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Contents lists available at ScienceDirect

American Journal of Infection Control

journal homepage: www.ajicjournal.org

Letters to the Editor

Re: Letter to the Editor, Regarding the pre-proof of “Implementation of a successful infection prevention and control governance structure and capacity building strategies during COVID-19 pandemic —A brief report”



To: The Editor, American Journal of Infection Control

Re: The Pre-Proof of “Implementation of a successful infection prevention and control governance structure and capacity building strategies during COVID-19 pandemic – a brief report” (Dempsey K, 2022).¹

As a collective group with expertise in workplace health and safety, occupational hygiene, occupational medicine, emergency medicine, paramedicine, infection prevention and control, and public health, we express our dismay at the suppositions in the article that the New South Wales Clinical Excellence Commission (NSW CEC) has resulted in positive outcomes during the pandemic. While it is noble for the authors to document their work during the pandemic for others to learn from, their conclusions, including that, “*the infection prevention and control measures and strategies implemented within health and non-healthcare, proved to be effective...*” is not evidence-based and does not stand up to external verification.

The following statements in the article are overstated:

“Since January 2020, the CEC has developed **extensive** COVID-19 IPAC guidance for healthcare and other settings to build IPAC capacity and capability at a systems level, with a focus on providing **timely expert advice on current and emerging problems** in HAI impacted by COVID-19. These resources are **regularly reviewed** and **updated in line with new and emerging evidence**.” [emphasis added]

The reluctance of the NSW CEC to recognize the need to protect healthcare workers from airborne transmission of disease has been strong. Early versions of the *COVID-19 Infection Prevention and Control Manual* in April 2021 restricted the use of airborne precautions (inclusive of P2/N95 respirators) to specific circumstances. That Manual outlined that only contact and droplet precautions were required if healthcare workers were within 1.5 m of patients, which reflects an ignorance of aerosol transmission dynamics as well as the risk of

transmission between staff. Airborne precautions were only required in cases of ‘moderate transmission’ where the non-evidence-based “aerosol generating procedures” were taking place, or if multiple patients were cohorted in one area. It was not until May of 2021 that the Manual was updated to include a recommendation that health care workers wear P2/N95 respirators to protect against SARS-CoV-2 based on an assessment of the risk of transmission (Clinical Excellence Commission).² This was some 6 months after conclusive evidence was published that SARS-CoV-2 was airborne, including more than 200 scientists calling for it to be recognized as such in a paper providing the evidence for this published in November 2020.³ This is not consistent with the authors claim that their expert advice was “timely” nor up to date with “emerging evidence.”

Indeed, that same Manual in February 2022 still referred to “aerosol generating procedures” and stated that, “SARS-CoV-2 is mainly spread by direct contact with respiratory droplets and these droplets can be of various sizes and can be aerosolized in **some specific conditions.**” [emphasis added]

We note that the NSW CEC only first published their Respiratory Protection Program Manual in December 2021,⁴ 9 months into the pandemic, more than a year after the state of Victoria, and more than 8 years after South Australia.

The NSW CEC has also repeatedly misunderstood the application of basic workplace safety processes such as the hierarchy of control. This is evidenced in the latest version of the Manual published in July 2022, through the following examples. Repeated, incorrect classification of controls artificially elevates their effectiveness, when in fact, they are lower level and prone to human errors.

- Categorizing “testing and quarantine” and “travel restrictions” as elimination controls, when these are in fact administrative controls;
- Categorizing “physical distancing” as a substitution control when it is administrative; and
- Categorizing “registration of all people entering the facility” as an engineering control when this is administrative.

A repeated failure to recognize the contribution of aerosol transmission was further reflected in the NSW CEC Infection Prevention and Control Manual for Quarantine Hotels which stated that, “*Whilst the risk of aerosol transmission requiring airborne precautions is acknowledged it is not the primary mode of spread for COVID-19 and requires a risk assessment approach.*”⁵ As a result, the control measures contained within that document did not adequately control the risk of transmission of COVID-19, due to the absence of control measures to address the risk of airborne/aerosol transmission.

But above all, the continual failure to recommend appropriate personal protective equipment for healthcare and other workers in high-risk settings was the most telling example of the lack of a multi-disciplinary approach from the NSW CEC. P2/N95 respiratory protection is the minimum level of respiratory protection for an airborne

virus. Yet such was restricted from workers who were required to be in environments where the potential to breathe ‘shared’ air occurred. This included hotel corridors, saliva screening, hotel entry temperature checking, guest floors, and when in direct contact with a guest (regardless of symptoms). The absence of a specific mention of the need for respiratory PPE fit-testing for use in hotel quarantine per the recognized Australian Standard was also of deep concern.⁶

That the authors claim the NSW CEC resources were appropriate, only further speaks to the insular nature and culture against continuous improvement and its failure to heed expert advice from other disciplines, including aerosol science, occupational hygiene, occupational medicine, workplace health and safety, and public health. This paper lacks scientific evidence and providing a platform for these unsubstantiated claims risks the reputation of the journal. To publish this paper unchallenged would promulgate the already insular culture of the Commission and continue to put the lives of Australian health care workers and broader community at ongoing risk.

References

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Kate Cole OAM, BSc Biotech, MEEM, MSc OHP, MAIOH, COH, CF^{a,*}
Jane Whitelaw, MAppSc, FAIOH, CIH, COH^b

Lisa Maher, PhD, FAHMS, FASSA^{c,d}

Alan McLean, BHLthSc, MHLthAdmin, DrPH, FCHSM, CHE^e

Karina Powers, FAFOEM (RACP), MBBS, MPH, PGDip Occ Hlth Sfty^f

David Caldicott, B.Sc(Hons)-[N.U.I.] MB.BS(Lond.), FRCEM, Dip Med Tox^{g,h,i}

^a Cole Health Pty Ltd, Balmain, NSW 2041, Australia

^b University of Wollongong Australia, Wollongong, NSW 2522, Australia

^c Kirby Institute for Infection and Immunity, Faculty of Medicine, UNSW Sydney, NSW 2052, Australia

^d Burnet Institute, Melbourne, VIC 3004, Australia

^e AMAC-Consulting St Andrews Ave Mount, Osmond, SA 5064, Australia

^f Occupational Physician, Private Practice, Subiaco WA, Australia

^g Emergency Department, Calvary Hospital 5 Mary Potter Cct, Bruce, ACT 2617, Australia

^h Emergency Medicine, Australian National University, Canberra, ACT 2600, Australia

ⁱ Health & Design, University of Canberra, The Australian National University, Canberra, ACT 2600, Australia

* Address correspondence to Kate Cole OAM, BSc, Biotech, MEEM, MSc OHP, MAIOH, COH, CF, PO Box 605, Balmain, NSW 2041, Australia.

E-mail address: kate.cole@colehealth.com.au (K.C. OAM).

<https://doi.org/10.1016/j.ajic.2022.08.009>

Implementation of a successful infection prevention and control governance structure and capacity building strategies during COVID-19 pandemic – A brief report



We would like to thank Cole et al for their letter to the editor and we welcome the opportunity to provide discussion and feedback. The Clinical Excellence Commission (CEC) has extensive, timely and well-documented gains in building an infection prevention and control (IPAC) response to the COVID 19 pandemic in New South Wales (NSW). The article *Implementation of a successful infection prevention and control governance structure and capacity building strategies during COVID-19 pandemic – a brief report*¹ focused on the governance structure of leading an IPAC response and how this was done in an unprecedented time. In documenting our governance work, we have highlighted only a modest portion of the significant impact we have had supporting the safety and wellbeing of staff and patients across NSW health system. It is, however, disappointing to see the misinterpretation of the intent of the article and note there are inaccuracies in the letter to the editor that warrants response and clarification.

There has been significant public discourse about the relative contribution of aerosols and airborne transmission in SARS-CoV-2. Unfortunately, this has been expressed in social media and other platforms as epithetical to frankly egregious and usually directed towards individuals and organisations who did not immediately recommend widespread use of N95 respirators in healthcare. Commentary typically included allegations about denial of science, but also included accusations that these individuals, or organisations were causing harm somewhat deliberately. We believe the statement by the authors implying reluctance of the CEC to recognise the need to protect healthcare workers from airborne transmission is emotive and without concrete evidence. The CEC guidance consistently reflected national and international guidelines and has always incorporated the escalation to airborne protection as risk assessed. The ability to risk adjust and assess through specific circumstances provided a balance of health worker protection with the delivery of quality and safe patient care.

The COVID-19 response at the CEC was informed by our work with experts, collaborative organizations to develop and refine guidance.² In addition, and critical to the final publicly available documents, there was broad and repeated consultation, predominantly with those who have expertise in infection prevention and control, outbreak management, infectious diseases (including virology), emergency, respiratory, anesthetic, intensive care medicine, occupational medicine, and public health. Productive collaborative networks also included the Ministry of Health, and agencies supporting workforce, supply, infrastructure and building, the critical intelligence unit, and health education and training. The purpose of our publication was to acknowledge that this inclusive and consultative response required robust governance.¹

The incursion of ancestral strains of SARS-CoV-2 in NSW was largely controlled through hard border closures and mandatory quarantine of returning travelers. Fortuitously, these strains were also much less effectively transmitted than later strains, including Delta and Omicron. In the early part of 2021, it was clear from overseas