Droplet	Airborne	Airborne
Recovery nurse	Droplet	Airborne	Airborne Optional PAPR
Medical imaging or allied health ⁶	Droplet	Airborne	Airborne
Surgical Reps ⁶	Droplet	Airborne	Airborne
Environmental cleaning	Standard clean	2-Stage Clean	Terminal clean after 3 – 5 air exchanges.
Operating Theatres ⁷	Non-COVID theatres	Non-COVID Theatres	COVID Theatres
Patient transportation	Droplet	Droplet	Droplet
Perioperative Staff Requirements	As per ACORN	As per ACORN	Outside runner for theatre team
Recovery of patients	Recovery unit	Extubate in OT, then recovery	Extubate and recover in OT

This is a list of AGPs, some of which will be occur in the operating theatre environment, including recovery. The division into higher and lower risk is based on data where available, and likelihood of aerosolisation. This

1. PPE: All include standard precautions. Droplet includes contact; **airborne** includes droplet
2. COVID Risk is based on current surveillance definitions
3. AGPs – see separate sheet (based on ANZCA April 9) and these may change based on local transmission rates
4. Apply a surgical mask to the patient if they are able to tolerate it
5. OAs are expected to be outside the OT during an AGP
6. Medical imaging/allied health and surgical reps should only be in the OT if absolutely necessary and scheduled to be outside the OT during an AGP
7. If COVID theatres have been identified, they can be added here

Adapted from Nepean Blue Mountains PPE for Surgery and Facility Risk Matrix from Northern Sydney LHD

COVID-19 Infection Prevention and Control Application of Risk

Introduction

National, state and local health services are meeting the challenge of increasing rates of COVID-19 (SARS-CoV-2) infection. As the situation is rapidly evolving, advice and resources for clinicians and the public are also changing to meet needs. Health workers should check the [NSW Health COVID-19](#) and the [Clinical Excellence Commission \(CEC\) Infection Prevention and Control COVID-19](#) web pages for the most up-to-date information.

The CEC has developed a number of risk matrix documents in response to risks associated with COVID-19. The purpose of this document is inform how to apply these risk matrix documents and their application in a number of healthcare settings. More detail can be sourced from key NSW and national sources:

- [NSW Infection Prevention and Control Practice Handbook](#)
- [National COVID-19 updates – Department of Health and Ageing](#)
- [CDNA National Guidelines for Public Health - Coronavirus Disease 2019](#)

As COVID-19 evolves there are a number of potential scenarios where a risk assessment, response and escalation should be applied:

- Increasing or high rates of community transmission
- High case presentations to healthcare facilities
- High and increasing rates of admissions related to COVID-19
- A combination of the above

Triggers for escalation to these guides will be communicated, where a risk level is released, unless otherwise stated it refers solely to the guide released.

Individual facility outbreaks should follow the [Triggers for Escalation Following Detection of Infection Outbreaks or Clusters GL2019_013](#) and is not included in the document.

The following documents will assist LHD/SHN to conduct a risk assessment and escalation process.

1. Response and escalation framework

The fundamental principles of infection prevention and control must be applied across all settings at times. A key focus during escalation is the use of personal protective equipment (PPE) including surgical masks in response to the level of community transmission.

http://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0008/595754/COVID-19-Infection-Prevention-and-Control-Response-and-Escalation-Framework.pdf

This risk matrix refers to increasing community transmission and as a control measure to minimise the likely impact on health workers, inpatients, outpatients and community patients within LHDs and SHN by

COVID-19 Infection Prevention and Control Application of Risk

assisting in controlling the community spread. The main focus of the risk matrix is the increased surgical mask use within 1.5 metres of patients to support all other infection prevention and control strategies. Guiding documents are listed below:



2. Emergency Department – PPE Quick Reference Guide

http://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0007/579780/CEC-Quick-Reference-Guide-COVID-19-FINAL-v8.pdf

This is a quick reference guide for PPE use in Emergency Departments. This guide provides a quick reference to support existing information for emergency departments when implementing their response and escalation framework.



COVID-19 Infection Prevention and Control Application of Risk

3. Application of PPE during COVID-19 (Version 2)

http://www.cec.health.nsw.gov.au/_data/assets/pdf_file/0006/590307/Application-of-PPE-in-COVID-19.pdf

This guidance relates solely to considerations of PPE and represents one section of infection prevention and control guidance for COVID-19. Other infectious diseases requiring PPE as part of standard and transmission-based precautions are not addressed in this document. This document should be used in conjunction with the New South Wales (NSW) Infection and Prevention Control Policy Directive, Infection Prevention and Control: Management of COVID-19 in Healthcare Settings and local procedures and guidance. The traffic lights applied here relates to provision of PPE and does not provide a risk matrix as set out by the Response and escalation framework



4. Personal protective equipment in the operating theatre COVID-19 pandemic decision support tool.

<https://www.health.nsw.gov.au/infectious/covid-19/communities-of-practice/Documents/guide-ppe-operating-theatre.pdf>

This tool outlines what specific personal protective equipment (PPE) is to be worn by each staff member in the operating theatre environment. The recommendation for PPE usage is based on a number of factors including national, state and local advice according to epidemiological parameters. This guide will be activated when changes to service provision is announced.



3.4 NSW Risk Matrix

Green Alert Low transmission risk	Yellow Alert Low to moderate transmission risk	Amber Alert Moderate to high transmission risk	Red Alert High transmission risk
Risk assessment of cases and community transmission will be determined by the Risk Escalation Review Panel Standard precautions apply at all times – transmission-based precautions apply as required Hand hygiene and physical distancing always apply			
• All patients with an acute respiratory infection (ARI) to wear a mask on presentation and transit if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Testing of symptomatic patients and health workers' (HWs) • HW to wear a surgical mask and eye protection when providing care for patients with an ARI • HWs in ED to wear surgical masks in clinical areas during patient care. Eye protection to be used when providing clinical care for patients with an ARI (within 1.5m) • Routine Cleaning	• All patients to wear a mask on admission and during transit if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Testing of symptomatic patients and HWs including targeted screening • Surgical mask for HWs in clinical areas (wards/clinics) including ED • Surgical Mask for all visitors on entry • Masks required in all clinical and publicly accessible spaces in the hospital • Eye protection to be used when providing clinical care for patients with an ARI (within 1.5m) • Enhanced cleaning of high touch points, shared toilet, and shower facilities	• All patients to wear a mask on admission and during transit if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Risk screening of all patients for symptoms, increased testing • Symptomatic and selected surveillance testing of patients and HWs • Surgical masks and eye protection to be worn in ED and other clinical areas for all patients when providing clinical care • Surgical mask for HWs in non-clinical area and shared spaces (e.g., on entry, corridors, office spaces) • Enhanced cleaning of high touch points, shared toilet, and shower facilities	• All patients to wear a surgical mask on admission and during transit if able • HWs managing suspected or confirmed COVID-19 patients to wear P2/N95 respirator and eye protection • Screening of all patients for symptoms, consider testing all admissions including ED presentations • Consider selected surveillance testing of some HWs • All ED HWs to wear P2/N95 respirators and eye protection in clinical areas when providing direct care • Surgical masks and eye protection to be worn in all clinical areas for all patients when with 1.5m • Universal surgical mask use by all HW within health facilities • Enhanced cleaning of high touch points, shared toilet, and shower facilities

Risk Matrix		LOW (GREEN ALERT) TRANSMISSION	MODERATE (AMBER ALERT) TRANSMISSION	HIGH (RED ALERT) TRANSMISSION	PURPLE EXTREME
Patients	All patients in hospital	Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene Exclude outpatients if suspected or confirmed COVID-19 unless urgent	All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible Manage suspected or confirmed COVID-19 patients in a single room where possible	All patients to wear a surgical mask on presentation and during transit if possible Manage suspected or confirmed COVID-19 patients in a single room where possible Prioritise single rooms based on patient's clinical condition and risk of transmission level or cohort confirmed cases if no single rooms available.	All patients to wear a surgical mask on presentation and during transit if possible Manage suspected or confirmed COVID-19 patients in a single room where possible Prioritise single rooms based on patient's clinical condition. Cohort confirmed cases if no single rooms available. Reduce bed numbers in multi-bed bays where possible
	Presenting directly to Emergency Department (ED)	Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene All patients with an ARI to wear a mask on presentation and transit	All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible	All patients to wear a mask (surgical or approved cloth mask) on presentation and during transit if possible	All patients to wear a mask (surgical or approved cloth mask) on presentation and during transit if possible.
	Patient presenting directly to delivery suite, medical imaging, outpatients, rehabilitation groups and community health services	Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene Patients to wear a mask if ARI suspected or confirmed	All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible	All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible	All patients to wear a mask (surgical or own approved cloth mask) on presentation and during transit if possible
	Maternity & paediatric patients	Standard Precautions: hand hygiene, physical distancing, cough etiquette, respiratory hygiene and personal hygiene	Mother and baby to stay together Children 12 years and under are not required to wear a mask	Mother and baby to stay together All adult patients to wear a mask during presentation and transit if possible Children 12 years and under are not required to wear a mask	Mother and baby to stay together All adult patients to wear a mask during presentation and transit if possible Children 12 years and under are not required to wear a mask



COVID-19 Risk Monitoring Dashboard – Healthcare settings

Date of release:
19 Apr 2023

This dashboard provides an assessment of transmission risk in healthcare settings – it is not an assessment of risk in the community.

Overall status

Yellow

The number of reported cases has increased, and the growth factor is currently 1.03 - indicating a 3% increase per day. Ward admissions, occupancy and the number of staff furloughed have also increased. Staff are reminded to comply with infection control measures; and not attend work with acute respiratory infection (ARI) symptoms. The risk status remains at Yellow (for information, see the updated COVID [IPAC manual](#)).

Categories

- Green
- Yellow
- Amber
- Red

Local transmission



	Week ending 17 Apr 2023	Previous week
Number of cases (PCR + RAT)	11,581[#]	9,363 [#]
7-day average daily cases	1,838[#]	1,172 [#]
Average growth factor, cases	1.03[#]	1.00 [#]
% of cases by age group		
<12 /	7%	8%
12-17 /	3%	4%
18-59 /	58%	54%
60+	33%	34%
Number of LHDs with ≥ 5 average daily cases per 10 000 population	0	0
Number of LHDs with average growth factor > 1.10	1	0

Public health



	Week ending 16 Apr 2023	Previous week
% PCR positive cases contacted by stop and stay message within 1 day	91%	90%
% of cases hospitalised with		
0 dose or no information /	17.9%	17.1%
1 dose /	1.0%	1.0%
2 doses /	11.0%	10.4%
3 doses /	23.9%	21.8%
4 or more doses	46.3%	49.7%
vaccinated (as of 18 Apr)		
Late presentations within 2 days of positive test # (% hospitalisations)	231 (55%)	126 (52%)
% of population vaccinated with at least 2 doses (age 16+) (29 Mar)	96%	96%
% of population vaccinated with at least 3 doses (age 16+) (29 Mar)	70.6%	70.6%
New cases in neighbourhood jurisdictions (PCR + RAT results)		
VIC	5,811	↑1%
QLD	3,472	↓12%

Healthcare setting



	As at 17 Apr 2023	Previous week
Number of cases on wards	1,129	1,041
Number of cases in ICU	23	23
Average length of stay of admissions (days / cases), discharged in the week ending 17 Apr	8.7 / 734	8.7 / 551
Average length of stay of ICU (days / cases), discharged in the week ending 17 Apr	4.8 / 40	4.0 / 35
Weekly new admissions to a ward / ICU	562 / 33	452 / 32
Number of cases self- managed (using 5 day isolation rule – see notes)	4,673	2,001
Number of LHDs with ≥20% hospitalisation capacity used by COVID-19 positive patients	0	0
Healthcare workers in isolation (18 Apr)		
- Community exposure	549	449
- Potential workplace exposure	1	4

[#]Reporting of cases, and case related indicators, were affected by the Easter Holidays. Smoothing has been applied to adjust for the artefactual effect. Cases before smoothing was 12,866 for week ending 17 Apr and 8,201 for the previous week.

Risk criteria and Metrics

Criteria / Metrics					
Weekly ED presentation for respiratory illness, fever and unspecified infections in per million pop	% Healthcare workers in isolation	Number of COVID-19 patients in hospital per 10k population	% ED accessible beds with COVID patients	Number of COVID-19 patients in ICU	% COVID patients ventilated
Up to 590 (5k presentations)	Up to 0.5% (600 staff)	Up to 0.5 per 10k pop (420)	Up to 5%	Up to 10	Up to 1.0%
Up to 832 (7k presentations)	Up to 1% (1.2k staff)	Up to 1 per 10k pop (841)	Up to 10%	Up to 25	Up to 2.5%
Up to 1188 (10k presentations)	Up to 2% (2.4k staff)	Up to 2 per 10k pop (1,683)	Up to 20%	Up to 50	Up to 5%
>1188	>2%	>2 per 10k pop	> 20%	>50	> 5%
Note:					

This week:

Section 3: Results - Data as at 17 April						
Community transmission		Risk of hospital admission		System impact		
Growth factor	Reported cases per 1000	Age distribution	Conversion rate	Furloughed staff	% ED accessible beds with COVID patients	% COVID patients ventilated
						<1%
1.01 – 1.03	Up to 0.5 per day				Up to 15%	
		Age 0-20%	0.0%			
1.03	0.22	33.0%	6.85%	pending	11.4%	0.95%

2 weeks ago:

Section 3: Results - Data as at 03 April						
Community transmission		Risk of hospital admission		System impact		
Growth factor	Reported cases per 1000	Age distribution	Conversion rate	Furloughed staff	% ED accessible beds with COVID patients	% COVID patients ventilated
≤ 1.00					<10%	<1%
	Up to 0.5 per day (4208)			Up to 1000		
			Up to 5%			
		Age 0-20%				
1.00	0.16	30.0%	4.25%	438	9.4%	0.85%

NSW Risk Matrix Summary¹

Health Worker (HW) – P2/N95 respirator and eye protection to be worn when managing suspected or confirmed COVID-19 patients as per TBP

Green Alert

Transmission risk – system prepared

- **Patients** with an acute respiratory infection (ARI) to wear a surgical mask on presentation and transit if able
- **HW** to wear surgical mask and eye protection for all ARIs and as per risk assessment
- **Visitors** to wear surgical mask as per risk assessment

Yellow Alert

Low to moderate transmission risk

- **Patients** with an ARI to wear a surgical mask on admission and during transit if able
- **HW** to wear surgical mask and eye protection for all ARIs
- **HW and visitors** to wear surgical mask in clinical and patient facing areas
- Testing of suspected ARI and symptomatic **patients**,

Amber Alert

Moderate to high transmission risk

- **Patients** to wear a surgical mask on admission and during transit if able
- **HWs and visitors** to wear surgical mask including non-clinical areas and shared spaces (e.g., on entry, corridors, office spaces)
- Symptomatic and selected surveillance testing of **patients and HWs**

Red Alert

High transmission risk

- **HWs and patients** - Universal surgical masking
- All ED **HWs** to wear P2/N95 respirators and eye protection in clinical areas when providing direct care
- **Visitors** must wear a surgical mask before entering the facility - visitation supported by exemption
- Screening of all **patients** for symptoms, consider testing all admissions
- Selected surveillance testing for **HWs**

FRAMEWORK COMPARISONS

STATE	MATRIX	LEVEL	MASKING	STATE/COUNTY	MATRIX	LEVEL	MASKING
QLD		Low rates and not in a COVID wave. Community focus Baseline		ACT	No alert levels/Matrix		
SA	No Matrix		Masks required in hospitals / Visitor Restrictions	NT	No alert levels/Matrix		still required to wear a face mask health care facilities.
TAS	3 Risk Levels Low = <400 cases Mod= 400-2000 High= >2000 Masks in HC	Low	Masks in HC	UK-NHS	Local Risk assessments		Masks required Healthcare removed Aug 2022 Reinstated by many trusts
VIC		COVID READY	Masking visiting or working in High risk setting	CANADA		Province and organisational risk assessment	Setting specific masking
WA		Blue Level – living with COVID	Mask for HW direct interaction with pts	US-CDC	Source Control based on risk		Masking as per risk assessment

NSW COVID-19 IPAC Framework for COVIDSafe Health care

The IPAC measures for preventing and managing COVID-19 at base-level, Tier 1 and Tier 2 provide guidance to NSW health facilities on levels of COVID-19 transmission risk and aligned preventative and management strategies. Changes to risk level are state-wide with the level of risk including escalation or de-escalation is assessed and provided by the Risk Escalation Review Panel (RERP). Escalation may also be applied during foundational level relevant to local epidemiology.

Foundational Level Strategies	TRANSMISSION RISK	CLINICAL & PATIENT CARE	VISITORS AND HEALTHCARE WORKERS	GENERAL PRINCIPLES
	System prepared	- Be aware of precautions² to reduce risk of exposure - Get tested for COVID-19 as soon as symptoms develop to enable timely access to antiviral medications - Patients with an acute respiratory infection (ARI) to wear a surgical mask on presentation and transit if able - Standard precautions. PPE as per Transmission based precautions - Outbreak management - Plan as per local health requirements - Review and maintenance of plans	- Visitor policy - Symptom screening - Stay away where symptomatic - Positive Health worker (HW) - stay home until acute symptoms resolve; asymptomatic positive stay home at least until day 3 (see HW return to work)	- Vaccination (COVID-19 & Flu) - Symptomatic testing - Infection Prevention and Control³ - Hand/respiratory hygiene - Personal Protective Equipment (PPE) including masks - Close contact monitoring for symptoms - Staff training - Maximise ventilation⁷ - HW to wear surgical mask and eye protection for all ARIs and as per risk assessment - Health Worker (HW) – P2/N95 respirator and eye protection to be worn when managing suspected or confirmed COVID-19 patients as per TBP
Scaled Up Strategies				
YELLOW	Low to moderate transmission risk	- Patients with an ARI to wear a surgical mask on admission and during transit if able - Testing of suspected ARI and symptomatic patients	- HW to wear surgical mask and eye protection for all ARIs - HW and visitors to wear surgical mask in clinical and patient facing areas	High community prevalence and/or Outbreak - Outbreak Management Plan activated and scaled up⁵ - Mask wearing for visitors⁶ - Staff surveillance testing - RAT screening of visitors⁴ - Surge workforce, if required - In-reach PCR/flu testing⁸ - National Medical Stockpile – deployment of additional PPE if required⁹
AMBER	Moderate to high transmission risk	Symptomatic and selected surveillance testing of patients	HWs and visitors to wear surgical mask including non-clinical areas and shared spaces (e.g., on entry, corridors, office spaces)	
RED	High transmission risk	Avoid indoor public places with high risk of infection transmission¹	- Capacity limits - Work from home, where possible	

¹ Patients considered to have additional risk - Individuals over 70 years old, COVID-19 at-risk medical conditions or immunocompromised.

² For example, mask wearing, physical distancing, maximising well ventilated/outdoor settings to socialise.

³

⁴ Includes aged care and disability care (residential and home), and hospital care settings.

⁵ Implementation of Infection Prevention and Control (IPC) measures determined by facility Work, Health & Safety policies and IPC guidelines in accordance with local risk assessment.

⁶ Aged care and disability residential care settings only. Visitors not required to wear masks at base level (so that residents can see faces). However, facilities will assess their own risk and may require visitor mask wearing at all times

⁷ Refer published guidance to [Optimising ventilation for infection prevention and control in healthcare settings](#)

IPAC Issues

HW with community acquired COVID risk bringing into Healthcare

Furloughed staff impact capacity of services – elective surgery, access

Impact in nonclinical areas with introduction of COVID-19

Staff confidence – HW safety

HAI COVID-19

Northern Hemisphere Winter Experience – COVID-19, Flu & RSV, iGAS, gastro

IPAC POST WINTER

Green Alert Level – Incorporating into BAU Guides, TBP Risk Assessment

Transfer Risk assessment of alert level to LHDs – Triggers for Escalation ?

VACCINATION – (opportunistic - pts, HWs

HAND HYGIENE
STANDARD PRECAUTIONS & TRANSMISSION BASED PRECAUTIONS

ENVIRONMENT CONTROLS – Spatial, Cleaning, HI Building R&R, Ventilation

Surveillance - Monitoring

Communication with IPAC – Planning, Strategy

Study Participants		
Participant Group	Member Numbers	Response Rate
Infection Prevention and Control Network	144	70%
CEC IPC/HAI Specialty Taskforce Representing the following specialties: Public Health; Infectious diseases; emergency, occupational medicine, nursing	28	14%
Directors of Clinical Governance (DCG) Committee	51	10%
NSW COVID-19 clinical council	25	6%
Health Services		
Metropolitan		48%
Rural/regional		35%
Other : disability, aged care; primary care setting and correctional health		17%
Specialty		
Acute Care		66%
Community and primary care; Aged care; Disability; Mental Health		34%

Collate info about Outbreak management and IPC, Framework benefit, use locally for COVID and others. Development of new framework.

Question	Strongly Agree/Agree	Question	Strongly Agree/Agree
1. The Response and Escalation Framework comprised different Alert levels (Red, Amber, Yellow and Green) and was developed to provide IPAC guidance to NSW health facilities on the various levels of COVID-19 transmission risk. The framework provided a useful IPAC management tool.	93%	8. The IPAC Response and Escalation Framework and each of its key elements was able to clearly inform guidance for the clinical setting .	85%
2. The Framework provided enough information on the IPC strategies needed for COVID-a9 that were aligned with the transmission risk	91%	9. The IPAC Response and Escalation Framework and each of its key elements was able to clearly inform guidance for the non-clinical setting	65%
3. The framework provided detailed instructions on each of the key Infection Prevention and Control (IPAC) elements (LIST)	78-96%	10. In my workplace the application and implementation of the IPAC Response and Escalation Framework and each of its key elements was clear . (LIST)	78%-90%
4. The framework improved implementation of relevant IPAC strategies in assisting my organisation or community of practice (COP) in fostering clinician engagement through adherence to IPAC	77%	11. The resources* and additional risk matrices provided effective additional guidance supporting the IPAC Response and Escalation Framework	85%
5. The IPAC Response and Escalation Framework improved the adherence to IPAC through increase of clinician engagement and interest in IPAC in each of the key elements (LIST)		12. The CEC guideline and resources were implemented in my workplace	86%
6. Overall, the CEC resources* related to COVID-19 infection prevention and control were accepted as the guidance to follow	84%	13. The IPAC Response and Escalation Framework, the COVID-19 IPAC manual and guides such as Health worker, patient and visitor risk matrices were frequently updated as information and the pandemic evolved	80%
7. My workplace was aware of the IPAC Response and Escalation Framework and each of its key elements	87%	14. The provision of CEC COVID IPAC resources, such as those listed above to my organisation was timely .	80%

* Resources refer to the COVID-19-IPAC Manual, IPAC guidelines, factsheets and tools found on the CEC COVID-19 IPAC website (<https://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19>)

Comments

Positive

- One source of truth
- The ability to refer NSW health care workers to 1 centralized repository for all IPAC guidance
- Clear and strong governance structure for IPAC
- The IPAC Framework enabled health organizations to coordinate varying response needs based on local risks/demand/circumstance/culture
- Brilliant with current and latest advice—unique and effective for rural and regional areas
- Providing a level of trust, confidence, and reassurance • Evidence-based and well-considered information • Showing coordinated support and leadership for IPAC from the statewide lead agency—CEC • Excellent and extremely resourceful

Challenges

Improvement opportunity

POSITIVE

- One source of truth
- The ability to refer NSW health care workers to 1 centralized repository for all IPAC guidance
- Clear and strong governance structure for IPAC
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- Brilliant with current and latest advice—unique and effective for rural and regional areas
- Providing a level of trust, confidence, and reassurance
- Evidence-based and well-considered information
- Showing coordinated support and leadership for IPAC from the statewide lead agency—CEC
- Excellent and extremely resourceful

CHALLENGING

- Sometimes were too much at times while the system was under pressure
- A little overly detailed sometimes
- Conflicting advice at times between Public Health orders, CEC IPAC guidelines, and Local Health District guidelines
- Resources were timely but took a long time for district implementation

IMPROVEMENT OPPORTUNITY

- More engagement and collaboration with the private sector being more beneficial
- Improving relatability of the IPAC Framework specifics to other settings such as oral health
- Improvement for implementation, communication, and updates between government departments

Comments

Evaluation of Framework Use During a Pandemic

- Demonstrates that the framework:
 - Supported **timely escalation and de-escalation**
 - Enabled shared understanding across clinical, operational, and executive teams
 - Improved consistency of IPC practices across settings
- Highlights its role in supporting:
 - Workforce confidence
 - Decision-making under uncertainty
 - Alignment between policy intent and frontline practice

Application Beyond Pandemic Conditions

The framework is **not disease-specific** and can be applied to:

- Seasonal respiratory infections
- Local outbreaks
- Emerging or novel pathogens
- Non-pandemic system pressures impacting IPC risk

Supports a shift from **crisis-driven responses** to **preparedness and routine readiness**.

Governance and Leadership Implications

Effective use relies on:

- Strong IPC leadership
- Defined escalation authority
- Executive sponsorship

Reinforces IPC as a **core patient safety and quality function**, not solely a crisis response mechanism.

Supports integration of IPC into **broader health system governance and risk management**.

Workforce and System Benefits

Provides a shared language for IPC risk and response.

Enhances:

- Situational awareness
- Multidisciplinary coordination
- Trust and transparency in decision-making

Helps reduce variation and cognitive burden for staff during high-pressure situations.

NSW IPAC Framework for Respiratory and COVID Safe Healthcare



Foundational level provides the minimum Infection Prevention and Control (IPAC) measures for preventing and managing Acute Respiratory Infections (ARIs) and COVID-19. Tier 1 (yellow and amber) and Tier 2 (red) levels provide escalation of preventative/management strategies and guidance to NSW health facilities in relation to the levels of transmission risk. Changes to risk level where state-wide, (including escalation or de-escalation) will be assessed by the Risk Escalation Review Panel (RERP) and directed by the NSW Health Secretary. Enhancement to IPAC may also be applied during foundational level, relevant to local epidemiology.

	TRANSMISSION RISK	CLINICAL & PATIENT CARE	VISITORS AND HEALTH WORKERS	GENERAL PRINCIPLES
Foundational Level Strategies	System prepared <i>Facility/unit outbreaks and/or community transmission increase</i> Implement enhanced IPAC precautions such as: - HWs and visitors to wear mask in clinical areas. - Symptom screening (if symptomatic, RAT test) - P2/N95 respirator and eye protection when providing care to patients with COVID-19	- Implement strategies^{1,2} to reduce risk of exposure - Get tested as soon as symptoms develop to enable timely access to antiviral medications - Patients with an acute respiratory infection (ARI) to wear a surgical mask on presentation and transit if able - Standard precautions, Personal Protective Equipment (PPE) as per Transmission Based Precautions (TBP) as required - Monitoring and management of cases through IPC contact tracing measures - Additional protection of vulnerable patients¹ - Outbreak management plans in place and reviewed, including notification processes	Visitors - Adhere to visitor policy (see guide to healthcare visitation) - Stay away if symptomatic - Symptom screening, mask wearing for high-risk areas and for vulnerable patients Health Worker (HW) - Positive HW - stay home until acute symptoms resolve; asymptomatic positive RAT / PCR stay home at least until day 3 (see HW return to work) - Additional controls for vulnerable patients¹	- Vaccination (COVID-19 & flu) recommended/required - Symptomatic testing /stay home if symptomatic or confirmed COVID-19 / flu - Infection Prevention and Control² - Hand/respiratory hygiene - PPE including masks / eye protection - Close contact monitoring for symptoms - HW training on IPAC principles - Airborne Precautions for AGPs /Aerosol generating behaviours - Optimise ventilation⁴ - HW to wear surgical mask and eye protection (≤1.5m) for all ARIs and as per risk assessment - HW – P2/N95 respirator and eye protection to be worn when managing suspected or confirmed COVID-19 and other communicable diseases patients as per TBP directions
Escalation Strategies Tier 1				
YELLOW	Low to moderate transmission risk	- All Patients to wear a surgical mask on presentation and during transit if able - Testing of suspected COVID-19 / flu / RSV and symptomatic ARI patients	- HW to wear surgical mask and eye protection for all ARIs - HW and visitors to wear surgical mask in clinical and patient facing areas	Consider increasing areas of mask wearing where indicated including publicly accessible areas
AMBER	Moderate to high transmission risk	- All patients to wear a mask on presentation and during transit if able - Symptomatic and selected surveillance testing of patients - Zoning of patients as required	HWs and visitors to wear surgical mask including non-clinical areas and shared spaces (e.g., on entry, corridors, office spaces)	High community prevalence and/or outbreak - Outbreak management plan activated and scaled up - Mask wearing for visitors³ - Limit visitor numbers - Staff surveillance testing - RAT screening of visitors - Surge workforce, if required - PCR COVID-19 / flu testing - National medical stockpile – deployment of additional PPE if required - Enhanced surveillance testing of patients
Tier 2				
RED	High transmission risk	- Universal surgical mask wearing - All ED HWs and HWs providing direct care in clinical areas to wear P2/N95 respirators and eye protection.	- Capacity limits, contingency staffing - Work from home, where possible - Selected surveillance testing for HWs	

¹ For example, Standard and TBP, isolation/cohorting, PPE (Mask + eye protection), case identification, in-hospital primary contact tracing, hand hygiene, cough/respiratory hygiene, optimising well-ventilated settings, environmental cleaning. For vulnerable patients (examples include but not limited to immune compromised, immunodeficiency, transplant) in protective precautions.

² Implementation of IPAC measures determined by CEC principles, facility IPAC guidelines in accordance with local risk assessment and Work, Health & Safety policies.

³ Aged care and disability residential care settings only. Visitors not required to wear masks at foundational level (so residents can see faces). However, facilities to assess their own risk and may require visitor mask wearing at all times.

⁴ Refer to published guidance [Optimising ventilation for infection prevention and control in healthcare settings](#).

Key Messages and Take-Home Points

- **Structured escalation frameworks strengthen IPC preparedness**, not just emergency response.
- **Pandemic-derived tools have enduring value** when systematically evaluated and adapted.
- Clear thresholds, actions, and governance enable **proportionate, timely IPC decisions**.
- IPC must be embedded as a strategic, system-level function rather than a reactive specialty response.
- Applying this framework beyond pandemics supports resilient, learning health systems.

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THU
18

June 18 @ 1:30 pm EDT

Monitoring and Evaluation to Optimize Microbiology and Care

Prof. Prameet Sheth, Queen's University, Canada

Free



TUE
23

June 23 @ 2:30 pm CEST

The Role of the Environment in the Transmission of Infection – How Can We Intervene?

An **International Federation of Infection Control (IFIC)** teleclass

Prof. Elaine Cloutman-Green, Great Ormond Street Hospital, UK

Free



July 2026

THU
9

July 9 @ 1:30 pm EDT

Mycobacterium tuberculosis Transmission in Healthcare Settings

Prof. Michael Klompas, Harvard University

Free



THU
16

July 16 @ 1:30 pm EDT

LTC Preparedness for the Next Pandemic Part 2 – Getting Ready

Dr. James Ayukekbong, Editor-in-Chief, Canadian Journal of Infection Control

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