Hospital acquired infection prevention submission to the Inquiry into Australia's COVID-19 response

Thank you for the opportunity to make a submission to the Inquiry into Australia's COVID-19 response. This submission will address the governance by health bodies, Ministers and policy makers, and key response measures terms of reference; particularly focusing on Australia's response to the ongoing risk of SARS-CoV-2 and the lack of recognition of airborne transmission and adequate airborne infection prevention controls to prevent nosocomial transmission and associated poor outcomes.

Australia is not alone in having failed to appropriately recognise and act to prevent airborne transmission and its impact on risk assessment and infection control. In May 2023, Australian Distinguished Professor Lidia Morawska's published a paper Coronavirus Disease 2019 and Airborne Transmission: Science Rejected, Lives Lost. Can Society Do Better? - PubMed (nih.gov) which detailed the action she and other experts took in the early years to get airborne transmission of SARS-CoV-2 recognised and how this is still having an impact on health policy today. Victoria listened and took many appropriate steps to recognise and prevent airborne transmission. Why then did other States and Territories and the Federal response fail to do so, and why are they continuing to ignore the need for airborne infection prevention controls, despite numerous calls from patients, patient organisations, and medical professionals and experts to do so?

The Australian Commission on Safety and Quality in Healthcare (ACSQHC) has a number of roles that are relevant. The most important of which is the Charter of Healthcare Rights that guarantees seven rights, including access to care that meets a person's needs, safe access to care, and respectful care. Australians are denied these rights because of the absence of appropriate airborne infection control policies; a direct consequence of the failure of ACSQHC's own Healthcare Acquired Infection committee. Members of that committee have been a barrier to recognition of, and action on airborne transmission since the beginning of the pandemic. The Healthcare Acquired Infection (HAI) committee of ACSQHC (which has been responsible for the National Hand Hygiene Initiative for many years) needed to implement a national airborne prevention initiative, but the committee's ideological rejection of the scientific evidence of airborne transmission documented by Morawska and others, leads it to act against its obligations.

We've attached correspondence one [redacted] have had with both NSW Clinical Excellence Commission (NSW CEC), on behalf of NSW Health Minister Ryan Park (Appendix one) and ACSQHC (appendix two) on this. Disappointingly, both NSW CEC and ACSQHC firmly pushed responsibility for personal patient safety back on to the severely immunocompromised patient, and ignored that they were needlessly creating a hazardous environment for essential health care. As advised by the CEC, the severely immunocompromised patient had the conversation with his treating team, both in advance of the scheduled operation and when he arrived for his [redacted] who all agreed with the need to prioritise his safety, and yet was treated almost entirely by unmasked healthcare workers in contravention of airborne infection prevention guidelines. This is despite the Charter of Healthcare Rights being prominently displayed in every cubicle and throughout the hospital. The theme of the responses is to fall back on national guidance which fails to grasp the implications of airborne transmission – particularly the need to do more than wearing surgical masks in high-risk clinical areas, as Western Australia did in reinstating surgical masks in high-risk areas in healthcare, in November.

SARS-CoV-2 is in the air. Airborne transmission means it's in the air in the emergency department, it's in the air in reception, it's in the air in all areas of hospitals and isn't restricted to 'high risk clinical settings'. But high-risk patients need to access all areas of healthcare, including reception and waiting rooms or being able to take family members to attend healthcare appointments as carers themselves.

We've excerpted some concerning points raised by the NSW CEC in their correspondence (attached in full in Appendix one) and will address those issues below:

1) The move to foundational level provides core Infection Prevention and Control (IPAC) measures with recommendations for escalation or enhancements, or de-escalation, in response to local need.

For many weeks the NSW Health Department have been noting that NSW is currently in a period of HIGH transmission, yet there has been no escalation of airborne infection prevention controls in healthcare settings in the State. Dr [redacted] response (see appendix one) claims that transmission was low and that that justified the foundation level response, but within weeks NSW Health was acknowledging moderate to high transmission and yet continuing not to act to prevent transmission. There has been no "escalation of enhancement in response to local need".

The use of respiratory personal protective equipment (N95 respirators) is widely recognised as both a source control and personal protective equipment control in the risk reduction of airborne pathogens -*with source control being the more effective risk reduction measure* (i.e. everyone masking versus one-way masking). The suggestion by NSW CEC and ACSQHC that patients may choose to wear a mask to protect themselves fails to acknowledge that *one-way masking* is insufficient protection: hospital-stays involve many moments where masks must be removed (eating, taking medications, treatments etc) and masking is impractical for infirm, elderly or confused patients. For example, patients, who understand the risks of airborne transmission and are wearing N95s, have to remove their respirators, in order to take pain medicine from unmasked healthcare workers. This is fundamentally not safe and in conflict with the *Charter of Healthcare Rights* (displayed on healthcare walls across the country), articulating his right to access safe healthcare. Providing a safe healthcare facility is the responsibility of the facility and cannot be transferred to patients.

'Masking fatigue' may be a motivation for the Australian Health Protection Principal (AHPPC)'s and other government department's reluctance to implement routine masking requirements, but as [redacted] et al., 2023 note, masking among health care workers can reduce nosocomial respiratory viral infections by ~60%. They also note that it would be a mistake to ignore the SARS-CoV-2 threat and that [redacted]

Masking plays an important role in employee safety in many sectors and should be integrated into healthcare occupational health and safety protocols. Employee training, education, and mask fit testing should now be routine to protect patients, visitors, and staff. Infection control procedures should be updated to include mitigations for airborne diseases. As above, access to safe healthcare services is one of seven *Rights* articulated in the Australian Charter of Healthcare Rights, which applies to all Australians who seek medical care. The provision of a safe work environment is also a basic employee right.

2) At this time, transmission is considered less likely when a person is asymptomatic, a view supported anecdotally by our local experiences. Most people with symptomatic COVID-19 have acute respiratory symptoms, even if quite minor, with a small proportion only having non-respiratory symptoms. Standard and transmission-based precautions equally apply to these scenarios.

Concepts such as "less likely" and "most" have no place in setting infection control policies. It is probably true that it is "less likely" a person with no visible contamination on their hands would spread disease than someone with filthy hands, and "most" people would not be infected anyway. To see such flippant statements from the CEC is highly alarming. It is widely recognised that SARS-CoV-2 is frequently asymptomatic, that some infected people have non-respiratory symptoms, and that many people are infectious for well beyond the minimum isolation requirements. More robust and comprehensive policies should be implemented. The NSW CEC in their response have prioritised anecdotal evidence over robust, published, peer-reviewed data and must be held to account for such a shockingly unscientific and nonchalant approach to patient safety.

The process of assessing risk of SARS-CoV-2 transmission in healthcare facilities needs to be reconsidered. SARS-CoV-2 is airborne, constantly present in the community and more than 50% infections are the result of asymptomatic transmission. All hospital patients should be regarded as 'high risk' given their current medical problems and in many cases, patients are unable to wear respirators (due to young or advanced age, confusion or during surgery, imaging, or other treatments) and thus rely entirely on the facility to provide a safe environment. 2022 data from Victorian hospitals noted a mortality rate of >10% in patients who acquired SARS-CoV-2 while in hospital and similarly alarming outcomes have been reported overseas. As part of good governance and optimising patient outcomes, healthcare facilities should explicitly prioritise protecting patients from contracting SARS-CoV-2 (or any other communicable disease) when in their care.

3) Transmission of COVID-19 within our facilities is unlikely associated or caused by ventilation.

Indoor air ventilation systems – including in healthcare facilities - are not currently designed for infection control, as attested to by the hundreds of millions of SARS-CoV-2 infections to date, with the vast majority of transmission occurring in indoor spaces. In time, ventilation, air cleaning and air quality monitoring systems will be upgraded to meet stringent new standards to ensure clean indoor air. In addition (and while engineering controls are being enhanced), masks should be adopted as a routine element of infection control within healthcare systems, just as surgical gloves are routinely worn during surgery to prevent wound infections.

We would like to draw your attention to some excellent, Australian-based, multidisciplinary research involving air quality assessments within the Royal Melbourne Hospital. The expert authors have also been awarded several research grants to improve indoor air quality to minimise transmission of airborne respiratory pathogens and have provided submissions and expert testimony to the Inquiry on Long COVID and Repeated COVID Infections, conducted by the House of Representatives Standing Committee on Health, Aged Care and Sport. Ventilation is absolutely associated with transmission of SARS-CoV-2 and other airborne viruses, in all settings, and we highly commend these documents to the committee as a template for best practice regarding indoor air quality measures.

4) Considerations now also include level of vaccination, hybrid immunity and disease severity.

Past infection (and therefore so-called 'hybrid immunity') has been shown to be associated with increased reinfection risk and should not be being relied upon as a preventative strategy. Additionally, past infection has also been shown to weaken the immune response to vaccination so allowing rampant transmission of SARS-CoV-2 in pursuit of 'hybrid immunity' is in fact undermining our vaccination strategy, while also ignoring the significant risks of long COVID.

Equally concerning, members of this Committee have been quoted in the Australian media, as recently as 29th December 2023, heralding the benefits of 'hybrid immunity', suggesting that with "each wave people's prior immunity is helping them avoid infection, not just have a more mild infection". The published scientific evidence does not support this statement, and members of this Committee should ensure that this Inquiry maintains its independence by refraining from making such statements to media that may undermine their own independence.

5) Unfortunately, your situation had not been discussed or escalated to the Infection prevention and control unit, however some internal strategies were being implemented to rectify the issues you have raised.

As the Inquiry Committee will be aware, the ACSQHC have a duty to uphold the charter of healthcare rights, which as mentioned above, expressly states people will have access to care that meets their needs, safe care and respectful care. At no point should this involve high risk patients having to ask repeatedly for appropriate infection prevention controls, or to escalate their concerns to the appropriate teams. These rights are simply not met with the abandonment of masks in healthcare settings for immunocompromised and high-risk people.

Conclusion

The Covid Inquiry in the UK has been explosive in terms of the position of the Johnson government, particularly with respect to "why anything should be done to protect people who are going to die anyway" – i.e. the immunocompromised, disabled and elderly. Absolutely incredible to hear the callousness, yet here in Australia, in 2023, why is so little being done to prevent the rising number of outbreaks in health and aged care settings despite the learnings from home and abroad?

Although national data on deaths due to hospital-acquired SARS-CoV-2 infection is not available, extrapolation from numbers obtained under Freedom of Information from Victoria and Queensland indicate that well over 1,000 Australians died in the last 12 months after catching SARS-CoV-2 in hospital. Even if improved infection control were only partially effective, hundreds of lives can be saved over the next year. Infection controls must not be relaxed simply because such precautions are inconvenient, or people are "over it". This has never been a valid consideration and should not be adopted now without rigorous debate, justification and opportunity for stakeholder engagement.

Why is ACSQHC not upholding the charter of healthcare rights and ensuring that people who are already extremely vulnerable to SARS-CoV-2 infection, are protected from being infected while in healthcare, and how does this fit with the national strategy of protecting the vulnerable and leaving no one behind? How is the national strategy to protect the vulnerable and leave no one behind being met when 'the vulnerable' can't even access healthcare safely?

We kindly urge the Committee to reflect upon and reconsider the current suite of SARS-CoV-2 -related policies and mitigations that the Australian community is relying upon when accessing healthcare. A national airborne prevention initiative should be prioritised which will protect patients and staff today, and into the future. AHPPC, and all involved in setting the National Strategy, including ACSQHC, should refresh and update their approach to SARS-CoV-2, putting the health of patients firmly at the core of its new strategy, safeguarding the Australian Charter of Healthcare Rights.