Interim Guidance for Work Exclusion and Monitoring Recommendations for Healthcare Settings and EMS

3/19/20

Work Exclusion and Monitoring Determinations

Once a COVID-19 case has been confirmed in a facility, work exclusions and home monitoring plans should be implemented. In general, staff (including providers, nurses, EMS, medical assistants, patient care techs, EVS, dietary services, radiology staff, contracting staff (who removes sharps containers, etc), security officers, chaplains, behavioral therapists, clerks, other ancillary staff with access to patients.) with the following risk factors should be excluded from work and monitored for fever or respiratory symptoms (see Table 1):

- Patient interaction that did not include aerosol-generating procedures without a regular facemask or respirator and eye protection (goggles or face shield).
- Patient interaction that involves extensive contact with the patient and their immediate environment (e.g., logrolling, toileting) without using gown and gloves in addition to facemask or respirator and eye protection.
- Patient interaction that did include aerosol-generating procedures without all elements of full PPE requirements (respirator, eye protection, gown, and gloves).

Facilities could consider allowing asymptomatic staff who have had an exposure to a COVID-19 patient to continue to work after consultation with their occupational health program. The decision to allow continued work should be made on an individual basis, with a thorough risk assessment. (See footnote f in Table 1 for more information.) The risk assessment should include the staff's level of exposure, ability to reliably undergo daily active monitoring, and the constraints that work restrictions would place on the facility's workforce. Re-assignment of the staff to non-patient care duties during the monitoring period should also be considered. These staff should still undergo daily active monitoring prior to starting work and mid-shift.

If staff 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.

The following table provides considerations for sample staff activities to aid in decision making regarding exclusion and monitoring plans. Examples are generally limited to those that involve patient care. Other factors may alter risk determination, including but not limited to patient symptoms, ability to comply with source control, and duration of exposure. (See Table 1, next page. HCP refers to all staff as noted above.)

Table 1: Work Exclusion and Monitoring Plan Considerations for HCP Activities by PPE and Source Control Utilization

Sample Activity	Personal Protective Equipment Used by HCP					Source Control	Work Restriction	Follow up and Monitoring Plan
	Respirator[a]	Regular Mask	Goggles or Face Shield	Gown	Gloves	Patient Masked		
HCP walks by patient, but has no direct contact with patient or their secretions	–	–	–	–	–	–/+	None	Standard respiratory illness precautions[b]
Brief check-in interactions or brief entrance into patient room without contact with patient secretions	–	–	–	–	–	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
Patient care with no aerosol- generating procedures[e]	+	–	+	+	+	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	–	+	+	+	+	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	–	+	+	–	–	–/+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	+	–	–	–	–	+	None	HCP self-monitoring for 14 days after last exposure[b,c]
	–	+	–	–	–	+	None	HCP self-monitoring for 14 days after last exposure[b,c]
Patient care with aerosol- generating procedures (Appendix I)	+	–	+	+	+	N/A	None	HCP self-monitoring for 14 days after last exposure[b,c]
Patient care with no aerosol- generating procedures	–	–	–	–	–	–/+	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
	–	–	+	+	+	–/+	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
	+	–	–	+	+	–	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
	–	+	–	+	+	–	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]
Patient care with aerosol- generating procedures (Appendix I)	Any variation that does not include the full recommended PPE (respirator, eye protection, gown, and gloves)					N/A	Work exclusion or return to work with mask[f]	Active monitoring for 14 days after last exposure[b,d]

Green: no identifiable risk; **Yellow**: low-risk exposure; **Blue**: medium-risk exposure **Red**: high-risk exposure
+ designated PPE category used throughout the activity, assumes appropriate donning, doffing, and hand hygiene
– designated PPE category not used;
+/– designated PPE category either used or not used, action steps not contingent on this item.

[a] Respirator: Refers to respiratory protection at least as protective as a fit-tested NIOSH-certified disposable N95 filtering facepiece respirator, including NIOSH-approved powered air-purifying respirators (PAPRs).

[b] Standard respiratory illness precautions: All HCP with fever or respiratory symptoms should stay home if ill for 7 days from illness onset or 72 hours after symptoms resolved, whichever is longer.

[c] HCP self-monitoring: HCP perform self-monitoring for fever or respiratory symptoms for 14 days from last exposure under the supervision of a healthcare facility's occupational health or infection control program.

[d] Active monitoring: Daily communication to assess for the presence of fever or respiratory symptoms (cough, sore throat, or shortness of breath) conducted by healthcare facility's occupational health or infection control program, if excluded from work.

[e] Provision of patient care that requires extensive direct contact with the patient and their immediate environment (e.g. logrolling, toileting) should include use of gown, gloves, and appropriate hand hygiene. Failure to use gown and gloves in addition to specified PPE would elevate exposure risk and may warrant work exclusion and active monitoring.

[f] Work exclusion period should be 14 days from date of last exposure. **Facilities could consider allowing asymptomatic HCP who have had any medium- or high- risk exposure to a COVID-19 patient to continue to work after consultation with their occupational health program**. The decision to allow continued work should be made on an individual basis. The healthcare facility should evaluate the HCP prior to each shift and at mid- shift by taking the HCP's temperature and assessing for symptoms. Exposed HCP should be asked to wear a facemask while at work for the 14 days after the exposure event, if there is a sufficient supply of facemasks. It is recommended that HCPs be restricted from working with severely immunocompromised patients until 14 days after illness onset. 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. See: https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html and https://www.cdc.gov/coonavirus/2019-ncov/healthcare-facilities/hcp-return-work.html