Guidelines for Occupational Health Follow Up of Communicable Diseases For Manager/Supervisors

Introduction

Purpose of this Guideline

This reference guide provides the following information from an Occupational Health perspective

- Defines communicable disease specific instructions,
- Outlines any required work modifications or restrictions, Note*: All timelines for work exemptions are dependent on the co-morbidities to any personal health related condition*
- Indicates whether clinical management of the exposed or infected healthcare worker is required,
- Assists in determining urgency of clinical management of worker.

Service Provision

This document applies to WRHA OESH Occupational Health Nurses who provide services to

WRHA Corporate and Community Health Services	Health Sciences Centre
Concordia Hospital	Victoria Hospital
Grace Hospital	Seven Oaks Hospital
Deer Lodge Centre	Middlechurch
River Park Gardens	Churchill

The WRHA OESH Occupational Health Nurses also provide contracted services to CancerCare Manitoba, Shared Health (former DSM), City of Winnipeg, University of Manitoba, University of Manitoba Medical Group, and Riverview Health Centre (Post Exposure Protocol).

This document does not apply to Occupational Health Nurses employed by individual sites (St. Boniface Hospital, Misericordia Health Centre, Riverview Health Centre (Immunizations), St. Amant.

Collaborative Relationships

Within the Winnipeg Regional Health Authority there are three departments which work collaboratively during events of exposures to or outbreaks of communicable disease.

- Population and Public Health (PPH)
- Infection Prevention and Control (IP&C)
- Occupational Health Unit of Occupational and Environmental Safety & Health (OESH)

Healthcare Worker (HCW) exposure to communicable diseases may occur in our workplaces or in the community however any staff exposure or illness is referred to Occupational Health for follow-up and/or treatment.

PPH information can be found here http://www.wrha.mb.ca/extranet/publichealth/index.php.

IP&C Manuals can be found here https://professionals.wrha.mb.ca/old/extranet/ipc/manuals.php and include Policies, Operational Directives, information on Routine Practices and Additional Precautions as well as Specific Disease Protocols for patients/residents/clients.

Notification of Communicable Disease Illness/Exposures/Outbreaks

HCW illness/exposure in the Community

HCWs must report an incidence of communicable disease illness or exposure to Occupational Health. In some cases, staff report to their supervisors who are advised to contact Occupational Health immediately. Occupational Health will assess and treat where applicable as well as notify IP&C of the possibility of patient exposure. Occupational Health will also follow up with any other HCW who may have been exposed to the communicable disease through contact with the affected worker(s).

HCW illness/exposure at work

HCWs are advised to notify their supervisor if they suspect a patient/client/resident has an undiagnosed communicable disease. Supervisors are to follow instructions in the applicable IP&C manual and contact their assigned IP&C professional (https://professionals.wrha.mb.ca/old/extranet/ipc/contact.php). IP&C will notify Occupational Health who will obtain a list of exposed staff and contact, assess and treat where applicable as outlined in the OESH Standing Orders.

In most cases, notification to IP&C and OESH is necessary to ensure that both HCWs and patients/client/residents can be assessed and/or treated.

Reporting Illness/Exposures/Outbreaks to Occupational Health

Potential exposure Monday - Friday regular business hours: call the site Occupation al and Environmental Safety and Health (OESH) unit for follow up of exposed workers. Contact list can be found here https://professionals.wrha.mb.ca/old/professionals/safety/contact.php

Potential exposure all other times: in most cases the occupational exposure of staff can and should be handled on the next business day in the OESH unit at the site. This is preferable as the health care worker should meet with an occupational health nurse who will

- review potential exposure to determine need for prophylaxis and take a medical history relevant to the exposure,
- review any contraindication to prophylaxis;
- document exposure on a work-related Injury/Near Miss form and the employee's confidential medical history;
- arrange for any other follow up visits.

If clinical management is recommended on an urgent basis the healthcare worker should be seen as an outpatient in the Emergency/Urgent Care Department.

Costs related to treatment or prophylaxis provided by OESH is the responsibility of OESH. Costs related to visit; treatment or prophylaxis provided by Emergency, Urgent Care, Walk in Connected Care, Physician, etc. will be paid by WCB.

Workers Compensation Board (WCB) Claims

When to File INM for WCB consideration:

- The worker has missed time from work and/or received medical attention from an outside care provider due to the exposure.
- Patient must be confirmed by healthcare provider as diagnosed with the condition/disease.
- Worker must have been exposed to the infected patient in the method of transmission of which the disease is spread. (ie: BBF splash, skin to skin contact, etc.)
- Worker must be diagnostically tested and diagnosed with the same condition as the infected patient.

Diseases or conditions that are present at work as well as in the general community are generally considered "ordinary disease of life" and more likely than not acquired outside of work as IP&C precautions, when followed correctly, are in place to prevent exposure in the workplace.

"Occupational Disease" is defined in Section 1 (1) of the Workers Compensation Act as: *a disease arising out of and in the course of employment and resulting from causes and conditions*

(a) peculiar to or a characteristic of a particular trade or occupation; or
(b) peculiar to the particular employment;
*but does **not** include*
(c) an ordinary disease of life; and
(d) stress, other than an acute reaction to a traumatic event (immediately after the event)

"Ordinary Disease of Life" is defined in WCB Policy 40.44.20 (Disease/General) as "*a disease will not be considered to be an ordinary disease of life if the risk of contracting the disease through the employment can be shown to be greater than the risk associated with ordinary living experience".*

Adherence to and enforcement of IP&C Precautions

Additional Precautions are initiated for all individuals meeting the case definition. As per the Workplace Safety and Health Act and Regulation

- workers are required at all times, when the nature of his work requires, use all devices and wear all articles of clothing and personal protective equipment designated and provided for his protection by his employer, or required to be used and worn by him by the regulations;
- supervisors are required to ensure that workers comply with the safe work procedures which include infection control practices based on specific modes of transmission that may be used in situations where certain diseases or micro-organisms require extra caution;

This means that staff must follow these precautions and may be subject to discipline if they do not.

Antibiotic Resistant Organisms (AROs)

Healthcare workers (HCW) who acquire an ARO may acquire it from occupational exposure or from a community exposure. Transmission of an ARO to patients may be minimized by consistent practice of hand hygiene and Routine Practices.

Antibiotic resistant organisms (ARO) continue to increase in number and variety and include but are not limited to the following:

- Carbapenum Resistant Enterobacteriaceae (CRE)
- Extended Spectrum Beta-Lactamase (ESBL)
- Methicillin Resistant Staphylococcus aureus (MRSA)
- Multi-drug Resistant Gram-Negative Bacteria
- Vancomycin Intermediate Staphylococcus aureus (VISA)
- Vancomycin Resistant Enterococci (VRE)
- Vancomycin Resistant Staphylococcus aureus (VRSA)

When to Contact OESH

HCWs with documented infections must contact OESH. HCW who experience an unprotected exposure to a patient with a documented ARO should watch for signs of infection and contact OESH if concerns arise.

Work Practices/Exclusions from Work

HCW EXPOSED TO AN ARO

- HCWs that have unprotected exposure or contact with a person known to be colonized or infected with an ARO do not require medical evaluation, treatment or investigation.
- No modifications to work practices or work restrictions are necessary provided there is no evidence of infection. Routine Practices should be followed at all times as hand hygiene is the key to prevention.

HCW INFECTED WITH AN ARO

- Work Assignment Modification: The Occupational Health Professional in conjunction with the Infection Prevention & Control Professional shall determine the need for modification of work assignment or work restriction and liaise with the HCW's manager. The Occupational Health Professional will provide education to the HCW regarding their responsibility in the need for meticulous hand hygiene as well as other Routine Practices if required.

- Clearance to Return-to-Work/Assignment Following Work Modification: Occupational Health shall provide the clearance for the HCW to Return-to-Work (RTW) and to full duties. HCWs who are instructed to RTW by their health care provider must still receive clearance to return by Occupational Health. If upon evaluation by the Occupational Health Professional, the ARO infection has resolved and the HCW is no longer thought to be a risk, the HCW may be returned to their regular work assignment.

HCW with an ARO infection of the lower arms or hands:

- If HCW will not be able to perform adequate hand hygiene the HCW will be restricted from all direct patient care and patient care activities.
- A reassignment to non-direct patient care duties is acceptable and will be assessed on a case by case basis determined by Occupational Health staff in conjunction with Infection Prevention & Control.
- HCW must keep any wound properly and securely bandaged while in the workplace.

HCW with an ARO infection on other areas of the skin:

- HCW may be allowed to have direct patient care if affected area can be properly covered and securely dressed with an appropriate dressing and drainage contained. These workers may be reassigned to areas/wards housing lower risk patients. Reassignment to non-direct patient care duties are also acceptable and can be determined by the HCW manager in discussion with Occupational Health staff and the staff from the Infection Prevention and Control program.
- HCW will be restricted from all patient care and patient care areas if affected area cannot be properly covered and securely dressed with an appropriate dressing.

HCW WHO HAS BEEN COLONIZED WITH AN ARO - No Discharge

- Nasal Colonization without discharge - An asymptomatic HCW with ARO colonization that has not been linked epidemiologically to patient cases may remain at work and does not require work reassignment or work restrictions.
- The HCW is not required to wear a surgical/procedure mask when providing patient care when colonized with MRSA. Other organisms would be assessed on a case by case basis by the OHN.

HCW WHO HAS BEEN COLONIZED WITH AN ARO - With Discharge

- Nasal Colonization with discharge - A HCW who is colonized with ARO and has nasal discharge will be restricted from care of all high-risk patients.
- Reassignment to areas/wards housing low risk patients is acceptable and can be determined by the HCW manager in discussion with the Occupational Health Professional. Once symptoms abate, no follow-up is necessary. HCW will wear a surgical/procedure mask while providing all patient care as respiratory shedding of ARO is possible.

OUTBREAK SITUATIONS

- If an ongoing outbreak of ARO infection occurs in the workplace, there may be a need to consider culturing all HCWs common to the infected patients. THIS IS CONSIDERED AN EXCEPTIONAL circumstance and is undertaken in discussion with Occupational Health and Infection Prevention and Control. Colonized or infected HCWs are rarely the source of ongoing transmission, so this strategy should be reserved for settings where specific HCWs have been implicated in the transmission of multi-drug resistant organisms.
- To proceed with this follow-up, approval is required from Occupational Health management following consultation with Infection Prevention and Control management. If this occurs, in most cases culturing would include cultures of the HCW nares and any obvious open wounds. Specific follow-up directives will be required for each specific outbreak situation.
- HCW implicated in transmissions of ARO are candidates for decolonization, should be treated and culture negative before returning to direct patient care. They cannot work in a patient care area. In contrast, HCWs who are colonized with ARO but are asymptomatic and have not been linked epidemiologically to transmission do not require decolonization.
- If an HCW is identified, the healthcare facility or employing authority shall pay for the antimicrobial treatment if it is deemed that the ARO infection/colonization occurred as a consequence of the HCWs employment. Any required time off work may be covered by Workers Compensation Board so it may not be necessary to use the HCWs accumulated sick time. This would only occur if the HCW is found to have acquired ARO from the workplace.
- Consider reassignment of HCW if decolonization is not successful and ongoing transmission to patients persists.

Signs and Symptoms: See IP&C link below
Transmission: See IP&C link below
Time for Symptoms to Develop: See IP&C link below
Contagious Time Period: See IP&C link below

Health Care Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate Step 2: Notify Occupational and Environmental Safety and Health (OESH) Important Information: • OESH will direct the HCW to their treating health care provider. HCWs diagnosed with an ARO infection (regardless of where the infection may have been acquired) will be assessed by an Occupational Health Professional before returning to work. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH and follow IP&C protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results Step 3: Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH. Step 4: Where applicable, ensure HCW is assessed by OESH prior to returning to work/regular duties.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/ARO_SDP.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/AntimicrobialResistantOrganisms-AROs-July2018.pdf

Blood and Body Fluid Exposures

Blood and Body Fluid (BBF) Exposure – An event where a person is exposed to potentially infectious blood and body fluids through one of the following:

- *Percutaneous* exposure through puncture of the skin by a needle stick or another sharp object
- *Permucosal* exposure through contact with mucous membranes
- *Non-intact skin exposure* through eczema, scratches and damaged skin
- *Human Bites*

Blood and Body Fluids: Body fluids most at risk for transmitting blood-borne diseases. This includes but is not limited to blood, tissue, semen, genital fluids, cerebrospinal, synovial, peritoneal, pleural, pericardial fluid, amniotic fluid and breast milk, any other fluid with visible blood, and laboratory specimens that contain HBV, HCV, and HIV.

When to Contact OESH

Follow site/regional Post Exposure Protocol direction on the BBF Package. Notify OESH of all Blood and Body Fluid Exposures.

Cimex Lectularius (Bed Bugs)

Bed bugs are an infestation and not considered the cause of infections. Infestations require Housekeeping Services and Facility Management to take the lead in pest control with the support of Infection Prevention and Control & Occupational Environment and Safety Health (OESH). To confirm an infestation of Bed Bugs, a pest control professional must be consulted.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Cimex_Lectularius_Bed_Bugs.pdf

Infection Prevention & Control specific disease protocol for Community Health Services can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/community/6.1.4.pdf

Creutzfeldt-Jakob Disease (CJD)

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH:

A healthcare worker who has had a percutaneous exposure or direct contact with high or low infectivity tissues of a person with suspect CJD

- Refer to the table for tissue risk for CJD found here https://professionals.wrha.mb.ca/old/extranet/ipc/files/manuals/acutecare/CJD_SDP.pdf
- Non-invasive contact does not transmit CJD

Work Practices/Exclusions from Work

None required

Transmission: CJD belongs to a family of human and animal diseases known as the transmissible spongiform encephalopathies (TSEs). TSEs, also known as prion diseases, are a group of rare degenerative brain disorders characterized by tiny holes, giving the brain a "spongy" appearance. Although there have been no confirmed cases of occupational transmission of TSE to humans, cases of CJD in healthcare workers have been reported in which a link to occupational exposure is suggested. Therefore, it is prudent to take a precautionary approach. In the context of occupational exposure, the highest potential risk is from exposure to high infectivity tissues through needle-stick injuries with inoculation; however, exposure to either high or low infectivity tissues through direct inoculation (e.g., needle-sticks, puncture wounds, sharps injuries, or contamination of broken skin) must be avoided. Exposure by splashing of the mucous membranes (notably the conjunctiva) or unintentional ingestion may be considered a hypothetical risk and must also be avoided. Healthcare personnel who work with patients with confirmed or suspected TSEs, or with their high or low infectivity tissues, should be appropriately informed about the nature of the hazard, relevant safety procedures, and the high level of safety which will be provided by the proposed procedures described throughout this document.

Time for Symptoms to Develop: many years

Health Care Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). **Important Information:** • OESH will evaluate and document exposure.	Step 1: Notify OESH and follow IP&C protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results .

Infection Prevention & Control specific disease protocol for Acute Care can be found at http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/CJD_SDP.pdf

Diarrhea (Bacterial, Clostridium difficile (C. difficile), Viral)

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A healthcare worker who has had direct or indirect oral contact with infectious feces should inform OESH. Exposure may also occur with ingestion of contaminated food or water.

Work Practices/Exclusions from Work

A Healthcare Worker Exposed to any of the above listed causes of diarrhea
No modifications to work practices or work restrictions.

A Healthcare Worker Symptomatic with an infectious cause of diarrhea
Healthcare workers with diarrhea shall be excluded from work until they are no longer symptomatic.

Signs and Symptoms: Loose watery stools, abdominal pain and cramping, fever, mucous or blood in the stool, dehydration, a change in stool odour.
Transmission: direct or indirect oral contact with infectious feces. Exposure may also occur with ingestion of contaminated food or water.
Time for Symptoms to Develop: Variable
Contagious Time Period: no defined timeline as there is chance of re-infection

Health Care Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and direct the HCW to their treating health care provider for medical management where appropriate. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH and follow IP&C protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results Step 3: Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH. .

Infection Prevention & Control specific disease protocol for Acute Care can be found at
https://professionals.wrha.mb.ca/old/extranet/ipc/files/manuals/acutecare/Diarrhea_SDP.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/ManualPCH_Sec09_Diarrhea.pdf

Infection Prevention & Control specific disease protocol for Community Health Services can be found at
http://www.wrha.mb.ca/extranet/ipc/files/Diarrhea.pdf

Group A Streptococcus

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

Group A Streptococcus infection include: Sore throat, Otitis media, Skin infections- impetigo, Scarlet fever, Puerperal fever, Pneumonia, Septicemia, Wound infections, Cellulitis

When to Notify OESH

A healthcare worker who has had droplet, direct, or indirect contact of oral or nasal mucous membranes, or direct contact of non-intact skin with infectious respiratory or wound secretions from an infectious person with invasive disease during the period of communicability (from within 7 days before the onset of GAS until completion of 24 hours of effective antibiotic therapy).

Work Practices/Exclusions from Work

A Healthcare Worker Exposed to Group A Streptococcus

- No modifications to work practices or work restrictions

A Healthcare Worker Symptomatic of a Group A Streptococcus infection

- Healthcare workers shall be excluded from work until completion of 24 hours of effective antibiotic therapy

Signs and Symptoms: Symptoms at the onset of these infections may be vague and may include pain of unusual severity (out of proportion to the clinical findings), Swelling, Fever, chills, Flu-like symptoms, generalized muscle aches, Generalized macular rash, Bullae

Transmission: Transmission is through direct or indirect contact, or droplet spread depending on the infection listed above. Pneumonia, pharyngitis and scarlet fever are spread by direct contact with respiratory droplets and discharge from nose and throat of infected or colonized persons.

Time for Symptoms to Develop: The incubation period is usually short, usually 1 to 3 days, and rarely longer.

Contagious Time Period: Individuals with Group A Streptococcus pneumonia are infectious until 24 hours after effective antibiotic therapy. Individuals with pharyngitis and scarlet fever can be infectious for 10-21 days. Persons with untreated streptococcal pharyngitis may carry the organism in the pharynx for weeks or months.

Health Care Worker's Role	**Supervisor/Manager's Role**
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and refer HCW to Urgent Care/Walk-in Connected Care. Referral includes notification to receiving site of suspected Group A Streptococcus. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	**Step 1**: Notify OESH of suspected Group A Streptococcus and follow IP&C Protocol (link below) **Step 2**: If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3**: Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Group_A_Strep_SDP.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/ManualPCH_Sec09_GroupAStrep.pdf

Hand Foot and **Mouth** Disease – Primarily Coxsackievirus-A16

Healthcare workers may become exposed to the virus causing Hand foot and mouth disease either at work or in the community. All exposures to individuals diagnosed with Hand foot and Mouth disease must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A healthcare worker who has had direct or indirect oral contact with feces of an individual with Hand Foot and Mouth disease.

Work Practices/Exclusions from Work

A Healthcare Worker Exposed to an individual diagnosed with Hand Foot and Mouth Disease

- No modifications to work practices or work restrictions

A Healthcare Worker Symptomatic from Hand Foot and Mouth Disease

- Healthcare workers shall be excluded from work until no further symptoms

Signs and Symptoms: Fever, reduced appetite, sore throat, feeling unwell. 1-2 days after fever sores can develop in the mouth small red dots at the back of the mouth blister and painful. Rash may also present on the palm of hands, knees, elbows, buttocks and genitals. Adults often show no symptoms.

Transmission: Spread through close personal contact, airborne with coughing, and contact with feces of infected persons. Items like utensils, diaper-changing tables, and toys that come in contact with body fluids that contain the virus may also transmit them to other individuals. Although people of any age, including adults, can get infected, the majority of patients with coxsackievirus infection are young children.

Time for Symptoms to Develop: Signs and symptoms usually appear 3-6 days after exposure to the virus (Coxsackievirus A16 or other causative enteroviruses) and last approximately one week.

Contagious Time Period: Coxsackieviruses are most contagious during the first week of symptoms. However, viable virus microbes have been found in respiratory tracts for up to three weeks and then in feces up to eight weeks after initial infection, but during this time, the viruses are less contagious.

Health Care Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and determine fitness to work. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	**Step 1:** Notify OESH of suspected Hand, Foot, Mouth **Step 2:** If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3:** Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Influenza:

Healthcare workers may become exposed either at work or in the community.

When to Notify OESH

A healthcare worker who has had droplet or indirect contact of oral, nasal, or conjunctival mucous membranes with respiratory secretions of an infectious person during the period of communicability (1 day before to 7 days after onset of symptoms) and is symptomatic.

Work Practices/Exclusions from Work

A Healthcare Worker Exposed to Influenza
No modification to work practices or work restrictions, unless directed by Infection Prevention & Control or Public Health during an outbreak situation.

A Healthcare Worker Symptomatic with Influenza
Healthcare workers shall be excluded from work for 3-5 days after onset of symptoms, HCWs should only return to work when they are well enough to work and have been afebrile (without fever) for 24 hours.

Signs and Symptoms: fever/chills (not always), cough, sore throat, runny/stuffy nose, muscle/body aches, headaches, fatigue
Transmission: large droplet direct /indirect contact
Time for Symptoms to Develop:
Incubation Period: usually 2days but ranges from 1 to 4 days
Contagious Time Period: Adults can transmit influenza from the day before symptom onset until approximately 5 days after becoming sick. Children can transmit influenza for several days before illness onset, and can be infectious for 7-10 days after onset of illness or longer. Immunocompromised individuals may shed virus for longer periods.

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). **Important Information:** • OESH will assess and treat as outlined in OESH Standing Orders. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH of increase in HCW reporting influenza like illness symptoms. Step 2: Exclude employee from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Seasonal_Influenza_Protocol.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/ManualPCH_Sec09_Influenza.pdf

Measles/Rubeola

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A contact is defined as any individual who has spent any length of time in a room or enclosed space with a confirmed measles case during that case's infectious period; or spent time in a room previously occupied by a measles case, during that case's infectious period, within 2 hours after that individual left the room/space.

Regardless of their immunity status, all healthcare staff entering the room of a case of suspected measles should use respiratory protection consistent with airborne infection control precautions (N95 respirator). Individuals who are not known to be immune to measles should not look after suspected or confirmed cases of measles.

Work Practices/Exclusions from Work

A Healthcare Worker Exposed to Measles/Rubeola

- Healthcare workers immune status shall be determined by OESH by checking previous vaccine status.
- Healthcare worker with evidence of immunity do not need to be excluded from work following an exposure.
- Healthcare worker with a history of a single dose of measles vaccine will be given a second dose ideally within 72 hours of exposure and have their immunity checked. While waiting for the serology results, HCWs should be excluded from work from the fifth day to the 21st day after the last exposure. If their IgG measles antibody results are positive, they can be considered immune and returned to work. If their IgG measles antibody results are negative, they should be considered susceptible and excluded from work from the fifth to 21st day post exposure.
- Healthcare worker without evidence of immunity, exclude from day 5 of first exposure until day 21 after last exposure.

A Healthcare Worker Symptomatic or Infected with Measles/Rubeola

- Physician confirmed diagnosis
- Healthcare workers shall be excluded from work until day 5 after the rash first appears

Signs and Symptoms:

- Fever, dry cough, runny nose, red/swollen eyes, nasal congestion, sneezing,
- White spots on mouth
- Rash starting on face spreading down the trunk and out to arms and legs.

Transmission:

- Respiratory secretions, airborne

Time for Symptoms to Develop:

- 7-21 days

Contagious Time Period:

- 4 days before onset of rash (1-2 days before onset of symptoms) until 4 days after onset of rash.

Health Care Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. **Step 2:** Notify Occupational and Environmental Safety and Health (OESH). **Important Information:** • OESH will check immune status and provide clinical management as per OESH standing orders • OESH will refer pregnant, susceptible HCWs to their physician for clinical management • Employee will be excluded from work as outlined in	**Step 1**: Notify OESH of suspected Measles/Rubeola and follow IP&C Protocol (link below) **Step 2**: If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3**: Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Measles_Rubeola.pdf

Infection Prevention & Control specific disease protocol for Community Health Services can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/community/CHS_Measles_Rubeola.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/ManualPCH_Sec09_Measles.pdf

Meningitis

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

Meningitis is an inflammation of the membranes (meninges) and cerebrospinal fluid surrounding your brain and spinal cord, usually due to the spread of an infection. The cause of most cases of meningitis is a viral infection, but bacterial and fungal infections also can lead to meningitis.

A number of strains of bacteria can cause bacterial meningitis. The most common include:
Neisseria meningitidis (meningococcus)
Streptococcus pneumoniae (pneumococcus)
Haemophilus influenzae (haemophilus)
Listeria monocytogenes (listeria)
Viral meningitis
Chronic meningitis
Fungal meningitis

When to Contact OESH

Post exposure prophylaxis of health care workers is not required for cases of viral meningitis or bacterial meningitis, with the exception of Neisseria meningitidis (meningococcus). Prophylaxis is not considered until the case has been confirmed.

The decision to provide prophylaxis to HCWs who experience an exposure outlined below to Meningococcal meningitis (Neisseria meningitidis) is made by OESH in consultation with IP&C:

- HCW's, who were not masked, may need antibiotic prophylaxis IF
  - he/she was in close proximity when an aerosol-generating procedure was being performed (e.g. intubation, resuscitation)
  - he/she was in close proximity (one metre or less) to the face of a case when the case was expelling oral secretions during coughing, vomiting etc.

  - HCW 's, who did not mask, will NOT need antibiotic prophylaxis IF
    - no aerosol-generating procedure was performed;
    - he/she was not in close proximity when an aerosol-generating procedure was being performed; or
    - the case wasn’t producing any spray of oral or nasopharyngeal secretions from coughing, vomiting, etc.
    - these HCW 's are advised to contact their Occupational Health unit to discuss their contact if concerned;

Work Practices/Exclusions from Work

A Healthcare Worker who was exposed as described above but is asymptomatic does not need to be excluded from work but should be offered prophylaxis.

A Healthcare Worker Symptomatic or Infected with Meningococcal meningitis (Neisseria meningitidis)
Healthcare workers shall be excluded ·from work until appropriately treated and well enough to work.

Signs and Symptoms: It's easy to mistake the early signs and symptoms of meningitis for the flu. They may develop over a period of one or two days and typically include: high fever, severe headache, vomiting or nausea with headache, confusion or difficulty concentrating sensitivity to light, and skin rash in some cases, such as in viral or meningococcal meningitis.

Transmission: see specifics in IP&C manual link below

Time for Symptoms to Develop: see specifics in IP&C manual link below

Contagious Time Period: see specifics in IP&C manual link below

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and provide prophylaxis as outlined in their standing orders as appropriate. • Symptomatic HCW will be referred to Emergency/Urgent Care for medical management. Referral includes notification to receiving site of suspected Meningococcal meningitis. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	**Step 1:** Notify OESH of suspected Meningio-meningitis case and follow IP&C Protocol (link below) **Step 2:** If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3:** Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Meningitis.pdf

Lice (Pediculosis - of the head):

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A healthcare worker who has had direct or indirect hair- to-hair contact with an infested person or skin-to-skin contact with clothing or bedding of an infested person prior to 24 hours of effective treatment.

Work Practices/Exclusions from Work

A Healthcare Worker Exposed to Pediculosis (of the head)
No modification to work practices or work restrictions.

A Healthcare Worker Symptomatic or Infected with Pediculosis (of the head)
Healthcare workers shall be excluded from work until the completion of one application of effective treatment (available without a prescription at a Pharmacy).

Signs and Symptoms: itching, sensation of something moving in the hair irritability sleeplessness, sore on head from scratching
Transmission: contact with hair eyebrows or eyelashes of infected person
Time for Symptoms to Develop: up to 4-6 weeks
Contagious Time Period: until treated
Treatment: pediculicides
Prophylaxis: none

Healthcare Worker's Role	**Supervisor/Manager's Role**
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and may treat as appropriate. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH of suspected case of Lice and follow IP&C Protocol (link below) **Step 2:** Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Pediculosis_Lice.pdf

Mumps

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

Mumps virus is spread through contact with respiratory droplets from an infected person, direct contact with the saliva of an infected person, or contact with a contaminated surface. Unprotected exposures are defined as having a face to face interaction within one meter of an infectious mumps case without the use of proper personal protective equipment. Health care personnel who have had unprotected exposures, between two days before through five days after parotitis onset in a case of mumps, should be identified and considered contacts.

Work Practices/Exclusions from Work

Healthcare worker immune status shall be determined. Considered immune if they have laboratory confirmed evidence of either immunity or disease or a history of two doses of a mumps containing vaccine. If two doses of vaccine are documented there is no need to test titres.

A Healthcare Worker Exposed to Mumps

- HCW assessed as immune. Healthcare personnel with evidence of immunity do not need to be excluded from work following an unprotected exposure.
- HCW who have had only one dose of a mumps containing vaccine. These HCW may continue working following an unprotected exposure to mumps. Such personnel should receive a second dose as soon as possible, but no sooner than 28 days after the first dose.
- HCW without evidence of immunity. HCW should be excluded from work from the 12th day after the first unprotected exposure to mumps through the 25th day after the last exposure. Previously unvaccinated healthcare personnel who receive a first dose of vaccine after an exposure are considered non-immune.

A Healthcare Worker Symptomatic or Infected with Mumps

- Symptomatic HCW should be excluded from work until five days after the onset of parotitis (inflammation of the parotid gland).

Signs and Symptoms: Painful swelling of the salivary glands, Fever, Headache, Muscle aches, Loss of appetite
Transmission: Saliva, droplet, direct contact
Time for Symptoms to Develop: 12-25 days
Contagious Time Period: 2 days before to 5 days after onset of parotitis (inflammation of the parotid gland).

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. **Step 2:** Notify Occupational and Environmental Safety and Health (OESH). **Important Information:** • OESH will check immune status and provide clinical management as per standing orders. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	**Step 1:** Notify OESH of suspected case of Mumps and follow IP&C Protocol (link below) **Step 2:** If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3:** Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Mumps.pdf

Pertussis (Whooping Cough)

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A healthcare worker who has direct or indirect contact of their oral or nasal mucous membranes with respiratory secretions of an infectious person during the period of communicability, or until 5 days after initiation of effective antibiotic therapy.

A close contact of a patient with pertussis is a person who had face-to-face exposure within 3 feet of a symptomatic patient. Respiratory droplets (particles >5 µm in size) are generated during coughing, sneezing, or talking and during the performance of certain procedures such as bronchoscopy or suctioning; these particles can be propelled through the air for distances of approximately 3 feet.

Close contacts also can include persons who;

- have direct contact with respiratory, oral, or nasal secretions from a symptomatic patient (e.g., cough, sneeze, sharing food and eating utensils, mouth-to-mouth resuscitation, or performing a medical examination of the mouth, nose, and throat)
- shared the same confined space in close proximity with a symptomatic patient for >1 hour.

HCWs that have close contact as defined above and are at high risk may be considered for prophylaxis.

Work Practices/Exclusions from Work

Immunity to pertussis from childhood vaccination and natural disease wanes with time; therefore, adolescents and adults who have not received a booster vaccination are at risk of infection and its consequent transmission of the bacteria to others.

A Healthcare Worker Exposed to Pertussis

- Post exposure antimicrobial prophylaxis is recommended for all HCP who have unprotected exposure to pertussis and are likely to expose a patient at risk for severe pertussis (e.g. immunocompromised people, neonates and pregnant women).
- No modification to work practices or work restrictions required for exposed healthcare workers who are taking prophylactic antibiotics. HCP who refuse antibiotic prophylaxis and work with high risk patients should either have their duties altered so as to work with lower risk patients or be furloughed from day 6 to 21 days following last exposure.
- Other HCP should either receive post-exposure antimicrobial prophylaxis or be monitored daily from day 6- 21 days after pertussis exposure and treated at the onset of signs and symptoms of pertussis.

A Healthcare Worker Symptomatic or Infected with Pertussis

- HCWs that become symptomatic must be assessed and treated by the occupational health physician or the OESH occupational health nurse. HCP in whom symptoms (i.e., unexplained rhinitis or acute cough) develop after known pertussis exposure might be at risk for transmitting pertussis and should be excluded from work until 5 days after the start of appropriate therapy.
- If untreated from the beginning of onset of symptoms through the third week after onset of coughing

Signs and Symptoms: Pertussis infection can cause symptoms similar to those of the common cold. These include a runny nose, red watery eyes, mild fever and cough. The cough may worsen until the infected individual experiences severe coughing spells followed by a "whoop" sound before the next breath. This cough can last 6 to 12 weeks.

Transmission: Droplet transmission

Time for Symptoms to Develop: The incubation period is average 5-10 days up to21 days.

Contagious Time Period: Non-immune contacts are considered infectious from day 12 to day 25 after exposure. The period of communicability is until 3 weeks after onset of paroxysms if not treated; or until 5 days of appropriate Antimicrobial therapy received.

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and provide prophylaxis/clinical management where appropriate as outlined in their standing orders. • OESH will refer pregnant or immunocompromised HCWs to their physician for clinical management • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH of suspected Pertussis and follow IP&C Protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3:** Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Pertussis.pdf

Rubella/German Measles

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A healthcare worker who has had direct or droplet contact of their oral or nasal mucous membranes with respiratory secretions of an infectious person (for congenital rubella syndrome, this also includes contact with infected infant's urine) during period of communicability (7 days before and 7 days after onset of symptoms).

Work Practices/Exclusions from Work

HCWs that have been exposed to a confirmed case of rubella should have their immune status reviewed. Individuals are considered immune to rubella if they have laboratory confirmed evidence of either immunity or disease or a history of one dose of a rubella containing vaccine after their first birthday.

A Healthcare Worker Exposed to Rubella

- HCW with evidence of immunity as described above do not need to be excluded from work following an exposure.
- Health care personnel without evidence of immunity: In healthcare settings, exposed healthcare personnel without adequate presumptive evidence of immunity should be excluded from duty beginning 7 days after exposure to rubella and continuing through either 23 day after their last exposure.
- Exposed nonimmune HCW should be vaccinated. Post vaccination, they should still be excluded as described above as the effectiveness of post-exposure vaccination in preventing rubella infection has not been shown.

Health Care Worker is Symptomatic or Infected with Rubella

- Healthcare workers shall be excluded from work for 7 days after onset of rash

Signs and Symptoms: Pink rash beginning on face moving to trunk then arms and legs, enlarged and tender lymph nodes. mild fever, inflamed/red eyes, headache and runny nose.
Transmission: Respiratory secretions, droplet, direct contact.
Time for Symptoms to Develop: 14-23 days
Contagious Time Period: 1 week prior to rash until 7 days after onset of rash.

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate, review immune status and provide clinical management as outlined in their standing orders. • OESH will refer pregnant/susceptible HCWs to their physician for clinical management • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH of suspected Rubella exposure and follow IP&C Protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3:** Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Rubella_German_measles.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/ManualPCH_Sec09_Measles.pdf

Scabies

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

Typical - A healthcare worker who has had direct skin-to-skin contact with an infested person during the period of communicability (4-8 weeks before symptom s develop, and up until 24 hours after effective treatment).

Crusted (Norwegian) - A healthcare worker who has had minimal direct or indirect contact with infested person during period of communicability (4-8 weeks before symptoms develop, and up until 24 hours after effective treatment). Only minimal contact is required with Norwegian Scabies because of large number of mites present on source person. Note: symptoms may develop within 1 to 4 days if person was previously infected.

Work Practices/Exclusions from Work

A Healthcare Worker Exposed to Scabies but asymptomatic:

- Typical - No modification to work practices or work restriction is required.
- Crusted (Norwegian) - Asymptomatic HCW will be offered prophylaxis as outlined below.
- Staff can remain at work on the day that they are assessed and apply the treatment after completion of their shift.
- Asymptomatic staff do not need to wear gloves or gowns post treatment

A Healthcare Worker Symptomatic or Infested with Scabies:

Staff must remain off work during the time that cream is on the skin. Staff can return to work for the next scheduled shift but are required to wear gloves/gown for every patient contact for the time period between completion of treatment and their re-assessment by OESH.

Signs and Symptoms:

- Typical Scabies: Scabies presents as a pimple-like (papular) itchy rash affecting much of the body or is limited to common sites such as the flexor surfaces of the wrists, finger webs, and sides of digits, elbows, axillae, male genitalia, nipple areola, and periumbicular area. The rash may also be on the head, neck, palms, and soles in infants. Sensitization to the proteins and feces of the mite causes the itchy rash. Characteristically, the burrows appear as tiny and crooked grayish-white or skin-colored lines on the skin surface. The itching is often worse at night or after bathing. The intense itching of scabies leads to scratching that can cause skin sores. These sores can become infected with bacteria on the skin
- Crusted (Norwegian) Scabies: Some immunocompromised, elderly, disabled or debilitated persons are at risk for a severe form of scabies called crusted or Norwegian scabies. This type of scabies is characterized by vesicles and thick crusts over the skin, which contains large numbers of scabies mites and eggs. Persons with crusted/Norwegian scabies may not demonstrate the usual signs and symptoms of scabies such as the characteristic rash or itching. This can be due to the person's altered immune status or neurological condition. The rash in these cases may resemble psoriasis or eczema.

Transmission: see above

Time for Symptoms to Develop:

- Exposure: 4-8 weeks
- Previously infected: 1-4 days

Contagious Time Period:

- As long as untreated and until the day after first treatment

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and provide treatment where applicable for HCW and bed partner. • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH of suspected Scabies case and follow IP&C Protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results. Step 3: Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Scabies_Protocol.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/ScabiesOG.pdf

Infection Prevention & Control specific disease protocol for Community Health Services can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/community/CHS_Scabies.pdf

Tuberculosis:

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A healthcare worker who has had airborne contact with an infectious person with active pulmonary TB. If the healthcare worker was wearing a NIOSH approved N95 fit-tested respirator, he/she is not to be considered exposed.

Work Practices/Exclusions from Work

OESH (OHN and Physician) individually assess staff exposures, risks and previous TST results and will advise as follows:

- Staff **with** previous positive documented TST, previous treatment for TB disease or previous treatment for latent TB infection who are
  - **Symptomatic** will be sent for further testing (e.g., chest x-ray). They are not required to be excluded from work while awaiting the results but should be encouraged to don a mask as with any respiratory illness.
    - *Positive Results of further testing* – will be excluded from work during treatment (usually approximately 2 weeks but may be longer in certain situations – e.g., multidrug resistant TB) and referred to and treated by Respiratory Out-Patient Clinic at HSC. IP&C will advise OESH when treatment is complete**. Staff must receive clearance from OESH prior to returning to duties**.
    - *Negative Results of further testing* – do not require exclusion from work. Treat as asymptomatic. As with any respiratory symptoms, continue to don a mask until asymptomatic.
  - **Asymptomatic** will be educated about signs and symptoms and told to report such immediately if they develop.
- Staff **without** previous positive documented TST, previous treatment for TB disease or previous treatment for latent TB infection will book an appointment with the Occupational Health Nurse 8 weeks following possible exposure at which time a TST will be performed.

Signs and Symptoms: Cough lasting more than 3 weeks, fever, night sweats, unexplained weight loss, unexplained loss of appetite, hoarseness, chest pain, fatigue, and blood in sputum.
Transmission: There is no specific length of time in which transmission may occur as each TB case is individual and depends on the infectiousness of the source case, extent of exposure and immunologic vulnerability.
Time for Symptoms to Develop: The incubation period for infection (LTBI) is 4 to 12 weeks after exposure.
Contagious Time Period: The risk of progression to active TB disease is greatest within the first two years after infection. TB infection may exist for an individual's lifetime as a latent infection (LTBI). Note: if your body's defenses are strong, your body will usually control the infection and LTBI may never convert to active TB. If the immune system is compromised, for example, if a person with LTBI develops a chronic illness (e.g., HIV) or is taking cancer treatments or other immune suppressive drugs, the TB can be activated.

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will provide clinical management (assessment, counselling and plan of action) as per standing orders • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH of suspected Tuberculosis contact and follow IP&C Protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results. Step 3: Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
https://professionals.wrha.mb.ca/old/extranet/ipc/files/manuals/acutecare/TB_Protocol.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
https://professionals.wrha.mb.ca/old/extranet/ipc/files/TuberculosisPreventionControlResourceGuide-July2018.pdf

Infection Prevention & Control specific disease information for Community Health Services can be found at
http://www.wrha.mb.ca/extranet/ipc/files/Tools/PPE_QRG_CHS_Clinic_Setting.pdf

http://www.wrha.mb.ca/extranet/ipc/files/manuals/community/HomeAirSafetyCF.pdf

http://www.wrha.mb.ca/extranet/publichealth/files/HomeIsoTBPrtcGdl.pdf

Varicella Zoster Virus (Chicken Pox)

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

A susceptible healthcare worker who has been in an enclosed airspace or had face-to-face contact with an infectious person during the period of communicability (2 days before onset of symptoms and until all lesions have dried and crusted). Exposure can also occur by direct or indirect contact with vesicle fluid through the oral or nasal membranes of healthcare workers.

Work Practices/Exclusions from Work

HCWs that have been exposed to a confirmed case Varicella Zoster Virus (Chicken Pox) should have their immune status reviewed. Individuals are considered immune if they have a convincing history of the disease before 2004, positive titres, or two doses of Varivax III.

A Healthcare Worker Exposed to Chickenpox

- Exposed immunized HCW with no symptoms will be monitored daily but may remain at work.
- Susceptible healthcare workers shall be referred for clinical management within 96 hours of exposure.
- Exposed susceptible healthcare workers shall be excluded from work from day 8 after first exposure to day 21 after last exposure.

A Healthcare Worker Symptomatic or Infected with Chickenpox

Healthcare workers shall be excluded from work until all lesions are dry and crusted with no new lesions evident.

Signs and Symptoms: 1-2 days fever and malaise prior to onset of rash. Rash starting on head/neck/shoulder moving to trunk/arms/legs. Itchy small lesions on skin developing in crop of lesions. Lesions can occur on mouth, respiratory tract, eyes and genitalia.

Transmission: It is spread through respiratory droplets in the air formed when an infected person coughs or sneezes. It is also spread through direct contact with skin lesions caused by the virus.

Time for Symptoms to Develop/Incubation Period: 10-21 days after first exposure with the usual period being 14-16 days after exposure.

Contagious Time Period: Persons are most contagious for 1 to 2 days before and shortly after the onset of rash. Communicability however, can persist until crusting of lesions, which typically occurs in 5 days.

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify supervisor or designate. **Step 2:** Notify Occupational and Environmental Safety and Health (OESH). **Important Information:** • OESH will provide clinical management (assessment, counselling and plan of action) as per standing orders • OESH will refer susceptible HCWs for clinical management • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	**Step 1:** Notify OESH of suspected Chickenpox exposure and follow IP&C Protocol (link below) **Step 2:** If work related exposure confirms diagnosis of patient with physician and advise OESH of results. **Step 3:** Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
https://professionals.wrha.mb.ca/old/extranet/ipc/files/manuals/acutecare/Varicella_Zoster_Virus_VZV.pdf

Infection Prevention & Control specific disease protocol for Community Health Services can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/community/6.1.5.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/VaricellaHZ.pdf

Shingles (Herpes Zoster), Disseminated Zoster

Healthcare workers may become exposed either at work or in the community. All exposures must be reported to Occupational Health following the steps outlined in the chart below.

When to Notify OESH

Shingles (Herpes Zoster): A susceptible healthcare worker who has had direct or indirect contact of oral or nasal mucous membranes with the vesicle fluid of an infectious person during the period of communicability (until the lesions are dried and have crusted).

Disseminated Herpes Zoster: A susceptible healthcare worker who has been in an enclosed airspace with an infectious person or had face-to-face contact with an infectious person during period of communicability (until the lesions are dried and have crusted).

Work Practices/Exclusions from Work

HCWs that have been exposed to a confirmed case of Shingles (Herpes Zoster), Disseminated Zoster should have their immune status reviewed. Individuals are considered immune if they have a convincing history of the disease prior to 2004, positive titres, or two doses of Varivax III.

A Healthcare Worker Exposed to Herpes Zoster:

- Exposed HCPs who have received 2 doses of vaccine should be monitored daily during days 10 – 21 after exposure to determine clinical status (i.e. daily screening for fever, skin lesions and systemic symptoms). If asymptomatic they may remain at work. Wearing of an N95 respirator is not necessary. They should also be instructed to report any symptoms as they occur without delay.
- Susceptible healthcare workers shall be referred for clinical management within 96 hours of exposure.
- Exposed susceptible healthcare workers shall be excluded from work from day 8 after first exposure to day 21 after last exposure.

A Healthcare Worker Symptomatic with Herpes Zoster:

- Healthcare workers shall be excluded from work if unable to cover lesions with occlusive dressing and clothing.
- If disseminated zoster, healthcare workers shall be excluded from work until lesions are dried and have crusted.

Signs and Symptoms:

- Localized Zoster:
  - Lesions appear along one or more nerve roots.
  - Lesions appear in crops in a cluster or in an irregular fashion along nerve root.
- Disseminated Zoster:
  - Lesions appear along more than one nerve root and branch outwards off primary root.
  - Rash is more severe and prolonged and may involve the throat, mouth and lungs.

Transmission:

- Localized Zoster: drainage from lesions, direct & indirect contact,
- Disseminated Zoster: drainage from lesions, respiratory secretion, and airborne, direct & indirect contact.

Time for Symptoms to Develop:

- Variable

Contagious Time Period:

- 1-2 days before onset of rash until all lesions have crusted and no new lesions are forming.

Healthcare Worker's Role	Supervisor/Manager's Role
Step 1: Notify Supervisor or designate. Step 2: Notify Occupational and Environmental Safety and Health (OESH). Important Information: • OESH will evaluate and provide clinical management as outlined in their standing orders. • OESH will refer susceptible HCWs for clinical management • Employee will be excluded from work as outlined in Work Practices/Exclusions from work or as recommended by OESH due to co-morbidities to any personal health related condition.	Step 1: Notify OESH of suspected Shingles exposure and follow IP&C Protocol (link below) Step 2: If work related exposure confirms diagnosis of patient with physician and advise OESH of results. Step 3: Exclude from work as outlined in Work Practices/Exclusions from work or as advised by OESH.

Infection Prevention & Control specific disease protocol for Acute Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/acutecare/Varicella_Zoster_Virus_VZV.pdf

Infection Prevention & Control specific disease protocol for Long Term Care can be found at
http://www.wrha.mb.ca/extranet/ipc/files/manuals/ltc/VaricellaHZ.pdf