Guidance for Return to Work of Healthcare Workers

MINISTRY OF HEALTH
MANATŪ HAUORA

Introduction

This guidance can be used to manage staff absence related to infection or exposure of COVID-19.

This document provides technical guidance for clinical leaders and managers.

This document provides guidance for managing the return to work of staff who have completed their isolation requirements and service provision is at not at risk of substantial compromise due to staff absences. This document also provides specific guidance for situations where service provision is at risk of substantial compromise due to staff absences. This guidance provides structured return to work pathways which enable regions and services to make decisions appropriate for their individual circumstances.

This guidance applies to Healthcare Workers (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 regularly reviewed and updated as the COVID-19 situation evolves. Updates will be made available through the Ministry of Health website. The Ministry of Health and DHBs welcome any feedback to inform future iterations.

MINISTRY OF HEALTH
MANATŪ HAUORA

Table of Contents

Guidance for Return to Work of Healthcare Workers 1
Introduction 2
Table of Contents 3
Continuing to do 'the basics well' 4
Background 5
Definition of a critical health care worker 7
Definition of mild symptoms 7
1. Healthcare Workers that are Contacts 7
1.1. Return to work for health care workers who are COVID-19 Level I-III health care contacts or community close (non-household) contacts 7
Table 1: Return to work for health care workers who are COVID-19 Level I-III 7
1.2. Return to work for health care workers who are Level IV health care contacts (see Appendix 1) or household contacts 8
1.2.1. Non-critical HCW: Where service delivery is not at risk by their absence 8
1.2.2. Critical HCW: Where service delivery is at risk by the healthcare worker's absence 8
Table 2: Management of COVID-19 Level IV health care contacts, or household contacts, for critical health care workers 9
2. Healthcare Workers that are Cases 10
2.1 Return to work for health care workers who are COVID-19 cases 10
Non-critical HCW where service delivery is not at risk by their absence: 10
Table 3: Return to work from Day 8 where service delivery is not at risk 11
2.2 Critical HCW: Where service delivery is at risk by the healthcare worker's absence 12
Table 4: Return to work from Day 4 for critical HCWs 13
Table 5: Return to work from Day 8 for critical HCWs for highly critical service continuity situations 14
Table 6: Return to work from Day 0 for critical HCWs for highly critical service continuity situations to a COVID-19 ward / unit / situation 15
Use of public transport 16
Key considerations include: 16
Appendix 1 17
Table A: Factors to consider in risk assessment 17
Table B: Exposure risk categorisation of healthcare workers for WORKPLACE exposures 18

MINISTRY OF HEALTH
MANATŪ HAUORA

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-like symptoms gets tested** and for work purposes, liaises with their manager/ clinical leader about next steps.

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): it 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.

MINISTRY OF HEALTH
MANATŪ HAUORA

Background

1. There are several controls, including the requirement for staff to have booster vaccinations, in healthcare settings which means the risk of COVID-19 transmission in these 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. Additional precautions are appropriate for the health care environments to protect vulnerable patients and other staff.

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. Ensure everyone who has COVID-19-like symptoms gets tested and for work purposes, liaises with their manager/ clinical leader about next steps.

5. In Phases 3 of the Omicron response 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.

ii. **Where work from home options are appropriate, they should be utilised to support care to continue. 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 Record 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.

Definition of mild symptoms

- No fevers (without fever-reducing medication such as paracetamol)
- Minimal cough/sneeze
- Minimal runny nose, does not require mask removal to wipe
- Feeling well enough to return to work

1. Healthcare Workers that are Contacts

1.1. Return to work for health care workers who are COVID-19 Level I-III health care contacts or community close (non-household) contacts

Table 1: Return to work for health care workers who are COVID-19 Level I-III

	Level I-III health care exposures /close (non-household) contacts from community exposure
Precautions, as long as asymptomatic	• 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 **recommendation is to complete them for three consecutive days**, with each test taken 24 hours apart (but this is not required). You can continue to work as long as your results are negative and your symptoms are mild (see above for definition) or have resolved.

1.2. Return to work for health care workers who are Level IV health care contacts (see Appendix 1) or household contacts

1.2.1. Non-critical HCW: 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 isolation requirements for household contacts should be followed, with the HCW's manager having been informed about their exposure.

- This means the non-critical HCW can return to work on day 8 **if they are well and had a negative RAT on day 7.**

- With the 7 - day reduction in isolation requirements for household contacts, additional workplace precautions are recommended for a further 3 days. These additional precautions should include a combination of the following:

- Continuing pre-shift daily RATs until day 10
- Continuing pre-shift daily RATs while there is an active case in the household
- Correct use of a well-fitting (advice on this is available) fluid resistant medical mask (Type IIR or Level 2-3)
- Practice other IPC measures (hand/sneeze/cough hygiene, maintain physical distancing)
- Being very careful if in shared breaks and eating areas
- Daily symptom monitoring
- Consider redeployment of these staff during this period, if they usually work in high patient-risk areas

1.2.2. Critical HCW: Where service delivery is at risk by the healthcare worker's absence

Where their ability to work is critical to service continuity, Table 2 below outlines the recommended course of action. This framework assumes that:

- The health care worker involved has had a full primary COVID-19 vaccine course +/- booster and always wears a medical mask as a minimum.

- They must continue to follow self-isolation requirements when not at work.

Table 2: Management of COVID-19 Level IV health care contacts, or household contacts, for critical health care workers

<table>
<tr><th colspan="3">Level IV health care contacts & Household close contacts</th></tr>
<tr><th>Worker Type</th><th>Non-Critical Workers</th><th>Critical Workers</th></tr>
<tr><td rowspan="3">Precautions, as long as asymptomatic</td><td>Stood down from attending work for the 7-day isolation period

Negative day 7 RAT required before presenting to work on day 8</td><td>• No work stand-down required. Can work during the 7-day isolation period as long as they are asymptomatic and have a negative pre-shift RAT before presenting to work.
• Outside of work, isolate at home until the initial case in your household is released after completing their 7 days isolation.
• Negative RAT:
• Required before every shift up to day 7
• Required on Day 3 and 7 of the initial case in their household
• Highly recommended (but not required) until day 10 and while there is an active case in the household
• Managers to consider redeployment of these staff during this period, if they usually work in high patient-risk areas</td></tr>
<tr><td colspan="2">Other precautions for all Level IV and Household Close Contacts – these should continue until day 10 and/or while there is an active case in the household</td></tr>
<tr><td colspan="2">•Recommended to continue pre-shift daily RATs until day 10 and while there is an active case in the household

•If you test positive at any point (i.e. become a case) you must immediately stand down from work and discuss with your manager
•Be vigilant for symptoms. If new COVID-19-like symptoms develop, immediately test using a RAT.
• If these are new symptoms, behave as if you are a probable case and start self-isolation. If three consecutive negative RATs, each 24 hours apart, or negative PCR at 48 hours, you are not a probable case and can return to work if symptoms have resolved or are mild.
• For people that have a history of COVID-like symptoms due to other causes (e.g. hayfever, asthma), if you get your usual symptoms during this period, test using a RAT and continue working if negative and only mildly symptomatic. It is recommended that you repeat three consecutive negative RATS, each 24 hours apart, to confirm the symptoms are not due to COVID-19.

• Correct use of a well-fitting (advice on this is available) fluid resistant medical mask (Type IIR or Level 2-3)

• Practice other IPC measures (hand/sneeze/cough hygiene, maintain physical distancing)

• Being 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

• Outside of work, avoid attending high risk settings such as aged care facilities, prisons, hospitals (in this case as a visitor) until 10 days have passed since exposure to COVID-19.</td></tr>
</table>

* 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

2. Healthcare Workers that are Cases

2.1 Return to work for health care workers who are COVID-19 cases

Non-critical HCW where service delivery is not at risk by their absence:

Where service delivery is not at risk by their absence, workers should inform their manager about their infection and isolate for 7 days. Additional precautions are required for Days 8-10 for the workplace, compared with the standard community isolation pathway. When not at work, staff do not need to isolate at home beyond the standard 7 days.
1. Workers can return to work from Day 8, if they are asymptomatic or mildly symptomatic and have had two negative RAT results 24-hours apart (see Table 3 for more details).
2. If workers continue to test positive at Day 10, they can return to work on Day 11 if asymptomatic, with no further testing requirements.

Table 3: Return to work from Day 8 where service delivery is not at risk

Symptom status	Stand-down from work	Measures on Return to Work
Asymptomatic or mildly symptomatic (and improving) 	Stand-down from work for 7 days and RAT day 7* If negative, RAT day 8 prior to shift If both Day 7 and Day 8 RAT are negative, return to work on Day 8 If RAT positive at Day 7, continue daily RAT 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)^	Correct use of a well-fitting (advice on this is available) fluid resistant medical mask (Type IIR or Level 2-3)+ Practice other IPC measures (hand hygiene, maintain physical distancing) Be careful if in shared breaks and eating areas, noting the transmission risks described above Manager to consider deploying staff to lower patient-risk areas until day 11
	If the HCW is still RAT positive at day 9, no further RATs are required. You can return to work on day 11 if you are asymptomatic, or mildly symptomatic and improving	No additional measures required on return to work
More than mildly symptomatic and not improving	Continue to remain at home.Seek medical attention as required	The HCW should liaise with their employer and/or Occupational Health for ongoing management of their return to work
No surveillance or symptomatic testing: no RAT for 4 weeks, no PCR for 12 weeks (unless requested to do so by a doctor). There is no need to isolate or follow additional precautions if identified as a close/Level IV contact for 90 days. If new COVID-like symptoms develop after 4 weeks HCWs should seek a further RAT. Follow usual processes to reduce transmission of non-Covid illness and seek medical attention as required.		

* 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 at home 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
# In particular, someone who is unwell, has a fever, coughing/sneezing is considered to have a higher transmission risk

2.2 Critical HCW: Where service delivery is at risk by the healthcare worker's absence

Where the HCW is critical to service continuity and other options for maintaining service continuity have been unsuccessful, there are three options to enable HCWs who are cases to return to work (see table 4,5,6).
In each situation, the wellbeing of the HCW and the need for the HCW to be at the workplace will be reviewed daily for the duration of the time they would otherwise be required to be in isolation or to remain away from work. It is expected these pathways would be implemented in a step-wise fashion. Use advice in tables 4, 5 & 6 as follows:
• **table 4** - use this advice first • **table 5** - to be used only if the situation remains critical (despite following table 4) • **table 6** - to be used only if all other options have been exhausted.
The options include use of RAT to indicate whether someone might be infectious or not. However, they also recognise the correlation between a positive RAT and infectivity is not absolute, and clinical judgement about whether someone has symptoms that are likely to be associated with transmissibility risk is part of the risk assessment when safe service delivery is at risk.

Table 4: Return to work from Day 4 for critical HCWs

Table 4 outlines the requirements for HCWs to return to work from Day 4. This requires them to be asymptomatic or mildly symptomatic (i.e., they are not acutely unwell), and to have two negative RAT results 24-hours apart.
If tests continue to be positive, return to work is permitted on Day 11, if asymptomatic, with no further testing requirements.

Symptom status	Stand-down from work	Measures on Return to Work
Asymptomatic or mildly symptomatic (and improving) 	Stand down for 3 days, and RAT Day 3*. If negative, RAT test day 4 prior to shift. If both Day 3 and Day 4 RAT are negative, return to work on Day 4. If RAT positive on Day 3 or Day 4, continue daily RAT until negative, then return to work after a second negative RAT prior to their shift (i.e. two negative tests 24-hours apart)^ A negative RAT is required before every shift until day 6.	Correct use of a well-fitting (advice on this is available) fluid resistant medical mask (Type IIR or Level 2-3)+. Practice other IPC measures (hand/sneee/cough 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). Until the HCW has completed 7 days isolation they must continue to follow public health instructions for community cases when they are outside of work. The worker is not under compulsion to work until they have completed their isolation period, and should agree with their manager that they will return to work during their isolation period. Manager to consider deploying staff to lower patient-risk areas until day 11.
	If the HCW is still RAT positive at day 9, no further RATs are required. You can return to work on day 11 if you are asymptomatic, or mildly symptomatic and improving	No additional measures required on return to work
More than mildly symptomatic and not improving	Continue to remain at home. Seek medical attention as required.	The HCW should liaise with their employer or Occupational Health for ongoing management of their return to work
No surveillance or symptomatic testing: no RAT for 4 weeks, no PCR for 12 weeks (unless requested to do so by a doctor). There is no need to isolate or follow additional precautions if identified as a close/Level IV contact for 90 days. If new COVID-like symptoms develop after 4 weeks HCWs should seek a further RAT. Follow usual processes to reduce transmission of non-Covid illness and seek medical attention as required.		

* 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 at home 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 5: Return to work from Day 8 for critical HCWs for highly critical service continuity situations

Table 5 outlines the requirements for HCWs that continue to test positive to enable return to work on Day 8 without a requirement for additional testing. This applies only if the HCW is asymptomatic, and there is a highly critical service continuity situation.

Symptom status	Stand-down from work	Measures on Return to Work
Asymptomatic or mildly symptomatic (and improving) 	Stand down for 3 days, and RAT Day 3* If negative, RAT day 4 prior to shift If both Day 3 and Day 4 RAT are negative, return to work on Day 4 If RAT positive at Day 3, continue daily RAT 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)^ A negative RAT is required before every shift until day 6	Correct use of a well-fitting (advice on this is available) fluid resistant medical mask (Type IIR or Level 2-3)+ 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 The worker should agree with their manager that they will return to work during their isolation period Consider deploying staff to lower risk patient areas until day 11 or until the HCW has had two negative RAT results 24-hours apart.
	If the HCW is still RAT positive at day 6, no further RATs are required. You can return to work on day 8 if asymptomatic, or mildly symptomatic and improving	Consider deploying staff to lower risk patient areas until day 11 or until the HCW has had two negative RAT results 24-hours apart.
More than mildly symptomatic and not improving	Continue to remain at home. Seek medical attention as required	The HCW should liaise with their employer or Occupational Health for on-going management of their return to work
No surveillance or symptomatic testing: no RAT for 4 weeks, no PCR for 12 weeks (unless requested to do so by a doctor). There is no need to isolate or follow additional precautions if identified as a close/Level IV contact for 90 days. If new COVID-like symptoms develop after 4 weeks HCWs should seek a further RAT. Follow usual processes to reduce transmission of non-Covid illness and seek medical attention as required.		

Table 6: Return to work from Day 0 for critical HCWs for highly critical service continuity situations to a COVID-19 ward / unit / situation

Table 6 outlines the requirements to enable HCWs to return to work from Day 0. This applies only to work in a COVID-19 ward/unit/situation, in critical situations when all other options have been exhausted. The HCW must be asymptomatic or mildly symptomatic and improving, and the HCW must agree to return to work (it must be clear to the worker that they are not required to work).

<table>
<tr><th>Symptom status</th><th>Stand-down from work</th><th>Required measures for return to work</th></tr>
<tr><td rowspan="3">Asymptomatic/ very mildly symptomatic
  </td><td>Nil</td><td>These are exceptional circumstances with no requirement for RAT testing
The HCW must only work in COVID-19 wards/units/ situations 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
The HCW and all other staff must wear appropriate PPE. An N95 must be worn and should be donned before entering the workplace
The employing organisation needs to consider:
• 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 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)
• The worker should not attend in-person meetings, unless all other staff are positive or recently recovered
• Outside of work, the worker should ensure they follow all current self-isolation requirements for COVID-19 positive cases
• Public transport should not be used to get to work unless it is unmanageable to get to work otherwise (see further detail below)</td></tr>
<tr><td>Continue to remain at home. Seek medical attention as required.</td><td>The HCW should liaise with their employer or Occupational Health for on-going management of their return to work</td></tr>
<tr><td colspan="2">No surveillance or symptomatic testing: no RAT for 4 weeks, no PCR for 12 weeks (unless requested to do so by a doctor). There is no need to isolate or follow additional precautions if identified as a close/Level IV contact for 90 days. If new COVID-like symptoms develop after 4 weeks HCWs should seek a further RAT. Follow usual processes to reduce transmission of non-Covid illness and seek medical attention as required.</td></tr>
</table>

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:

Key considerations include:

- Where there is a required negative RAT, it should be done at home 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).

MINISTRY OF HEALTH
MANATŪ HAUORA

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

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

Note:	**Low Risk Exposure**	**Moderate Risk Exposure**	**High Risk Exposure**	**Highest Risk Exposure**
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	**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	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	**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	**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, or; **Aerosol generating procedures (AGPs)** during procedure or settle time
	*All above based on a vaccination status of **FULL** for the healthcare worker being assessed.			
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 individual risk assessment
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.

Staff who are cleaning up spillage or toilets used by cases who have vomiting, or diarrhoea need an individualised risk assessment. 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. **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.

MINISTRY OF HEALTH
MANATŪ HAUORA

MINISTRY OF HEALTH
MANATŪ HAUORA