CHS COVID19 Staff Management Ideas v1.0

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Three AIMs:
1. Prevent staff nosocomial infections
2. Prevent patient nosocomial infections from staff
3. Prevent family/community transmission from staff

BEFORE starting work

Should we be screening our staff for COVID-19?

Screening involves taking staff's **temperature** and asking them about **symptoms of an acute respiratory infection**

Is this effective?

85-90% of cases will have a fever at some point, and *65-70% will have a cough*

However, there is evidence that up to about 20% of cases with positive PCR will be asymptomatic, and may have a viral load high enough to cause transmission

So, although monitoring of signs and symptoms of infection is important, this is why good PPE and infection prevention is important, as well as hygiene and social distancing

How do we screen?

Staff must fill out a daily questionnarie on symptoms, and have their temperature taken

Information could be entered into an app, or a webform which is monitored by a team leaders, a clinical epi team, or infection prevention

Ideas include:

- Giving each staff member a thermometer to take their own temperature
- Having defined entry points for staff with screening
- Thermal scanners at entry points

What if a staff member has a fever or symptoms?

Any HCW with a **fever (≥38 dC)** or history of fever (night sweats, chills) **OR acute respiratory infection (eg. cough, SOB, sore throat)** is a **suspect case**

Staff should be treated as a **suspect case**, and sent to a rapid staff fever clinic

This will require rapid testing, and isolation must occur until test results are available

AT work

What happens if staff have/had contact with a CONFIRMED case?

Appropriate PPE used?

If using **<u>appropriate</u> PPE at the time**, monitor for symptoms **as per normal**

PPE not used? Or failure of PPE? Or incorrect PPE for AGP?

If PPE was not used --> see CDNA guidelines for "close contact" def.

If failure of PPE or no PPE and **contact with body fluids or specimens** of a confirmed case --> **ISOLATE**

If in the room **during an AGP and not using airborne precautions --> ISOLATE**

Can I be tested and released from isolation?

NO

Although the median incubation is reported to be ~5 days, you may initially test negative but could still be infected and go on to develop evidence of infection

AT home

Do we need to isolate staff from their families?

Although there is very limited evidence, this has occured in some countries...

This has primarily occured in countries such as China and Singapore.

If we don't isolate staff, what are some things we could consider?

- Ensure staff are following social distancing and good hygiene practices
- Give staff scrubs to change out of at the end of the day (washed at the hospital)
- Ensure daily fever and symptom screening for staff working in COVID19 areas
- Possibly recommend seperate bathrooms and sleeping in seperate beds to partner
- Supply food and drinks to staff working in COVID19 areas
- Ensure staff feel adequately supported including access to psychological support survices and senior clinicians
- If staff have high risk famliy members at home, consider supplying staff with accomodation

Consider factors that lead to HCW infections:

- Lack of understanding of the pathogen and importance of PPE
- Lack of access to PPE and equipment, poor ward set-up
- Exposure to large numbers of infected patients and high risk procedures
- Pressure and work intensity, high nursing requirement and lack of rest
- Shortages of PPE, changes in PPE types due to supply chain issues
- Lack of adequate training and staff unfamiliar with practices

Other recomendations:

- TRAINING, PRACTICE and SIMULATION of PPE USE
- Limit staff movements between facilities - only allowed to work at one healthcare facility
- Have dedicated COVID19 teams - enter and leave hot zone at same time, small teams, maintain logs of staff movements into rooms
- Restrict access to whole hospital for visitors and non-essential personnel
- Ensure clear and timely communication for hospital leadership