Proper adherence to currently recommended infection control practices, including all recommended PPE, should protect HCW 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 HCW should still perform self-monitoring with delegated supervision.

Table1. Exposure Levels Description

Exposure Level	Description
High Risk	• Prolonged unprotected close contact with patients with COVID-19 – patient did not wear face mask • Unprotected and 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
Medium Risk	• Prolonged unprotected close contact with patients with COVID-19 – COVID-19 patient was wearing a face mask • HCW 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 aerosol-generating procedure had not been performed, they would have been considered low-risk. See Table 1 for additional examples.
Low Risk	• Brief interactions with patients with COVID-19 - patient was wearing a face mask • Prolonged protected close contact with patients who were wearing a facemask for source control while HCW were wearing a face protection and mask or N95 • HCW who were wearing a gown, gloves, eye protection and a facemask and aerosol-generating procedures were NOT performed

Unprotected = healthcare worker was not wearing any PPE
Protected = healthcare worker was wearing face protection, and mask or N95

Table 2. Type of Monitoring and Description

Type of Monitoring	Description
Self	• 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 contact Employee health if they develop fever or respiratory symptoms during the self-monitoring period; they may contact their primary care physician or telehealth to determine whether medical evaluation is needed
Active	• Employee Health 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 may include telephone calls or any electronic or internet-based means of communication

*Fever is either measured temperature >100.0oF or subjective fever

All employees are to **self-monitor on a daily basis** and report any onset of symptoms to Employee health. If the symptom onset is during a schedule shift the employee must put a mask on, leave the work place, and phone the Employee Health department.

When a positive COVID-19 case is identified and there is a question as to when Enhanced Droplet + Contact Precautions were instituted. IPAC will prepare an Exposure form and send to the managers of the impacted areas to complete follow up (per Employee Exposure Policy). Employee Heal shall evaluate the type of exposure (refer to Table 1) with each staff member listed, and determine the recommended monitoring and any work restriction based on Table 3. The current communicability period for COVID-19 is considered to be 48 hours before symptoms onset to 14 days after onset.

Table 3. Epidemiologic Risk Classification1 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 HCW
Prolonged close contact with a COVID-19 patient who was wearing a facemask i.e., source control)			
HCW PPE: None	Medium	Active	Exclude from work for 14 days after last exposure
HCW PPE: Not wearing a facemask or respirator	Medium	Active	Exclude from work for 14 days after last exposure
HCW PPE: Not wearing eye protection	Low	Self	None
HCW PPE: Not wearing gown or gloves[a]	Low	Self	None
HCW PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)	Low	Self	None
Prolonged close contact with a COVID-19 patient who was not wearing a facemask (i.e. no source control)			
HCW PPE: None	High	Active	Exclude from work for 14 days after last exposure
HCW PPE: Not wearing a facemask or respirator	High	Active	Exclude from work for 14 days after last exposure
HCW PPE: Not wearing eye protection[b]	Medium	Active	Exclude from work for 14 days after last exposure
HCW PPE: Not wearing gown or glove[a,b]	Low	Self	None
HCW PPE: Wearing all recommended PPE (except wearing a facemask instead of a respirator)[b]	Low	Self	None

HCW=healthcare worker; PPE=personal protective equipment

[a]The risk category for these rows would be elevated by one level if HCW 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 HCW 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, HCW 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.

Return to Work Procedures

- Healthcare workers (HCWs) should follow **isolation and clearance with a non-test based approach** (waiting 14 days from onset) unless they have required hospitalization during the course of their illness in which case a test based approach is preferred.
- Symptomatic HCWs awaiting test results must remain off work
- Asymptomatic HCWs awaiting test results may continue to work using appropriate precautions recommended by the facility, which will depend on the reason for testing

In **exceptional circumstances** where clinical care would be severely compromised without additional staffing, an earlier return to of a COVID-19 positive HCW may be considered under work self-isolation recognizing the staff may still be infectious.

Work self-isolation means maintaining self-isolation measures outside of work for 14 days from symptom onset (or 14 days from positive specimen collection date if consistently asymptomatic) to avoid transmitting to household members or other community contacts. While at work, the HCW must adhere to universal masking recommendations, maintain physical distancing (remain greater than 2 meters from others), except when providing direct care, and performing meticulous hand hygiene. Positive COVID-19 HCW should ideally be cohorted to provide care for COVID-19 positive patients as much as possible.

Table 4. Recommendations for HCW Return to Work

Symptoms	Test Result	Recommendation
Yes	Positive	• If not deemed essential then HCW to remain off work for 14 days from onset of symptoms • If deemed essential, work self-isolation may start after a minimum of 72 hours after illness resolving, defined as resolution of fever and improvement in respiratory and other symptoms • Continue with work-self-isolation for 14 days after symptom onset
Yes	Negative	• Return to work 24 hours after symptom resolution and continue work self-isolation until 14 days from last exposure • If HCW was self-isolating due to an exposure at the time of testing, return to work should be under work self-isolation until 14 days from last exposure
Never	Positive	• If there has been a recent potential exposure (e.g. tested as part of an outbreak investigation or other close contact to a case), work self-isolation (i.e. return to work) could start after a minimum of 72 hours from the positive specimen collection date to ensure symptoms have not developed in that time, as the positive result may represent early identification of the virus in the pre-symptomatic period • If there has been no known recent potential exposures (e.g. tested as part of surveillance and no other cases detected in the facility or on the unit/floor), there is no minimum time off from the positive specimen collection date as it is unclear when in the course of illness the positive result represents (i.e. consistently asymptomatic HCWs can continue working in work self-isolation until 14 days from the specimen collection date).
Yes	Positive & **HCW hospitalized**	• Return to work after 2 negative tests collected at least 24 hours apart • Testing for clearance may begin after the individual has become afebrile and symptoms are improving. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. • If swab remain positive, test again in approximately 3-4 days. If swab is negative, retest in 1-2 days (and at least 24 hours apart).

Staff Transfers

Table 5. Staff Transfers from Patient Care Zones or Other Facilities

From	To	Recommendation

HOT	COLD	**For planned redeployment:**
		• Home unit manager to complete redeployment checklist and interview staff member to determine if appropriate PPE was consistently worn, there were no known unprotected exposures, and staff member is not exhibiting any signs and symptoms of COVID-19
		• COVID-19 testing is recommended within 1 week prior to staff transfer to COLD unit within WRH
		  • Staff may continue to work in the HOT unit until they are able to transfer to the COLD unit (as long as they have no symptoms & continue to wear PPE in the workplace)
		  • If staff agrees to be swabbed they do not need to be placed off work pending swab results (they are to continue to self-monitor and report any symptoms to Employee Health)
		  • If staff declines swab, staff must continue to self-monitor and Employee Health to check in with staff at 72 hours to ensure no symptoms have developed
		  • Staff transferring from HOT unit to COLD unit may eat in the same lunchroom/breakroom as other staff, but must maintain physical distancing measures in place.
		• Staff to self-monitor
		When no confirmed COVID-19 patients are in-house on the HOT unit (excluding resolved cases):
		• Staff may work HOT and COLD
		• Staff to self-monitor

HOT	HOT	• Staff to self-monitor
COLD	HOT	• Staff to self-monitor
COLD	COLD	• Staff to self-monitor
US Hospital	Canadian Hospital	• Staff to be deemed non-essential and must remain off 14 days from last shift worked in US hospital • If staff was only in US as part of a patient transfer, then staff may work self-isolate for 14 days from date of transfer • May be approved on a case by case basis
Any LTC, RH, Residence	Hospital	• Staff to be deemed non-essential and must remain off 14 days from last shift worked in LTC, RH, Residence

HOT = hot zone, i.e. COVID-19 patient care area
COLD = hot zone, i.e. non-COVID-19 patient care area

References:

1. Centers for Disease Prevention and Control (2020). *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). National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases. Retrieved March 24th, 2020 from: https://www.cdc.gov/coronavirus/2019-ncov/HCW/guidance-risk-assesment-HCW.html

2. Ministry of Health (2020). *Public Health management of cases and contacts of COVID-19 in Ontario*. Health System Emergency Management Branch. Retrieved March 31st, 2020 from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-cases-contacts.html

3. Ministry of Health (2020). COVID-19 Quick Reference Public Health Guidance on Testing and Clearance. Health System Emergency Management Branch. Retrieved March 31st, 2020 from: http://health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_testing_clearing_cases_guidance.pdf