



# 2019 Novel Coronavirus [COVID-19]

[cdh.idaho.gov/dac-coronavirus](http://cdh.idaho.gov/dac-coronavirus) | [cdc.gov/coronavirus/2019-ncov/index.html](http://cdc.gov/coronavirus/2019-ncov/index.html)

## Guidance for Healthcare Workplaces: Responding to Sick or Possibly Sick Employees with COVID-19

This information is intended for healthcare administrators in response to sick or possibly sick employees with COVID-19. **It is important that if you have an employee in your workplace with COVID-19 that you keep it confidential.** Healthcare settings differ from average businesses; this information incorporates guidance relevant to all employers and incorporates additional information for healthcare scenarios. The enclosed content is derived from Centers for Disease Control and Prevention (CDC) guidance and is subject to change as more is learned about COVID-19 response. Please see the Resource section of this document for links to the most up-to-date information.

### Healthcare Personnel Exposures and Risk

In situations of potentially exposed HCP, contact tracing, risk assessment and appropriate implementation of HCP work restrictions is the recommended strategy for identifying and reducing the risk of transmission of COVID-19 to HCP, patients, and others. However, it is not practical or achievable in all situations.

Community transmission of COVID-19 in the United States has been reported in multiple areas. This development means some recommended actions (e.g., contact tracing and risk assessment of all potentially exposed HCP) are impractical for implementation by healthcare facilities. In the setting of ongoing community transmission, all HCP are at some risk for exposure to COVID-19, whether in the workplace or in the community. Devoting resources to contact tracing and retrospective risk assessment could divert resources from other important infection prevention and control activities.

Facilities should **shift emphasis** to more routine practices and universal source control, which include asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of COVID-19, use facemasks or cloth face coverings for source control, and not report to work when ill. Facilities should develop a plan for how they will screen for symptoms and evaluate ill HCP. This could include having HCP report absence of fever and symptoms prior to starting work each day.

***For facilities able to complete contact tracing and risk assessment, Central District Health (CDH) is available for consultation. Generally, the facility will notify and monitor exposed staff members, the facility will notify the patients, and CDH will aid in monitoring.***

**High Risk** exposures refer to HCP who have had prolonged close contact with patients with COVID-19 (beginning 48 hours before onset of symptoms) who were not wearing a cloth face covering or facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction) on patients with COVID-19 (beginning 48 hours

before onset of symptoms) when the healthcare providers' eyes, nose, or mouth were not protected, is also considered *high-risk*.

**Medium Risk** exposures generally include HCP who had prolonged close contact with patients with COVID-19 (beginning 48 hours before onset of symptoms) who were wearing a cloth face covering or facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19.

**Low Risk** exposures generally refer to brief interactions with patients with COVID-19 (beginning 48 hours before onset of symptoms) or prolonged close contact with patients (beginning 48 hours before onset of symptoms) who were wearing a cloth face covering or facemask for source control while HCP were wearing a facemask or respirator. Use of eye protection in addition to a facemask or respirator would further lower the risk of exposure.

**High and Medium Risk** exposures should be excluded from work and monitor for signs and symptoms for 14 days after their last exposure. Low Risk should monitoring for signs and symptoms for 14 days after their last exposure.

#### **Community or travel-associated exposures in HCPs**

HCP with [community-](#) or [travel-associated](#) exposures to COVID-19 should inform their facility's occupational health program that they have had a community or travel-associated exposure. Decisions about restriction from work should be made in consultation with the occupational health program.

### **Return to Work Criteria for HCP with Confirmed or Suspected COVID-19**

#### **Symptomatic HCP with suspected or confirmed COVID-19:**

- *Symptom-based strategy*. Exclude from work until:
  - At least 3 days (72 hours) have passed *since recovery* - defined as resolution of fever without the use of fever-reducing medications **and** improvement in respiratory symptoms (e.g., cough, shortness of breath); **and**,
  - At least 10 days have passed *since symptoms first appeared*
- *Test-based strategy*. Exclude from work until:
  - Resolution of fever without the use of fever-reducing medications **and**
  - Improvement in respiratory symptoms (e.g., cough, shortness of breath), **and**
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected  $\geq 24$  hours apart (total of two negative specimens)<sup>[1]</sup>. See [Interim Guidelines for Collecting, Handling, and Testing Clinical Specimens for 2019 Novel Coronavirus \(2019-nCoV\)](#). Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

## **HCP with laboratory-confirmed COVID-19 who have not had any symptoms:**

- *Time-based strategy.* Exclude from work until:
  - 10 days have passed since the date of their first positive COVID-19 diagnostic test assuming they have not subsequently developed symptoms since their positive test.
    - If they develop symptoms, then the *symptom-based* or *test-based strategy* should be used (see above). Note, because symptoms cannot be used to gauge where these individuals are in the course of their illness, it is possible that the duration of viral shedding could be longer or shorter than 10 days after their first positive test.
- *Test-based strategy.* Exclude from work until:
  - Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive nasopharyngeal swab specimens collected  $\geq 24$  hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individual are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

\*Note that detecting viral RNA via PCR does not necessarily mean that infectious virus is present.

## **Return to Work Practices and Work Restrictions**

*After returning to work, HCP should:*

- Wear a facemask for source control at all times while in the healthcare facility until all symptoms are completely resolved or at baseline. A facemask instead of a cloth face covering should be used by these HCP for source control during this time period while in the facility. After this time period, these HCP should revert to their facility policy regarding [universal source control](#) during the pandemic.
  - A facemask for source control does not replace the need to wear an N95 or higher-level respirator (or other recommended PPE) when indicated, including when caring for patients with suspected or confirmed COVID-19.
  - Of note, N95 or other respirators with an exhaust valve might not provide source control.
- Self-monitor for symptoms, and seek re-evaluation from occupational health if respiratory symptoms recur or worsen

## **Strategies to Mitigate Healthcare Personnel Staffing Shortages**

Maintaining appropriate staffing in healthcare facilities is essential to providing a safe work environment for HCP and safe patient care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to HCP exposures, illness, or need to care for family members at home. Healthcare facilities must be prepared for potential staffing shortages and have plans and processes in place to mitigate them, including considerations for permitting HCP to return to work without meeting all return to work criteria above. Refer to the CDC's [Strategies to Mitigate Healthcare Personnel Staffing Shortages](#) document for information. As part of this, asymptomatic HCP with a recognized COVID-19 exposure might be permitted to work as a crisis capacity strategy to address staffing shortages if they wear a facemask for source

control for 14 days after the exposure. This time period is based on the current incubation period for COVID-19, which is 14 days.

### **Cleaning:**

*For healthcare and patient areas:*

- Routine cleaning and disinfection procedures (e.g., using cleaners and water to pre-clean surfaces prior to applying an EPA-registered, hospital-grade disinfectant to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) are appropriate for SARS-CoV-2 in healthcare settings, including those patient-care areas in which aerosol generating procedures are performed.
- Management of laundry, food service utensils, and medical waste should also be performed in accordance with routine procedures.
- Additional information about recommended practices for terminal cleaning of rooms and PPE to be worn by environmental services personnel is available in the [Healthcare Infection Prevention and Control FAQs for COVID-19](#)

*For office areas if an employee is positive:*

If the employee was in the building while infectious (starting 2 days before onset of symptoms) and it has been less than a week since the employee was last in the building, cleaning is recommended. If it has been more than a week since the employee was last in the building, then special cleaning is not necessary.

It is recommended to close off areas used by the ill employee and wait as long as practical before beginning cleaning and disinfection to minimize potential for exposure to respiratory droplets. If possible, wait up to 24 hours before beginning cleaning and disinfection. The CDC offers guidance on how best to clean an area in which an infectious person was present. <https://www.cdc.gov/coronavirus/2019-ncov/prepare/disinfecting-building-facility.html>

### **Resources:**

- CDC: Resources for Healthcare Providers:
  - <https://www.cdc.gov/coronavirus/2019-nCoV/hcp/index.html>
  - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>
  - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html>
  - <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>
- Central District Health COVID-19 Webpages for Healthcare Providers:
  - <https://cdh.idaho.gov/dac-coronavirus-hc.php>
  - <https://cdh.idaho.gov/dac-healthprofessionals-healthalertnetwork.php>