Public Health Emergency Operations Centre

Guidelines for management and contact tracing of COVID-19 with exposure in the hospital setting
## Version control

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Revised by</th>
<th>Changes</th>
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<tbody>
<tr>
<td>1.0</td>
<td>26 May 2020</td>
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<td>Updated definitions. Contact tracing form.</td>
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1 Summary
This guideline describes the management and contact tracing for COVID-19 cases where there has been exposure in the hospital setting. This would primarily be cases in health care workers, or patients where appropriate infection control processes were not in place during their presentation and admission to hospital. It describes the role of infection prevention and control (IPC) units, staff health or delegated officers in hospitals responsible for contact tracing, and the role of public health.

2 Definitions
Case and contact definitions relevant to this document are taken from the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units which is updated frequently. Check for updated definitions. The definition provided below is in accordance with Version 3.6 published 31st July 2020, section 7, page 10.

Confirmed case
A person who:

- tests positive to a validated specific SARS-CoV-2 nucleic acid test,
- OR has the virus isolated in cell culture, with PCR confirmation using a validated method,
- OR undergoes a seroconversion to or has a significant rise in SARS-CoV-2 neutralising or IgG antibody level (e.g. four-fold or greater rise in titre).

Probable case
A person who has detection of SARS-CoV-2 neutralising or IgG antibody AND has had a clinically compatible illness AND meets the epidemiological criteria outlined in the suspect case definition below.

OR has detection of SARS-CoV-2 neutralising or IgG antibody AND has had a compatible clinical illness AND is a close contact of a confirmed or probable case of COVID-19.

Suspect case
Clinical criteria: Fever (≥37.5°C) or history of fever (e.g. night sweats, chills) OR acute respiratory infection (e.g. cough, shortness of breath, sore throat) OR loss of smell or loss of taste AND

Epidemiological criteria: in the 14 days prior to illness onset, any of the following apply:

- Close contact with a confirmed or probable case
- Healthcare aged or residential care workers and staff with direct patient contact
- International travel
- Passengers or crew who have travelled on a cruise ship.
- People who have lived in or travelled through a geographically localised area with elevated risk of community transmission, as defined by public health authorities.

2.1 Close contact definition
The definition provided below is in accordance with the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units version 3.6 published 31st July 2020, section 10, page 23.

In the hospital setting, all persons identified as having had contact with a case should be assessed to see if they should be classified as a close contact. A close contact is defined as requiring:

- face-to-face contact in any setting with a confirmed or probable case, for greater than 15 minutes cumulative over the course of a week, in the period extending from 48 hours before onset of symptoms in the confirmed or probable case, OR
- sharing of a closed space with a confirmed or probable case for a prolonged period (e.g. more than 2 hours) in the period extending from 48 hours before onset of symptoms in the confirmed or probable case (such as an ED waiting room; communal room in a hospital).

A close contact in the hospital setting includes the above and in addition:

- Direct contact with the body fluids or laboratory specimens of a case without recommended Personal Protective Equipment (PPE) or failure of PPE.
• A person in the same hospital room when an aerosol generating procedure is undertaken on the case, without recommended PPE.

Healthcare workers (HCWs) and other contacts who have taken recommended infection control precautions, including the use of required PPE, while caring for a symptomatic confirmed or probable COVID-19 cases are not considered to be close contacts.

Contacts who do not meet the close contact definition but may have had some exposure to the infectious case (e.g. workplaces) should be identified and provided information where feasible.

2.2 Healthcare worker case definition

Healthcare workers (HCWs) are people in contact with patients or the patient space. For example, doctors and nurses and cleaners who enter the patient’s room or cubicle and frontline administrative staff would be included as HCWs. Staff who work in non-clinical areas who do not enter patient rooms are not included as HCWs for this purpose. However, they still require follow up by the IPC unit or delegate with support from the Public Health Operations (PHOps).

2.3 Definition of an outbreak in a healthcare setting

An outbreak is defined as a single confirmed case of COVID-19 in a patient, staff member or visitor of a hospital where there has been exposure in that setting. This applies to inpatients and outpatients, clinical and non-clinical staff and attendees of a hospital, such as visitors or external consultants. An outbreak may be confined to a ward or involve the entire hospital and the response can be scaled accordingly.

2.4 Public Health Emergency Operations Centre (PHEOC) and Public Health Operations (PHOps)

The Public Health Emergency Operations Centre (PHEOC) is leading the public health response to the COVID-19 pandemic in WA.

In recognition of the need to provide a coordinated state-wide approach to case follow up and contact tracing, which could be scaled across the state in response to COVID-19 epidemiological variances, the PHEOC created the Public Health Operations (PHOps) cell. This cell merged the existing contact tracing workforce of Metropolitan Communicable Disease Control (MCDC), with the WA Country Health Services (WACHS) Public Health Units under one functional unit for the COVID-19 response.

PHOps cell is the functional unit that is responsible for case follow up and contact tracing activities in Western Australia (WA) who will be working with hospitals in this setting. Contact details are to ncovcontact@health.wa.gov.au phone 92220221. WACHS hospitals can also contact their local public health units.

3 Role of Public Health Operations in referral of COVID-19 case

PHOps interview all confirmed COVID-19 cases and ascertain date of onset of illness, infectious period and close contact groups. PHOps follow up contacts in the community. However, if the case is found to be infectious whilst in the hospital setting PHOps urgently refers this case to the infection prevention and control (IPC) unit or delegated officer to follow up this exposure. PHOps will undertake the following:

• Referral of case to the IPC unit or delegated officer with their name, DOB, contact numbers, date of onset of illness, defined infectious period (from 48 hours prior to onset of illness) and a summary of dates and locations they were in the hospital setting whilst infectious.

• Ensure that the IPC unit urgently notifies their hospital Executive Director/ Manager and emergency operations officer.

• Ensure cases are aware that the hospital will be notified, and the IPC unit or delegated officer will be contacting them to elicit further information for contact tracing in the hospital setting.

• Provide the hospital with a template COVID-19 contact letter and COVID-19 isolation fact sheet.

• Provide the Guidelines for management and contact tracing for COVID-19 cases with exposure in the hospital setting.

• Provide the hospital with a case and contact spread with the variables required for data entry and follow up.

• Nominate a public health nurse to be the lead and liaison person with the IPC unit or delegated officer.

• Provide ongoing support via email and phone for the IPC unit or delegated officer.
• It is important to notify hospitals of all HCWs and staff in their facility diagnosed with COVID-19, even where their infection was not acquired in the hospital and they were not infectious whilst at work, to allay concerns about risk to the facility.

4 Role of hospital Infection Prevention and Control
Refer to Appendix 1 for a Checklist for the management of COVID-19 cases and contact tracing with hospital exposure.

4.1 Nominate a lead in the infection prevention and control unit
Nominate a staff member from the infection prevention and control (IPC) unit/ staff health or delegated officer to be the lead. They should:
• Be the point of contact between PHOps and the hospital.
• Ensure a designated person / point of contact for PHOps for afterhours weekends and public holidays.
• Liaise with key stakeholders within the hospital including, Executive, infectious diseases physicians, medical / nursing leads, allied health, support services, pathology services.
• Implement infection prevention and control measures.
• Initiate a workplace risk assessment.
• Interview the case to ascertain exposure whilst infectious in the hospital.
• Coordinate contact tracing within the hospital.
• Keep a list of confirmed and suspect cases, deaths and contacts.
• Update PHOps regularly with updated case and contact spread sheet (timeframe agreed between PHOps and the IPC unit or delegated officer).
• Activate the hospitals outbreak management plan and establish an outbreak committee if required.

4.2 Establishing a hospital outbreak management committee
Hospitals need to activate their hospital outbreak committee when there has been exposure from a COVID-19 case in the hospital setting. This committee needs to consider taking additional measures to manage the ongoing risk to staff and patients in this facility.

The committee should include, but not be limited to:
• IPC unit staff health nurse, or (if none available) delegate
• Infectious diseases physician or clinical microbiologist
• Medical lead
• Nursing lead
• PHOps representative
• Others including; allied health, PathWest, patient support, communication team

4.3 Immediate management of health care worker as a suspect case
Any HCW who meets the suspect clinical case definition should be:
• Isolated immediately and tested; the HCW is to remain isolated until results are available.
• Testing doctor will need to provide a sick certificate.
• Provided with verbal and written advice for suspect cases regarding isolation.
• Advise how they will receive their results.
• Be notified by the testing doctor to the WA DoH as a suspect case by completing the notification form either online or by printing out the notification form.
4.4  Follow up of confirmed case

Infectious period and close contacts

- Cases are infectious from 48 hours prior to onset of symptoms until they meet the criteria for release from isolation or return to work.
- The IPC unit or delegated officer will also need to interview the case to ascertain exposure whilst infectious and possible source of infection within their facility.
- Document date and time from which the case has been in isolation.
- Review of medical records/charts may be required.
- Compile a list of close contacts including inpatients, discharged inpatients, outpatients and emergency department patients, visitors, HCWs and other staff and add to the case and contact spreadsheet, including accurate contact information.
- If there are multiple confirmed cases, each confirmed case needs a separate form/tab completed.

Source of infection for health care workers

Consider whether the HCWs infection may have been acquired within the health service (via a patient or staff member) or via an external exposure, within the incubation period of 14 days prior to onset of illness.

- Consider contact with anyone with fever or acute respiratory symptoms.
- Consider whether the HCW had been in close contact with any confirmed cases and whether they were in isolation at the time of symptom onset.
- Consider whether the HCW engaged in any recent aerosol generating procedures (AGPs) that may have increased their exposure risk.
- Consider whether the HCW may have had a breach of PPE which may have led to an exposure.
- Consider if there had been any other issues in infection prevention control that may have impacted on HCW exposure.

4.5  Follow up of close contacts

While the IPC units or delegated officers in hospitals will need to identify all close contacts for patients, visitors and staff, PHOps will assist with contacting some groups of these contacts, as outlined below.

General principles for identified close contacts

- In-patients need to be followed up by IPC until discharge.
- Place any inpatients into isolation (for 14 days from last close contact with the case) and ensure that droplet and contact precautions (or airborne and contact precautions for AGPs) are followed when caring for these patients as outlined at COVID19-Infection-Prevention-and-Control-in-WA Healthcare facilities
- Provide inpatients with verbal and written information as provided by PHOps.
- HCWs and other staff need to be identified by the IPC, verbal and written information provided, and sent into isolation.
- For these contacts interviewed by the IPC, provide information on the case contact spread sheet, for PHOps to enter onto their contact tracing database for their 14 days SMS follow up.
- Visitors need to be referred to PHOps for follow up and need to remain in isolation and not visit patients in a hospital (for 14 days from last close contact with the case).
- Discharged patients, outpatients and non-admitted emergency department patients and those who attended with them, need to be referred to PHOps for follow up and need to remain in isolation and not attend the hospital (for 14 days from last close contact with the case).
- For those visitors and discharged patients in the community for follow up by PHOps, provide contact and exposure details to enable follow up.
**Process of close contact follow up**

- Provide a PHOps COVID-19 contact letter and a contact factsheet.
- Provide verbal advise as outlined in PHOps COVID-19 contact letter.
- Collect demographic and epidemiological data and contact details and enter onto the case contact spread sheet to be sent to PHOps for entering onto the contact tracing database for 14 days follow up via SMS.
- Advise isolation at home for 14 days following the last contact with the case.
- Counsel about their risk and the symptoms of COVID-19.
- Advise on the processes for seeking medical care. Before presenting for medical attention they must phone ahead and alert that they are close contacts in isolation. This would include an ambulance, their GP, where telehealth may be an option, or a hospital COVID-19 clinic or ED.
- Advise that if they develop fever or respiratory symptoms consistent with COVID-19 during the isolation period, they must respond “Yes” to their daily SMS text. This will generate a call from PHOps who will organise testing for COVID-19.
- Symptomatic contacts who test negative by PCR will still need to remain in isolation for 14 days from last contact with case and may require re-testing if their symptoms worsen or persist.
- Advise HCWs and other staff that their contact letter requiring home isolation can be used in lieu of a sick certificate.
- Advise HCWs and other staff that the SMS they receive on their final day of isolation will be evidence that PHOps has cleared them to be released from isolation and return to work.

4.6 **Workplace risk assessment**

The aim of a workplace risk assessment is to establish the following:

- Whether the case was infectious while at the workplace.
- Whether additional cleaning and disinfection of certain areas are required.
- Whether enhanced surveillance for symptoms of COVID-19 in the workplace is required.
- Whether closure of certain areas is required to facilitate cleaning and allow for the investigation to be completed.
- Whether there are high risk/vulnerable patients for which enhanced surveillance for symptoms and possibly enhanced use of PPE could be considered (e.g. immunocompromised patients).

4.7 **Escalation**

The outbreak management committee needs to consider the triggers for escalation which are:

- If there are a large number of exposures within the hospital.
- If there is exposure in a vulnerable cohort, for example immune-compromised patients.
- If there is ongoing transmission within the hospital, so new cases emerging.
- Identified issues with adequate infection protection and control processes.
- If a hospital exceeds capacity at a specialist level, for example an oncology ward if effected by the outbreak, or at a hospital wide level.

The trigger for escalation will vary depending on the size and location of a hospital. For a small hospital in a remote location in regional WA escalation may be more rapid.

The process for escalation is:

- Through the hospital's emergency response process to their Chief Executive / Hospital Manager.
• In Perth, hospital’s will then escalate directly to the Incident Management Team (IMT) in the State Health Incident Coordination Centre (SHICC).

• In WACHS hospitals will then escalate through the WACHS Emergency Operations Centre (EOC), who can activate a rapid deployment team to support the hospital on the ground. If this is beyond the capacity of WACHS the EOC will escalate to the Incident Management Team in SHICC.

• PHOps who are within PHEOC will also alert SHICC.

5 Role of the Public Health Operations (PHOps) in follow up

5.1 Contacts

• PHOps will follow up those exposed in the hospital setting who are now in the community. This includes visitors, discharged patients, outpatients and non-admitted emergency department patients and those who attended with them.

• The IPC unit or delegated officer will supply PHOps with a line listing of these contacts who need follow up, including contact details.

• If any hospital contacts in isolation develop COVID-19 provide this information to the IPC unit or delegated officer.

HCW contacts and other staff

• The hospital IPC unit will have provided verbal and written information and sent contact into isolation.

• Using the case contact spread sheet provided by the IPC unit add HCWs onto the contact database for the 14 day follow up via SMS.

• If any HCWs or other staff in isolation develop COVID-19 provide this information to the IPC unit.

5.2 Confirmed cases

• Follow up as outlined in the Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units. Active COVID-19 cases are phoned daily by PHOps for follow up.

• Clearance letter to patient and for HCWs copy to IPC or delegate at their workplace for return to work.

5.3 Close of outbreak

At close of the outbreak send a summary to the IPC unit / staff health or delegate and the hospital outbreak committee. Review and evaluate case and outbreak management and if needed amend outbreak plan
Appendix 1. Checklist for the management of COVID-19 cases and contact tracing with hospital exposure

This process should be managed by the hospital IPC, staff health or delegated officer

<table>
<thead>
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<th>Checklist</th>
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<tr>
<td><strong>Detection and confirmation of case(s)</strong></td>
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<tr>
<td>Support staff with fever or acute respiratory infection to self-isolate. Ensure testing and isolation for symptomatic staff and patients. Confirm diagnosis.</td>
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<td>Determine the symptom onset date and infectious period in liaison with PHOps and determine whether the case was infectious whilst in hospital, for contact tracing.</td>
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<td>Work with staff to provide advice, reduce anxiety and provide reassurance.</td>
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<td><strong>Management of health care worker cases</strong></td>
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<tr>
<td>For HCW cases ensure they are self-isolating and reiterate that they should not return to work until PHOps has determined that they meet the return-to-work criteria.</td>
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<td>Ensure the HCW knows where to seek medical advice if they become more unwell.</td>
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<td><strong>Contact tracing</strong></td>
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<td>Enter the confirmed case details in the Case and contact data spreadsheet provided by PHOps.</td>
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<td>If there are multiple confirmed cases each confirmed case requires a separate data spreadsheet completed. Ensure accurate contact details for each person is recorded in the case contact spreadsheet.</td>
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<tr>
<td>Immediately compile a list of all <strong>staff</strong> (paid and volunteer) who may be contacts of the case. Check rosters, sign-in sheets and other records as necessary. Liaise with staff member’s manager and workforce.</td>
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<tr>
<td>Immediately compile a list of all <strong>inpatients, outpatients and ED patients</strong> who may be contacts of the case. Check ward lists, ED presentations, admissions, discharges and transfers for the relevant ward.</td>
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<tr>
<td>Immediately compile a list of all <strong>visitors</strong> who may have been exposed to the case. Check visitor sign-in sheets and other records.</td>
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<tr>
<td>For HCW cases review <strong>medical records</strong> to determine documented contact with patients.</td>
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<tr>
<td>From the above lists, identify <strong>potential close contacts</strong> from the available evidence (see definition of close contact above).</td>
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<td>Discuss with the case to <strong>confirm</strong> the type and duration of contact they had with the above contacts to confirm who qualifies as a <strong>close contact</strong> of the case.</td>
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<tr>
<td>Record all information in the case and contact spreadsheet and provide this to PHOps. Identify discharged patients, outpatients, ED patients or visitors that require follow up by PHOps.</td>
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<tr>
<td><strong>Quarantine contacts</strong></td>
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<td>For close contacts identified within the hospital setting the IPC unit or PHOps should have;</td>
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<tr>
<td>- Notified them that they have been identified as a contact of a confirmed case and inform them of the next steps required. That they are required to go into isolation for 14 days from their last exposure to the confirmed case and that they will be monitored during this period. (please note that an employer cannot disclose confidential information about the confirmed case and should only notify close contacts that they have been identified as a close contact with a confirmed case).</td>
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• Distribute close contact letter and isolation fact sheet provided by PHOps.

For inpatients, additionally:
• Implement contact and droplet precautions
• Ensure testing if they develop symptoms

• Keep a record of each close contact and when they were informed of their potential exposure.

### Implement infection prevention control measures

Quarantine patients who are close contacts of the case (cohort patients if necessary).

Consider temporary closures (e.g. rooms, wards) to facilitate investigation of the positive case and allow terminal cleaning. This decision can be made in consultation with PHOps.

Implement droplet and contact precautions (e.g. masks, gloves, gowns, eye protection) for all patients identified as a case or close contact of a case.

Provide PPE outside rooms / wards / facility.

Display sign outside rooms / wards.

Reinforce standard precautions (social distancing hand hygiene, cough etiquette) throughout facility.

Increase frequency of environmental cleaning (minimum twice daily where there are confirmed cases in patients).

### Monitor/update

Arrange for daily symptom check and observations for inpatients who are close contacts. Arrange testing for those who develop symptoms of COVID-19 whilst in quarantine as a close contact.

Ensure the IPC lead is informed of all positive results as soon as possible.

The IPC lead must update PHOps on an agreed basis (daily, every second day, etc.) or when there is a significant issue (e.g. a death).

### Communication

Contact PHOps on ncovcontact@health.wa.gov.au phone 92220221

Keep hospital stakeholders informed.

Keep patients, staff and families informed.

### Restrict

Restrict movement of HCWs between areas of a facility and between facilities.

Avoid patient transfers if possible.

Restrict visitors where practical and in compliance with most recent direction on hospital visitors.

Do not allow HCWs to return to work until cleared by PHOps.

### Declare and review

Declare the outbreak over when there have been no new cases for a defined period (in consultation with PHOps).

Review and evaluate case and outbreak management and if needed amend outbreak plan.