All District Health Boards

Protecting Vulnerable DHB Staff During COVID-19
Guide for People Leaders and Line Managers

Introduction

In response to the COVID-19 pandemic, the New Zealand government has adopted a four-level alert system - the NZ Covid-19 Alert Levels. This system specifies public health and social measures to take against COVID-19.

There is a separate **Covid-19 National Hospital Response Framework** which is designed to provide escalation levels to support a managed approach to clinical service delivery in hospitals. There are also four levels in the Hospital Response Framework and the decision on which of the four levels your DHB is sitting at is made locally. Depending how the COVID-19 situation evolves, DHBs may be at different response levels around the country.

Health services are expected to remain up and running at all alert levels. Health care workers are at higher risk of infection, which requires the need for controls. Employers must continue to meet health and safety obligations. There is an array of controls which have been implemented to reduce the risk for health care workers [see Appendix B, Standard Control Measures].

CONTENTS

Staff Categorised as Vulnerable

Some health care workers have underlying health conditions which can render them more susceptible to respiratory infection or to severe consequences of infection. Other demographic factors such as age and obesity also affect vulnerability. The Ministry of Health notes that "*as in previous epidemics and pandemics of infectious respiratory agents, severe disease burden is likely to fall unequally on Māori, Pacific peoples and older people*".[1]

To reduce the risk of complications from COVID-19 infection in vulnerable staff, a process has been implemented to help guide where and in which tasks vulnerable staff may safely work.

DHB staff who have identified themselves as potentially vulnerable to COVID-19 infection will have been categorised from Category 1 to Category 4 by Occupational Health[2]. As their manager, you will have been informed of their category. Any staff without categorisation are by default Category 1 i.e. able to work in all areas/ tasks.

By necessity, the risk assessment process has been rapidly formulated and established in the DHBs nationwide. Adjustments continue to occur, as we learn more about COVID-19 transmission and health consequences in specific patient populations.

Modifying Duties and Returning to Normal Duties

Staff who are vulnerable may have been moved into alternative work areas as a protective measure when COVID-19 prevalence was high. As the prevalence of COVID-19 falls in the population, the risk of being unexpectantly exposed to a patient with COVID-19 becomes extremely low. With this in mind, and with the corresponding increase in the range of health services being re-established, it makes sense to move staff back towards their normal roles. For some this means moving out of their bubble at home back to a non-clinical role at work and for others this means moving from non-clinical duties back into patient-facing roles. Some staff are understandably anxious about breaking their bubble by returning to work, either due to concerns about their own health or that of others in their bubble.

There remains a balance between the need for protection of vulnerable staff, concerns about staff and their family welfare and the need for health services to provide a safe and efficient service.

Your DHB will provide regular guidance on suitable deployment options for vulnerable staff. The Incident Controller or Executive Lead, in consultation with local specialist teams including Clinical Technical Advisory Groups, Infectious Diseases, Occupational Health and Infection Prevention and Control, will consider local circumstances including current prevalence of COVID-19 in the community to determine which guidance applies. Please refer to the guidance in the tables in Appendix A which indicate where it is safe to work for vulnerable staff considering the above factors.

If you require further specific advice, please contact your Occupational Health, Infectious Disease or Infection Prevention and Control Team. If you need to know which table applies currently, contact your Emergency Operations Centre and/or Emergency Coordination Centre.

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[1] Ministry of Health. 2020. COVID-19 Health and Disability System Response Plan. Wellington: Ministry of Health.

[2] We acknowledge that some staff have concerns about vulnerable family members in their bubble. These concerns are being addressed through HR processes within the DHB. This may involve occupational health advice to managers.

Clinical Work

A relatively small proportion of people affected by COVID-19 will require hospital inpatient care. Most COVID-19 infections cause mild symptoms only.

Universal precautions, as with all clinical work, remain paramount. The latest guidance on personal protective equipment should always be followed. Reassuringly, where these protective measures are put in place, the evidence shows that they are very effective in preventing patient to staff spread.

All DHB facilities have processes in place to separate suspected COVID-19 from non-COVID-19 cases into COVID-19 / non-COVID-19 streams respectively. Staff working in the COVID-19 stream will have appropriate PPE. Streaming is undertaken at a pre-Emergency Department triage stage using a very cautious approach. Patients remain assigned to these streams until such time as clarity have been achieved with further clinical workup and/or laboratory testing. Most suspected COVID-19 cases subsequently turn out to have other illness.

The use of streaming and appropriate PPE allows staff categorised as vulnerable to be able to work in a non-COVID environment with negligible risk.

Examples:

- On arrival to hospital Mrs Smith is triaged to the COVID stream as she has a fever. Covid-19 testing returns a negative result and clinical examination reveals she has cellulitis. She can now be moved to the non- COVID stream for further hospital care.
- An orthopaedic ward has one suspected COVID patient still being evaluated within the COVID stream. Only category 1 staff with appropriate PPE are tending to this patient. There is no need for staff in the rest of the ward to be involved in the COVID stream. The risk on the rest of the ward is negligible and so staff categorised as vulnerable can continue to work on this ward.
- A suspect case in the COVID stream requires a CT investigation. The radiology department are prepared for this and utilise category 1 staff only for any contact with this case. Other staff remain safe either in control rooms or in other areas of the department.

Non-Clinical Work

In non-clinical work the significant risk of being in close contact with ill patients is absent. This allows much more confidence in these work environments being safe. The risk relates to workplace contact with other colleagues. Physical distancing is expected to be maintained where possible. In some work environments this will be easy to maintain. In others it will be impractical to regularly maintain physical distance but this should still be strived for as much as possible.

The simple and effective measures outlined in the Standard Control Measures Table should be in place. Staff who have been in contact with COVID-19 cases or whom have respiratory illness are required to stay away from work.

There remains a possible risk of catching COVID-19 via spread from a colleague who does not have symptoms. This route of spread is documented but is far less likely than with a symptomatic individual. As the community prevalence of COVID-19 falls, this risk lowers correspondingly and Category 4 staff can have increasing confidence in their ability to safely return to non-clinical work areas. Again, simple precautions such as regular hand-washing are the best defence against this type of spread.

Having a conversation with Occupational Health is advised where concern remains about a work area or an individual staff member.

Appendix

A. Tables to Inform Staff Placements

These tables provide the guidance for where vulnerable staff can work under various circumstances. It is up to your DHB to issue the most current table based on a variety of factors relating to the risk of COVID-19 exposure.

Explanation of Recommendations in Tables Below	
Yes	Suitable work for staff of this category
Risk Assess	Specific advice required from occupational health
No	Not recommended

Note:

i. For all situations **below**, where work from home is possible then this should be facilitated.

ii. Physical distancing means maintaining appropriate separation from others. Where this can't be maintained, then proximity should be for as short a duration as possible.

The tables **below** display a progression from a situation where this is relatively high community prevalence of COVID-19 through to a situation where COVID-19 prevalence is lower.

Highest Prevalence: Maximum Need for Protection of Vulnerable Staff	**Staff Vulnerability Category**			
	1	2	3	4
Clinical work [direct patient contact]				
Clinical work with COVID-19 stream	yes	no	no	no
Clinical work with non COVID-19 stream	yes	yes	no	no
Non-clinical work [no direct patient contact]				
Non-clinical work where physical distancing is difficult to maintain	yes	yes	risk assess	no
Non-clinical work where physical distancing can be maintained	yes	yes	yes	no

Lower Prevalence: Moderate Need for Protection of Vulnerable Staff

	Staff Vulnerability Category			
	1	2	3	4
Clinical work [direct patient contact]				
Clinical work with COVID-19 stream	yes	no	no	no
Clinical work with non COVID-19 stream	Yes	yes	risk assess	no
Non-clinical work [no direct patient contact]				
Non-clinical work where physical distancing is difficult to maintain	Yes	yes	risk assess	no
Non-clinical work where physical distancing can be maintained	yes	yes	yes	yes

Low Prevalence: Low Need for Protection of Vulnerable Staff

	Staff Vulnerability Category			
	1	2	3	4
Clinical work [direct patient contact]				
Clinical work with COVID-19 stream	yes	no	no	no
Clinical work with non COVID-19 stream	yes	yes	yes	risk assess
Non-clinical work [no direct patient contact]				
Non-clinical work where physical distancing is difficult to maintain	yes	yes	yes	risk assess
Non-clinical work where physical distancing can be maintained	yes	yes	yes	yes

Lowest Prevalence: Staff Returned to Normal Duties

	Staff Vulnerability Category			
	1	2	3	4
Clinical work [direct patient contact]				
Clinical work with COVID-19 stream	yes	no	no	no
Clinical work with non COVID-19 stream	yes	yes	yes	yes
Non-clinical work [no direct patient contact]				
Non-clinical work where physical distancing is difficult to maintain	yes	yes	yes	yes
Non-clinical work where physical distancing can be maintained	yes	yes	yes	yes

B. Standard Control Measures for COVID-19 in Clinical Areas

Table. Standard Control Measures for COVID-19	
Elimination	Non-urgent activity/ services have been delayed
	Visitor restrictions - either non visitor policy or process ensuring visitors do not have respiratory symptoms
Substitution	Vulnerable staff have been moved from high risk clinical tasks/ areas
	Non-aerosolising techniques are in place where possible
	Tele-health/ virtual consultations are used where possible
Isolation	Risk assessment /triage process is in place for patients who meet case definition [COVID/ non-COVID]
	COVID / non-COVID designated areas are in place
	Isolation/ negative pressure rooms are used for suspected COVID cases where possible
	Perspex screens on reception points
	Closed system ventilators/ suction is in use
	Patient monitoring equipment is located outside patient rooms to minimise entry where possible
	Showers and changing rooms are available for staff where possible to reduce risk of taking infection home
	When high risk procedures are being undertaken, the minimum number of workers are in the room
Administrative controls	Physical distancing is maintained in the department where possible
	Hand hygiene facilities are accessible with adequate supplies
	Sneeze/cough hygiene education has been provided
	Staff are aware to report respiratory illness or fever, stand-down and proceed for testing
	Staff are current with influenza vaccination
	Regular disinfection of surfaces is being undertaken and checked regularly
	Staff have been educated on how to reduce the potential risk to their bubbles of taking COVID-19 home
Personal Protective Equipment [PPE]	PPE suitable for task is available to staff
	Fit-testing of PPE is in place for individuals who undertake aerosol generating procedures e.g. intubation on COVID patients
	PPE training has been provided for all staff needing to use PPE
	PPE fit checking by buddy is in place and used for all PPE donning
	Monitoring of PPE compliance and correct use is in place
	PPE is disposed of before moving between wards/ areas
	Re-usable PPE is being cleaned/ sterilised
	Clean and dirty donning/ doffing areas are in place where physically feasible

C. Clinical Work with COVID-19 Stream

Aerosol generating procedures [e.g. intubation/ extubation/ CPR on COVID case/ sputum induction/ BiPAP, CPAP/ bronchoscopy/ manual ventilation/ nebuliser administration to COVID case/ high flow O2 delivery/ high speed tool use
Autopsy
Close contact when nursing/ examining
Working in ICU ward or similar
Assessing/ nursing Emergency presentations meeting case definition criteria
Attending suspected COVID-19 case in the community
Cleaning rooms during/ following COVID-19 occupancy. Cleaning medical equipment used for COVID-19 care
Transporting suspected COVID-19 case via vehicle
Phlebotomy

The above tasks involve close exposure to COVID-19 cases. Vulnerable staff have potential for higher consequence in the event of a COVID-19 infection. On that basis these tasks are ideally performed by staff who are Category 1. i.e. healthy or with well-controlled health conditions.

In some circumstances, such as staffing shortages, Category 2 staff may be considered for these tasks. This should be in consultation with occupational health and /or infectious diseases.

Recommendation	Category 1 staff Other staff only following discussion with Occupational Health

D. Clinical Work with Non-COVID-19 Stream

Aerosol generating procedures on patients other than COVID-19 stream
Assessing/ nursing low risk patient presentations in Emergency Departments e.g. where patients have been triaged on basis of symptoms, signs and close contact. Physical and staff separation in the department is in place.
Nursing/ attending inpatients in clinical areas that are designated COVID-19 free areas
Nursing/ attending outpatients in clinical areas that are designated COVID-19 free areas
Nursing/ attending community patients who have been risk-assessed as low risk of COVID-19.
Non-clinical work in COVID-19 free clinical areas where physical distancing from patients is practical
Specimen collection

The above tasks do not involve exposure to COVID-19 stream. Vulnerable staff with potential for higher consequence in the event of a COVID-19 infection can be reassigned to these tasks in line with the tables in Appendix A.

Recommendation	Staff deployment in line with tables in Appendix A

E. Non-Clinical Work where Physical distancing is Difficult to Maintain

Work in large kitchens/ stores with many others where physical distancing cannot be maintained
Non-clinical work where regular contact with the general public occurs [healthy members of the public rather than patients] where physical distancing cannot be easily maintained
Work in laboratories with many others where physical distancing cannot be maintained

With non-clinical work the significant risk of being in close contact with ill patients is absent. This allows much more confidence in these work environments being safe, however in some work locations physical distancing is difficult to maintain so interaction with others will occur.

Recommendation	Staff deployment in line with tables in Appendix A

F. Non-Clinical Work where Physical Distancing can be Maintained

Work in large kitchens/ stores with many others but where physical distancing can be maintained
Non-clinical work where regular contact with the general public occurs [healthy members of the public rather than patients] where physical distancing can be maintained
Non-clinical work in a large open plan office/ common work area where physical distancing can be maintained
Attending meetings with colleagues [non-clinical meetings] which are longer e.g. 60 mins or longer
Working in an area where relatively isolated from colleagues or members of the public, but not necessarily in an individual room/office
Working in a shared office/ work area with several other colleagues
Attending short meetings e.g. 30 mins where physical distancing can be maintained
Working in a single office/ work area with closed door [possibly on a revolving arrangement with co-workers]
Work in laboratories with many others where physical distancing can be maintained

Due to a combination of this work being non-clinical and physical distancing being in place the risk involved with coming to these work environments is similar to being at home in the bubble. This is the lowest category risk work in the DHB.

Recommendation	Apart from the maximal protection scenario in Appendix A, Category 1-4 staff can be deployed in this work

G. Community Based Assessment Centre Staffing

Patients arriving at Community Based Assessment Centres [CBACs] will by and large meet the suspected case criteria for COVID-19. The risk of transmission of COVID-19 to health care workers manning CBACs is minimal when appropriate PPE is used. Staff with underlying health conditions/ adverse demographic factors have potential for higher consequence in the event of a COVID-19 infection. On that basis these tasks are ideally performed by staff who are Category 1. i.e. healthy or with well-controlled health conditions.

Recommendation	Category 1 staff

H. Laboratories

With laboratory work, the significant risk of being in close contact with ill patients is absent. Physical containment level 2 practices mitigate the risk of the transmission of microorganisms. This allows much more confidence in these work environments being safe, however in some work locations physical distancing is difficult to maintain so interaction with others will occur.

A risk assessment must be undertaken for higher risk sample types including respiratory and stool samples and for procedures which generate droplets or aerosols.

Recommendation	Staff deployment in line with tables in Appendix A