Weisman Children's Rehabilitation Hospital

INFECTION CONTROL MANUAL

SUBJECT: COVID 19 Exposure/Positive Employee Return to Work **NO: EH119**

Effective Date: 1/5/22

Reviewed/Revised: 8/22, 2/23, 4/23, 1/24 **Page: 1 of 6**

Policy:

It is the policy of Weisman Children's Rehabilitation Hospital to ensure that healthcare personnel with confirmed or suspected SARS-CoV-2 (COVID-19) infection utilize the appropriate criteria for returning to work. New Jersey Department of Health/ Centers for Disease Control and Prevention guidance will be utilized.

Definitions:

"Close Contact" refers to someone who has been within 6 feet of a person with confirmed SARS-CoV-2 infection or having unprotected direct contact with infectious secretions or excretions of the person with confirmed SARS-CoV-2 infection. Distances of more than 6 feet might also be of concern, particularly when exposures occur over long periods of time in indoor areas with poor ventilation.

"Prolonged": An exposure of 15 minutes or more is considered prolonged. This could refer to a single 15-minute exposure to one infected individual or several briefer exposures to one or more infected individuals adding up to at least 15 minutes in a 24-hour period. However, the presence of extenuating factors (e.g., exposure in a confined space, performance of aerosol-generating procedure) could warrant more aggressive actions even if the cumulative duration is less than 15 minutes. For example, **any duration** should be considered prolonged if the exposure occurred during performance of an aerosol generating procedure.

"Coronavirus" is a virus that causes mild to severe respiratory illness.

"COVID-19" (short for coronavirus disease 2019) is a respiratory disease caused by a novel (new) coronavirus that was first identified during an investigation into an outbreak in Wuhan, China.

"Higher-Risk Exposure" refers to exposure of an individual's eyes, nose, or mouth to material potentially containing SARS-CoV-2, particularly if present in the room for an aerosol-generating procedure. This can occur when staff do not wear adequate personal protective equipment during care or interaction with an individual

- HCP was not wearing a respirator (or if wearing a facemask, the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask)
- HCP was not wearing eye protection if the person with SARS-CoV-2 infection was not wearing a cloth mask or facemask
- HCP was not wearing all recommended PPE (i.e., gown, gloves, eye protection, respirator) while present in the room for an aerosol-generating procedure

"Mild Illness" is individuals who have any of the various signs and symptoms of COVID-19 (e.g. fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

"Moderate Illness" is individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

"Severe Illness" is individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for patients with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

"Critical Illness" is individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

"Severely Immunocompromised" Some conditions, such as being on chemotherapy for cancer, hematologic malignancies, being within one year out from receiving a hematopoietic stem cell or solid organ transplant, untreated HIV infection with CD4 T lymphocyte count < 200, combined primary immunodeficiency disorder, and taking immunosuppressive medications (e.g., drugs to suppress rejection of transplanted organs or to treat rheumatologic conditions such as mycophenolate and rituximab, receipt of prednisone >20mg/day for more than 14 days, may cause a higher degree of immunocompromise and inform decisions regarding the duration of Transmission-Based Precautions. Other factors, such as advanced age, diabetes mellitus, or end-stage renal disease, may pose a much lower degree of immunocompromise and not clearly affect decisions about duration of Transmission-Based Precautions. Ultimately, the degree of immunocompromise for the patient is determined by the treating provider, and preventative actions are tailored to each individual and situation.

Policy Explanation:

This policy is to guide facility leadership with making decisions about return to work for healthcare personnel (HCP) with confirmed SARS-CoV-2 infection, or who have suspected SARS-CoV-2 infection but were never tested for SARS-CoV-2.

Compliance Guidelines:

1. For HCPs who were suspected of having COVID-19 but following evaluation another diagnosis is suspected or confirmed, return to work decisions should be based on their other suspected or confirmed diagnoses.
2. The decision about return to work for HCP with SARS-CoV-2 infection should be made in the context of local circumstances. The time period used depends on the HCP's severity of illness and if they are severely immunocompromised. Further evaluation from the HCP's healthcare provider may be required.

(COVID-POSITIVE EMPLOYEES)

Work Restrictions for HCP with SARS-CoV-2 Infection

1. HCP with mild to moderate illness who are ***not*** moderately to severely immunocompromised may return to work:
    a. After 7 days since symptoms first appeared if negative viral testing is obtained prior to returning.
        i. NAAT (molecular test) – Only one negative test is required within 48 hours before returning
        ii. Antigen test – two negative tests are required on day 5 and day 7
        iii. Example, NAAT: Day of first symptoms is day 0, negative test on day 5, return to work on day 8.
        iv. Example, Antigen test: Day of first symptoms is day 0, negative test on day 5, negative test on day 7, return to work on day 8

v. If negative viral testing is NOT obtained, HCP may return to work after 10 days

b. At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and** Symptoms (e.g., cough, shortness of breath) have improved.

2. HCP who were asymptomatic throughout their infection and are ***not*** moderately to severely immunocompromised may return to work:

   a. After 7 days since their first positive viral test and if negative viral testing is obtained prior to returning.

      i. NAAT (molecular test) – Only one test is required on day 5

      ii. Antigen test – two negative tests are required on day 5 and day 7

      iii. Example, NAAT: Day of first positive viral test is day 0, negative test on day 5, return to work on day 8.

      iv. Example, Antigen test: Day of first positive viral test is day 0, negative test on day 5, negative test on day 7, return to work on day 8

      v. If negative viral testing is NOT obtained, HCP may return to work after 10 days

3. **HCP with severe to critical illness who are *not* moderately to severely immunocompromised may return to work:**

   a. **After at least 10 days and up to 20 days after symptoms first appeared**

   b. At least 24 hours have passed *since last fever* without the use of fever-reducing medications, **and** Symptoms (e.g., cough, shortness of breath) have improved.

   c. The test-based strategy as described below for moderately to severely immunocompromised HCP can be used to inform the duration of work restriction.

      i. Test results are negative from at least two consecutive respiratory specimens collected 48 hours apart (total of two negative specimens) tested using an antigen test or NAAT.

4. **HCP who are moderately to severely immunocompromised**

   a. May produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test.

   b. Use of a test-based strategy and consultation with an infectious disease specialist or other expert and an occupational health specialist is recommended to determine when these HCP may return to work.

Any HCP with SARS-CoV-2 Infection who returns before day 11 must wear source control at ALL TIMES.

(COVID-EXPOSED EMPLOYEES)

Work Restrictions for HCP with high-risk exposures to SARS-CoV-2

In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2. However, work restrictions may be considered when HCP are unable to be tested, unable to wear source control for 10 days following the exposure, are moderately to severely immunocompromised

or care for patients/residents who are, or work on a unit experiencing ongoing transmission not controlled by initial interventions.

See attachment: NJDOH Healthcare Personnel Exposure to a Confirmed COVID-19 Case Risk Algorithm to determine exposure risk. In general, HCP who have had prolonged close contact with someone with SARS-CoV-2 in the community (e.g., household contacts) should be managed as described for higher-risk occupational exposures.

1. Asymptomatic HCP with a higher-risk exposure

a. Test for SARS-CoV-2 no earlier than 24 hours after the exposure and, if negative, test again 48 hours after the first negative test and, if negative, test a third time 48 hours after the second negative test.

   i. Where exposure is day 0, this will <u>normally</u> be at day 1, day 3, and day 5.

b. Follow all recommended infection prevention and control practices, including:

   i. Use of well-fitting source control in all areas for 10 days following exposure

   ii. Not reporting to work when ill

   iii. Self-monitoring for fever or symptoms consistent with COVID-19.

c. Due to challenges in interpreting the result, testing is generally **not recommended** for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days.

d. For those who have recovered in the prior 31-90 days antigen testing must be used instead of NAAT testing. This is because some people may remain NAAT positive but not be infectious during this period.

2. Symptomatic HCP with a higher-risk exposure, tested negative:

a. Symptomatic HCP with a higher-risk exposure should be excluded from work

b. Testing:

   i. NAAT – a single negative test is sufficient in most circumstances

      1. If a higher level of clinical suspicion for SARS-CoV-2 infection exists, consider maintaining work restrictions and confirming with a second negative NAAT

   ii. Antigen test - a negative result should be confirmed by either a negative NAAT or a second negative antigen test taken 48 hours after the first negative test.

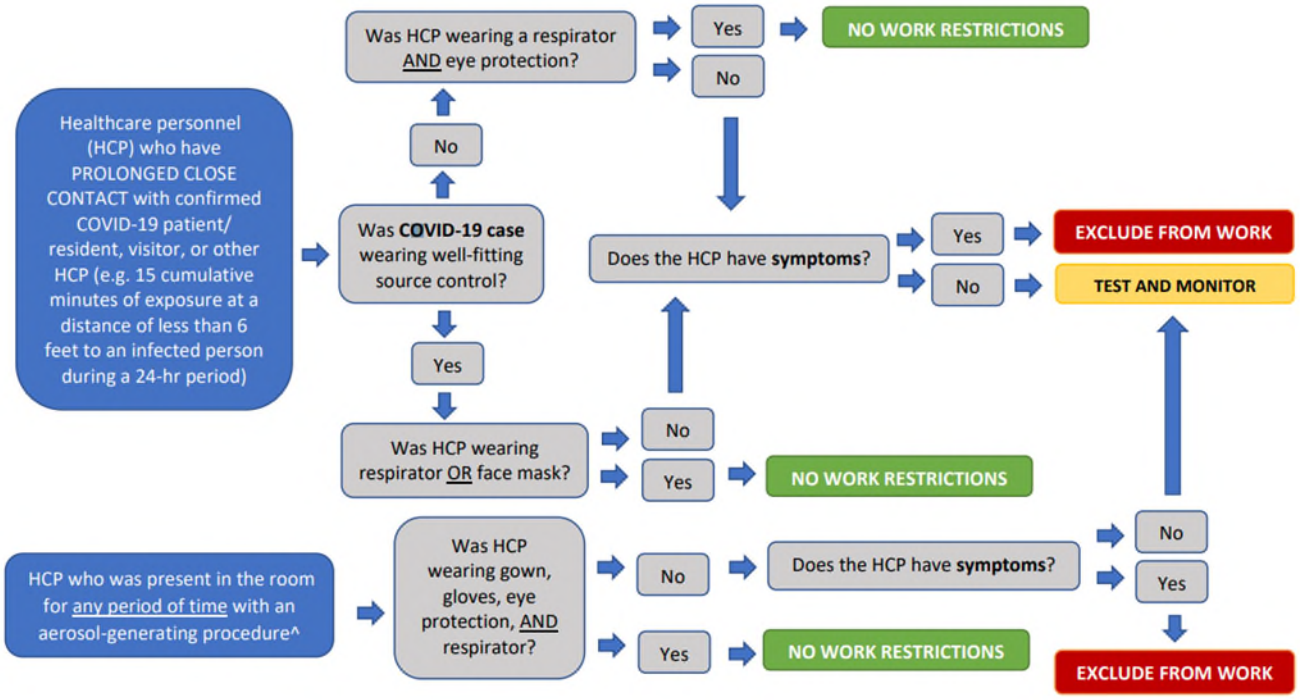
c. If suspected of having COVID-19 but following evaluation another diagnosis is suspected or confirmed, decisions on when to return onsite should be based on their other suspected or confirmed diagnoses.

3. At a minimum, HCP will be excluded from work for at least 24 hours after symptoms resolve, including fever, without using fever-reducing medications, if applicable. For gastrointestinal symptoms (nausea, vomiting, diarrhea), HCP will be excluded for at least 48 hours after symptoms resolve.

Reference:

Centers for Disease Control and Prevention. (2024, March 18). *Interim Guidance for Managing Healthcare Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2*. https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html

Attachment 1:



Work Restrictions*	Additional Recommendations***
EXCLUDE FROM WORK	• **Perform SARS-CoV-2 testing no earlier than 24 hours after the exposure and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure if day 0), day 3, and day 5. HCP can return to work *after* day 7 following the exposure (day 0) if all viral testing is negative for SARS-CoV-2 and there is no alternate diagnosis that would restrict them from work.** • **If the HCP is never tested, the decision to return to work can be made based on time from symptom onset where HCP can return to work *after* a minimum of 10 days following symptom onset or higher-risk exposure, which ever was later.**
TEST AND MONITOR**	• **Perform SARS-CoV-2 testing no earlier than 24 hours after the exposure and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5.** • **Follow the recommendations provided below.**
NO WORK RESTRICTIONS	• Follow all recommended infection prevention and control practices, including use of well-fitting source control for 10 days following exposure, not reporting to work when ill, and monitoring for fever or symptoms consistent with COVID-19. • Any HCP who develop fever or symptoms consistent with COVID-19 should immediately contact their established point of contact (e.g., occupational health program) to arrange for medical evaluation and testing.
NOTE: Testing is generally not recommended for asymptomatic people who have recovered from SARS-CoV-2 infection in the prior 30 days. Testing should be considered for those who have recovered in the prior 31-90 days; however, an antigen test instead of NAAT is recommended.	

^Procedures likely to generate aerosols or that might create uncontrolled respiratory secretions include but are not limited to cardiopulmonary resuscitation; endotracheal intubation and extubation; bronchoscopy; sputum induction; manual ventilation; open suctioning of airways; and non-invasive ventilation (e.g., BiPAP, CPAP). Refer to CDC *Clinical Questions about COVID-19: Questions and Answers* at https://www.cdc.gov/coronavirus/2019-ncov/hcp/faq.html#Infection-Control.

*In general, asymptomatic HCP who have had a higher-risk exposure do not require work restriction, regardless of vaccination status, if they do not develop symptoms or test positive for SARS-CoV-2.

**Work restrictions *may* be considered when HCP are unable to be tested, unable to wear source control for 10 days following the exposure, are moderately to severely immunocompromised or care for patients/residents who are, or work on a unit experiencing on-going transmission not controlled by initial interventions.

*** Licensed health care providers subject to DCA Administrative Order No. 2022-01 are required to follow NJDOH guidance.