Department for Health and Wellbeing

Assessing and managing the risk: COVID exposures in **hospitals and facilities co-located with hospitals**

1. Procedure Statement

This document provides updated interim guidance on the public health management of a potential outbreak and unprotected exposures involving staff, patients, contractors and/or others to SARS-COV2 in a South Australian healthcare facility (HCF) or associated service (e.g. South Australian Ambulance Service (SAAS). This protocol considered the **South Australia COVID-Ready Plan** and changes scheduled to be implemented on November 23rd 2021 as well as the current version of the Coronavirus Disease 2019 (COVID-19) **CDNA National Guidelines for Public Health Units**.

For guidance relating to risk assessment and furloughing of staff, this document and appendices align with the current version of the **CDNA National Guidelines for Public Health Units** which refers to the Australian Government DoH **Work permissions and restrictions framework for workers in health care settings**.

Guidance includes recommendations following the identification of a positive COVID-19 case, and the investigation for exposure assessment and contact tracing of exposed HCWs, patients and visitors. HCWs can include clinical and non-clinical staff such as HCF medical, nursing, allied health, orderlies, cleaning and administrative staff.

The intent of this document is to assist with risk assessment and the management of staff following possible exposures to COVID-19, while preserving critical HCF functions and the continuity of safe patient care. It aims to provide guidance on staff management which reflects the situation existing at the time imposed by the degree of COVID-19 incursion into the community and the impacts on HCFs. The Outbreak Response Team (ORT), in collaboration with the HCF Incident Management Team (or equivalent), will determine the appropriate response at differing stages of threat to the HCF function by COVID-19 so that an effective workforce can be maintained.

This document does not provide guidance on use of PPE or other infection prevention and control protocols. Refer to the **SA Health COVID-19 Personal Protective Equipment (PPE) Decision Matrix Protocol**.

The document sets out roles and responsibilities for the relevant SA Health personnel during the phases of the investigation, which may include:

- an initial rapid assessment to enable identification and quarantine/isolation of those HCW, patients and visitors who are most likely to be close contacts of the case
- interim implementation of restrictions and possible service closures while a thorough outbreak investigation and response occurs, and
- a detailed contact risk assessment to guide subsequent actions, including application of work restrictions or quarantine/isolation requirements for HCW contacts.

The overall governance, roles and responsibilities are outlined in the **SA Health Viral Respiratory Disease Pandemic Response Plan (including COVID-19, influenza, SARS and MERS), and associated subplans**. The recommendations are not able to anticipate every scenario within a HCF or in the community and are therefore subject to change based on public health and clinical data available at the time. Expert clinical judgement based on all available information should be used to summarise the exposure risk, identify contacts and determine the need for work restrictions. All case and contact definitions are based on the **Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units**.

2. Background

COVID-19 is a serious disease caused by the highly infectious SARS-CoV-2 virus. It can affect people of all ages and is particularly serious for vulnerable people such as the aged, immunocompromised, or others with debilitating underlying conditions. Accumulated experience and scientific evidence have shown that the predominant route of transmission is by the inhalation of infectious aerosols and/or droplets, with risk increasing with closer proximity to an infected person.

In the situation of community transmission of SARS-CoV-2 it is likely that COVID-19 will be unknowingly introduced into a HCF by a patient/resident, healthcare worker or visitor. Given the infectious period may extend up to 72 hours prior to symptom onset (depending on the variant), asymptomatic and unrecognised infection has the potential to spread quickly within a HCF.

3. Scope

The advice in this document applies to South Australian public hospitals and facilities co-located with hospitals (this may include residential aged care facilities co-located with hospitals) and where applicable SAAS.

The principles can also be applied to private hospitals and may support local private hospital planning.

The document **does not** address the management of cases in other health care settings such as GP clinics, or residential aged care and disability residential services. Information relevant to these settings can be found on the SA Health website: **Coronavirus Disease 2019 (COVID-19) resources and links for health professionals** and the **Series of National Guidelines (SoNGs)**.

This document includes guidance on recommended actions regarding:

- previously unidentified COVID-19 cases not managed with transmission-based precautions
- personal protective equipment (PPE) breaches while managing a known or suspected COVID-19 case
- clusters of cases (e.g. HCF based outbreak and/or exposures) where the likely transmission event may have occurred within the HCF.

Management of community exposures are not within the scope of this document. However if a HCW is exposed to COVID-19 within the community, the ORT can liaise with CDCB COVID Operations to risk assess return to work permissions.

4. Definitions

***Authorised Officer* (AO) –** refers to a police officer or person appointed as an authorised officer under section 17 of the *South Australian Emergency Management Act 2004*

***Case* –** refers to any person in a healthcare facility with confirmed COVID-19

***CDCB COVID Operations* –** Communicable Disease Control Branch COVID Operations

***Close Contact* –** is currently defined by the **Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units** as a person who has:

- had face-to-face contact with a confirmed case during their infectious period; or
- shared a closed space with a confirmed case during their infectious period, where there is reasonable risk of transmission based on a risk assessment performed by the public health unit (in SA CDCB COVID Operations), taking into account: transmission having been proven to have readily occurred in this (or a similar) setting; the specific variant of SARS-CoV-2; the adequacy of air exchange in an indoor environment; or the nature of the exposure (e.g. type of contact, mask use, whether shouting or singing, size of venue etc).

Contractors -

- Onsite/internal contractors may include visiting medical staff, ancillary staff, catering.
- Offsite/external contractors may include tradespeople, service technicians, construction workers.

***COVID-19* –** an infectious respiratory illness caused by the SARS-CoV-2 coronavirus first identified in China in 2019

***Healthcare Facility* (HCF) –** includes hospitals and facilities associated with the hospital i.e. attached residential aged care facilities.

***Healthcare Worker* (HCW) –** for the purpose of this document, this includes clinical and non-clinical staff such as HCF medical, nursing, allied health, orderlies, cleaners, security officers, students, administration staff. Others that can be considered HCWs for the purpose of identifying people who may need to be considered for risk assessment includes paid or unpaid people working within the HCF, pastoral carers and volunteers etc.

***Incident Management Team* (IMT) –** For the purpose of this document the Incident Management Team is defined as the Local Health Network (LHN) management team which is derived of senior personnel appointed to be responsible for the overall functions of operations, planning, and logistics relating to the outbreak incident. As an incident scales up or down, so does the size of the IMT. The IMT is usually led by an Incident Controller who may be the LHN or HCF Chief Executive Officer or delegate. IMT members may include Heads of Service/Units, nursing directors/leads, Infectious Diseases/Public Health Doctor leads, infection control nursing lead, Worker Health and Safety lead, risk management or disaster management and other subject matter experts. This team may also include specialist SA Health representation from external to the LHN if required as part of compliance with the South Australian Emergency Management Act (2004).

***Outbreak Response Team* (ORT) –** For the purpose of this document the Outbreak Response Team is responsible for outbreak response decision making, including critical clinical decisions. The ORT can be comprised of key clinical staff and is preferably led by a medical officer e.g. Infectious Disease Physician or Public Health specialist. Other members of the ORT can include staff with suitable qualifications and experience in public health, worker safety, infection prevention and control and others as proxies as deemed appropriate by the ORT lead. Refer to Appendix B for draft template of ORT members.

State-wide Services - Onsite state-wide services may include radiology, pathology, orderlies, security. Offsite state-wide services may include SAAS, laundry staff, equipment technicians, transport or delivery services.

5. Glossary – Acronyms

AGB Aerosol Generating Behaviour

AGP Aerosol Generating Procedure

AO Authorised Officer

CDCB Communicable Diseases Control Branch

CDNA Communicable Diseases Network Australia

DHW Department of Health and Wellbeing

HCF Healthcare Facility

HCW Healthcare Worker

IMT Incident Management Team

LHN Local Health Network

ORT Outbreak Response Team

PCR Polymerase Chain Reaction

PFR Particulate Filter Respirator

PHU Public Health Unit

PPE Personal Protective Equipment

RAT Rapid Antigen Testing

SoNG Series of National Guidelines

6. Procedure Detail

6.1. Governance

As outlined in the *South Australian Emergency Management Act 2004*, SA Health is the Hazard Leader for human disease and control agency for human epidemics, food and waterborne diseases. The *South Australian Public Health Act 2011* also provides legislative and administrative powers in the event of a human disease outbreak.

The **SA Health Viral Respiratory Disease Pandemic Response Plan** and associated sub-plans provides a strategic outline of the South Australian Government and SA Health's response to a viral respiratory disease pandemic in Australia.

The public health response is led by the SA Chief Public Health Officer and is supported by the State Control Centre SA Health (SCC-H) and the CDCB COVID Operations team in accordance with the *COVID-19 Emergency Response Act 2020* and the *South Australian Public Health Act 2011*.

COVID-19 is a **notifiable disease** under the *South Australian Public Health Act 2011* and is reported to the Australian National Notifiable Diseases Surveillance System (NNDSS). All laboratories performing COVID-19 tests are required to notify positive results to SA Health COVID Operations by direct electronic feed.

6.1.1 Outbreak and immediate response

A single suspected or confirmed case of COVID-19 in a patient (not previously managed under appropriate transmission-based precautions), a staff member, or visitor to a HCF where there has been exposure in the HCF or community (e.g. the staff member exposure has occurred within the community and now represents a possible exposure risk within the HCF) is classified and defined as an outbreak trigger and requires an immediate response (see Appendix C).

The LHN and HCF must activate and implement its local COVID-19 Outbreak Control Plan in accordance with the principles as per the **SA Health Viral Respiratory Disease Pandemic Response Plan**. This includes the establishment and standing up of a HCF IMT and ORT with appropriate membership as per Appendix B. The SA Health CDCB COVID Operations team will provide expert public health advice to support the facility's IMT and ORT.

6.2. The role of the HCF incident management/outbreak response teams

The HCF IMT and ORT should undertake work concurrently to manage the risks to the HCF and the risk of disruption to services provided by the HCF. Clear lines of communication and delegation of authority between the IMT and ORT will be imperative to ensure governance, delineation and implementation of tasks to support these actions will be undertaken in a clear and controlled process. Actions to be undertaken include but are not limited to:

- provision of operational leadership and coordination of the public health response to COVID-19 incidents within the facility, including clinical assessment and decision making for patients with complex needs
- coordination of hospital-wide emergency response activities including safety and security, continuity of essential services, logistics and supply management and communication strategies (refer to **SA Health viral respiratory disease pandemic response plan** and sub plans)
- initiation of an initial rapid risk assessment, including the isolation of suspected and confirmed positive COVID-19 cases, and provision of infection control advice and direction
- direction and coordination of the healthcare worker exposure risk assessment in consultation with the SA Health CDCB COVID Operations staff.
- facilitation and oversight of the implementation of the joint public health and facility procedure for case investigation and contact tracing of potentially exposed patients, staff and visitors by the provision of additional resources trained in the process of contact tracing (see 5.4)
- facilitation of the collection of information to assist with risk assessments and contact tracing activities
- activation of surge capacity plans, including inpatient capacity, medical supplies, and human resources.

6.3. Risk Assessment process

An immediate and proactive approach to managing the exposure or outbreak is required by the IMT and ORT and others as indicated. An initial rapid assessment by worker health and infection control representatives should identify and confirm the known facts of the incident. This should enable identification, exposure risk assessment and quarantine or isolation of those HCW, patients and visitors who are most likely to be close contacts. This will also allow interim implementation of effective restrictions and service closures, if deemed necessary.

A more detailed exposure assessment to guide subsequent actions should commence immediately. For HCW exposure refer to Appendix A HCF COVID-19 exposure risk assessment guide. As a starting position, **all staff on relevant shifts (i.e. shifts when the case was present) should be assessed**. Shifts with staff cross-over in the relevant geographical workspace should also be regarded as potentially at risk of being a contact and requiring assessment.

Potential sources of information might include staff shift rosters/tearoom logs, patient allocation lists/movement logs, QR codes/patient visitor logs, patient documentation, closed-circuit television review (in specific circumstances), in addition to interviews with the case and potential contacts.

Of note:

- It is important to consider all groups of people who may have been present in the same location at the same time as the positive case, taking into consideration the pre symptomatic infectious period
- People exposed can include but are not limited to the following: medical, nursing, allied health, paramedics, pharmacy, orderly staff; cleaners, pastoral care, security, contractors, students, administrative staff, volunteers, people accompanying patients and visitors.
- In addition to face-to-face contact with a case during patient care, other settings such as tearooms, shared work areas, changing rooms and bathrooms should be considered as potential locations where transmission may occur, particularly if the case is a staff member.

6.4. Contact tracing

6.4.1 Role of SA Health CDCB COVID Operations

The CDCB COVID Operations team can provide varying levels of support to assist HCFs, depending on their level of preparedness and access to local expertise. In collaboration with the ORT, CDCB COVID Operations will:

- Nominate a medical officer, infection control expert and outbreak coordinator to liaise with the ORT
- Interview all laboratory confirmed cases for the purpose of the identification and management of all community contacts (primary contacts and secondary contacts if required).
- In the event that a contact is identified, but has been transferred to another HCF, CDCB COVID Operations will notify the facility that the contact has been transferred to, of the facilities responsibilities and actions for managing the contact.
- Identify and manage secondary contacts (contacts of contacts) including the household members of primary contacts
- Responsible for the public health management of cases who may be discharged from the HCF during their infectious period, either at home or in supervised quarantine.
- Determine the size of the outbreak and establish the exposure site classification(s) (Tier 1 to Tier 4)
- Maintain a comprehensive database of all cases and contacts including those being managed by the HCF
- Provide epidemiological information to local HCF and CDCB COVID Operations outbreak teams
- Provide epidemiological information for State and National reporting purposes
- Assist HCFs in the identification and management of all visitors, contractors and volunteers potentially exposed in a HCF setting.

6.4.2 Role of the HCF infection control / Clinical Worker Health team or lead

The HCF Infection Prevention and Control (IPC) / Clinical Worker Health team or lead will undertake the following:

- Nominate a team member to participate in the HCF ORT. The lead or delegate will serve as the liaison person or point of contact between the HCF ORT and CDCB COVID Operations.
- Work with CDCB COVID Operations and HCF ORT to facilitate initial rapid assessment to enable identification, assessment and quarantine/isolation of those healthcare workers, patients/residents and visitors who are most likely to be close contacts.
- Implement interim restrictions and infection prevention and control measures including service closures (if necessary) while a more thorough outbreak investigation and response occurs.
- Lead a detailed assessment of potential exposures and sources of transmission risk, to guide ongoing outbreak control actions across the facility, utilising all relevant sources of information and engagement with relevant key stakeholders.
- Liaise with the HCF executive and Human Resources executives to ensure appropriate industrial/human resources processes are in place to exclude staff close contacts from the HCF and to support and manage those employees.
- Oversee the implementation of appropriate infection prevention and control measures, including standard and transmission-based precautions, staff in-service education including appropriate PPE supplies and other recommended measures as per current national and state guidelines.

6.5. Actions following contact tracing and exposure assessment

The Department of Health and Wellbeing and LHN IMT and ORTs will need to establish/discuss the capacity for the HCF to undertake the required public health actions, including risk assessment, identification of contacts and any subsequent directions for quarantine/isolation, and explore additional assistance from another HCF or CDCB COVID Operations as required.

6.5.1 HCW contacts (including contractors and volunteers)

The HCF ORT will identify all HCW contacts of the case. The HCF will follow up any HCW contacts as decided in a risk assessment with CDCB COVID Operations. Refer to Appendix A for further information on management of HCWs.

It should also be identified if the household contacts of HCW deemed to be close contacts of a COVID-19 case are at higher risk or work in a high-risk setting. The management of these secondary contacts will be determined on a case-by-case basis in consultation with the CDCB COVID Operations.

6.5.2 Inpatient/resident contacts

The HCF ORT will primarily identify all inpatient/resident contacts of the case. The HCF will follow up any inpatient/resident contacts until their date of discharge or transfer to another facility at which point responsibility for quarantine follow-up is handed over to CDCB COVID Operations.

Quarantine/isolation directions where required will be issued to all close contacts by an Authorised Officer.

The HCF ORT will:

- maintain all relevant inpatient/resident contact information on a line listing, which will be shared with CDCB COVID Operations
- manage the communication process for any inpatient/resident identified through the exposure assessment process as being a close contact of a confirmed COVID-19 case to advise that they have been identified as a close contact and may be required to quarantine/isolate for 14 days from their last known contact with the case and will be tested according to current CDCB COVID Operations Authorised Officer directions.

6.5.3 Visitors, contractors and volunteers

The HCF ORT will identify contacts of the identified case who are visitors, contractors, state-wide service staff or volunteers (if possible).

- initiate an immediate local investigation and assessment of all potential contacts
- maintain all relevant contact information on a line list, which will be shared with the CDCB COVID Operations for further assessment and follow-up.
- Consideration should be given to the restriction of visitors, volunteers, state-wide service staff and contractors entering the facility to minimise potential further transmission

CDCB COVID Operations will use QR codes, manual sign-in sheets, patient/resident interviews and other relevant information including as provided by the HCF to identify contacts.

- The ongoing management of these individuals will be the responsibility of the CDCB COVID Operations throughout their quarantine/isolation period – or a shared responsibility with the Quarantine Stream DHW.
- All contacts will be risk assessed according to the internal SA Health *"Guideline for the Public Health Management of COVID-19 contacts, CDCB COVID Operations"*

6.6. Further actions following risk assessment

Consideration should also be given to the potential diversion or closure of non-essential services, and the possible transfer of some patients/residents to other facilities, where deemed appropriate.

SA Pathology (or other pathology provider in the case of a private hospital) should be notified of the situation by a member of the HCF ORT and arrangements made for expedited testing of exposed individuals where possible if testing capacity allows.

In the setting of a defined time of exposure within a HCF, consideration should be given during a risk assessment with SA Health COVID Operations and ORT to ensure safe entry into quarantine/isolation (if required by the ORT) to allow continuity of patient care at the HCF. The period of time that staff can continue working before undertaking public health measures (i.e. quarantine) should not exceed 12 hours from time of exposure.

Refer to Appendix A for recommended actions following a HCW exposure.

7. Responsibilities

The HCF ORT is responsible for the implementation of this protocol as well as other relevant LHN/HCF specific plans. The role of the HCF IMT is to remain responsible for the overall functions of operations, planning, and logistics relating to the outbreak incident.

Individual LHNs and HCFs have a responsibility to maintain an effective and up to date COVID-19 outbreak response plan. CDCB COVID Operations will support LHN IMT and ORTs in responses.

HCFs are responsible for the management of staff breaches in PPE.

HCFs can consider routine surveillance testing of staff i.e. nasopharyngeal (PCR), saliva (PCR) or Rapid Antigen Test (RAT) as per current **directions**, risk assessment and LHN policy.

A seamless and effective response requires effective information flow between the IMT, ORT and CDCB COVID Operations. Where cases are being discharged or transferred to an alternative facility or home, CDCB COVID Operations must be engaged early and included in essential communications regarding the discharge/transfer planning process.

8. References

- Australian Government Department of Health, ***Coronavirus 2019 Series of National Guidelines***, version 6.3 – 24 December 2021
- Australian Government Department of Health, ***Work permissions and restrictions framework for workers in health care settings***, October 2021
- Queensland Health, *Management of COVID-19 outbreaks in hospital settings – Interim guideline*, version 1.1 - 23 February 2021

Appendix A –

COVID-19 exposure risk and assessment guide: Hospitals and facilities co-located with hospitals

It is important that a contact tracing investigation commences immediately following notification of a COVID-19 case who spent time in a HCF to identify potential exposure to patients, visitors or healthcare workers.

Refer to the **Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units Appendix D: Work Permissions and Restrictions Framework for Workers in Health Care Settings for HCF COVID-19**:

"The framework supports safe decision making when determining whether to place work permissions/restrictions, independent of quarantine, on a worker after a COVID-19 exposure in a health care setting in the context of an outbreak and community transmission of COVID-19".

As per this framework, the following steps for exposure assessment and work restrictions are recommended:

STEP 1: Undertake an individual risk assessment of affected workers in health care settings and determine level of exposure. Refer to:

Table 1: Workers in health care settings exposure risk matrix – Fully vaccinated for COVID-19*

Table 2: Workers in health care settings exposure risk matrix – Unvaccinated or partially vaccinated for COVID-19*

STEP 2: Assess the impacts of the work restrictions

STEP 3: Once exposure risk is determined, refer to the recommended work permissions and restrictions action matrix. Refer to:

Table 3: PPE breach risk assessment and actions*

Table 4: Recommended work permissions and restrictions as determined by risk*

* These tables represent minimum national recommendations. HCFs may implement additional requirements above these minimum national recommendations in collaboration between the IMT & ORT.

This table is provided from the current version (Published 8 Oct 2021) of the **work permissions and restrictions framework for workers in health care settings**. Always refer to the electronic copy for the latest version.

Table 1: Workers in health care settings exposure risk matrix – Fully vaccinated for COVID-19

Note: This table represents minimum national recommendations. Jurisdictions may implement additional requirements above these minimum national recommendations.

NB: All exposure category decisions are based on a local risk assessment Case = Any confirmed positive case of COVID-19 (co-worker, patient, or other)	**EXPOSURE EVENT SCENARIO#**			
PPE WORN BY STAFF& CASE DURING EXPOSURE	**Low Risk Scenario**: Transient, limited and distanced contact that does not meet the definition for face-to-face or close contact.	**Medium Risk Scenario**: Transient face-to-face contact with a confirmed case **OR** Non-transient distanced contact in an indoor space.	**Highest Risk Scenario**: Providing direct care to a case **OR** Non-transient face-to-face contact with a confirmed case **OR** Prolonged/cumulative contact in the same enclosed/confined space **OR** Where the types of care or potential behaviours increase the risk of COVID-19 transmission **OR** Contact with multiple COVID-19 cases.	
Staff: No effective PPE Case: With or without mask	Low to Moderate Risk	Moderate Risk	High Risk	
Staff: Surgical mask only Case: No surgical mask	Low Risk	Low to Moderate Risk	High Risk	
Staff: Surgical mask + eye protection* Case: No surgical mask	Low Risk	Low to Moderate Risk	Moderate Risk Depending on risk assessment	High Risk Depending on risk assessment
Staff: Surgical mask only Case: Surgical mask§	Low Risk	Low Risk	Moderate Risk Depending on risk assessment	High risk Depending on risk assessment
Staff: Surgical mask + eye protection* Case: Surgical mask§	Low Risk	Low Risk	Low to Moderate Risk Depending on risk assessment	Moderate Risk Depending on risk assessment
Staff: P2/N95 + eye protection* Case: With or without surgical mask	Low Risk	Low Risk	Low Risk	
Staff: Full PPE – P2/N95, eye protection, gown, gloves; no breaches Case: With or without surgical mask	Low Risk	Low Risk	Low Risk	

* If gown/apron or gloves were also worn during the exposure event, this should be documented and may be factored into the exposure event risk assessment.

§ Incorrect mask use is to be considered the same as 'no surgical mask'. For cases, P2/N95 mask use to be considered the same as surgical mask.

Documented risk assessment for all exposure events should include evaluation of occupational exposures and of the space (including size and ventilation, where possible).

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Table 2: Workers in health care settings exposure risk matrix – Unvaccinated or partially vaccinated for COVID-19

Note: Mandatory vaccination requirements for workers in health care settings will be set by jurisdictions.

Note: This table represents minimum national recommendations. Jurisdictions may implement additional requirements above these minimum national recommendations.

<table>
<tr><td colspan="2" rowspan="2">NB: All exposure category decisions are based on a local risk assessment
Case = Any confirmed positive case of COVID-19
(co-worker, patient, or other)</td><td colspan="6">EXPOSURE EVENT SCENARIO#</td></tr>
<tr><td colspan="2">Low Risk Scenario:
Transient, limited and distanced contact that does not meet the definition for face-to-face or close contact.</td><td colspan="2">Medium Risk Scenario:
Transient face-to-face contact with a confirmed case
OR Non-transient distanced contact in an indoor space.</td><td colspan="2">Highest Risk Scenario:
Providing direct care to a case
OR Non-transient face-to-face contact with a confirmed case
OR Prolonged/cumulative contact in the same enclosed/confined space
OR Where the types of care or potential behaviours increase the risk of COVID-19 transmission
OR Contact with multiple COVID-19 cases.</td></tr>
<tr><td rowspan="7">PPE WORN BY STAFF & CASE DURING EXPOSURE</td><td>Staff: No effective PPE
Case: With or without mask</td><td colspan="2">Moderate Risk</td><td colspan="2">Moderate Risk</td><td colspan="2">High Risk</td></tr>
<tr><td>Staff: Surgical mask only
Case: No surgical mask</td><td>Low to Moderate Risk
Depending on risk assessment</td><td>Moderate Risk
Depending on risk assessment</td><td colspan="2">Moderate Risk</td><td colspan="2">High Risk</td></tr>
<tr><td>Staff: Surgical mask + eye protection*
Case: No surgical mask</td><td colspan="2">Low to Moderate Risk</td><td>Low to Moderate Risk
Depending on risk assessment</td><td>Moderate Risk
Depending on risk assessment</td><td colspan="2">High Risk</td></tr>
<tr><td>Staff: Surgical mask only
Case: Surgical mask§</td><td colspan="2">Low Risk</td><td>Low to Moderate Risk
Depending on risk assessment</td><td>Moderate Risk
Depending on risk assessment</td><td colspan="2">High Risk</td></tr>
<tr><td>Staff: Surgical mask + eye protection*
Case: Surgical mask§</td><td colspan="2">Low Risk</td><td>Low Risk
Case: Surgical mask</td><td>Low to Moderate Risk
Depending on risk assessment</td><td colspan="2">High Risk</td></tr>
<tr><td>Staff: P2/N95 + eye protection*
Case: With or without surgical mask</td><td colspan="2">Low Risk</td><td>Low Risk
Case: Surgical mask</td><td>Low to Moderate Risk
Case: No mask</td><td>Low to Moderate Risk
No prolonged/ cumulative/ physical contact</td><td>Moderate Risk
Prolonged / cumulative/ physical contact</td></tr>
<tr><td>Staff: Full PPE – P2/N95, eye protection, gown, gloves; no breaches
Case: With or without surgical mask</td><td colspan="2">Low Risk</td><td colspan="2">Low Risk</td><td colspan="2">Low Risk</td></tr>
</table>

* If gown/apron or gloves were also worn during the exposure event, this should be documented and may be factored into the exposure event risk assessment.

§ Incorrect mask use is to be considered the same as 'no surgical mask'. For cases, P2/N95 mask use to be considered the same as surgical mask.

Documented risk assessment for all exposure events should include evaluation of occupational exposures and of the space (including size and ventilation, where possible).

This table is provided from the current version (Published 8 Oct 2021) of the **work permissions and restrictions framework for workers in health care settings**. Always refer to the electronic copy for the latest version.

Table 3: PPE breach risk assessment and actions

Note: This table represents minimum national recommendations. Jurisdictions may implement additional requirements above these minimum national recommendations.

Determine level of exposure		Immediate actions	Actions once risk confirmed
LOW RISK BREACH	• Breaches in PPE that occur below the neck and are managed immediately (e.g., torn glove)	• Remove from situation • Remove PPE • Perform hand hygiene • Inform line manager	Follow actions for low risk as outlined in Table 4: Recommended work permissions and restrictions.
MODERATE RISK BREACH Increased risk of infection	• Incorrect use of PPE • Incorrect PPE for task • Contamination occurs during doffing (occurs above neck)	• Remove from situation • Remove PPE • Perform hand hygiene/flush site or relevant care • Inform line manager • Screening/testing • Continuous monitoring	Follow actions for moderate risk as outlined in Table 4: Recommended work permissions and restrictions.
HIGH RISK BREACH Likely risk of infection	• Exposure of mucous membranes by direct droplets from confirmed COVID positive (e.g., spitting in HCW face by confirmed COVID case) • Contamination occurs during doffing	• Remove from situation • Remove PPE • Perform hand hygiene/flush site or relevant care • Inform line manager • Closely monitor • Screen/test • Remove from immediate duties	Follow actions for high risk as outlined in Table 4: Recommended work permissions and restrictions.

This table is provided from the current version (Published 8 Oct 2021) of the **work permissions and restrictions framework for workers in health care settings**. Always refer to the electronic copy for the latest version.

Table 4: Recommended work permissions and restrictions as determined by risk

Note: This table represents minimum national recommendations, noting that adjustments may be made based the individual assessment (step 1) and consideration of impacts (step 2). Jurisdictions may implement additional requirements above these minimum national recommendations.

	RISK LEVEL			
	LOW RISK	**LOW TO MODERATE RISK**	**MODERATE RISK**	**HIGH RISK**
Work restrictions	Continue to work.	Continue to work.	Isolate until Day 2 RT-PCR test. If test result negative can return to work. Whilst at work, restricted from break rooms and other locations where there is potential to remove mask. Recommended to eat or drink in a separate designated area.	**Work restrictions** **Leave workplace immediately**. **Isolate** as a close contact **Potential to return to work early** if Day 5 test result is negative. Whilst at work, restricted from break rooms and other locations where there is potential to remove mask. Recommended to eat or drink in a separate designated area.
Testing	Be alert to mild symptoms, test if symptomatic	**Day 2 RT-PCR** test **Day 5 RT-PCR** test.	**Day 2 RT-PCR** test If test result negative may return to work. **Day 5 RT-PCR** test **Day 13 RT-PCR** clearance test.	**Day 2 RT-PCR** test. **Isolate**. **Day 5 RT-PCR** retest. **Isolate while result pending**. **Day 13 RT-PCR** clearance test.
	Any staff who develop symptoms must get a throat-nose swab and **isolate** until their result is known and symptoms have resolved.			
Return to work	N/A	N/A	**Work permissions. If Day 2 test is negative may return to work.** Workplace to consider need for additional surveillance testing; Daily or less frequent saliva testing.	**Work permissions. If Day 2 test and Day 5 test are negative**, may return to work at a single site, with additional surveillance testing; daily saliva tests and; **RT-PCR** retest **day 9 and 13.** Additional: - Be alert to mild symptoms - Test if symptomatic - Limit work to a single site/area.
Additional PPE Requirements on return to work?	**Wear a surgical mask at all times** in indoor spaces including staff only spaces, unless eating/ drinking.	**Wear a surgical mask at all times** in indoor spaces including staff only spaces, unless eating/ drinking. Continue until clearance following **Day 13 RT-PCR test.**	**Wear a surgical mask at all times** in indoor spaces including staff only spaces. Continue until clearance following **Day 13 RT-PCR test.**	**Wear a surgical mask at all times** in indoor spaces including staff only spaces. Continue until clearance following **Day 13 RT PCR test.**
Work across sites?	**In general, Yes**. Inform all employers of cross-site details.	**In general, Yes**. Inform all employers of cross-site details.	**No.** Consider limiting work to a single site/area. Exclude from work with high risk patients, where possible (E.g. oncology wards). **Consider redeployment** if work in with vulnerable persons.	**No.** Limit work to a single site/area. Exclude from work with high risk patients, where possible (E.g. oncology wards). **Consider redeployment** if work is with vulnerable persons.
	If there is an outbreak at a workplace—i.e. if there is previously demonstrated transmission—even low-risk exposures should limit work to a single site.			
	Workers in COVID Streaming Areas must follow any jurisdiction workplace directions from the Chief Health Officer.			

Appendix B –

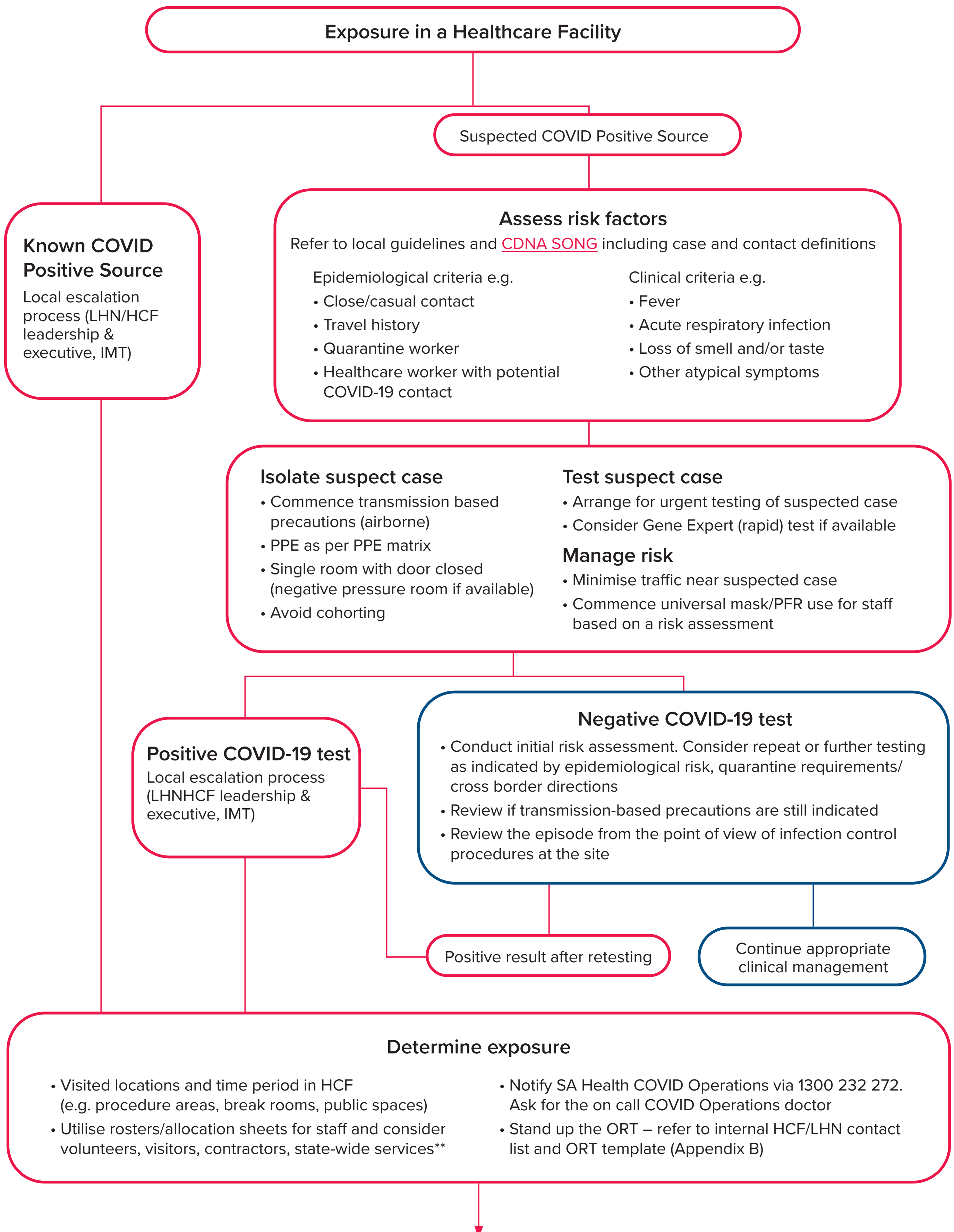
Draft Template of Outbreak Response Teams (ORT) Representatives

Draft Template of ORT Representatives

Role	Contact Phone Number
Infection Control Lead	
Infectious Diseases Physician	
Worker Health Lead	
Executive member of LHN IMT	
COVID Operations Medical Lead	
COVID Operations Outbreak Management Lead	
SCC-H Representative	
Pathology Lead	

Appendix C –

Flowchart: Recommended actions following an unprotected exposure to a suspected or confirmed COVID-19 case in a HCF*



Conduct collaborative risk assessment

- Collaboration between HCF/LHN, SA Health COVID Operations, State Command Centre – Health (SCC-H) & ORT
- Consider size of exposure/outbreak and HCF capacity to manage outbreak/contacts to determine what support is required from SA Health COVID Operations and ORT
- Determine location and length of time since exposure
- Establish management of contacts based on risk
- Refer to Appendix A
- SA Health COVID Operations and HCF to establish responsibility for initial and ongoing management of contacts (including testing regimes and quarantine requirements)

Commence contact tracing including but not limited to:

- Inpatients/residents
- Staff, volunteers, contractors and state-wide services
- Discharged & transferred patients/residents
- Visitors

Confirmed COVID-19 inpatients/residents

- Manage as per PPE Matrix
- Symptom monitoring
- Other support as required
- Testing as indicated
- Ongoing communication with SA Health COVID Operations if discharged or transferred prior to 14 day isolation period

Consider quarantine options (staff exposure only)

- SA Health COVID Operations/Department of Health to liaise with HCF s/LHN s & SCC-H to determine appropriate staff quarantine locations
- Options may include home quarantine (other household members may need to relocate) or a Medi-Hotel
- In the setting of a defined exposure within a HCF, consideration should be given during a risk assessment with SA Health COVID Operations, ORT and HCF to ensure safe quarantine entry and continuity of care at the HCF. The time period should not exceed 12 hours from point of exposure.
- Staff exposed should wear appropriate PPE and continue work until they can be safely removed from the clinical environment and begin quarantine.
- If approved to return to place of residence prior to entering quarantine, avoid unnecessary contact with high risk settings or members of the public and perform essential tasks only prior.
- Directions to immediately enter quarantine may occur based on individual risk assessments.
- Quarantine directions including location and time of commencing quarantine to be provided by an Authorised Officer

Consider staff wellbeing

- Employee Assistance Program
- Symptom monitoring
- Testing regime details from Authorised Officer
- Other support as required

Ongoing case/outbreak management

Refer to state and local outbreak policies and procedures

*e.g. patient or visitor presents with a non COVID-19 related diagnosis and is then subsequently identified as a suspect or confirmed COVID-19 case by either clinical or epidemiological risk factor(s); OR staff member is exposed to COVID-19 within the workplace or community and is notified of exposure.

Refer to **definitions on page 2.

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