

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.

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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

experience that Delta was both more transmissible and more pathogenic than earlier strains. In response to this, CEC guidance was changed to reflect the increased risk of transmission, including airborne transmission, of SARS-CoV-2 and was published in April 2021. What is important to understand is that the web publication is the very last step in the development process and practices change before the publication date because a large number of our stakeholders were (and continue to be) consulted. It is important to note, that in the first few months of 2021, Australia (not just NSW) was experiencing a daily case count of about 1/1,000,000 population.³

Central to infection prevention and control is protection from transmissible infections of patients, staff, visitors, contractors, and anyone who enters a health facility as outlined within IPAC policy and guidelines. The IPAC framework in fact has been in place internationally prior to 1996, and whilst consistent with the hierarchy of controls which ranks controls from the most to the least effective, it is important to note here the difference in language used which is well embedded in IPAC. This language may not be familiar to those with expertise outside IPAC yet can be the subject of unjustified criticism, as seen throughout the pandemic. In general, a recurring theme throughout the pandemic has been claims in relation to IPAC expertise by those with limited to no specific experience to IPAC practices, frameworks, risk assessment or the health care environment.

For staff, we specifically centred guidance on the early detection of infection (patients), the appropriate use of personal protective equipment (PPE) (which included the rapid implementation of a respiratory protection program), physical distancing where possible, and recognition that staff transmission to other staff was mostly occurring in shared spaces such as break rooms/meeting rooms (For example see health worker safety posters developed by the CEC⁴). With support from other agencies, further steps to ensure additional measures were put in place.² These included enhanced staff access to on-site rapid testing, availability of sick leave provision for staff and their families, consistent and reliable availability of PPE, and review of health facility air quality with mitigation implemented as required. Alongside this, there were detailed reviews of any health worker who acquired COVID-19, together with robust reporting of infections in health facilities. Enhanced surveillance for COVID-19 infections in health workers was implemented by NSW Health early in the pandemic with the aim to identify any areas to improve in COVID-19 procedures and practices in the workplaces where infections occur or where potential transmission events were identified.

The respiratory protection program (RPP) guidance and related material was first published in August 2020 and has continued to be revised and refined. In December 2021 the RPP guidance documents were incorporated in to an RPP manual. The suite of materials supporting the RPP includes training materials for the use of PPE and videos demonstrating appropriate fit checking for the variety of respirators available in the Australian context (videos). Furthermore, CEC's role in implementing and sustaining a respiratory protection program in the midst of a pandemic is well documented in our recent publication *Implementation of a Respiratory Protection Program within Healthcare Facilities during the COVID-19 Pandemic- Lessons Learned in the AJIC*.⁵ There has also been work mitigating pressure injuries related to respirators (see publication⁶) as well as providing evidence that respirators can be used in staff who are unable to remove their beards for religious or medical reasons (see publication⁷).

Cole et al's reference to the hotel quarantine manual is misinformed however we appreciate that we cannot expect the authors to have a comprehensive understanding of the entire program. All advice and guidance in this manual is underpinned by IPAC principles adapted for a setting that fell outside normal health care parameters. The quarantine hotel program managed 225,441 arrivals × 14

quarantine days (possible exposure days) with over 4,626,174 private hotel security hours in surgical masks in addition to other mitigation strategies in the period 29 March 2020 through to 19 September 2021.^{8,9} During this period, there was only four recorded incidents of COVID-19 transmission linked to hotel quarantine and nil health worker transmissions. The program did have a fit test program for staff required to wear respirators, and we note that for the areas that the authors criticised, no transmission events were recorded.

The notion of success defined by our article is less about the content detail Cole et. al. focus on nonetheless more about the importance of a clear governance structure to improve clinical engagement. The article aims to demonstrate a governance structure that increased engagement from many disciplines, inclusive of occupational physicians and professional specialties (as per detail outlined earlier in this response). The divide between the approach and language across IPAC and other distantly related disciplines should not be seen as a disregard for the strong elements in those disciplines but rather an acknowledgement of approaches and an environment built on risk assessment in healthcare designed for health worker safety balanced with quality and safe patient care.

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