Guidance for healthcare workers who are COVID-19 cases or contacts during an Omicron outbreak

This guidance will be effective once there is evidence of community spread of a highly transmissible SARS-CoV-2 variant (e.g. Omicron)

Introduction and Contents

This document provides technical guidance for clinical leaders and managers. Accompanying FAQs for staff are in development.

It covers:

- Being prepared for the situation when SARS-CoV-2 variant Omicron is becoming more widespread in the community
- Key principles for using this guidance
- The management of healthcare workers who are:
    - COVID-19 cases or probable cases
    - COVID-19 contacts

This document provides guidance for situations where service provision will be at risk of substantial compromise due to staff absence related to Omicron infection or exposure. It refers to the 'companion' document, the current guidance for management of healthcare worker (HCW) exposure events – 'Risk Assessment and Categorisation of Healthcare Workers Exposed to COVID-19 at Work'. That document remains the 'base' guidance for management of healthcare COVID-19 exposure events, particularly in the initial 'Stamp it Out / Containment' phase of New Zealand's Omicron response. Even once New Zealand moves to the 'Manage it' phase of the response, if there is no criticality to the workforce or service, then the current guidance for management of HCW exposure events in healthcare settings, and standard public health case and community exposure advice, is to be followed. Within the parameters of that criticality, this is an enabling framework to allow individual services and regions to make decisions appropriate for their circumstances.

This guidance applies to HCWs and services across the sector; specifically it applies to aged residential care, primary and community services, home support services provided for a variety of clients including mental health and disability support services, and is appropriate for use by NGO and private providers.

In district health board (DHB) settings, support to use this guidance may be provided by occupational health, infectious diseases, clinical microbiology, infection prevention and control (IPC) and/or service leadership. In non-DHB settings it is recommended that a registered health professional is nominated by the organisation to take the lead / support managerial use of this guidance to work with staff who are COVID-19 contacts and cases.

This advice will be updated as the COVID-19 situation continues to evolve. Updates will be made available through the Ministry of Health website. The Ministry of Health and DHBs welcome any feedback to inform future iterations.

Preparedness

- **The 'basics' matter** now more than ever.
    - Continue to support and encourage **all staff, and where possible patients/clients, to (correctly) wear a medical mask at all times** in healthcare settings, to maintain physical distance, and be vigilant about hand hygiene.
    - There is increasing understanding that wearing a 'well fitting' mask that has at least three layers improves its effectiveness and protection. There are a variety of techniques to improve the fit of a medical mask. For further information see 'Improve how your mask protects you'.
    - Ensure everyone who has COVID-19 symptoms stays home and gets tested.
- **Receiving a booster dose of COVID-19 vaccination** substantially reduces transmission risk, compared with a completed primary vaccination series. Boosters should be strongly encouraged for everyone who is eligible. Boosters are now mandated for HCWs in New Zealand – those who are eligible for a booster, are required to receive this by 15 February 2022. In the meantime, boosted and unboosted staff are both treated as 'vaccinated' for the purposes of this guidance.
- **Staff breaks / mealtimes are key occasions to allow for rest and refreshment.** However, if physical distancing is not optimal and when time spent with others is more than 15 minutes, removing masks at mealtimes means the risk of exposure is increased during breaks if a COVID-19 case has worked during their infectious period. Some services/organisations have implemented rostered/staggered meal breaks, encourage breaks to be outside, and have asked staff to limit the time they spend with others when on breaks. **There is a need to be creative and supportive to maintain team morale. It is as critical that we ensure staff get breaks as it is that we keep them safe during these times.** Facilities for staff only and preferably department only meal and rest breaks areas should be made available to further limit potential transmission, where possible and practical.
- **Communications are important.** All service providers need to talk with their staff about the potential scenario when this guidance will be applied and what that means in practice. This guidance describes exemptions for staff who are recovering cases or close / higher-risk contacts to return to or continue to work to maintain critical services in the face of a large-scale community COVID-19 outbreak, while

balancing the risks that involves. It does not mean affected staff are free to carry on life in the community outside of their home as if they were not a case or contact; outside of work staff will need to comply with relevant public health instructions for cases and contacts.

- **Use of Rapid Antigen Tests (RATs) will be important** to safely allow implementation of this guidance. Given the high likelihood of many staff coming into contact with or contracting highly transmissible COVID-19 variants, and potential logistical issues in delivering RATs to individual staff members, all health care organisations are recommended to have arrangements in place to facilitate access for all staff to a supply of RATs. This supply of RATs should include instructions for use.

Key Principles

1. There are several controls in healthcare settings which mean the risk of COVID-19 transmission in our workplaces is considerably less than in general community settings. When this guidance is applied, the transmission risk in the community setting will be high and will be the most likely place HCWs will acquire COVID-19 infection. However, the following guidance applies regardless of where someone is infected or potentially infected.
2. In the setting of increasing numbers of Omicron cases and as per Ministry of Health guidance, most people in the community will be expected to self-manage their COVID-19 exposure and case experience. This means we will need to have systems for staff to self-report exposure or illness, rather than there being workplace notification via public health. Each workplace will need to arrange for this process to be set up and understood by staff.
3. International experience of Omicron suggests that within 2-3 weeks of initial community transmission, service provision will be at risk of potentially substantial compromise by staff absence related to Omicron infection or exposure. In New Zealand, this would be on top of already stretched workforce capacity. There will be a need therefore to make pragmatic decisions on the management of healthcare workers who are COVID-19 cases or exposed to COVID-19 at work or in the community. This means balancing transmission risk, the health and safety of the individual, their family and whānau and co-workers, with the ability to deliver safe healthcare. Safety considers impacts on the workers themselves, co-workers as well as patients, clients and whānau.
4. This guidance has been developed based on international recommendations, which note the need for a pragmatic approach, balancing risks and the limited evidence about the options proposed. It is divided into two sections and applies to all healthcare workers, across the health sector, who have been exposed to COVID-19 or may actually have COVID-19 i.e. contacts and COVID-19 positive healthcare workers, in the context of an Omicron outbreak as follows:
    i. If there is no criticality to the workforce or service, then the current advice for management of HCW COVID-19 exposures in healthcare settings, and standard public health case and community exposure advice is to be followed. Where work from home options are appropriate, they should be utilised to support care to continue.
    ii. **BUT**, and only as a last resort, if there is a risk because of a critical workforce situation (either because of the criticality of the service provided or the number of people able to work) then different scenarios will be in effect if the individual is infected or exposed.
5. It is important that staff management is appropriately documented. Records should be kept locally. Staff should be directed to fill out online self-notification of their case / contact status once that option is available from the Ministry of Health.

1. Management of health care workers who are COVID-19 cases or probable cases

a. Where service delivery is not at risk by their absence, workers should follow general public health advice for isolation, having informed their manager about their infection.

b. If however, their ability to work is critical to service continuity, and if the worker is asymptomatic or mildly symptomatic and improving (i.e. they are not acutely unwell), **Table 1** outlines the recommended course of action.

Table 1: Management of COVID-19 Omicron cases, in critical health care workers

Vaccination status	Symptom status	Stand-down from work	Measures on Return to Work
Boosted, or primary course COVID-19 vaccination only	Asymptomatic or mildly symptomatic (and improving)	Stand down for 5 days, and RAT test day 5* If negative, RAT test day 6 prior to shift If both Day 5 and Day 6 RAT tests are negative, return to work on Day 6 If RAT positive at Day 5, continue daily RAT testing until negative, then return to work the following day after a further negative RAT prior to their shift (i.e. negative tests two days in a row)^ If Day 10 and asymptomatic return to work without requiring a negative RAT test	Correct use of a well-fitting (advice on this is available) fluid resistant medical mask (Type IIR)⁺ Practice other IPC measures (hand hygiene, maintain physical distancing) Be very careful if in shared breaks and eating areas, noting the transmission risks described above Avoid public transport while commuting unless it is unmanageable for you to get to work otherwise (see further below) Outside of work, continue to follow public health instructions for community cases
	More than mildly symptomatic and not improving	Continue to remain at home	The HCW should liaise with their employer for ongoing management of their return to work

* Day 0 is either day of symptom onset, or day of first positive test if asymptomatic throughout
^ Any RAT undertaken to return to work should be done before going to work (not at work prior to starting a shift)
⁺ Please check with the supplier or IPC advisors regarding masks that meet this standard

Use of public transport

Getting to work is considered part of 'being able to work'. If healthcare workers need to use public transport to enable them to continue to work in their critical role, this is deemed part of their exemption. However, public transport should only be used as a last resort if no other transport options are available. Key considerations include:

- The required negative RAT test prior to the return to work must be done before using public transport (not once arriving at work)
- If using public transport, workers should be meticulous about the correct use of their mask, distancing from others, hand hygiene and recording their movements
- If private transport options are available, these should be used where possible, and staff should avoid commuting with other staff if using private transport (unless in a pre-arranged work bubble).

Examples of how transport options might be addressed will be included in the accompanying FAQs.

2. Management of health care workers who are COVID-19 contacts

a. Again, where service delivery is not at risk by their absence, the current advice for management of HCW COVID-19 exposures in healthcare settings, and standard public health community exposure advice should be followed, with the HCW's manager having been informed about their exposure.

b. Where their ability to work is critical to service continuity, their level of risk will be assessed using standard HCW risk assessment and categorisation tables in Appendix One (from the companion document 'Risk Assessment and Categorisation of Healthcare Workers Exposed to COVID-19 at Work') and then Table 2 below outlines the recommended course of action. This framework assumes that:
   i. The health care workforce involved has had a full primary COVID-19 vaccine course +/- booster and has always worn a medical mask as a minimum.
   ii. The actions for staff who have been exposed in the community and categorised as close contacts are the same as for higher risk health care exposures at work.

Table 2: Management of COVID-19 contacts (exposed at work or in the community), for critical health care workers

	Lower risk health care exposures / Casual contact in the community	**Higher risk health care exposures / Close contact from community exposure**
Exposure Type	Level I or II health care contacts / Casual contact in the community	Level III or IV health care contacts / Close contact in the community
Restrictions or stand-down, as long as asymptomatic	No stand-down required • Remain vigilant for symptoms • Stay home if symptoms develop and get a test • Surveillance testing if recommended and already in place for the staff group of which the worker is a part	• Negative Day 1[+] RAT test before presenting to continue working • Negative RAT required before any/each shift for 10 days[++] post last* exposure (depending on the current settings for Close Contacts), where possible • Correct use of a well-fitting fluid resistant medical mask (Type IIR)** • Be very careful if in shared breaks and eating areas, noting the transmission risks described above • Avoid shared transport for work commuting unless it is unmanageable for you to get to work otherwise • Be vigilant for symptoms. Stay home if symptoms develop and get a test • Outside of work, continue to follow public health instructions for community contacts. Where contacts have ongoing exposure to a case (i.e. in their household), the quarantine period and/or period of testing using RATs may need to be extended[++]

[+]Day 0 is the day of, or last day of, exposure(s), day 1 is the first day following the day of, or last day of, exposure

[++]Note the duration of RAT testing relates to standard period of isolation time for COVID-19 close contacts. The isolation time was lengthened from seven to ten days on 21 January 2022; this will be in place for the duration of Phase One. It is likely that the isolation time will revert to seven days when New Zealand moves to Phase Two. Corresponding changes to this document will be notified. The current state can also be checked on the Ministry of Health website, at Contact tracing for COVID-19 | Ministry of Health NZ. In the meantime, all current contacts in these categories need to move to 10 days of testing.

* Household contacts should minimise contact with the case in their household as much as possible. For household contacts with ongoing exposure, testing before each shift begins when they return to work and needs to continue until 10 days after last exposure (e.g. when the case they are living with is declared non-infectious). Similarly, outside of work they need to follow public health instructions about quarantine as per current household contact requirements. The management of household contacts will be reviewed as New Zealand moves through the different phases of our Omicron response; this document will be updated accordingly.

** Please check with the supplier or IPC advisors regarding masks that meet this standard

Appendix One: Risk assessment and categorisation of healthcare workers[1]

Table A: Factors to consider in risk assessment

Risk assessment should always take into account the community prevalence of COVID-19 as well as the following:				
Exposure details • Known in-hospital transmission provides a higher risk of further transmission • Exposure outside of work including when commuting to work • Exposure at work but with no known transmission	**Case details** • Case infectiousness (e.g., CT value where available) • Presence and type of symptoms, such as respiratory distress or delirium which increase the risk of transmission • Aerosol/droplet generating behaviours (AGB/DGB) by the case, such as shouting, coughing, respiratory distress, sneezing, vomiting, spitting or exercise • Aerosol generating procedures (AGPs) being performed on the case • Confirmed secondary cases • COVID-19 vaccination status	**Contact details** • Whether exposure is confirmed or only possible • Type of contact with case • Physical distance from case • Duration of exposure • Type of procedure performed (if relevant) e.g., aerosol-generating • COVID-19 vaccination status	**Infection prevention and control details** • Mask use and hand hygiene by patient • Use of appropriate PPE including medical mask, or where required P2/N95 respirator use (and whether fit tested), by HCW • Use of eye protection during AGP or AGB/DGB • Hand hygiene by staff member • Correct donning and doffing of PPE (i.e., no breaches)	**Environmental exposure details** • Use of shared equipment • Use of communal spaces (e.g., tea rooms, workstations, offices) • Ventilation • Room size and configuration

[1] This risk assessment advice and risk matrix are extracted from the standard guidance for risk assessment and categorisation of health care workers exposed to COVID-19, effective 24 January 2022.

Table B: Exposure risk categorisation of healthcare workers

Note: All exposure category decisions are based on a local risk assessment. This matrix should be seen as guidance only. The highest risk duration or proximity parameter met should be used (e.g., face-to-face trumps <30min in the room and >1.5m) **Case =** confirmed positive case in a patient, staff member or other person in the health care environment. **No increased risk =** transient, not face-to-face, limited contact that does not meet the definition of face-to-face contact. **PPE** = Personal protective equipment	**Low Risk Exposure** • Shared indoor space: In general, more than 1.5m apart and under 30 minutes cumulative in 24 hours OR • Exposure outdoors: less than 1.5m for more than 30 minutes & no AGP/AGB	**Moderate Risk Exposure** • Any face-to-face contact/care within 1.5 metres and less than cumulative 15 minutes in 24 hours OR • In general, shared indoor space more than 1.5m away for greater than cumulative 30 mins in 24 hours OR • Based on agreed documented individual risk assessment including assessments of occupational exposures and of the physical environment	**High Risk Exposure** • Prolonged face-to-face contact within 1.5 metres and greater than cumulative 15 minutes in 24 hours OR • Contact with multiple COVID-19 confirmed cases/suspected cases/probable cases OR • Based on agreed documented individual risk assessment including assessments of occupational exposures and of the physical environment	**Highest Risk Exposure** • Aerosol generating behaviours (AGBs from the case e.g., uncontrolled coughing, singing, shouting, exercise) where the person is not able to adopt respiratory etiquette OR • Direct exposure to the mouth/nose/eyes with infectious body fluids (e.g., coughed, sneezed, vomited on) from the case[2] OR • Aerosol generating procedures (AGPs) during procedure or settle time •
	Vaccination status of the healthcare worker			
	Full[3]	**Full**	**Full**	**Full**
No effective PPE worn by staff member or case (no PPE or PPE with major breaches such as mask below nose)	**Level I** / **Level II** Based on risk assessment	**Level II**	**Level III**	**Level IV**
Medical mask only worn by staff member • Case not wearing mask	**Level I**	**Level I**	**Level II**	**Level IV**
Medical mask worn by staff member AND • Case wearing mask	**Level I**	**Level I**	**Level I**	**Level IV**
Staff member in P2/N95 but no eye protection with no breaches	**Level I**	**Level I**	**Level I**	**Level IV or Level III with individualised risk assessment[4]**
Staff member in P2/N95 and eye protection with no breaches	**No increased risk** over background – general surveillance testing where in place should continue			

Note: Eye protection may be recommended for IPC purposes to reduce transmission risk in the workplace, but not wearing eye protection does not constitute sufficient exposure risk to warrant inclusion in exposure event criteria EXCEPT when aerosol generating procedures are being undertaken or aerosol generating behaviours result in direct exposure to the eyes. However, employees should follow all IPC guidance provided by their employers at all times and this may include the routine use of eye protection.

Laboratory staff (technicians, scientists, pathologists and support staff) handling COVID-19 specimens, where a breach in best laboratory practice has occurred, should report the exposure to the senior scientist on duty, who may seek guidance from the on-call clinical microbiologist if required.

Use of gown/apron and gloves should be risk assessed based on individual incident, exposure to body substance and chances of environmental contamination.

[2] Staff who are cleaning up spillage or toilets used by cases who have vomiting, or diarrhoea need an individualised risk assessment.
[3] Full = is greater than or equal to 7 days following 2nd dose (https://www.health.govt.nz/our-work/immunisation-handbook-2020/5-coronavirus-disease-covid-19#23-5) or completion of primary course if immunocompromised. Advice on booster doses may result in the Ministry of Health changing this definition in the future.
[4] Degree of controls in the environment need to be taken into consideration: e.g., controlled intubation in ICU less risk than acute resuscitation situation; and degree of exposure, e.g., patient use of unvented CPAP but in otherwise controlled environment would be lower risk. Alternative actions include potential to review at day 5 regarding return to work or classification as lower risk.