

Ministry of Health

COVID-19 Interim Guidance: Omicron Surge Management of Critical Staffing Shortages in Highest Risk Settings

Version 2.0 – January 12, 2022

This Interim Guidance document provides basic information only. It is not intended to provide medical advice, diagnosis or treatment or legal advice.

In the event of any conflict between this Interim Guidance document and any orders or directives issued by the Minister of Health or the Chief Medical Officer of Health (CMOH), the order or directive prevails.

- Please check the Ministry of Health (MOH) [COVID-19 website](#) regularly for updates to this document, mental health resources, and other information,
- Please check the [Directives, Memorandums and Other Resources](#) page regularly for the most up to date directives.

Purpose

- The purpose of this guidance is to provide a framework for employers and operators of certain highest risk settings to use when considering early return to work of **staff** who are otherwise not eligible for early return to work as mitigation to critical staffing shortages, and without approval of the local public health unit.
- For the purposes of this guidance, highest risk settings for consideration of early return to work to mitigate critical staffing shortages applies to:
 - Hospitals including complex continuing care facilities and paramedic services; and
 - Congregate living settings, including long-term care homes, retirement homes, First Nation elder care lodges, group homes, shelters, hospices, and correctional facilities.
- Other settings that are not included in the above highest-risk setting list should follow the [COVID-19 Interim Guidance for Case, Contact and Outbreak Management in Omicron Surge for return to work management of cases and contacts](#).

- Direction on early return to work from local hospital IPAC and/or Occupational Health should continue to be followed in addition to any instructions, if applicable, issued by the local medical officer of health
- Setting specific direction on early return to work from other relevant ministries (e.g., Ministry of Long-Term Care, Ministry of Seniors and Accessibility, Ministry of Children, Community and Social Services, Ministry of Municipal Affairs and Housing, and Ministry of the Solicitor General) should also continue to be followed.
- Employers and operators who implement an early return to work process should consult with the joint health and safety committee about the measures and procedures that are being taken for workplace safety.

Background

- Based on the [Interim Guidance for Cases, Contacts and Outbreak Management in Omicron Surge](#), cases and close contacts who work in highest risk settings are required to not attend work for 10 days from symptom onset/positive test or last exposure to a case if a close contact.
- Cases (positive test or symptoms-based) do not require a test to return to work after 10 days isolation.
- Close contacts with a single negative PCR test collected on/after day 7 after last exposure¹ OR two negative RATs collected 24 hours apart on day 6 and 7 after last exposure can return to work. Close contacts in highest-risk settings who develop any [symptoms of COVID-19](#) should self-isolate and be tested immediately.
- At this time of high community transmission, these requirements may lead to staffing shortages impacting patient/resident care in these highest-risk settings.
- Settings that are not highest risk settings for purposes of this guidance (listed above) should refer to the [COVID-19 Interim Guidance for Case, Contact and Outbreak Management in Omicron Surge](#)

¹ For close contacts who are not able to effectively isolate away from the COVID-19 case (i.e., providing care to a COVID-19 positive household member) 'last exposure' would be the last time they interacted with the COVID-19 case during the COVID-19 case's self-isolation period.

- All settings should fully utilize staffing strategies in their continuity of operations plan to avoid and mitigate situations of staffing shortages impacting care **before** utilizing early return to work for staff in isolation.
- **Options with lower risk should be exhausted prior to progressing to options with more risk. The use of options with more risk should be commensurate to the risk of insufficient staffing to patients/residents.**
- RATs have been prioritized to highest risk settings for use for test-to-work strategies to support early return to work when required for critical staffing. Use of options that include rapid antigen testing for staff who are close contacts should be prioritized.

Considerations for early return to work:

Administrative Considerations for Selecting Staff for Early Return to Work

- The fewest number of staff who are close contacts or who are COVID-19 cases should be returned to work early to allow for business continuity and safe operations.
- Staff who are nearest to completion of their self-isolation period should be returned first, within the framework levels.
- Where possible, preferential early return to work for those who have received three doses of vaccine should be considered due to decreased risk of developing symptomatic infection with Omicron infection compared to those with two doses.
- Those with lower risk exposures (i.e., non-household close contact) can be prioritized to return before those who have ongoing exposure to a household member where the risk of transmission is higher (e.g. providing direct, ongoing care to a COVID-19 positive household member).
- Individuals who have had a COVID-19 infection (i.e., tested positive on molecular or rapid antigen test) in the past 90 days have a lower risk of re-infection. Staff who are close contacts and who have had a resolved test-positive infection in the past 90 days may be prioritized to return to work due to lower risk of becoming infected from current exposure.

Workplace Considerations for Reducing Risk of Exposure

- Where possible, avoid assigning staff on early return to work to vulnerable patients/residents (e.g., immunocompromised, unvaccinated, other underlying risks for severe disease).

- PPE and IPAC practices should be reviewed (include audits) to ensure meticulous attention to measures for staff on early return to work.
- Prioritize cohorting of staff who are early returned cases to working with COVID-19 positive patients only, due to risk of transmission.
- Additional precautions for individuals on early return to work include:
 - Active screening ahead of each shift and taking temperature twice a day to monitor for fever;
 - Not eating meals in a shared space (e.g., conference room, lunch room) with other staff to reduce risk of exposure to co-workers;
 - Working in only one facility, where possible;
 - Ensuring well-fitting source control masking for the staff on early return to work to reduce the risk of transmission (e.g. a well fitting medical mask or fit or non-fit tested N95 respirators or KN95s).

Framework for critical staffing prioritization

The following table outlines progressive levels of risk options for contingency staffing with early return of close contacts and cases. For close contact, use of rapid antigen testing options is preferred to options when testing is not available.

It is the responsibility of the organization implementing this guidance to determine what staffing option to use under their current staffing shortage circumstances.

Table 1: Return to Work Testing Requirements for Cases and Contacts

Risk Level	Close Contacts – Rapid Antigen Testing available	Close Contacts – Contingency when Rapid Antigen Testing is not available	Cases – With or Without Testing Available
Lowest Risk Staffing Option	<ul style="list-style-type: none"> • Return to work after negative molecular test collected on/after day 7 from last exposure <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • Return to work on day 7 after negative RATs on day 6 and day 7 collected 24 hours apart after last exposure. 	Return to work after 10 days from last exposure to the case	<ul style="list-style-type: none"> • Return to work after 10 days from symptom onset or positive test (whichever is earliest) <p style="text-align: center;">OR</p> <ul style="list-style-type: none"> • Return to work after single negative PCR or two negative RATs collected 24 hours apart any time prior to end of time-based clearance (10 days)² <p>And symptoms improving for 24 hours (48 hours if vomiting/diarrhea).</p>

² If the individual tests positive on a test before day 10, they should not continue testing on subsequent days and wait until day 10 prior to returning to work. Routine PCR testing of cases is NOT recommended due to the high likelihood of ongoing positivity, but may be considered if initial test was indeterminate or low level positive.

Risk Level	Close Contacts – Rapid Antigen Testing available	Close Contacts – Contingency when Rapid Antigen Testing is not available	Cases – With or Without Testing Available
Moderate Risk Staffing Options	<ul style="list-style-type: none"> • Return to work after negative initial molecular test after exposure <p>OR</p> <ul style="list-style-type: none"> • Return to work after two negative RATs collected 24 hours apart <p>Continue daily RAT until end of 10 day work self-isolation period based on last exposure OR until meet negative PCR or RAT criteria for lowest risk option.</p>	Return to work on day 7 from last exposure, with workplace measures for reducing risk of exposure until day 10.	Return to work on day 7 from symptom onset or positive test (whichever is earliest) without testing, AND if ONLY caring for COVID-19 positive patients/residents. And symptoms improving for 24 hours (48 hours if vomiting/diarrhea).
Higher Risk Staffing Options	Return to work after single negative RAT prior to first shift. Continue daily RAT until end of 10 day work self-isolation period based on last exposure OR until meet negative PCR or RAT criteria for lowest risk option.	Return to work on day 5 after last exposure and continue workplace measures for reducing risk of exposure until day 10.	Return to work earlier than day 7 (i.e., day 6 preferable to day 5, etc) without testing, AND if working ONLY with COVID-19 positive patients/residents. And symptoms improving for 24 hours (48 hours if vomiting/diarrhea)