Appendix for Primary Care: 'Risk Assessment and Categorisation of Healthcare Workers Exposed to Covid-19'

16 February 2022

This appendix is intended to support implementation of risk assessment and categorisation of healthcare workers' (HCWs) exposed to COVID-19 in primary care settings.

Please note, this is not intended to cover situations where a HCW may be a household contact or close contact from exposure outside of the workplace setting or becomes a case themselves. These situations will need local public health advice. This guidance covers HCW COVID-19 exposure in the workplace setting, from clients or other staff.

It is intended to provide an understanding of expected processes and the implications for clinical practice and service continuity. It has three parts:

A. Preparedness, including three key messages that come from reviewing application of the *'Risk Assessment and Categorisation of Healthcare Workers Exposed to Covid-19'* (the matrix) to primary care scenarios, which can assist practices in preventing impacts from exposure events.

B. An outline of the current process and roles and responsibilities for management of COVID-19 exposure events in primary care, as at mid-February 2022. This recognises the approach is evolving, and it will be reviewed on a two-weekly schedule along with the review of the overarching document this appendix sits under. Templates referred to are attached.

C. Example scenarios and categorisations based on applying the matrix.

This guidance anticipates that all health care staff have already had two doses of COVID-19 vaccine as required by the Vaccinations Order (2022) for HCWs. Receiving a booster dose of COVID-19 vaccination substantially reduces transmission risk, compared with a completed primary vaccination series. Boosters are now mandated for HCWs in NZ – those who are eligible for a booster, are required to have this by 24 February 2022. In the meantime, boosted and unboosted staff are both treated as 'vaccinated' for the purposes of this guidance. Staff who are at a higher clinical risk if they get COVID-19 should have had an opportunity to disclose this information to employers as appropriate.

A. Preparedness

Make sure it is easy to undertake a risk assessment of a COVID-19 exposure event by having a 'living' summary of the relevant information about your practice. Filling out *Template One* of the *'Exposure Events Management Templates'* and reviewing it monthly is an easy way to do this. This relates to Table 1 on page one of the matrix ('*Factors to consider in risk assessment*').

. Your PHO may be able to assist you with implementation of this guidance.

Three key messages that come from reviewing application of the matrix to primary care scenarios

1. **Asymptomatic surveillance swabbing as well as symptomatic swabbing** should always be undertaken in the red stream with appropriate PPE. https://www.health.govt.nz/system/files/documents/pages/hp7716-ppe-for-taking-covid-19-naso-oropharyngeal-swabs-12aug2021.pdf

2. **Medical masking of all staff** (including non-clinical) is important to protect staff from inadvertent COVID-19 exposure - from patients or from other staff who may have acquired COVID-19 in the community. Reception staff are often the first point of contact for patients and visitors to the practice and can sometimes have prolonged interactions with patients, helping people fill in forms, etc. There is increasing emphasis on wearing a 'well-fitting' mask. The fit of a medical mask can be improved in various ways (e.g. knotting the ear loops and tucking in the sides of the mask to reduce the 'gaps' in the front of the ears. See further 'Improve how your mask protects you'). Medical masks must be discarded once wet/soiled.

3. **Staff breaks / mealtimes are key occasions** when exposure can happen someone becomes a case and has worked during their infectious period. People take their masks off at mealtime, may not be distanced and often spend more than 15 minutes together. Some practices have been asking staff who are not fully vaccinated to have staggered meal breaks, or go outside for meal breaks, and limit to 15 minutes. There is a need to be creative to maintain team morale.

B: Outline of the process for primary care COVID-19 exposure events as at mid November 2021.

The suggested process will vary in application based on local, regional and national practices and policies over the next few months as the COVID-19 response planning continues to change and adapt to the Omicron variant. It is important that **providers check in with their regional PHU and DHB on what best suits their regional response.**

Templates referred to are attached.

1. Potential or actual exposure event identified
    - positive result via lab notification and the patient has recently attended the practice (need to check timing for infectious period – see below), or
    - staff member rings to inform you they are a case, or
    - public health ring because they have identified an exposure event from a case interview

2. Practice completes *'Exposure Event Management Templates'*. It is important to document an exposure event and the information used in decision-making about contacts. Use *Template Two (a)* where the case is a patient, or *Template Two (b)* where the case is a staff member, to record and assess the interactions within 1.5 metres more than transiently (e.g., 30 sec). Then record the details of each person involved in the '*Template for Recording Potential Contacts'* Excel spreadsheet provided.
3. Using the '*Risk Assessment and Exposure Categorisation of Healthcare Workers Exposed to COVID-19'* guidance document, review each staff member and determine the level of exposure and resulting actions, and record in the *'Template for Recording Potential Contacts-Staff'* Excel spreadsheet.
    - Assume more contact rather than less (the highest degree of contact for that worker category and the interaction – it is unrealistic in most instances to expect people to dissect the detail days later). In most instances this will still not mean people have to be stood down but affects other advice for management.
    - Everyone else in the clinic at the time should be listed but indicating there were no known interactions.
4. Follow the advice about next actions as determined by the exposure level in the healthcare worker exposure event guidance, to draft a simple management plan. A nominated clinical lead should have oversight of this process.
5. Where testing and follow up of staff who are contacts is necessary (Levels II – IV), monitor and record this follow up.
6. Record all staff contacts in the *'Template for Recording Potential Contacts-Staff'* Excel spreadsheet. This must be available if requested by the National Investigation and Tracing Centre (NITC). Keep a copy of this spreadsheet for practice records.

C. Example scenarios and categorisations based on applying the matrix

Scenario	Group within the scenario	Categorisation	Rationale
1. Patient comes into clinic in green stream for a routine check-up, is wearing a mask. Discloses towards the end of the consult that they have a mild runny nose from hayfever.	Clinician in the green stream fully vaccinated wearing medical mask	Level I	High risk exposure but clinician is fully vaccinated and wearing a medical mask. Risk becomes low.
	Receptionist fully vaccinated, short interaction but not wearing a mask	Level II if considered face to face interaction, rather than shared indoor space	Moderate risk exposure, staff member isn't wearing a mask so risk is moderate.

Walks out to their car and has a COVID swab which turns out to be positive. An unvaccinated Healthcare Assistant working in a non-clinical role bumped into the patient while they were walking out of the clinic.	Unvaccinated masked healthcare worker who bumped into patient in the hallway	Not a contact	Transient, not face to face, no increased risk
2. Doctor got COVID in the community. Has been wearing a medical mask when seeing patients, but no mask in the workplace when not seeing a patient (tearoom, having lunch).	Fully vaccinated, unmasked other staff members (e.g., meal breaks)	Level III	High risk exposure [just as well they are vaccinated!]
	Partially vaccinated, unmasked staff	Level IV	High risk exposure, and no mask, unvaccinated - risk is highest.