



HEALTHCARE PROVIDER (HCP)

COVID-19

STAFFING RESOURCE TOOLKIT

Version 2 | May 16, 2020

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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:

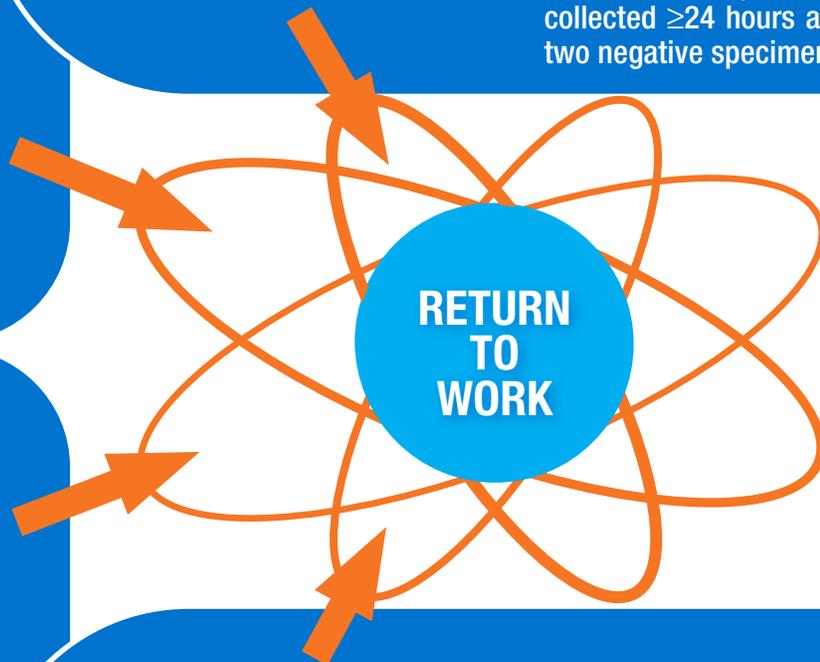
Exclude from work until resolution of fever without the use of fever-reducing medications and improvement in respiratory symptoms (e.g., cough, shortness of breath), and negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens).

HCP has Potential Low Risk Exposure to COVID*

Perform self-monitoring with delegated supervision for 14 days and if asymptomatic, no work exclusions.

HCP has Potential Med-High Risk Exposure to COVID*

Conduct active monitoring, including exclusion from work in any healthcare setting until 14 days after their last exposure.



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. 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 respiratory specimens collected ≥ 24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

*HCP in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

Refer to full guidance document for additional details.

Source: Centers for Disease Control and Prevention.

CDC Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)

Updated April 15, 2020

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html>

WHO THIS IS FOR

This interim guidance is intended to assist with assessment of risk, monitoring and work restriction decisions for HCP with **potential exposure** to COVID-19. This guidance is based on currently available data about COVID-19. Recommendations regarding which HCP are restricted from work may not anticipate every potential scenario and will change if indicated by new information. Healthcare facilities, in consultation with public health authorities, should use clinical judgement as well as the principles outlined in this guidance to assign risk and determine need for work restrictions.

■ **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. Some low-risk exposures are considered medium-risk depending on the type of care activity performed. For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol generating procedure would be considered to have a medium-risk exposure. If an AGP had not been performed, they would have been considered low-risk.

■ **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.

■ **No identifiable risk** is HCP with no direct patient contact and no entry into active patient management areas who adhere to routine safety precautions do not have a risk of exposure to COVID-19 (i.e., they have no identifiable risk.)

MANAGEMENT OF RISK CATEGORIES

HCP in any of the risk exposure categories who develop signs or symptoms compatible with COVID-19 must contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

High- and Medium-risk Exposure Category

HCP in the **high- or medium-risk category** should undergo active monitoring, including restriction from work in any healthcare setting until 14 days after their last exposure. If they develop any fever (measured temperature >100.0°F or subjective fever) OR respiratory symptoms

consistent with COVID-19 (e.g., cough, shortness of breath, sore throat)* they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority and healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation.

Low-risk Exposure Category

HCP in the **low-risk category** should perform self-monitoring with delegated supervision until 14 days after the last potential exposure. **Asymptomatic HCP in this category are not restricted from work.**

They should check their temperature twice daily and remain alert for respiratory symptoms consistent with COVID-19 (e.g., cough, shortness of breath, sore throat.)* They should ensure they are afebrile and asymptomatic before leaving home and reporting for work. If they do not have fever or respiratory symptoms they may report to work. If they develop fever (measured temperature >100.0°F or subjective fever) OR respiratory symptoms they should immediately self-isolate (separate themselves from others) and notify their local or state public health authority or healthcare facility promptly so that they can coordinate consultation and referral to a healthcare provider for further evaluation. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, facilities could consider having HCP report temperature and symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

HCP Who Adhere to All Recommended Infection Prevention and Control Practices

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision as described under the low-risk exposure category.

No Identifiable Risk Exposure Category

HCP in the no identifiable risk category do not require monitoring or restriction from work.

Community or Travel-associated Exposures

HCP with potential exposures to COVID-19 in community settings, should have their exposure risk assessed according to CDC guidance. HCP should inform their facility's occupational health program that they have had a community or travel-associated exposure. HCP who have a community or travel-associated exposure should undergo monitoring as defined by that guidance. Those who fall into the high- or medium- risk category described there should be excluded from work in a healthcare setting until 14 days after their exposure. HCP who develop signs or symptoms compatible with COVID-19 should contact their established point of contact (public health authorities or their facility's occupational health program) for medical evaluation prior to returning to work.

IMPORTANT NOTES

Both high- and medium-risk exposures place HCP at more than low-risk for developing infection; therefore, the recommendations for active monitoring and work restrictions are the same for these exposures. However, these risk categories were created to align with risk categories described in the Interim US Guidance for Risk Assessment and Public Health Management of Persons with Potential Coronavirus Disease (COVID-19) Exposure in Travel-associated or Community Settings, which outlines criteria for quarantine and travel restrictions specific to high-risk exposures. Use that Interim Guidance for information about the movement, public activity, and travel restrictions that apply to the HCP included here.

The highest risk exposure category that applies to each person should be used to guide monitoring and work restrictions.

While respirators confer a higher level of protection than facemasks, and are recommended when caring for patients with COVID-19, facemasks still confer some level of protection to HCP, which was factored into our assessment of risk.

DEFINITIONS

Self-monitoring means HCP should monitor themselves for fever by taking their temperature twice a day and remain alert for respiratory symptoms (e.g., cough, shortness of breath, sore throat.)* Anyone on self-monitoring should be provided a plan for whom to contact if they develop fever or respiratory symptoms during the self-monitoring period to determine whether medical evaluation is needed.

Active monitoring means that the state or local public health authority assumes responsibility for establishing regular communication with potentially exposed people to assess for the presence of fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat.)* For HCP with high- or medium-risk exposures, CDC recommends this communication occurs at least once each day. The mode of communication can be determined by the state or local public health authority and may include telephone calls or any electronic or internet-based means of communication.

For HCP, active monitoring can be delegated by the health department to the HCP's healthcare facility occupational health or infection control program, if both the health department and the facility are in agreement. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

Self-monitoring with delegated supervision in a healthcare setting means HCP perform self-monitoring with oversight by their healthcare facility's occupational health or infection control program in coordination with the health department of jurisdiction, if both the health department and the facility are in agreement. On days HCP are scheduled to work, healthcare facilities could consider measuring temperature and assessing symptoms prior to starting work. Alternatively, a facility may consider having HCP report temperature and absence of symptoms to occupational health prior to starting work. Modes of communication may include telephone calls or any electronic or internet-based means of communication.

Occupational health or infection control personnel should establish points of contact between the organization, the self-monitoring personnel and the local or state health departments of authority in the location where self-monitoring personnel will be during the self-monitoring period. This communication should result in agreement on a plan for medical evaluation of personnel who develop fever or respiratory symptoms (e.g., cough, shortness of breath, sore throat)* during the self-monitoring period. The plan should include instructions for notifying occupational health and the local public health authority, and transportation arrangements to a designated hospital, if medically necessary, with advance notice if fever

or respiratory symptoms occur. The supervising organization should remain in contact with HCP through the self-monitoring period to manage self-monitoring activities and provide timely and appropriate follow-up if symptoms occur in a HCP. Note, inter-jurisdictional coordination will be needed if HCP live in a different local health jurisdiction than where the healthcare facility is located.

Close contact for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the patient; or sitting within 6 feet of the patient in a healthcare waiting area or room); or b) having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand.)

Data are limited for definitions of close contact. Factors for consideration include the duration of exposure (e.g., longer exposure time likely increases exposure risk), clinical symptoms of the patient (e.g., coughing likely increases exposure risk) and whether the patient was wearing a facemask (which can efficiently block respiratory secretions from contaminating others and the environment), PPE used by personnel and whether aerosol-generating procedures were performed. Data are insufficient to precisely define the duration of time that constitutes a prolonged exposure. However, until more is known about transmission risks, it is reasonable to consider an exposure greater than a few minutes as a prolonged exposure. Brief interactions are less likely to result in transmission; however, clinical symptoms of the patient and type of interaction (e.g., did the patient cough directly into the face of the HCP) remain important. Recommendations will be updated as more information becomes available.

Risk stratification can be made in consultation with public health authorities. Examples of brief interactions include: briefly entering the patient room without having direct contact with the patient or their secretions/excretions, brief conversation at a triage desk with a patient who was not wearing a facemask. See the table later in this document for more detailed information.

Healthcare Personnel: For the purposes of this document HCP refers to all paid and unpaid persons serving in healthcare settings who have the potential for direct or indirect exposure to patients or infectious materials, including body substances; contaminated medical supplies, devices and equipment; contaminated environmental surfaces; or contaminated air. For this document, HCP does not include clinical laboratory personnel.

ADDITIONAL CONSIDERATIONS AND RECOMMENDATIONS

While contact tracing and risk assessment, with appropriate implementation of HCP work restrictions, of potentially exposed HCP remains the recommended strategy for identifying and reducing the risk of transmission of COVID-19 to HCP, patients, and others, 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 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, which include asking HCP to report recognized exposures, regularly monitor themselves for fever and symptoms of respiratory infection 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.

Facilities could consider allowing asymptomatic HCP who have had an exposure to a COVID-19 patient to continue to work after options to improve staffing have been exhausted and in consultation with their occupational health program. These HCP should still report temperature and absence of symptoms each day prior to starting work. Facilities could have exposed HCP wear a facemask while at work for the 14 days after the exposure event if there is a sufficient supply of facemasks. If HCP develop even mild symptoms consistent with COVID-19, they must cease patient care activities, don a facemask (if not already wearing), and notify their supervisor or occupational health services prior to leaving work.

* Fever is either measured temperature $>100.0^{\circ}\text{F}$ or subjective fever. Note that fever may be intermittent or may not be present in some patients, such as those who are elderly, immunosuppressed, or taking certain medications (e.g., NSAIDs). Clinical judgement should be used to guide testing of patients in such situations. Respiratory symptoms consistent with COVID-19 are cough, shortness of breath, and sore throat. Medical evaluation may be recommended for lower temperatures ($<100.0^{\circ}\text{F}$) or other symptoms (e.g., muscle aches, nausea, vomiting, diarrhea, abdominal pain headache, runny nose, fatigue) based on assessment by public health authorities.

Epidemiologic Risk Classification for Asymptomatic Healthcare Personnel Following Exposure to Patients with Coronavirus Disease (COVID-19) or their Secretions/Excretions in a Healthcare Setting, and their Associated Monitoring and Work Restriction Recommendations

Epidemiologic risk factors	Exposure category	Recommended Monitoring for COVID-19 (until 14 days after last potential exposure)	Work Restrictions for Asymptomatic HCP
Prolonged close contact with a COVID-19 patient who was wearing a facemask (i.e., source control)			
HCP PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator.	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection	Low	Self with delegated supervision	None
HCP PPE: Not wearing gown or gloves ^a	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self with delegated supervision	None
Prolonged close contact with a COVID-19 patient who was not wearing a facemask (i.e., no source control)			
HCP PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing eye protection ^b	Medium	Active	Exclude from work for 14 days after last exposure
HCP PPE: Not wearing gown or gloves ^{a, b}	Low	Self with delegated supervision	None
HCP PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator) ^b	Low	Self with delegated supervision	None

^a The risk category for these rows would be elevated by one level if HCP had extensive body contact with the patients (e.g., rolling the patient).

^b The risk category for these rows would be elevated by one level if HCP performed or were present for a procedure likely to generate higher concentrations of respiratory secretions or aerosols (e.g., cardiopulmonary resuscitation, intubation, extubation, bronchoscopy, nebulizer therapy, sputum induction). For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosolgenerating procedure would be considered to have a medium-risk exposure.

ADDITIONAL SCENARIOS

Refer to the footnotes above for scenarios that would elevate the risk level for exposed HCP. For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosolgenerating procedure would be considered to have a medium-risk exposure.

Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCP having prolonged close contact with patients infected with COVID-19. However, to account for any inconsistencies in use or adherence that could result in unrecognized exposures, HCP should still perform self-monitoring with delegated supervision.

HCP not using all recommended PPE who have only brief interactions with a patient regardless of whether patient was wearing a facemask are considered low-risk. Examples of brief interactions include: brief conversation at a triage desk; briefly entering a patient room but not having direct contact with the patient or the patient's secretions/excretions; entering the patient room immediately after the patient was discharged.

HCP who walk by a patient or who have no direct contact with the patient or their secretions/excretions and no entry into the patient room are considered to have no identifiable risk.

NJDOH COVID-19 FEVER AND SYMPTOM MONITORING LOG FOR HCP

Day	Date	Time	Temperature
1	____/____ MONTH DAY	____AM ____PM	____°F ____°F
2	____/____ MONTH DAY	____AM ____PM	____°F ____°F
3	____/____ MONTH DAY	____AM ____PM	____°F ____°F
4	____/____ MONTH DAY	____AM ____PM	____°F ____°F
5	____/____ MONTH DAY	____AM ____PM	____°F ____°F
6	____/____ MONTH DAY	____AM ____PM	____°F ____°F
7	____/____ MONTH DAY	____AM ____PM	____°F ____°F
8	____/____ MONTH DAY	____AM ____PM	____°F ____°F

Symptom Monitoring			
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty-Breathing
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		Muscle-Ache
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty-Breathing
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		Muscle-Ache
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty-Breathing
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		Muscle-Ache
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty-Breathing
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		Muscle-Ache
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty-Breathing
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		Muscle - Ache
Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No		Difficulty-Breathing
Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		Muscle-Ache

Continue on the next page

NJDOH COVID-19 FEVER AND SYMPTOM MONITORING LOG FOR HCP *Continued*

Day	Date	Time	Temperature	Symptom Monitoring			
9	____/____/____ MONTH DAY	____ AM	____ °F	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
		____ PM	____ °F	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
				Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
10	____/____/____ MONTH DAY	____ AM	____ °F	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
		____ PM	____ °F	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
				Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
11	____/____/____ MONTH DAY	____ AM	____ °F	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
		____ PM	____ °F	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
				Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
12	____/____/____ MONTH DAY	____ AM	____ °F	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
		____ PM	____ °F	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
				Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
13	____/____/____ MONTH DAY	____ AM	____ °F	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
		____ PM	____ °F	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
				Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
14	____/____/____ MONTH DAY	____ AM	____ °F	Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	Difficulty-Breathing	<input type="checkbox"/> Yes <input type="checkbox"/> No
		____ PM	____ °F	Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No		Headache
				Sore Throat	<input type="checkbox"/> Yes <input type="checkbox"/> No	Muscle-Ache	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Vomiting	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
				Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No

- (1) Name: _____ Age (yrs): _____ Sex: M F
- (2) Street address: _____ City, State: _____ Telephone number: _____
- (3) Exposure Level (High or Medium) _____ Furloughed from work? _____
- (4) Case ID number (from contact listing form): _____ Contact number (from contact listing form): _____
- (5) Facility where the contact occurred case occur: _____
Date of last contact with the case (mm/dd/yyyy): _____

Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19

Interim Guidance | Updated April 30, 2020

<https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>

WHO THIS IS FOR

Occupational health programs and public health officials making decisions about return to work for healthcare personnel (HCP) with confirmed COVID-19, or who have suspected COVID-19 (e.g., developed symptoms of a respiratory infection [e.g., cough, sore throat, shortness of breath, fever] but did not get tested for COVID-19).

Decisions about return to work for HCP with confirmed or suspected COVID-19 should be made in the context of local circumstances. Options include a symptom-based (i.e., time-since-illness-onset and time-since-recovery strategy) or time-based strategy or a test-based strategy. Of note, there have been reports of prolonged detection of RNA without direct correlation to viral culture.

Symptomatic HCP with suspected or confirmed COVID-19 Either strategy is acceptable depending on local circumstances:	
Symptom-based strategy. Exclude from work until:	Test-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.	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 respiratory specimens collected ≥ 24 hours apart (total of two negative specimens)[1]. 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 Either strategy is acceptable depending on local circumstances:	
Time-based strategy. Exclude from work until:	Test-based strategy. Exclude from work until:
10 days have passed since the date of HCP 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. 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	Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

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.

Note: 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. N95s 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 [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 in 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.

¹ All test results should be final before isolation is ended. Testing guidance is based upon limited information and is subject to change as more information becomes available. In persons with a persistent productive cough, SARS-CoV-2-RNA might be detected for longer periods in sputum specimens than in upper respiratory tract specimens.

Sample HCP Return to Work Policy Following Suspected or Confirmed COVID-19 Infection

I. POLICY

Facility Name, in accordance with Centers for Disease Control and Prevention guidelines, has outlined in the following policy, actions to be taken to allow healthcare providers (HCP) to return to work after a suspected or confirmed COVID-19 infection.

II. PROCEDURE

1. In the event that a HCP has been infected with COVID-19, occupational health, in coordination with infection prevention, infectious disease and public health, will advise the HCP of the following actions that must occur prior to returning to work within the healthcare setting.
2. Options for return to work clearance include a test-based strategy or a non-test-based strategy (i.e., time-since-illness-onset and time-since-recovery strategy).

Symptomatic HCP with suspected or confirmed COVID-19 Either strategy is acceptable depending on local circumstances:	
Symptom-based strategy. Exclude from work until:	Test-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.	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 respiratory specimens collected ≥ 24 hours apart (total of two negative specimens)[1]. 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 Either strategy is acceptable depending on local circumstances:	
Time-based strategy. Exclude from work until:	Test-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. 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.	Negative results of an FDA Emergency Use Authorized COVID-19 molecular assay for detection of SARS-CoV-2 RNA from at least two consecutive respiratory specimens collected ≥ 24 hours apart (total of two negative specimens). Note, because of the absence of symptoms, it is not possible to gauge where these individuals are in the course of their illness. There have been reports of prolonged detection of RNA without direct correlation to viral culture.

3. Upon meeting the aforementioned requirements, the HCP must receive documented approval to return to work from occupational health.

4. After returning to work, HCP should comply with the following:

- 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. 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.

Reference:

Centers for Disease Control and Prevention (April 30, 2020). Criteria for Return to Work for Healthcare Personnel with Suspected or Confirmed COVID-19 (Interim Guidance) <https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html>.

Clinical Care Team Models

The following priorities will help maintain appropriate staffing and care capabilities during an infectious disease outbreak in general and the COVID-19 crisis in particular:

- Planning for surge capacity based on CDC projections for individual hospitals and the region.
- Limiting the spread of COVID-19 within the hospital to protect healthcare workers and patients.
- Finding ways to maintain, augment and stretch the hospital workforce.
- Allocating healthcare resources in a rational, ethical and organized way to do the greatest good for the greatest number of people.

Hub and Spoke Model	COVID Primary Care Team	Surgical, Diagnostic, and Procedural COVID Teams	Other Specialty Teams
<p>A specialty trained HCP (ie. critical care nurse, CCRN) leads a team of newly cross trained staff. The specialty trained HCP provides guidance and support to the team members. The team lead should coordinate closely with the staff education department to ensure rapid training and competency assessments of new staff. This model allows for staff flexibility in critical care settings.</p> <p>Example: 1 CCRN oversees 3 med-surg nurses caring for a team of 6 critical patients.</p>	<p>A dedicated team of nurses, physicians, and respiratory therapists provide care for the COVID patients. This approach may help to conserve PPE, reduce exposures to HCP, and provide a coordinated approach to treatment and management of COVID patients.</p>	<p>A dedicated team of HCPs to provide surgical, diagnostic and procedural care to COVID patients. These teams should coordinate closely with the COVID Primary Care Team to ensure that all treatments/procedures that are ordered/performed are reviewed to ensure they are necessary and appropriate for the treatment/management of the COVID patient.</p>	<p>There are many other important patient and staff needs during the COVID pandemic. Patient end of life goals of care, patient and family engagement and support, and staff resilience and morale. Palliative care providers, patient and family engagement advisors and spiritual leaders are critical and should coordinate with leadership to ensure that these important needs are met during this difficult time.</p>

Surge Priority Planning COVID-19: Critical Care Staffing and Nursing Considerations

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BACKGROUND

Effective management of critically ill patients infected with the COVID-19 virus is dependent upon the efficient provision of evidence-based care. Ensuring the safety and resilience of nursing staff during pandemic-related surge capacity is an essential component of disaster preparedness. The suggestions in this article are focused on nursing leadership and administrative considerations, strategies for optimizing staffing resources, and maintaining staff safety and resilience. The suggestions in this article are important for hospital administrators, nursing leaders, and bedside nursing personnel.

SUMMARY OF SUGGESTIONS

■ Identifying alternate staffing resources

We suggest that hospitals consider alternate sources of staffing to supplement existing critical care nursing staff. These may be internal or external resources.

Internal Resources

1. Identify alternate staffing resources within the facility who may have prior critical care experience. These include advanced practice nurses (Clinical Nurse Specialists, Certified Registered Nurse Anesthetists and Nurse Practitioners), as well as nurses in procedural areas (such as the post-anesthesia care unit, cardiac catheterization lab, electrophysiology lab and operating room.)
2. Identify nurses in progressive care units (intermediate care, telemetry or stepdown units) who could contribute to team-based care with the guidance and expertise of a critical care nurse.
3. Identify staff who could provide support to both associates and patients, such as psychiatric counselors and social workers.

External Resources

1. Identify critical care nurses who have transitioned to ambulatory settings but have only been out of critical care environment for less than 3 years.
2. Consider partnering with prehospital resources to support the ICU care team.^{1,2}
 - a. Local emergency medical services (EMS) to utilize paramedics or emergency medical technicians for appropriate patient care skills as part of the critical care team approach.
 - b. Neighboring medical practices (RNs and medical assistants) and urgent care facilities.³
3. Consider utilizing telemedicine, particularly in community facilities with limited specialist support. EICU monitoring (remote monitoring of patients by critical care nurses and providers at an offsite facility) is also a potential means of force expansion to provide support to on-site staff.^{4,5}
4. Utilize additional established resources through the US Department of Health and Human Services Assistant Secretary of Preparedness Response (ASPR) Technical Resources, Assistance Center, and Information Exchange (TRACIE) at <https://asprtracie.hhs.gov/>.

Develop a team-based approach for critical care patient management

A team-based approach with critical care registered nurses (RNs) supported by additional staff members would increase the capacity for care of critically ill patients. Utilizing the unique skill set of each team member in a collaborative approach would provide force multiplication. This team-based approach has been demonstrated to work effectively in both aeromedical transportation and disaster medicine settings. Role definition is an essential component of this approach to patient care.^{1,4}

1. To establish group norms, we recommend utilizing the principles of highly reliable organizations (HRO) and the American Association of Critical-Care Nurses' Healthy Work Environment Standards.⁶

- a. HRO principles include preoccupation with failure, reluctance to simplify, sensitivity to operations, commitment to resilience, and deference to expertise. Determining the skill set and expertise of each team member will support staff comfort with deference to expertise.⁷
 - b. The Healthy Work Environment Standards include skilled communication, true collaboration, effective decision-making, appropriate staffing, meaningful recognition, and authentic leadership.
2. Utilize team huddles at the start of each shift and at regular intervals (such as every 4 hours) to discuss team assignments, patient care goals, and red flags that should be reported immediately to the critical care RN. This will enhance communication, optimize patient care activities, and allow each team member to discuss their clinical strengths and address any concerns. Huddles at regular intervals throughout the shift will inform all team members of changes in plan of care and provide the opportunity to address any concerns.⁸
 3. Determine appropriate tasks for team members without critical care training, designating the critical care RN as team lead for each patient care team. Examples include paramedics performing intubation, IV starts, and nebulizer treatments. RNs without critical care experience could be utilized to document vital signs, perform appropriate nursing interventions, such as routine medication administration, vital sign monitoring, and assisting with patient care activities.

Administrative Considerations for Nurse Staffing

Critical care surge capacity secondary to infectious disease presents unique nursing administrative concerns. These include patient placement, addressing visitor policies, providing adequate amounts of advised personal protective equipment, and determining staff who should not be involved in direct care of COVID-19 infected patients. Formally addressing topics such as the potential need for staff isolation and compensation at the onset of surge will assist in mitigating staff concerns.

1. Visitation policies should be adapted based on exposure risk and patient population. We recommend that administrators clearly communicate changes to visitation policies, and ensure this information is available to patients and their families. Consider options for video communication so that patients do not feel isolated from their family members during this time and families are provided reassurance and regular updates.

2. We recommend that leadership provide just-in-time training to reinforce knowledge of COVID-19 symptoms, transmission, and other important clinical information. This training should include a review of donning and doffing of appropriate personal protective equipment (PPE). A brief but standardized orientation for outside health-care providers assisting in surge management should also be developed to ensure compliance with pertinent policies.⁹
3. The Centers for Disease Control and Prevention indicate that there is limited information on COVID-19 in pregnancy. High fever can increase the risk of birth defects in the first trimester of pregnancy. There are also documented cases of pregnancy loss with other related coronaviruses (SARS-CoV and MERSCoV). We recommend that administrators consider limiting exposure of pregnant nurses from care of patients with COVID-19, particularly during high risk procedures that increase exposure.
4. Administrators should also evaluate other high-risk staff (those who are immunocompromised or have respiratory illness) to determine their risk of exposure and ability to wear the required personal protective equipment for the required duration.
5. Staff members with potential exposure to COVID-19 may be placed on isolation. Those staff may have concerns regarding lodging, as well as compensation. We recommend that facilities develop a plan for housing and compensating staff who need to isolate away from family members and are unable to return to work during their isolation period.

Nursing Leadership Concerns

Nursing literature on the SARS epidemic identified challenges faced by nursing leadership during a period of patient surge related to infectious disease.¹⁰ Five stages experienced by nurse leaders were identified as facing shock and chaos, sourcing for reliable sources to clarify myths, developing and adjusting nursing care, supporting nurses and their clients and rewarding nurses.

1. We recommend that nurse leaders collaborate with hospital administrators to develop consistent and regularly scheduled methods of updating staff on operating conditions, safety concerns and other issues related to surge capacity.
2. Nurse leaders should be prepared to assist staff in managing internal conflict between personal and professional responsibilities.

3. We recommend that nurse leaders identify resources for assistance in mitigating internal conflicts among staff working under surge conditions, such as social workers and mental health personnel.
4. We recommend that even in times of surge, nurse leaders provide meaningful recognition to staff engaged in patient care efforts. This recognition promotes a healthy work environment and reinforces staff resilience.

Nurse Safety and Resilience

We suggest that facilities implement proactive strategies to prevent staff attrition due to fatigue or illness. These include the provision of mental health support, ensuring safe utilization of personal protective equipment to prevent staff infection and maintaining a healthy work environment. Perceived organizational support had an impact on predicting burnout in Canadian nursing staff during the SARS crisis.¹¹

1. We recommend implementation of a safety officer role to monitor PPE and staff exposure risk as part of a total staff safety model. This individual could be an Emergency Medical Technician or Nursing Technician familiar with PPE, or another identified individual who is trained in PPE utilization. The safety officer could provide just-in-time training for those not comfortable with donning and doffing of PPE, and, intermittently, audit PPE utilization.

2. We recommend that each care team designate a team safety officer to ensure team members are taking routinely scheduled breaks for hydration, rest, toileting, and refreshments. Staff should also be assessed for skin breakdown related to extended time periods in PPE.¹³
3. Provide staff with resources to plan with their family in advance of reporting to their first shift.
4. Promote a team culture, particularly if staff are staying on-site during their off time. This may include team meals, team exercise sessions, or other bonding activities.¹⁴
5. Provide access to mental health support for staff feeling overwhelmed or concerned. SARS team nurses in Taiwan demonstrated worry about infecting family and colleagues. Utilization of video communication with family members reduced nurse worry.⁸
6. We recommend that hospital administration maintain visibility with impacted patient care areas to provide support. Mechanisms should be in place for addressing staff concerns about psychosocial issues and working conditions. Meaningful recognition of staff providing support during the surge effort should be provided at regular intervals.^{11,15}

Original article and references

<http://www.chestnet.org/Guidelines-and-Resources/Resources/Surge-Priority-Planning-COVID-19-Critical-Care-Staffing-and-Nursing-Considerations>

Clinical Education and Staffing Resources

From the American Association of Critical Care Nurses

To date, the most serious reported symptoms from COVID-19 are pulmonary complications. “COVID-19 Pulmonary, ARDS and Ventilator Resources” quickly provides learners with the knowledge and resources to provide essential care to ICU patients with coronavirus. To support nurses who need to cross train to care for patients with COVID-19, AACN is making this eLearning course available for all nurses, at no charge, to provide vital resources during this challenging time.

<https://www.aacn.org/education/online-courses/covid-19-pulmonary-ards-and-ventilator-resources>

From the Society of Critical Care Medicine

SCCM and its members are committed to supporting all clinicians on the front lines of this pandemic through this access the Society of Critical Care Medicine's (SCCM) complimentary online training, Critical Care for Non-ICU Clinicians

<https://www.sccm.org/Disaster/COVID19-ResourceResponseCenter>

From the American Association of Colleges of Nursing

During disasters and time of uncertainty, nurses and other health professionals can promote resilience. This presentation includes a technique to renew energy, ways to support children during disasters and strategies to decrease social isolation and foster resilience. Access the link below for the AACN webinar “COVID-19: Promoting Resilience in Times of Crisis” and other COVID topics.

<https://www.aacnnursing.org/Professional-Development/Webinars/Archived-Webinars>