

Guidance for management of critical healthcare workers delivering critical health services who are COVID-19 cases or contacts during an Omicron outbreak to facilitate return to work prior to completion of self-isolation requirements

This guidance can be used where service provision is at risk of substantial compromise due to staff absence related to infection or exposure, in Phase 3 of the Omicron response.

Introduction

This document provides technical guidance for clinical leaders and managers.

It provides guidance for situations where service provision is at risk of substantial compromise due to staff absence related to Omicron infection or exposure. It refers to the 'companion' document 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 in New Zealand's Omicron response. Even in Phase Three of the response, if there is no criticality to the workforce or service, then the 'base' guidance for management of HCW exposure events in healthcare settings, and standard public health case and community/household exposure advice, is to be followed. Within the parameters of that criticality, this framework enables 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 continue to 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.

Contents

- Continuing to do 'the basics well' as the SARS-CoV-2 variant Omicron becomes widespread in the community
- Key principles for using this guidance
- Definition of a critical worker
- Requirements to enable early return to work for healthcare workers who are:
 - COVID-19 cases
 - COVID-19 contacts
- Use of Public Transport
- Risk assessment and categorisation of healthcare workers for WORKPLACE exposures (Appendix 1)
- Management of health care workers who are COVID-19 Level I-III health care contacts or community close contacts (Appendix 2)

Continuing to do 'the basics well'.

- **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. In health care settings, use of medical masks for all staff is mandated, when other PPE is not recommended. 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. HCWs are required to receive their booster as soon as they are eligible. In the meantime, boosted and unboosted staff who are not yet eligible 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. While stand-downs are not mandated for close contact exposures in the community nor (see later) for the equivalent exposure in a health care setting, this kind of exposure is still best avoided. 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 continue 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 cases in particular situation or household / higher-risk health care 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 it 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 relevant contacts.
- **Use of Rapid Antigen Tests (RATs) is 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 ensuring staff have access to RATs when needed to support their return to work, 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. In Phase 3 the COVID-19 transmission risk in the community setting is high and will be the most likely place HCWs will acquire COVID-19 infection.
2. On the other hand, additional precautions may be appropriate in some instances for the health care environment to protect vulnerable patients and other staff, compared with the intent just to 'suppress the curve' in community.
3. There are three levels of potential actions for COVID-19 cases and contacts – those that are legally mandated (MoH determined); those that are required by the workplace (DHB or other healthcare organisation determined) with staff stood down if not complying; those that are recommended but staff could continue to work if they choose not to follow the recommendation.
4. In all situations staff need to be vigilant for new symptoms and get tested straight away if symptomatic, even mid-shift.
5. In Phases 3 of the Omicron response, as per Ministry of Health guidance, most people in the community are expected to self-manage their COVID-19 exposure and case experience. This means systems for staff to self-report exposure or illness need to be in place, as in the vast majority of situations there will not be a workplace notification via public health. Each workplace needs to ensure this process is in place and understood by staff.
6. In New Zealand, the Omicron outbreak is occurring on top of already stretched workforce capacity. There is 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, in their home 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.
7. 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 household 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.
8. 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 on the My Covid App in addition to any internal processes.

Definition of a critical health care worker

A critical worker is a person who works for a critical health service (see <https://www.health.govt.nz/system/files/documents/pages/appendix-critical-services-list-25-02.pdf>), in a role that:

- Must be performed in person at the workplace; and
- Requires a person with particular skills; and
- Must continue to be performed to prevent an immediate risk of death or serious injury to a person; or prevent serious harm (social, economic or physical) to significant numbers in the community.

Management of return to work for critical health care workers who are COVID-19 cases

The following principles should apply:

1. Where service delivery is not at risk by their absence, HCWs should follow general public health advice for isolation, having informed their manager about their infection.
2. Where service delivery is under threat, and the HCW is critical to service continuity there are two options for HCWs to return to work prior to completing their full self-isolation period.
 - **Table 1** outlines the requirements for HCWs to return to work on Day 6. This applies only if their work is critical to service continuity, and if the worker is asymptomatic or mildly symptomatic (i.e., they are not acutely unwell), and the worker has agreed to return to work (it must be clear to the worker that they are not required to work).
 - **Table 2** outlines the requirements for HCWs to return to work on Day 0. This applies **only** to work on a COVID ward/unit, in critical situations when all other options have been exhausted. The HCW must be asymptomatic, and the HCW must agree to return to work (it must be clear to the worker that they are not required to work).
 - Note: In addition to hospital COVID wards / units (e.g. a dialysis unit dialysing only COVID positive patients), this arrangement could apply to a community facility where all the patients are COVID-19 cases – e.g. a Mental Health Respite 'red house', an ARC COVID wing.
3. The need for the person to be at the workplace will be reviewed daily for the duration of their isolation.

Table 1: Requirements for return to work on day 6 for critical HCWs who are COVID-19 Omicron cases

Vaccination status	Symptom status	Stand-down from work	Required 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 The worker is not under compulsion to work
	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

Table 2: Requirements for deployment of critical health care workers who are asymptomatic cases to a COVID ward / unit or a ward where all patients are COVID-19 positive from day 0

Vaccination status	Symptom status	Stand-down from work	Required measures for return to work
Boosted, or primary course COVID-19 vaccination only	Asymptomatic/very mildly symptomatic	Nil	<p>The HCW must only work on COVID-19 wards or wards where patients are either COVID-19 positive or have recently recovered from COVID-19. The HCW who is a case must stay within the fully COVID ward / unit and not go to other parts of the health care setting.</p> <p>The HCW and all other staff must wear appropriate PPE. An N95 must be worn and should be donned before entering the workplace</p> <p>The employing organisation needs to consider:</p> <ul style="list-style-type: none"> • food while working (either from home or provided to the ward/unit for the worker); sourcing food from staff cafeterias must be avoided • a place for the worker to take breaks separate from non-COVID-19 positive/recently recovered staff, and management of bathroom breaks or dedicated facilities (as people may take their mask off while in toilets) <p>The worker should not attend in-person meetings, unless all other staff are positive or recently recovered</p> <p>Outside of work, the worker should ensure they follow all current self-isolation requirements for COVID-19 positive cases.</p> <p>The HCW is not under compulsion to work. Daily check-ins should be undertaken with the HCW to ensure their wellbeing, and if symptoms worsen, they should be instructed to stand-down from work</p> <p>Public transport should not be used to get to work unless it is unmanageable to get to work otherwise (see further detail below)</p>

Management of return to work for HCWs who are household contacts or Level IV health care contacts (see Appendix 1)

The following principles should apply:

1. Where service delivery is not at risk by their absence, the current advice for management of HCW COVID-19 Level IV exposures in healthcare settings, and standard public health household contact advice should be followed, with the HCW's manager having been informed about their exposure. Table
2. Where their ability to work is critical to service continuity, **Table 3** below outlines the recommended course of action. This framework assumes that:
 - The health care workforce involved has had a full primary COVID-19 vaccine course +/- booster and always wears a medical mask as a minimum.
 - The actions for staff who household contacts are the same as for the highest risk health care exposures at work (Level IV exposures).

Table 3: Management of COVID-19 Level IV health care contacts, or household contacts, for critical health care workers

Exposure Type	Level IV health care contacts / Household contacts
Precautions, as long as asymptomatic	<ul style="list-style-type: none"> • Negative RAT test before presenting to continue working • Negative RAT required, before any/each shift for 7days post the exposure event for a Level IV health care exposure / until the household contact would be released after the Day 10⁺ of the initial case in their household, unless they have become a case. • For household contacts, a negative pre-shift RAT until the day the last case in the household recovers / while there is an active case in the house, is recommended but not required. • 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 test using a RAT. Behave as if a probable case and start self-isolation, but also do a daily RAT two days in a row, at least 24 hours apart. If two consecutive negative RATs, if possible, get a PCR test. Return to work continuing daily/pre-shift RATs** if symptoms have resolved or are mild and tests are negative. • Outside of work, whether exposed at work on in the household setting, continue to follow public health instructions for household contacts.

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

** Second RAT could be replaced by NAAT if local turnaround time is sufficiently short to assist with decision-making.

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).

Appendix One: Risk assessment and categorisation of healthcare workers for WORKPLACE exposures¹

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:				
<p>Exposure details</p> <ul style="list-style-type: none"> 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 	<p>Case details</p> <ul style="list-style-type: none"> 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 	<p>Contact details</p> <ul style="list-style-type: none"> 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 	<p>Infection prevention and control details</p> <ul style="list-style-type: none"> 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) 	<p>Environmental exposure details</p> <ul style="list-style-type: none"> Use of shared equipment Use of communal spaces (e.g., tea rooms, workstations, offices) Ventilation Room size and configuration

Table B: Exposure risk categorisation of healthcare workers for WORKPLACE exposures

<p>Note: All exposure category decisions are based on a local risk assessment. This matrix should be seen as guidance only.</p> <p>The highest risk duration or proximity parameter met should be used (e.g., face-to-face trumps <30min in the room and >1.5m)</p> <p>Case = confirmed positive case in a patient, staff member or other person in the health care environment.</p> <p>No increased risk = transient, not face-to-face, limited contact that does not meet the definition of face-to-face contact.</p> <p>PPE = Personal protective equipment</p>	Low Risk Exposure	Moderate Risk Exposure	High Risk Exposure	Highest Risk Exposure
		<ul style="list-style-type: none"> Shared indoor space: In general, more than 1.5m apart and under 30 minutes cumulative in 24 hours <p>OR</p> <ul style="list-style-type: none"> Exposure outdoors: less than 1.5m for more than 30 minutes & no AGP/AGB 	<ul style="list-style-type: none"> Any face-to-face contact/care within 1.5 metres and less than cumulative 15 minutes in 24 hours <p>OR</p> <ul style="list-style-type: none"> In general, shared indoor space more than 1.5m away for greater than cumulative 30 mins in 24 hours <p>OR</p> <ul style="list-style-type: none"> Based on agreed documented individual risk assessment including assessments of occupational exposures and of the physical environment 	<ul style="list-style-type: none"> Prolonged face-to-face contact within 1.5 metres and greater than cumulative 15 minutes in 24 hours <p>OR</p> <ul style="list-style-type: none"> Contact with multiple COVID-19 confirmed cases/suspected cases/probable cases <p>OR</p> <ul style="list-style-type: none"> Based on agreed documented individual risk assessment including assessments of occupational exposures and of the physical environment
	Vaccination status of the healthcare worker			
	Full³	Full	Full	Full

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 16 February 2022.

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.

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	Level II	Level III	Level IV
	Based on risk assessment				
Medical mask only worn by staff member <ul style="list-style-type: none"> Case not wearing mask 	Level I	Level I	Level I	Level II	Level IV
Medical mask worn by staff member AND <ul style="list-style-type: none"> Case wearing mask 	Level I	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 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.

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.

Appendix Two: Management of health care workers who are COVID-19 Level I-III health care contacts or community close contacts

Level I-III health care exposures / other (non-household) close contacts from community exposure	
Precautions, as long as asymptomatic	<ul style="list-style-type: none"> • No requirement to stand down or self-isolate • Self-monitor for symptoms for 10 days • If symptoms develop at any time during the 10 days, do a RAT immediately and if the result is negative AND your symptoms are mild and improving, or improved, return/continue to work. If RATs are available, the preference would be for a negative RAT three consecutive days, each taken 24 hours apart, for Level III health care or community close contacts but this is not required.