Healthcare Worker Cohorting in Acute Care During COVID-19 – Checklist

Background

There are recommendations for staff cohorting during COVID-19 in congregate living sites but no guidance is available for healthcare workers (HCW)* in acute care facilities. There are significant challenges to single unit HCW cohorting in acute care facilities because many HCWs work on multiple units. The risk of transmission to different units/facilities must be factored in to Outbreak Team (OT) decision making about any HCW cohorting model or HCW restrictions. As the factors affecting these decisions vary on a case-by-case basis, this tool/checklist can be used to assist with decision making in this regard.

*Healthcare Worker (HCW) is a more inclusive term than staff, including not only employees, but also physicians, midwives, students and volunteers. From the Alberta Health Public Health Notifiable Disease Guideline – COVID-19: Healthcare Workers (HCW) are individuals who provide service in a clinical care setting, including hospitals, clinics, continuing care facilities, licensed supportive living sites (including group homes), public health centres, community assessment centres, and any other settings where face-to-face patient care is provided (including fire fighters and EMS). Some HCWs work in multiple settings, providing clinical care services in some settings and non-clinical care services in others.

HCW Cohorting Tool / Checklist

Cohorting is a strategy that can be used to reduce risk of transmission of infection. HCW cohorting is the assignment of a HCW to patients or groups of patients based on patient exposure to, or infection with, the same laboratory-confirmed pathogen.

Goal

To reduce the risk of cross-contamination and transmission to both HCWs and patients while continuing to support the care needs of patients in a unit/facility and the needs of the larger health care system.

Principles

- There are existing documents describing cohorting of patients in acute care (see *References* below). This HCW cohorting tool/checklist is not meant to duplicate any of these.
- Cohorting of HCW may already be done as part of routine practice through clustering of care. Additional cohorting may be required in an outbreak situation.
- Collaboration among Infection Prevention & Control (IPC), facility/unit management (multiple levels), Workplace Health and Safety (WHS), Human Resources (HR), Medical Officer of Health (MOH) and others through the Outbreak Team is required to review and support the staffing plan throughout the outbreak.
- Zones should maintain up-to-date rosters of HCWs available for redeployment as required at both a zone level and unit/facility level to facilitate staffing decisions when multiple HCWs who are assessed as

exposed or ill are restricted from work or are restricted to working in one unit/facility because of an outbreak.

- Physician groups should prepare backup call rosters in the event an on-call physician is ill or otherwise restricted from work.
- Zones should prioritize testing of patients and HCWs on outbreak unit(s). Exposure investigation numbers (EI#s) should be used to facilitate reporting the results and linking them to the outbreak.
- WHS/Public Health (PH) processes ensure timely return to work once a HCW on isolation or quarantine is cleared.
- Cohorting decisions will depend on size and physical layout of the unit/facility, the number of patients affected, the size of the applicable healt care team, and the mix of HCWs on that team.

Considerations

- [ ] Current state of cases in geographic area/outbreaks in other acute care facilities in zone
- [ ] **Outbreak factors:**
    - Number of cases
    - Profile of the cases - in HCW only; in patients only; or both?
    - Extent of outbreak/distribution of cases - limited to one unit; several units; or whole facility?
    - Status of outbreak - new/expanding; stable as defined by OT; no new cases in a number of days?
    - Recommendations for testing of HCW and patients – what is purpose of testing (e.g. baseline); what is the extent of cases on the unit/facility; what is the feasibility of swabbing onsite or through online assessment; what kind of testing (e.g. rapid) is needed to inform decision-making and is it available?
- [ ] **Patient factors:**
    - Number/acuity of illness/care requirements of COVID-19 and non-COVID-19 patients, e.g. number on isolation. This is an indicator of the amount of care needed, including time needed for PPE donning and doffing.
- [ ] **Unit/facility factors:**
    - Number of beds/number of units – is it feasible to cohort HCW?
    - Physical layout of unit/facility – multiple units, acute care only? Multiple units, mix of acute care and continuing care?
    - Crowding on unit?
    - Crowding in breakroom spaces?
- [ ] **HCW factors:**
    - Is there reasonable access to the lists of units/facilities that HCW work at in addition to outbreak unit? Will physicians currently working at the outbreak facility/on the outbreak unit provide the names of other facilities they also work at?
        - Nursing staff dedicated to unit only? Or work on multiple units? At multiple facilities? Are there casual staff that work on the unit?
            - Wherever possible, staff should work only on the outbreak unit(s).
        - Physicians – dedicated to unit/work on multiple units? Work at facility only? Work at multiple facilities?
            - Wherever possible, recommend dedicated physician(s) for outbreak unit/facility.
        - Students – assess risk/benefit of continuing to have on unit/facility (educational facility may have own policy for their students).
        - Allied Health/all support services – assess and focus or dedicate staff as is relevant to care on unit/facility.
        - Volunteers – defer presence on outbreak unit/facility until outbreak over.

- Number of HCW deemed close contacts and excluded from work (Expedited Return To Work** may apply)
    - Enough HCW to provide care?

- ☐ **Work flow factors:**
    - Can nursing staff be assigned exclusively to provide care to COVID-19 positive patients? If not, consider providing care first to non-COVID-19 patients followed by COVID-19-positive patients, as much as possible. Cluster the care where possible.
    - Schedule breaks for nursing staff according to their patient assignments – staff providing care for COVID-19 positive patients should have same break time (after those not providing care). Manager should schedule break times to permit adequate physical distancing within allotted space for staff breaks (coffee, meals). See the Break Room Checklist.
    - PPE recommendations – see PPE table in IPC Cohorting Recommendations for COVID-19 in Acute Care, Recommendations for Cohorting Inpatients on Additional Precautions in Acute Care Facilities.

**HCW who are considered essential to the delivery of any non-elective critical patient care service may avail themselves of the Expedited Return to Work process if they are asymptomatic and on quarantine because of exposure risk, posted on Insite as follows:

- Request for Expedited Return to Work from COVID-19 Isolation
- Return to Work Conditions for Exposed HCWs including Medical Staff
- Return to Work FAQs

References

Patient Cohorting in Acute Care Facilities:

- IPC Cohorting Recommendations for COVID-19 in Acute Care
- Recommendations for Cohorting during Pandemic in Emergency Departments/Urgent Care Centers AHS Facilities
- Recommendations for Cohorting Inpatients on Additional Precautions in Acute Care Facilities

AH Public Health Disease Management Guideline – COVID-19