Review date: November 23, 2022

Protocol for Staff Exposed to COVID-19

General Comments

Adapted CDC Stratification of risks following exposure to COVID-19 – for DMHAS

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Updated September 23, 2022

- ***Low risk:*** *walking by a person who tested positive for COVID; HCP has facemask*
- ***Mild risk:*** *Being in the same room, within 6 ft of a COVID+ person but brief exposure time (less than cumulative period of 15mins/24hr period), and HCP has PPE.*
- ***High risk: 1)*** *Prolonged exposure is cumulative period of 15 mins or more in a 24hr period and distance within 6 ft of a COVID+ person. For aerosol generating event any exposure time is high risk*
  2) *Involves exposure of HCP's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if these HCP were present in the room for an aerosol-generating procedure*
  3) *Staff member living with a covid positive family member that is unable or unwilling to Isolate in the home has a very high risk of contracting covid.*

https://www.cdc.gov/coronavirus/2019-ncov/hcp/index.html

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

- ***Risk of contracting COVID-19 infection is markedly reduced in individuals who are up to date with COVID-19 vaccinations. Staff should be encouraged to take the COVID-19 vaccine.***

- *In all situations, risk is reduced if one or both parties have face mask on during the exposure and maintain social distancing.*

- *Staff members who have clinically recovered from a COVID-19 infection and are asymptomatic are not considered infectious and have very low risk of re-infection with COVID-19 for a period of 30 days from onset of symptoms. Re-infection may occur between 31-90 days after infection, however.*

  https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

  When You've Been Fully Vaccinated | CDC

- *Staff working directly with patients shall wear a surgical or N95 mask and a face shield as source control.*

- *A contact with a contact of someone who is suspected or confirmed COVID positive (i.e., a person twice removed from the COVID case) is at low risk and does not require additional monitoring or restrictions.*
- *Symptoms of COVID-19 include but not limited to: Fever, Cough, Shortness of breath, Chills, Sore throat, New onset loss of taste and smell, Fatigue, Muscle pain, New onset headaches, Diarrhea, Nausea/Vomiting, Congestion/running nose.*
- *High risk individuals for COVID-19 infection include Age >60; BMI >30; Diabetes; Asthma that requires daily medications; Chronic heart, liver, kidney, or lung disease; those receiving treatment for cancer; immunosuppressing illness or medications; and smokers.*

PROTOCOLS

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

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A. Staff with direct exposure to an asymptomatic person. The asymptomatic person later develops symptoms of and/or test positive for COVID;

Staff remains asymptomatic.

- *exposure occurred **48 hours or less** before onset of symptoms, **proceed directly to B (below).***
- *If exposure occurred **greater than 48 hours** before onset of symptoms, continue with the following:*
- Continue to work wearing a face mask as usual.
- Monitor temperature twice daily.
- Maintain social distance and frequent hand hygiene.
- If temperature is 100F or higher, or if symptoms of COVID-19 develop, do not come to work if home. If at work, leave work immediately.
  - Call your supervisor and HR.
  - Call your Primary Care Physician (PCP) for evaluation. Please do not seek medical advice from DMHAS providers and staff.
  - Follow protocol as in C below.

B. Staff with direct exposure to a suspected or confirmed case of COVID;

staff is asymptomatic.

https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

- **No quarantine in most cases**. Work restriction is not necessary for most asymptomatic staff following a higher-risk exposure, regardless of vaccination status.

  <u>Exceptions:</u> Quarantine high risk exposure only if:
  - staff is unable to be tested or wear source control as recommended for the 10 days following their exposure.
  - staff is moderately to severely immunocompromised.
  - staff cares for or works on a unit with patients who are moderately to severely immunocompromised.

Staff quarantine after COVID exposure is rare and only in the serious cases listed under <u>Exceptions</u> above. In these rare situations, quarantined staff can return to work after day 7 following the exposure (day 0) if they do not develop symptoms and all viral testing as described earlier is negative. If testing is not performed, staff can return to work after day 10 following the exposure (day 0) if they do not develop symptoms.

- Test (PCR) staff on days 1, 3 and 5. Note: Day of exposure is day 0.
- For asymptomatic staff who have recovered from COVID-19 infection in the prior 30 days, do not test. For those who have recovered in the prior 31-90 days, test with rapid (antigen) test (**<u>not</u>** PCR which may give a false positive) following a high-risk exposure occurred. If after 90 days, test with PCR test.
- Staff who lives with a covid positive family member who is unable or unwilling to isolate in the home, in addition to PCR testing on days 1,3 and 5, staff should test daily using Rapid (Antigen) test for 10 days. Staff should continue to work unless symptoms develop or they test positive.
- Wear Surgical or N95 mask.
- Maintain social distance as much as possible and frequent hand hygiene.
- Be alert to development of fever, respiratory symptoms, or other symptoms of COVID-19. If any symptoms develop, **as with any illness, staff should** stay or return home.
  - Call your PCP or 911 for severe symptoms
  - Call your supervisor and HR
  - Follow additional steps as stated in C (below)

C. Staff with suspected COVID-19 infection

- Stay home or if at work, inform supervisor and leave immediately.
- Inform HR and supervisor.
- Get tested for COVID-19 (PCR).
- Housekeeping staff will complete terminal cleaning and disinfection of staff's workspace, including desks, chairs, and computer, following CDC/DPH protocol.
- The supervisor will speak with the employee to identify the people with whom the employee interacted and the places the employee touched and stayed during the period 48 hours before the employee developed symptoms or tested positive. The supervisor will

complete the "Contact Sheet for Employees Who Have Worked in the Office." per CDC guidelines.

- HR will notify the employee about the various leave rights/accruals available to them.
- Without identifying the individual, the supervisor or designee will inform the staff's colleagues and patients from the staff's unit.
- If the staff's test comes back COVID-19 positive, staff will stay at home. High risk contacts of staff up to 48 hours from when staff last worked should follow recommendations in B above.
- If the tests are negative, staff will return to work as long as they are asymptomatic or as recommended by their PCP.

D. Return to Work: For staff with confirmed COVID+ test

https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-patients.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

- Staff will call supervisor to give updates of symptoms at mutually agreed frequency.
- Staff who were asymptomatic throughout their infection and are ***not*** moderately to severely immunocompromised should return to work after the following criteria have been met:
  - no fever for 24 hours without the use of fever reducing medications; **and**
  - no respiratory symptoms or significantly improved symptoms.
  - **and** at least 7 days have passed *since symptoms first appeared* if a negative PCR test is obtained within 48 hours (day 5) prior to returning to work (or 10 days if testing is not performed or if a positive test at day 5)

- For staff with severe to critical illness who are *not* moderately to severely immunocompromised could return to work after the following criteria have been met:

  - At least 10 days and up to 20 days have passed *since symptoms first appeared*

- For staff with immunocompromised status, two consecutive tests conducted 24 hours apart at minimum may be recommended by IP MD or PCP, in conjunction with facility medical director. In such situations, the timing of the return of staff to work will be on the recommendation of IP MD or DPH, in conjunction with facility medical director.

Routine (Weekly) Staff Testing for COVID-19

- Routine testing is currently reserved as accommodation for staff members who have been exempted from COVID-19 vaccination on religious or medical grounds.

DMHAS Travel Advisory

Updated August 24, 2022
https://www.cdc.gov/coronavirus/2019-ncov/travelers/travel-during-covid19.html
https://www.cdc.gov/coronavirus/2019-ncov/travelers/international-travel-during-covid19.html

Note:

- *It is strongly encouraged that staff should get up to date with your COVID-19 vaccines before you travel to protect themselves from getting seriously ill or being hospitalize.*
- *Consider getting COVID test before travel.*

- *There are no identified states excluded from the advisory. However, it is recommended you Check your destination's COVID-19 Community Level before traveling. State, tribal, local, and territorial governments may have travel restrictions in place*
- *After return from travel, individuals with symptoms suggestive of COVID-19 infection should return to work only after a confirmed negative COVID (PCR) test*
- *Staff members planning to travel out of state should contact their facility IP staff or medical director or designee before travel and on return from those states.*
- *For COVID tests, the PCR tests and **not** the rapid tests are required.*
- *If you have recovered from COVID-19 infection within 90 days:*
    - *If asymptomatic, no testing required within the first 30 days. However, if recovery is within 31-90 days, test with Rapid (antigen) test on day 5 of return from travel.*
    - *If you have COVID-19 symptoms, test and self-isolate until result is obtained. If positive, contact facility medical director and your PCP for guidance*
- *DMHAS staff members who live in neighboring states (NY, MA, RI) but commute to work in CT are considered CT indigenes for the purposes of this guidance. The travel advisory applies to them only when they travel outside of their state of residence and CT.*
- *For unusual circumstances, please discuss with facility (or DMHAS) medical director, or designee for guidance.*

Staff Up to Date with COVID 19 Vaccination: Fully vaccinated staff (if within 5 months for Pfizer/Moderna, and 2 months for J&J) and Boosted staff

*Since these travelers are less likely to contract and spread COVID-19, they can travel safely within the United States and do not have to test before or after travel (unless their destination requires it) and **do not have to quarantine after travel.***

*For Return from International Travel: You do NOT need to self-quarantine **after** arriving in the United States; You should still get tested (PCR test) 3-5 days **after** international travel but continue to work while awaiting result of test.*

For Staff <u>Not</u> Up to Date with COVID 19 Vaccination: Unvaccinated, partially vaccinated, or fully vaccinated but not boosted (over 5 months ago for Pfizer/Moderna or over 2 months for J&J)

<u>Domestic and International Travel</u>

2. *No need to self-quarantine*
3. *Test on day 5. If negative, continue to work.*
4. *Other exceptions may become necessary following discussion with the facility or DMHAS Medical Director or designee*

All Travelers regardless of vaccination status:

1. *Self-monitor for symptoms of COVID 19 for 10 days*
2. *Self-isolate and get tested if symptoms develop*
3. *Maintain source control measures (below) for prevention of COVID 19: Wear a mask over their nose and mouth; Stay 6 feet from others (as much as possible) and avoid crowds; Wash hands often or use hand sanitizer*

PPE Use: General Guidelines for Use of Face Masks

https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html; https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/face-masks.html

DMHAS utilizes universal source control measures therefore masking is required in all patient facing areas. Masks are optional in non-patient facing spaces or buildings. All patients should be encouraged to wear a surgical face mask when in a healthcare facility. Patients in the community may elect to wear a cloth mask but while in a healthcare facility, a surgical mask is recommended. Hospitalized patients should be given surgical face masks with ear loops with the metallic piece removed or DMHAS provided N95 for patient use if requested after due consideration if risks to patient and others. Cloth masks are not to be worn on inpatient units by staff or patients.

All staff, regardless of vaccination status, should wear an N95 or a surgical mask when in patient facing areas.

If a face mask is damaged, wet, or soiled or hard to breathe through before the end of the assigned time period, it should be exchanged.

When interacting *directly* with a patient with suspected or confirmed COVID-19, masks (N95 or surgical if not available), gloves, gown, and eye protection (face shields/goggles) are required.

All clinicians and staff performing high risk aerosol generating procedures such as nebulizer treatment, placing patient on CPAP or performing cardiopulmonary resuscitation (CPR) should wear an N95 mask (or surgical masks if not available), eye protection (face shield/goggles), gloves and gown regardless of patients' COVID-19 status. The number of staff involved in such these procedures should be kept to a minimum to prevent potential exposures.

Housekeeping staff cleaning and disinfecting room or area previously occupied by an individual with suspected or confirmed COVID-19 should wear a face mask (N95 or surgical mask if not available), gown, gloves, and eye protection (face shields/goggles).

* ***Homemade masks are not considered PPE, since their capability to protect HCP is unknown. Caution should be exercised when considering this option.***

General Guidelines: Screening, Meeting Rooms, Treatment Groups,
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html

Although there are no formal front door screening questions at DMHAS facilities, the following infection prevention practices should be implemented:

- Post visual alerts (e.g., signs, posters) at the entrance and in strategic places (e.g., waiting areas, elevators, cafeterias). These alerts should include instructions about current IPC

recommendations (e.g., when to use source control and perform hand hygiene). Dating these alerts can let help ensure people know that they reflect current recommendations.

- Establish a process to make everyone entering the facility aware of recommended actions to prevent transmission to others: e.g., Do not come to work or to visit if you have signs of COVID infection (fever, cough, running nose, sore throat, etc.) until cleared of COVID; Wear a face mask in patient care areas; maintain social distance; Frequent hand hygiene.

Treatment Groups

Plan for all treatment groups to be in person.

- Screen attendees asking for COVID symptoms. Send patients with symptoms home to see their PCP.
- Encourage all patients to wear a mask.
- Administer approved alcohol-based hand rub before entering room.
- Aim for some distance (use approximately 3 ft as guide) between patients. Depending on the size of the group, this may require splitting the group and providing the same treatment to the different groups.

Meeting Rooms/Conferences

- Individuals with symptoms of COVID should stay home, get tested for COVID and contact their PCP. If symptoms develop at work staff should not enter meeting/conference rooms but should leave the facility immediately.

- Individuals could choose not to wear a mask when they are in well-defined areas that are restricted from patient access (e.g., staff meeting rooms) if:
  - they do not have symptoms suggestive of COVID. Staff should wear a mask if COVID has been ruled out, but they have respiratory symptoms (cough, running nose, etc.)
  - Have not had a higher risk exposure in the past 10 days.

- Aim for some distance between meeting or conference attendees – may use 3ft as guide only.

*Individuals might also choose to continue using source control based on personal preference or comfort level, informed by their perceived level of risk for infection based on their recent activities (e.g., attending crowded indoor gatherings with poor ventilation) and their potential for developing severe disease.

Emergency Situations

- **Behavioral Codes (including Restraint and Seclusion) OR Cardiopulmonary Respiration (CPR)**
- **Emergency Cart**

To protect patients and colleagues during restraint and seclusion OR CPR, staff should wear the following:

Behavioral Code/Restraint/Seclusion: Surgical mask, gloves, and eye protection (face shields/goggles)

Cardiopulmonary Respiration: N95 mask (or surgical mask if not available), face shield, gloves, and gown.

All staff working in a suspected or confirmed COVID-19 unit should wear appropriate PPE (including N95 or surgical masks) when engaged in the procedures described above.

Emergency cart should include PPEs such as facemasks (N95 and surgical), face shields, gowns, and gloves.