

# HEALTH STAFF WITH A COVID-19 INFECTION

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## QUESTION

The incidence of COVID-19 infections in the population and the number of hospitalized COVID-19 patients is increasing, more clusters are occurring in nursing homes and an increased number of health care staff is absent because of a COVID-19 infection (isolation) or exposure (quarantine). A question was therefore made to assess the possibility that health care workers with a COVID-19 infection could continue to work in health care facilities and practices (hospitals, nursing homes, other care institutions, primary care HCW,...), including in non-COVID wards.

## CONTEXT

### Current advice

The current advice is that, in general, health care workers (HCW) with a suspected or confirmed SARS-CoV-2 infection follow the same measures of isolation as for other COVID patients:

- Suspected cases remain in isolation at home until the test result is known.
- If the result is negative, work can be resumed as soon as the clinical conditions allow, but with the wearing of a surgical mask until symptoms completely disappear.
- Confirmed cases remain in isolation at home for a minimum of 7 days after the onset of the symptoms AND at least 3 days without fever AND with improvement in respiratory symptoms; or, for asymptomatic cases, 7 days after the positive sampling result.
- Upon return to work the staff has to wear a surgical mask in the care facility at all times.

An asymptomatic HCW with a positive PCR test in a setting of screening can exceptionally be deployed to a COVID-19 department in the event of an acute shortage of personnel, provided that they wear personal protective equipment (PPE) (surgical mask, gloves, apron and goggles) and apply strict hand hygiene.

In addition, exceptionally, if this is the only possibility to ensure continuity of care/service, asymptomatic high risk contacts are allowed to work with respect of certain conditions (PPE, strict hygiene, close follow-up of the health status, keeping at all-time a distance of 1,5m), avoiding social contact outside work and no travel).

### Risk of care provider-to-patient transmission

There are few studies assessing the risk of transmission from HCWs to patients in a health care setting. Transmission is believed to be low, but this is mainly because from the beginning HCWs have taken protective measures and care providers with a confirmed COVID-19 infection stopped working. Nevertheless, for obvious reasons, it is recommended that infectious HCWs have as little contact as possible with hospitalized patients, other than COVID-19 patients.

## International guidance

All international guidelines state as a general rule that people with a positive test should self-isolate. No guidelines on the deployment of COVID-19+ health care workers were found for ECDC/WHO and our neighboring countries.

The US' Centre for Disease Control (CDC) developed guidance for 'Strategies to Mitigate Healthcare Personnel Staffing Shortages', in which they state that under certain conditions health staff with suspected or confirmed COVID-19, who are well enough and willing to work, could return to work in a healthcare setting before meeting all Return to Work Criteria (1):

*'There are Contingency and Crisis Capacity Strategies that healthcare facilities should consider in these situations. For example, if, despite efforts to mitigate, HCP staffing shortages occur, healthcare systems, facilities, and the appropriate state, local, territorial, and/or tribal health authorities might determine that HCP with suspected or confirmed COVID-19 could return to work before the full Return to Work Criteria have been met. Several of the Crisis Capacity Strategies are dependent on HCP wearing a facemask for source control while at work. Given ongoing shortages of personal protective equipment (PPE), facilities should refer to and implement relevant Strategies for Optimizing the Supply of Facemasks.*

*Developing criteria to determine which HCP with suspected or confirmed COVID-19 (who are well enough and willing to work) could return to work in a healthcare setting before meeting all Return to Work Criteria—if staff shortages continue despite other mitigation strategies.*

- *Considerations include:*
  - *The type of HCP shortages that need to be addressed.*
  - *Where individual HCP are in the course of their illness (e.g., viral shedding appears to be higher earlier in the course of illness).*
  - *The types of symptoms they are experiencing (e.g., persistent fever).*
  - *Their degree of interaction with patients and other HCP in the facility. For example, are they working in telemedicine services, providing direct patient care, or working in a satellite unit reprocessing medical equipment?*
  - *The type of patients they care for (e.g., immunocompromised patients or only patients with SARS-CoV-2 infection).*
- *As part of planning, healthcare facilities (in collaboration with risk management) should inform patients and HCP when the facility is operating under crisis standards, the changes in practice that should be expected, and actions that will be taken to protect them from exposure to SARS-CoV-2 if HCP with suspected or confirmed COVID-19 are allowed to work.'*

## ELEMENTS OF DISCUSSION

- Allowing (asymptomatic) infected HCWs taking care of other patients (even exclusively COVID+) is against all basic principles of epidemic/infection control, certainly in time aerosol transmission seems to increasingly occur.
- Other measures to mitigate staff shortage should be explored first, such as adjusting staff schedules, hiring additional HCW, rotating HCW, etc.
- Not all current absences/sick leaves are related to COVID-infections or high-risk contacts. Other reasons are e.g. demotivation, burn out, ... Allowing infected HCWs to work will not solve the problem of shortage and might even negatively impact on these other reasons.
- Hospitals should remain safe spaces that are trusted by the public. Employing COVID+ staff might damage the trust of the general public and lead to (more) delay in seeking healthcare for non-COVID conditions.
- The duration of isolation for COVID+ cases in Belgium (7 days for asymptomatic cases) is already shorter than in many other countries.

- It is important to give clear messages to the public. Exempting certain professions from the obligation to self-isolate in case of a positive test, might jeopardize compliance with self-isolation in the wider population and lead to increased demand of exceptions for other professions too.
- The current “exception” rule for allowing high-risk contacts to continue their work in case of shortage of staff is in practice more applied as general rule than an exception. The pressure might be high on HCWs to go working even if they have COVID-19.
- In case HCWs with suspected or confirmed COVID-19 need to be deployed, the following elements need to be taken into consideration:
  - the extent to which departments for COVID-19 patients are separated from the other departments (different entrances, different changing room, break space, etc.);
  - related to the HCW:
    - symptoms and type;
    - stage of the illness;
    - level of viral shedding, based on viral load or Ct level. Because Ct levels might differ according test used, an interpretation of a clinical biologist is needed (cfr previous [RAG advice](#));
    - diagnostic test: if diagnosis of infection based on a rapid Ag test, the person can be considered as surely contagious;
    - degree of interaction with patients and other HCP in the facility;
    - type of patients they care for (e.g., immunocompromised patients or only patients with SARS-CoV-2 infection);
    - transport mean used to come to work;
    - earlier (or existing) seroconversion does currently not confer protection against reinfection.

## RECOMMENDATIONS

1. **As a general rule, infected HCWs should never be deployed to work.**
2. As an exception rule, if the continuity of care is at risk and if all other measures to mitigate staff shortage have been exhausted, asymptomatic HCWs with a suspected or confirmed COVID-19 infection can be deployed, but only to take care of COVID-19 patients, in a COVID-19 unit.
3. In this case, contact with other people and staff needs to be avoided. Wherever possible, the COVID+ HCW uses different entrances, different changing rooms, break spaces, avoids public transport, etc.
4. In the following situations deployment of HCWs, even asymptomatic is never allowed:
  - a. HCW with a high viral load/low Ct level ( $\leq 25$ );
  - b. HCW with a positive rapid Ag test;
  - c. HCW feeling stressed or uncomfortable having to work while being infected;
  - d. Care giving to non-COVID patients.
5. Only shortages in HCW essential for a minimal standard of care should be considered. Staff providing other services in health care facilities (cleaning staff,...) are not concerned.
6. It should never be the HCW itself who takes the decision to return to work. In care facilities and nursing homes the decision should be taken by the direction jointly with the occupational physician/hygienist. For HCWs in primary care and home care, the decision should be taken by the occupational physician or in concertation with the “wachtkring/cercles de médecins”. Neither can HCWs be forced to work if they are COVID+.
7. The recommendation that in addition, exceptionally, asymptomatic high risk contact HCWs are allowed to work, is maintained. The considerations mentioned in point 3, 5 and 6 above are also important in this situation.

### **The following persons contributed to this RAG advice:**

Emmanuel André (UZ Leuven); Emmanuel Bottieau (ITG); Laura Cornelissen (Sciensano); Pierre-Louis Deudon (COCOM); Michèle Gérard (CHU St Pierre); Xavier Holemans (Grand Hôpital de Charleroi); Frédérique Jacobs (ULB-Erasme); Vicky Jaspers (KCE); Benoît Kabamba (UCL); Yves Lafort (Sciensano); Barbara Legiest (ZG); Tinne Lernout (Sciensano); Romain MAHIEU (COCOM); Pierrette Melin (Uliège); Paul Pardon (FOD); Koen Vanden Driessche (UZA); Roel Van Giel (Domus Medica); Steven Van Gucht (Sciensano).

### **REFERENCES**

(1) Available from: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html>