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 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 A, Standard Control Measures].

In some situations, it may not be possible to reconcile effective and safe service delivery with this advice. Managers will then need to consider what compromises can be made in the short-term and make plans that enable meeting both staff safety and service delivery outcomes.

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 work. This guide should be used to assist managers with deployment. *The staff member is an equal partner in the employment relationship and should be consulted in the decision-making.*

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]. Categorisation has been guided by the best evidence available. This Categorisation risk assessment framework was developed by Occupational Health (OH) specialists from across New Zealand to categorise the risk factors of individual healthcare workers into one of four risk categories. An individual with multiple risk factors will be at higher risk than someone younger with the same risk factors. Category 4 staff are at most risk of severe COVID illness if infected and need the most protection from exposure to COVID-19.

As their manager, you will have been informed of their category. Workers with no health vulnerabilities are by default Category 1. A worker will be regarded as Category 1 unless they have self-identified to occupational health for assessment.

Adjustments to this process continue to occur, as we learn more about COVID-19. Since the original version of this document was published, significant changes in the pandemic landscape have occurred which include the advent of new strains of COVID-19 including the Delta-strain and the development and roll-out of vaccination against COVID-19. More and more evidence is becoming available on the health consequences in specific patient populations and on the effectiveness of vaccination.

These guidelines would be appropriate in the majority of cases. Where there is concern that an individual's specific health condition or work circumstances do not fit this guidance then individual advice on risk should be sought from occupational health.

Even with a risk-based approach, unfortunately some workers with no known underlying health conditions may develop complications from COVID-19 infection. The risk to workers cannot be reduced to zero whilst still maintaining an effective health system.

---

[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 their 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.

Modifying Duties and Returning to Normal Duties

Staff who are vulnerable may need to be moved into alternative work areas as a protective measure when there is community spread of COVID-19. Some staff are understandably anxious about being at work, either due to concerns about their own health or that of those they live with.

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. Please refer to the guidance in Table A Vaccinated Vulnerable Workers and Table B Unvaccinated Vulnerable Workers below 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.

Tables to Inform Staff Placements

These tables provide the guidance for where vulnerable staff can work under various circumstances.
Follow up to date advice from your DHB on allowing or requiring staff to work from home.

	Risk is **very high**, avoid placing this worker in this scenario
	Risk is **high**, avoid unless essential to service provision**
	Risk is **moderate**, avoid where staffing levels allow flexibility to do so**
	Risk is **low**, no requirement to consider work adjustments

Table A - Vaccinated Healthcare Workers

		Regional Covid-19 prevalence scenario	
Work category	Staff vulnerability category*	No community cases	Community spread
Covid-19 stream Note: Pregnant staff should not work in Covid-19 Stream	4	4	4
	3	3	3
	2	2	2
	1	1	1
Non-Covid-19 stream clinical areas	4	4	4
	3	3	3
	2	2	2
	1	1	1
Non-clinical work in shared spaces e.g. offices	4	4	4
	3	3	3
	2	2	2
	1	1	1
Non-clinical work where good social distancing can be maintained and limited number of face to face contacts	4	4	4
	3	3	3
	2	2	2
	1	1	1

	Risk is very high, avoid placing this worker in this scenario
	Risk is high, avoid unless essential to service provision**
	Risk is moderate, avoid where staffing levels allow flexibility to do so**
	Risk is low, no requirement to consider work adjustments

Table B - Unvaccinated Healthcare Workers

		Regional Covid-19 prevalence scenario	
Work category	Staff vulnerability category*	No community cases	Community spread
Covid-19 stream	4	4	4
	3	3	3
	2	2	2
	1	1	1
Non-Covid-19 stream clinical areas	4	4	4
	3	3	3
	2	2	2
	1	1	1
Non-clinical work in shared spaces e.g. offices	4	4	4
	3	3	3
	2	2	2
	1	1	1
Non-clinical work where good social distancing can be maintained and limited number of face to face contacts	4	4	4
	3	3	3
	2	2	2
	1	1	1

*Seek Occupational Health advice if worker's health circumstances have changed since being previously categorised.

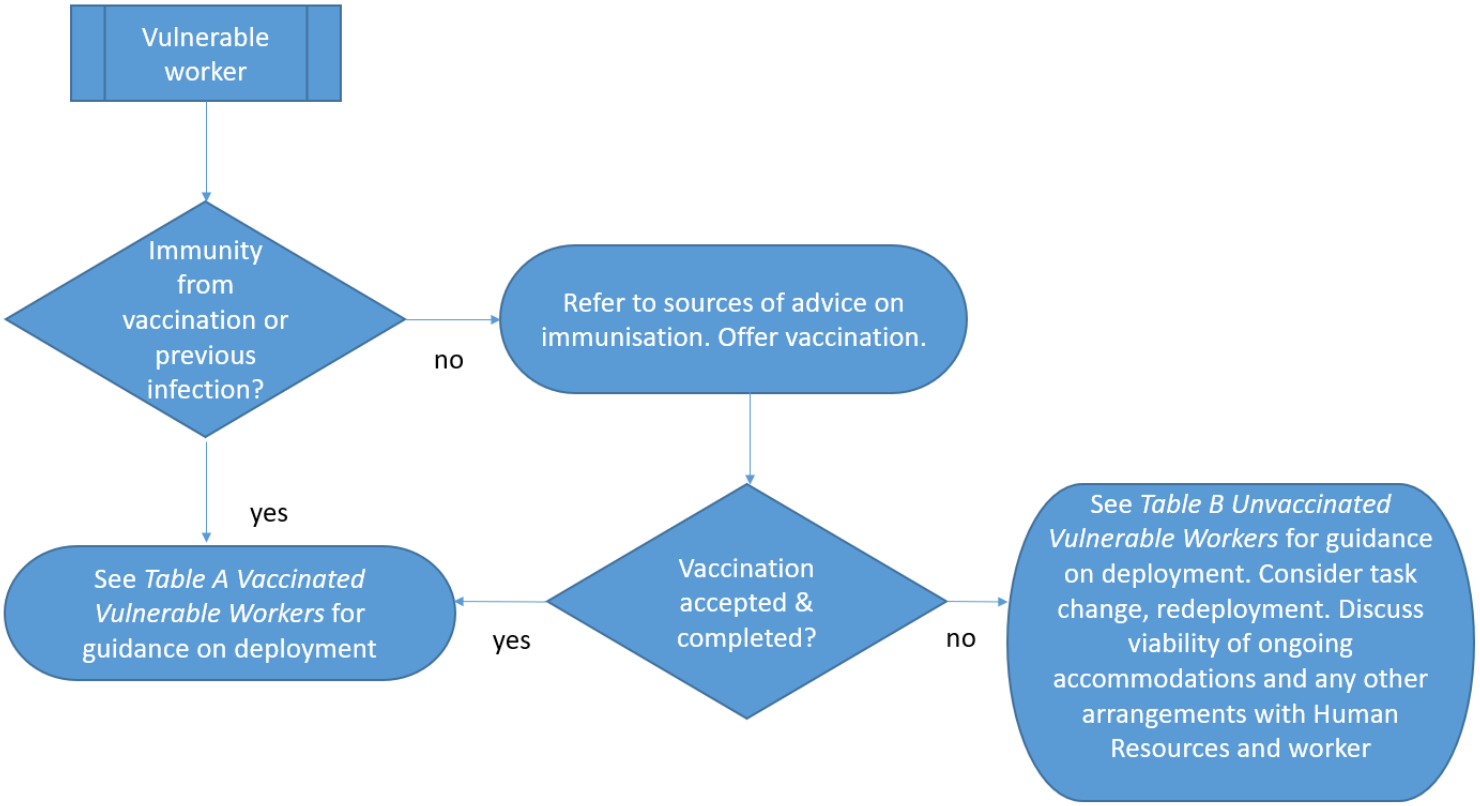
**In the event that Covid-19 infection rates have had minimal impact on staffing levels then service managers have the capacity to deploy staff. Conversely, where significant numbers of staff are either sick or isolating, then service disruption may be significant. This raises the threat of mortality and morbidity for patients being unable to access both routine and Covid-19 related healthcare needs e.g. impact on radiology/ cancer services. In those circumstances, service managers would need to balance the potential risk to individuals with the potential risk to the community should service disruption occur. This will predictably offer less flexibility in terms of making accommodations for vulnerable staff. For this reason, instead of a simple yes/ no recommendation, there are graduated advisories that should help service managers take this into account. Additionally, it is recommended that service managers plan ahead and have early discussions with staff about what may or may not be offered in future scenarios.

Notes

These guidelines would be appropriate in the majority of cases. Where there is concern that an individual's specific health condition or work circumstances do not fit this guidance then individual advice on risk should be sought from occupational health.

Specific immunity from vaccination or prior infection greatly reduces risk of infection, requirement for hospital or ICU admission, disease severity and mortality. The net effect is comparable to moving down one vulnerability category. The exception is in those with impaired immune response due to underlying health conditions e.g. those on dialysis, receiving active cancer treatment, severe immunosuppression – specific advice from occupational health will be required.

Flow diagram – Vulnerable worker decision making



Appendices

A. 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
	Staff are current with vaccination including for COVID-19 and influenza
	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
	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
	Face to Face staff meetings should be minimised but if necessary then physical distancing is mandatory and ventilation should be enhanced, e.g. meet outdoors or in large open spaces, or with windows and doors open if suitable.
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

B. Notes on COVID-19 Stream

COVID-19 stream refers to:
1. Work tasks where the worker is working with a patient considered to pose sufficient risk of COVID-19 (yet to be clarified by test results) as to be managed with additional precautions or confirmed as COVID-19

OR
2. Work in a physical location likely to pose risk of environmental spread of COVID-19 due to the occupancy of individuals at risk of being infectious, for example:

- managed isolation or quarantine facilities

- working on a ward where COVID-19 patients are being managed

- work that exposes workers to airborne transmission opportunities for the virus
- work that exposes workers to other body fluids or surfaces where the virus may reside
- work that exposes workers to close contact with close contacts of infected persons

Any of the above scenarios are risk exposures, and every single exposure provides an opportunity for transmission. Workers in the above scenarios are 'working in the COVID-19 stream' regardless of frequency of the scenario occurring.

In some cases, individual site determination will be required to define whether work would be considered COVID-19 stream or otherwise, looking at factors such as layout, ventilation, patient and worker movements and processes.

Community-based health care services may also pose COVID-19 exposure risk in certain circumstances. A risk assessment would inform when and if such encounters could be considered COVID-19 stream.

Note that it is not only "clinical" staff who are at risk in these environments – do not forget about other important support workers including cleaning, kitchen/catering and maintenance staff.

COVID-19 stream work should only be undertaken by fully vaccinated workers. Refer to Table A for guidance on which staff can be deployed to COVID-19 areas.

C. Notes on Non-COVID-19 Stream clinical areas

There is variation from DHB to DHB and even between different facilities within the same DHB (e.g. large hospital versus rural hospital) with regards exactly how patients are handled according to COVID-19 risk. As the prevalence of community spread of COVID-19 increases, there will be a commensurate increase in the risk of being exposed to COVID-19 in non-COVID-19 stream areas, either from patients or from colleagues. In general however, the risk should be lower than in COVID-19 stream. Some categories of vulnerable staff who may not be considered fit to work in COVID-19 stream can be reassigned to non COVID-19 stream tasks in line with Table A and Table B.

D. Notes on Non-Clinical Work in shared spaces e.g. offices

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, the new COVID-19 variants have shown much greater ability to spread via aerosol route so there remains risk of transmission in a common workspace. The previous "reassurance" thought to exist with adequate physical distancing is now less reassuring. For that reason, mask wearing in shared spaces is sensible and up to date advice should be followed. It is also a very important protective step for this workgroup that staff who are unwell do not come into the workplace and get tested if symptomatic.

Examples of this type of work include:

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

See Table A and Table B for advice on staff deployment in these areas.

E. Notes on Non-clinical work where good physical distancing can be maintained and limited number of face to face contacts

Previously, good social distancing was defined as a physical distance such as 2m separation which provided sufficient confidence against transmission. With the new variants such as Delta it is necessary to consider not only physical distancing but also room size, number of occupants, ventilation, duration of contact. Usual precautions should be followed including mask use and handwashing. It is also a very important protective step for this workgroup that staff who are unwell do not come into the workplace and get tested if symptomatic.

Examples of this type of work include:

- Work where regular contact with the general public occurs [healthy members of the public rather than patients] where social distancing can be maintained, or physical barriers are in place e.g. some reception areas
- Work in an open plan office/ common work area where good social distancing can be maintained
- 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 single office/ work area with closed door [possibly on a revolving arrangement with co-workers]

- Work with a limited number of colleagues with good spacing available

See Table A and Table B for advice on staff deployment in these areas.

F. COVID-19 Community Testing Centre Staffing

Patients arriving at COVID-19 Community Testing Centres will by and large meet the suspected case criteria for COVID-19. This work is classified COVID-19 stream. The risk of transmission of COVID-19 to health care workers manning these centres is minimal when appropriate PPE is used.

COVID-19 stream work should be undertaken by vaccinated workers. Refer to Table A for guidance on which staff can be deployed to Community Testing Centres.

G. 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.

See Table A and Table B for advice on staff deployment in this area.