# SESLHD PROCEDURE COVER SHEET

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| **-NAME OF DOCUMENT** | SESLHD COVID-19 Patient, staff and visitor management - contact tracing |
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| **EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR** | Director Clinical Governance and Medical Services |
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| **FUNCTIONAL GROUP(S)** | Infection Control |
| **KEY TERMS** | COVID-19, Contact tracing, Close contact, Casual contact, secondary close contact |
| **SUMMARY** | Process to ensure rapid identification and follow-up of patients, staff and visitors who have been deemed to be actual or potential close contacts of a person infected with the COVID-19 virus. Must be read in conjunction with latest control guidelines. |

## 1. POLICY STATEMENT

- In-hospital exposures to COVID-19 can occur when a staff member, visitor or patient spends time in a facility while infectious without being recognised as a risk, or in the event of a PPE breach. In such cases, a rapid investigation and response is required to identify and manage close and casual contacts, take measures to ensure no ongoing risk of transmission and identify and share any lessons learnt to reduce the risk of future events.
- Patients, staff or visitors who are identified as a close contact of a known case of COVID- 19, are at risk of becoming infected themselves, and may potentially transmit the disease to others.
- Patients who are close or casual contacts must be isolated in single rooms for 14 days from the last date of exposure. Staff who are close contacts must be excluded from work for 14 days from the last date of exposure. Operational impacts must be considered and addressed.
- Secondary close contacts are required to self-isolate until it is ascertained that the close contact was not infectious at the time of last contact with the secondary close contact.
- Casual contacts also pose a potential risk to healthcare facilities in the event they become positive.
- The facility also has a duty of care to notify visitors who may be close or casual contacts of their risk.
- Notification to staff, patients or visitors that they are close, casual contacts or secondary close contacts of a confirmed case of COVID-19 may induce anxiety about the risk of developing disease. All efforts must be made to keep patients and staff well informed during contact tracing process; and follow-up must occur at the end of the 14 day monitoring period; or until the person is recovered, for those who develop disease.
- Contact tracing must occur simultaneously with usual infection prevention and control assessment and mitigation strategies as early recognition is important to detect clusters and reduce potential outbreaks.

## 2. BACKGROUND

- SARS-CoV-2 (Severe Acute Respiratory Syndrome Coronavirus-2) is a novel coronavirus that was first identified as a human pathogen in 2019 in China. It has been declared a pandemic pathogen. SARS-CoV-2 is closely related to a bat coronavirus. SARS CoV-2 causes COVID-19 (Coronavirus Disease-2019).
- There is emerging evidence on treatments and availability of a COVID-19 vaccine.

### HOW IS THE VIRUS SPREAD?

- SARS CoV-2 is spread through contaminated droplets spread by coughing or sneezing, or by contact with contaminated hands, surfaces or objects
- Pathogens mainly transmitted by close contact can sometimes also be spread via airborne transmission under certain circumstances such as during aerosol generating procedures. Risk of airborne transmission may increase in poorly ventilated spaces or if increased exposure to respiratory particles, often generated with expiratory exertion (e.g. singing, shouting).

- The time between when a person is exposed to the virus and when symptoms first appear is typically 5 to 6 days, although may range from 2 to 14 days. For this reason, people who have been in close contact with a confirmed case are asked to self-isolate for 14 days.
- Most COVID-19 cases appear to be spread from people who have symptoms, however the potentially infectious period is 48 hours prior to symptom onset or from first positive test if the person does not have symptoms.

**WHAT ARE THE SYMPTOMS?**

- Patients may have fever, cough, runny nose, shortness of breath, diarrhoea, loss of smell or taste and other symptoms. Most people experience mild symptoms.
- In more severe cases, infection can cause pneumonia with severe acute respiratory distress.
- Please refer to latest COVID-19 case definition

## 3. RESPONSIBILITIES

### 3.1 Employees will:

- Ensure that inpatients and outpatients who are suspected or confirmed COVID-19 cases or close, casual or secondary close contacts of cases are managed in line with current infection control guidelines.
- COVID-19 positive employees should assist with contact tracing by providing information about their symptoms and any contacts. This may include other staff, patients, family or household contacts as guided by the contact tracing and public health unit staff.
- Employees must comply with instructions provided by contact tracing staff including work exclusions, and home isolation instructions.

### 3.2 Appropriately trained Infection Prevention and Control staff and Infectious Diseases practitioners will:

- Notify local executive as soon as possible that a contact tracing investigation has been initiated.
- Follow systematic approach for contact tracing affected staff and patients in conjunction with SESLHD PHU.
- Interview affected staff, patients, visitors and managers as necessary.
- Provide contact information to staff, patients and visitors
- Provide sit-reps or internal briefs as necessary.
- Ensure adequate stakeholder engagement for all contact tracing i.e. Staff health, General Manager, NUM/MUM (Midwifery Unit Manager)/ Line Manager, Incident Controller, DON, DDON, Infectious Diseases, SESLHD PHU. Email correspondence should include all persons necessary as part of contact tracing exercise and no-one else.
- Enter outbreaks or staff, visitor and patient exposure incidents into the Incident Management System according to the current incident management policy.

### 3.3 Hospital Executive/ Line Managers will:

- Ensure media risks are briefed as per SESLHD Policy.
- Follow up any issues identified during contact tracing which may prevent a patient, visitor or staff exposure in the future.
- Ensure process for notification and management of facility COVID exposures carried out in line with SESHLD protocol.
- Ensure open disclosure has occurred with patients, staff or visitors who are close, casual or secondary close contacts.
- Ensure incident management reporting and SafeWork NSW notifications are made in accordance with those policies.
- If a health care worker has acquired COVID-19 in any setting then the executive will ensure that a LHD/Health service investigation team will be established and investigation plan developed. The investigation plan will be determined by the initial investigation. The investigation team will include a representative from the relevant public health unit, an infectious diseases specialist, infection control team, clinical governance, and a member of the specialty team (e.g.: emergency department), with oversight by the Chief Executive. The investigation plan will consider the following:
    - All possible other sources of COVID-19 outside of the health care setting
    - Identification of contact with confirmed or suspected COVID-19 patients and staff
    - An investigation will be undertaken using a standardised HCW infection questionnaire
    - Results of assessments of close, casual or secondary close contacts of the HCW, including laboratory testing (COVID-19 PCR and serology as well as other relevant tests)
    - Identification of those specimens that require urgent COVID-19 genome sequencing – specimens from possible sources and the HCW should be transported urgently to ICPMR-NSW Health Pathology at Westmead Hospital for genomic analysis
    - An investigation report on the likely source of the infection will be submitted to Health Protection NSW by the Chief Executive within 7 days of notification.
- The responsible executive will complete the COVID-19 Impact Capture Webform according to the COVID-19 Workforce Impact Capture Process for staff who are cases, close contacts or casual contacts. Available at: https://vmsebus-lnx001.nswhealth.net/ops/leave/

### 3.4 Medical staff will:

- Ensure all suspect and confirmed cases are referred for appropriate medical follow-up. This will generally be via the local COVID-19 Telephone Assessment Clinic (CTAC) or Infectious Diseases or COVID-19 team.
- Ensure that public health notification has occurred according to the Public Health Act (2010).

## 4. RESULT NOTIFICATION OF POSITIVE COVID-19

- Notification received- SESLHD Public health unit (PHU), AHNM or via internal processes (Pathology, surveillance, Infectious Diseases).
- On receipt of positive result the local Infection Prevention and Control (in hours) and Infectious Diseases Physician on call should be notified ASAP. If the COVID-19 result is for a patient the nurse in charge of care of the patient will be informed to ensure isolation and correct infection control precautions in place; including other Infection prevention and control mitigation strategies to safely manage patient in the hospital or home as per CEC COVID-19 – Infection Prevention and Control Manual. A medical officer should give the result to the patient and conduct a clinical review.
- In the event a staff member is confirmed to have COVID-19 an immediate assessment must be made to ensure staff member is not on duty**.**
- A risk assessment informed by an ID physician should be undertaken for immediate risks to staff, patient or visitor safety i.e. staff may be asked to take special leave pending completion of contact tracing and move potential close contacts to single rooms.
- The facility Director or GM/facility executive on-call should be notified ASAP about any potential staff/patient/visitor/contractor/other health care worker exposure.
- The facility Director or GM/facility executive on-call will nominate an appropriately skilled lead or team to conduct an assessment of the potential exposure.
- Director PaCH AND facility exec on-call to notify by TEXT ASAP:

  i) in hours: EDOPs, CE, Director P&C ii) out of hours: District Exec on-call (district exec on-call to notify CE and Director P&C by email)

## 5. CONTACT TRACING PRINCIPLES AND CLOSE, CASUAL AND SECONDARY CONTACTS (Also refer to Appendix E for staff contacts of COVID-19)

**Contact identification:** Once someone is confirmed as infected with COVID-19, contacts are identified by reviewing necessary patient files, waiting room lists, iPM, EMR, First Net or by interviewing affected staff, patients, visitors and managers of department or clinical area to determine movements and contact time with others from onset of infectious period. Contacts should be categorised as close or casual contacts:

**A close contact is defined as a person who has:**

- had face-to-face contact of any duration or shared a closed space (for at least 1 hour) with a confirmed case
- during their infectious period (from 48 hours before onset of symptoms until the case is no longer infectious.
- An exposure of any duration depending on risk setting such as: transmission has already been proven to have readily occurred, there are concerns about adequate air exchange in an indoor environment or concerns about the nature of contact in the place of exposure

(e.g. the contact has been exposed to shouting or singing, or a PPE breach as per Appendix D)
- been exposed to a setting or exposure site where there is a high prevalence of infection
- been in a venue where transmission has been demonstrated to have occurred during the time frame in which the transmission would be expected to have occurred.

**A casual contact is defined as:**
- been in the same setting with a confirmed case in their infectious period, but does not meet the definition of a primary close contact

At the discretion of the PHU, some casual contacts may be classified as primary close contacts. This may be relevant in super spreading events, where there is evidence of transmission occurring to people who do not meet the primary close contact definition (e.g. in restaurants, pubs, places of worship). The following factors should be considered prior to classifying casual contacts as primary close contacts:
- Epidemiological context, risk tolerance and level of community transmission
- Potential for the venue or setting to result in large scale amplification

**A secondary close contact (or close contact of a close contact) is defined as:**

A person who has:
- had face-to-face contact in any setting with a primary close contact from 24 hours after the primary contact's exposure to the case
- the exposure to the primary close contact may be any duration depending on risk setting such as: transmission has already been proven to have readily occurred, there are concerns about adequate air exchange in an indoor environment or concerns about the nature of contact in the place of exposure (e.g. the contact has been exposed to shouting or singing)

**Notes for local implementation**

- Healthcare workers and other contacts who have taken recommended infection control precautions, including the use of appropriate PPE, while caring for an infectious confirmed COVID-19 case are not generally considered to be primary close contacts, provided that appropriate PPE has been worn and there has not been any breaches.

**Definitions are informed by Communicable Disease Network of Australia guidelines and NSW Ministry of Health guidance including that available here:**
https://www.health.nsw.gov.au/Infectious/diseases/Pages/2019-ncov-case-definition.aspx

**Compile Contact list:** All persons considered to have contact with the infected person should be listed as contacts. Efforts should be made to identify every listed contact and to inform patients and staff affected of their contact status, what it means, the actions that will follow, and the importance of receiving early care and testing if they develop symptoms. Contacts should also be provided with information about prevention of the disease. Isolation is required for close contacts, either at home, or in hospital until 14 days after the latest exposure occurred.

**Contact follow-up:** Regular follow-up should be conducted with all contacts to monitor for symptoms and test for signs of infection.

**Incident summary and follow-up actions post exposure:** To be completed as per local facility

## 6. MANAGEMENT OF POSITIVE STAFF AND PATIENTS

### 6.1 STAFF MEMBER FOUND TO HAVE CONFIRMED COVID-19

- If informed by PHU read brief obtained from SESLHD PHU, including onset of symptoms and duration of infectious period. Public health are to complete a detailed interview with the case within 6 hours. If the facility is the first to be aware of the case then they should inform public health and can commence with an initial interview of the case.
- See section 3.3. above for urgent additional management actions.
- Local Infection Prevention and Control team (IPAC)/ Infectious Diseases team to
  - Contact staff member and complete phone interview to confirm details in brief provided from the public health unit
  - Confirm what date symptoms commenced, including infectious period 48hrs prior. Ask if staff member is aware of likely source of COVID-19 **(in case additional contact tracing required).**
  - Ascertain dates staff at work and if at work during infectious period.
  - Ascertain if staff can remember activities undertaken during shift and what staff, patients or visitors they encountered during shift. For all identified contacts ask staff member to estimate to best of their ability the time in contact with each patient, staff or visitor during this time.
  - **Consider:** Lunch breaks, visits to external departments and travel to work (for those that carpool). Deployed staff, education sessions, meetings or visit to external departments for any reason such as to facilitate patient transfers. Document information which may be of interest to PHU e.g. staff member disclosing that they have picked up children from childcare or visit to supermarkets on their way home.
  - Inform staff member that you or someone else may call them back if you have any further questions or to clarify any information they provided. Provide reassurance as required.
  - **Consider** if data available from the QR code visitor entry data repository will assist with contact tracing information gathering activities. Contact SESLHD District Nursing & Midwifery Directorate or the Public Health Unit if this data is required.

- Contact NUM, MUM (during hours), AHNM or Exec on Call (after hours) if required
  - Obtain list of all staff that visited the wards on date(s) staff member present during infectious period, including: Nursing, Midwifery, Medical, Clerical, allied

## 6.1 STAFF MEMBER FOUND TO HAVE CONFIRMED COVID-19

health, students, auxiliary staff and visitors. Minimum information to be provided: Full name and contact number, ward or department.

- Obtain list of patients cared for by staff member through electronic medical records or clinic lists from IPM. Investigate contact type and duration for patients admitted, including any outpatient encounters during infectious period.
- Gather CCTV footage if available (e.g. waiting room spaces)

- Interview staff, patients and visitors identified to be potential contacts of staff source
  - Maintain confidentiality of affected staff member and request others who are interviewed also maintain confidentiality.
  - Where identity of staff member needs to be disclosed to other staff member consent should be gained from source.
  - Ensure open disclosure with affected patients as per SESLDHGL/058 Open Disclosure In event an interview needs to be undertaken with patient prior to determination of level of contact; Please use phone interview script and reassure patient you will call them back and give estimated timeframe. Where possible conduct interview and determine level of contact within interview. See Section 7 Patient Telephone Script. Document conversation details in EMR.
  - Conduct interviews with staff to ascertain their recollection of events during shift and likely contact with staff during shift including source.
  - Inform staff member and patients that you or another person may call them back if you have any further questions and to clarify the information they have provided. Provide reassurance as required.
  - Reassure patient or staff that a follow-up phone call will be made to provide more information once final assessment made with PHU staff and Infectious Diseases.
- Gather interview findings to determine if close or casual contact
  - If any details unclear repeat phone interviews to seek clarification
  - Document findings of interviews with site Executive / Infectious Diseases on call if required to determine if close or casual contact as per Section 5 Contact Tracing Principles – Close, Casual and Secondary Close Contacts.
- Contact Public Health Unit
  - Discuss interview findings, confirm decision making of close and casual contacts; and discuss priority of actions. (ASAP and within 24 hours of notification)
  - Finalise response plan with hospital executive. (ASAP and within 24 hours of notification)
  - Facility/service lead to convene with Public Health Operations and/or Control Lead to agree priority actions /plan, ascertain risks related to context of casual and incidental contacts and items for briefing to facility and district

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exec.

- Facility/service lead to convene a phone call with GM or facility exec on-call, EDOPS or district exec on-call, Director PaCH, public health lead, Health Safety and Wellbeing (HSW) manager and media to go through the management plan before enacting~

  (In hours – EDOPS to brief the CE, out of hours - district exec on-call to brief the CE)

- Provision of information to staff, patients and visitors deemed to be casual. close or secondary close contacts

  Patients/ staff /visitors deemed **close contacts** provide Close Contact Factsheet and information in person or over phone as Section 7 Patient Telephone Script.

  - Affected staff who are deemed to be close contacts will be excluded from work for 14 days from the time of last exposure. If staff exposed are already symptomatic ensure testing for COVID-19 has occurred in case secondary contact tracing is required.
  - Affected patients who are deemed to be close contacts will be isolated in a single room if admitted with airborne, droplet and contact precautions until 14 days has passed since the last contact. This isolation may continue at the patient's home if they are well enough for discharge prior to the end of the 14 day isolation period. If patient exposed already has symptoms, ensure rapid isolation and testing for COVID-19 has occurred in case secondary contact tracing is required. If a close contact is discharged from hospital notify PHU.
  - Affected staff or patients require a COVID-19 swab day as per PHU guidelines.

- Patients/ staff / visitors deemed **Secondary close contacts** may be provided Secondary Close Contact Factsheet and further instructions as required (home isolation, isolation in single room, testing, infection control precautions). This information can also be provided in person or over phone as per Section 7 Patient Telephone Script.
- Patients/ staff / visitors deemed **casual contacts** may be provided Casual Contact Factsheet if required as this may assist to additional provide reassurance about risk to patients and staff involved. This information can also be provided in person or over phone as per Section 7 Patient Telephone Script. All patients /staff /visitors deemed casual contacts must be still asked to self-monitor for symptoms for 14 days after last contact.
  - Inform staff, visitors and patients that casual contacts do not require isolation.
  - All contacts regardless if close or casual should be advised to self-monitor for any signs of respiratory illness which may be suggestive of COVID-19.
  - A COVID-19 swab is required as per PHU guidelines.
  - A risk assessment is required as per local procedures to determine suitability to return to work.

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- Patients (outpatients) or staff who develop symptoms must present straight to COVID clinic/ ED for testing if symptoms develop. Staff should inform Infectious Diseases or IPAC and their line manager if they have been a contact and develop symptoms.
- There is no routine testing undertaken if patient / staff are asymptomatic
- Inpatients who develop symptoms must be escalated to medical officer for urgent review and consult with Infectious Diseases. Airborne, Contact and droplet precautions must be in place for assessment.
- Staff and patients should be provided with link to NSW health COVID-19 website https://www.health.nsw.gov.au/Infectious/factsheets/Factsheets/covid- 19-find-the-facts-fact-sheet.pdf
- Patients: Facility contact tracing lead to ensure daily review for symptom check during their 14 day isolation period.
- Staff: Facility contact tracing lead to ensure daily review for symptom check and provide confirmation of return to work date.
- Visitors/ contactors/ health care workers not employed in the facility can be referred to the public health unit for follow-up – provide name, address, date of birth and contact phone number.

- Notification to Executive, Internal brief, Incident Management System report or sit rep and follow-up of contacts
  - Email/ Notify key stakeholders as per Section 8
  - Complete Sit Rep or Internal Brief as required by local executive. The report should include the likely place of acquisition of infection of the case(s), the type and number of close and casual contacts, number of staff on home isolation, any service effects and any external issues at a minimum.
  - Complete incident notification according to incident management policy
  - Ensure follow-up is undertaken following completion of home or hospital isolation periods are complete. Document findings as per local documentation requirements
- The responsible executive will complete the COVID-19 Impact Capture Webform according to the COVID-19 Workforce Impact Capture Process for staff who are cases, close contacts or casual contacts. Available at: https://vmsebus- lnx001.nswhealth.net/ops/leave/

## 6.2 PATIENT FOUND TO HAVE CONFIRMED COVID-19

- If informed by PHU read brief obtained from SESLHD PHU.
- Isolate the patient with full airborne, contact and droplet precautions.
- Local IPAC/ID team to confirm details provided by PHU or assess patient to determine onset of symptoms and confirm infectious period and likely timeframe contact tracing required.
    - Review medical documentation and interview patient if necessary to confirm onset of symptoms and likely infectious period. Ask patient if they are aware of likely source of COVID-19 and report findings to PHU and local response team **(in case additional contact tracing required).**
    - Establish how the patient was admitted through iPM- (ward, ED, clinic). Ensure outpatient visits included.
- In the event staff, patient and visitor contacts are likely, contact tracing staff are to notify local executive team that contact tracing investigation has been initiated and further investigation required.
- **Consider** if data available from the QR code visitor entry data repository will assist with contact tracing information gathering activities. Contact SESLHD District Nursing & Midwifery Directorate or the Public Health Unit if this data is required.
- Contact relevant department NUMS, MUMS, AHNM or Exec on Call (after hours) if required
- **Emergency Department**- Ascertain if staff wore appropriate PPE, confirm details on Patient Journey report FirstNet, See Section 9. This will identify how long the patient was sitting in the waiting room or ambulance bay or in other areas of ED. Ensure PHU aware of ambulance booking number if likely NSW Ambulance exposure.
    - Assess details of potential exposure in waiting room/ ambulance bay/ other zones. Obtain a list of all the patients in rooms of interest from the ED data manager and determine timeframes patients spent with case. Determine if patient sitting next to others or if patients in adjacent beds. Obtain information from case regarding symptoms whilst in each zone i.e. coughing. Refer to hospital security footage if available for waiting room.
- **Other departments (e.g. COVID clinic) -** Ascertain if patient isolated on admission to department and length of stay. Determine if in shared room with others and for what timeframe with or without mask.
- Obtain list of staff, patients and visitors who may have had contact with the patient during encounter. Managers to provide full names and phone numbers. This information should be cross checked against notes and tests undertaken in EMR. Please consider all staff who identified as part of patient care i.e. nursing, midwifery, medical, students, pathology, radiology staff etc. and ascertain with all

## 6.2 PATIENT FOUND TO HAVE CONFIRMED COVID-19

staff identified if appropriate precautions taken i.e. Airborne, droplet and contact precautions

Consider- If the patient left the ED or department. Were they transferred to other areas of the hospital e.g. Nuclear Medicine, operating theatre, etc. Once there, Consider if the patient was left in the waiting room and what staff were present there. Were family or carers present with or without masks. Did family members or carers display any symptoms of respiratory illness?

- Interview staff, patients and visitors identified to be potential contacts of patient source
  - Maintaining confidentiality of affected patient where possible, especially when speaking to other patients.
  - Ensure open disclosure with affected patients as per SESLDHGL/058 Open Disclosure
  - In event an interview needs to be undertaken where level of contact cannot be determined. Please use the phone interview script and reassure patient you will call them back and give estimated timeframe. Where possible conduct interview and determine level of contact within interview. See Section 7 Patient Telephone Script Document conversation details in EMR.
  - Conduct interviews with staff to ascertain their recollection of events during shift and likely contact with source during shift. Compare against EMR notes.
  - Inform staff member and patients that you may call them back if you have any further questions. Provide reassurance as required.
  - Reassure patient or staff that a follow-up phone call will be made to provide more information once final assessment made with PHU staff and Infectious Diseases.
- Gather interview findings to determine if close or casual contact
  - If any details unclear repeat phone interviews to seek clarification
  - Document findings of interviews with site executive / Infectious Diseases on call if required to determine if close or casual contact as per Section 5 Contact Tracing Principles – Close, Casual and Secondary Contacts.
- Contact Public Health Unit
  - Discuss interview findings, confirm decision making of close and casual contacts; and discuss priority of actions
- Finalise response plan with hospital executive
  - Facility lead to convene a teleconference with facility and district exec on call, Director PaCH, public health, media, HSW Advisor to review and approve course of action
- Provision of information to staff, patients and visitors deemed to be casual or close contacts
  - Patients/ staff/ visitors/ contactors/ health care workers not employed in the facility deemed **close contacts** may be provided Close Contact Factsheet

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and information in person or over phone as Section 7 Patient Telephone Script and ask to self-monitor for symptoms for 14 days.

- Affected staff who are deemed to be **close contacts** will be excluded from work for 14 days. If staff exposed already have symptoms ensure testing for COVID-19 occurs as soon as possible in case secondary contact tracing is required.
- Affected patients who are deemed to be Close contacts will be isolated in a single room if admitted with airborne, droplet and contact precautions until 14 days has passed since last contact. If patient exposed already has symptoms ensure testing for COVID-19 occurs as soon as possible in case further contact tracing is required. An ongoing risk assessment for secondary close contacts will be attended.
- Patients/ staff / visitors deemed **Secondary close contacts** may be provided Secondary Close Contact Factsheet and further instructions as required (home isolation, isolation in single room, testing, infection control precautions). This information can also be provided in person or over phone as per Section 7 Patient Telephone Script. All patients /staff
- Patients/ staff/ visitors/ contactors/ health care workers not employed in the facility deemed **casual contacts** may be provided Casual Contact Factsheet if required as this may assist to additional provide reassurance about risk to patients and staff involved. This information can also be provided in person or over phone as per Section 7 Patient Telephone Script. All patients/ staff deemed casual contacts must be still asked to self-monitor for symptoms for 14 days.
    - All contacts regardless of close or casual should be advised to self-monitor for any signs of respiratory illness which may be suggestive of COVID-19.
    - Patients (outpatients) or staff who develop symptoms must present straight to COVID clinic/ ED for testing if symptoms develop. If staff develop symptoms they must contact their line manager and Infectious Diseases or Infection Control should be notified
    - There is no routine testing undertaken if patient / staff is asymptomatic
    - Inpatients who develop symptoms must be escalated to medical officer for urgent review. Airborne, Contact and droplet precautions must be in place for assessment. Infectious Diseases or Infection Control should be notified.
    - Staff and patients should be provided with link to NSW Health COVID-19 website
    - Patients: Facility contact tracing lead to ensure daily review for symptom check during their 14 day isolation period.
    - Staff: Facility contact tracing lead to ensure daily review for symptom check and provide confirmation of return to work date.
    - Visitors/ contactors/ health care workers not employed in the facility can be referred to the public health unit for follow-up. Please provide full name, date

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of birth, address and contact phone number.

- Notification to Executive, Internal brief, incident report or sit rep and follow- up of contacts
  - Email/ Notify key stakeholders as per Section 8
  - Complete Sit Rep or Internal Brief as required by local executive. The report should include the likely place of acquisition of infection of the case(s), the type and number of close and casual contacts, number of staff on home isolation, any service effects and any external issues at a minimum.
- Complete incident report in incident management system according to incident management policy
- Ensure follow-up is undertaken following completion of home or hospital isolation periods are complete. Document findings as per local documentation requirements
  - The responsible executive will complete the COVID-19 Impact Capture Webform according to the COVID-19 Workforce Impact Capture Process for staff who are cases, close contacts or casual contacts. Available at: https://vmsebus- lnx001.nswhealth.net/ops/leave/

## 7. TELEPHONE SCRIPT FOR INTERVIEWS PATIENT AND STAFF POTENTIALLY EXPOSED

- Hello, this is (name) calling from (Hospital). May I speak to <title> <name> please?
- Can I please confirm your DOB (for patients)?
- I am calling about your recent stay in <insert department> on <date/dates>
- Enquire how staff member or patient is feeling at present.
- You may be familiar with media reports of a Novel Coronavirus called COVID-19 circulating in our community
- Unfortunately, it has come to our attention that there was a person (visitor/ patient/ / staff member) who has been found to be positive with COVID-19 during your stay. Whilst we cannot disclose what person was involved, <we have carried out an assessment of likely contact with you during time in hospital>/ < or need to gather more information about your stay to ascertain your risk of having exposure to the confirmed case > (Cross out what not applicable).
- Can I confirm that you were at <place> between the hours of <time_1> and <time_2> on <date>? Do you have any recollection of this <time in hospital/ shift in question> <Do you remember sitting next to others?> (Cross out what not applicable).
- Based on our conversation today it is likely that the estimated contact time that you may have been in the same room as this person was estimated to be that of a Casual Contact or Close Contact or Secondary Close Contact See Section 6 for more advice.
  - If in doubt, ask patient /staff if they are happy for you to contact them if any further questions or clarification of events if necessary. Provide timeframe for

return call.

- Inform patient and staff that follow-up phone call will likely occur after interviews discussed with Infectious Diseases team and PHU staff to confirm management strategies.

- Again I apologise for providing this news and please feel reassured we are investigating this matter further to ensure processes are in place to avoid another incident happening like this again. If you have further questions please contact (provide site contact details)

### 7.2 ADDITIONAL TELEPHONE SCRIPT INFORMATION FOR INTERVIEWS PATIENT AND STAFF

Verification of management strategies (i.e. Close Contact) may not be able to occur until completion of interviews and teleconference has occurred with site Infectious Diseases and SESLHD PHU staff has occurred, with endorsement by hospital and district executive. When calling patients and staff to provide final summary.

- Staff Close Contacts or Secondary Close Contacts: If Close Contact inform affected staff who are deemed to be close contacts that they will be excluded from work for 14 days from last contact with source. Staff are to urgently present for testing if symptoms develop. Provide reassurance and provide links to Employee Assistance Program (EAP) Phone 1300 687 327. For Secondary Close contacts, plan for isolation and testing will be based on risk assessments of Primary Close Contact.
- Patient Close Contacts or Secondary Close Contacts: Notify ward if patient admitted and document findings in EMR. Ensure treating team aware and open disclosure to occur with patients. Affected patients who are deemed to be close contacts will be isolated in a single with airborne, contact and droplet precautions, or will be asked to stay in home isolation. Provide home isolation instructions for close contacts not admitted. Staff must wear gown, eyewear, mask and gloves when entering room until 14 days has passed; and monitor closely for symptoms. If patients develop symptoms they are to urgently present for testing and assessment in ED or local fever clinic. Provide details of local clinic. For Secondary Close contacts, plan for isolation and testing will be based on risk assessments of Primary Close Contact
- Visitor Close Contacts: Inform visitor close contacts that they are required to stay in home quarantine for 14 days after last contact with the case. They should seek testing if symptoms develop either at the hospital COVID clinic or through their GP. Provide home isolation instructions and advise they can call the public health unit on 9382 8333 if they have any other concerns.
- Patient / Staff /Visitor Casual Contact: inform patient/staff that they are low risk for getting COVID-19 but must self-monitor for symptoms for the 14 days and to seek immediate medical attention should you become unwell. At this stage you do not need to quarantine away from others unless you become unwell, but we ask that you practice social distancing and hand hygiene. Advise no routine testing if asymptomatic.
- Send factsheet information in person, via email or post.
- Patients and staff can be provided with image to receive more information on home isolation with COVID-19, see the NSW Health website

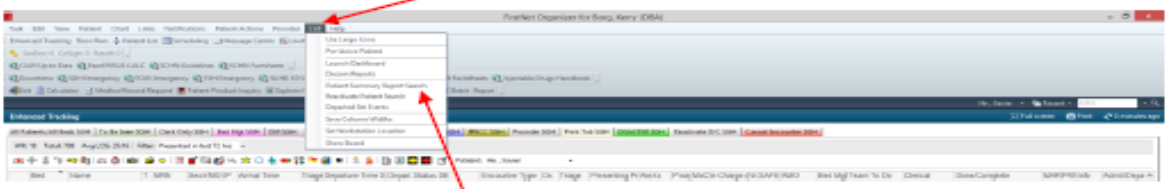
## 8. DOCUMENTATION

- Enter information collected into spreadsheet for distribution to SESLHD PHU and executive team
- All email correspondence received to be saved into local hospital drive as per usual protocols.
- Prepare list of all staff identified as close contact with their return to work date. Distribute list to their respective NUM, MUM, line manager, staff health, Workforce, and executive
- Hospital executive/ incident controller must be notified of outcome of contact tracing as per usual sit-rep, internal brief and in-hours/out of hour's notification channels.
- Enter incident in Incident Management System as per NSW Ministry of Health Policy Directive PD2020_047 - Incident Management Policy.
- Ensure documentation of management strategies including brief details of contact tracing clearly written in patient notes including dates of monitoring, whether open disclosure has occurred with patient/ family; and whether patient deemed close, casual and secondary close contact.

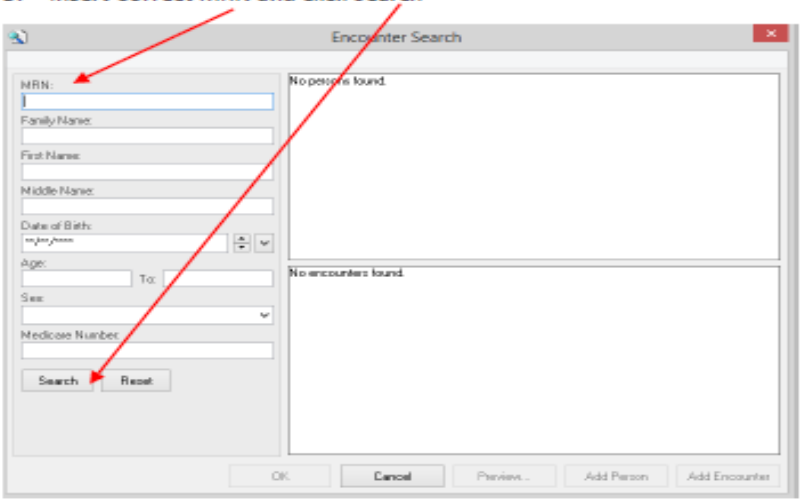
**9. PATIENT SUMMARY REPORT FIRSTNET -** report usually needs to be from ED computer

**Instructions for Printing Patient Summary Report**

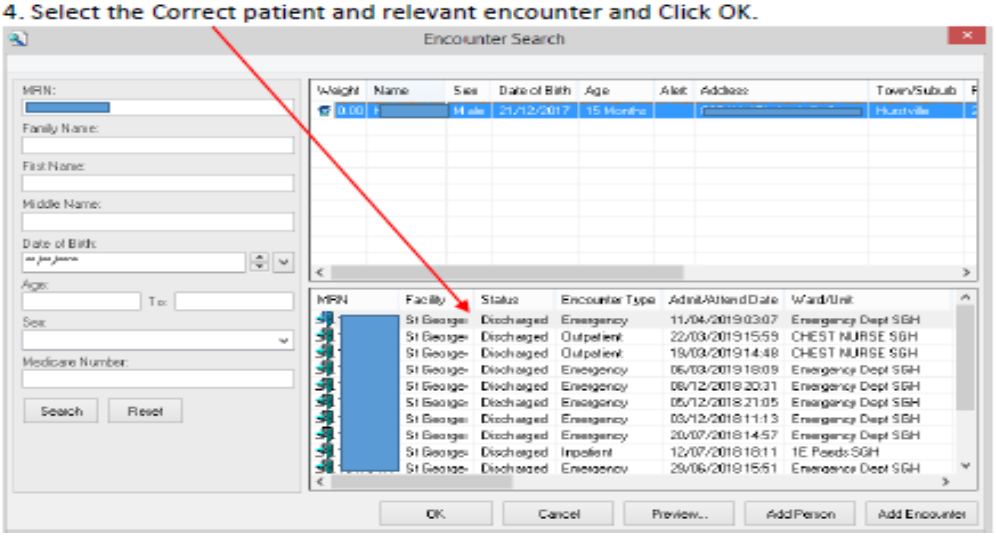
1. Select List at the top of eMR toolbar



2. Select Patient Summary Report Search
3. Insert Correct MRN and click Search




4. Select the Correct patient and relevant encounter and Click OK.



## 10. REFERENCES

Australian Government. 2020 Coronavirus (COVID-19) resources https://www.health.gov.au/resources/collections/novel-coronavirus-2019-ncov-resources Population and Community Health. 2020. In hospital COVID exposure-contact flow chart. Version 6: 9 July 2021. Process for notification and management of facility COVID exposures. (Appendix A)

NSW Health Fact Sheet for secondary close contacts

COVID-19 factsheet for close contacts

COVID-19 factsheet for casual contacts

CDNA National Guidelines for Public Health Units Version 4.7

CEC COVID-19 Infection Prevention and Control Manual

World Health Organisation. 2020 Contact tracing https://www.who.int/features/qa/contact- tracing/en/

Protocol for investigation of possible health care worker acquisition of COVID-19 in a health care setting NSW Health. 4 May 2020. H20/43888 (Appendix B)

## 11. REVISION AND APPROVAL HISTORY

| Date | Revision No. | Author and Approval |
|---|---|---|
| 4 June 2020 | 1 | SESLHD Infection Control Policy Working Party, A/Prof Jeffrey Post (Head of Infectious Diseases, Prince of Wales Hospital), Dr Marianne Gale, Director Primary and Community Health. Approved by Executive Sponsor to be tabled at June 2020 Clinical and Quality Council. |
| June 2020 | 1 | Approved by Clinical and Quality Council.<br>Published by Executive Services. |
| October 2020 | 2 | Minor review approved by Executive Sponsor.<br>The addition of the following line to section 6.1 and 6.2: *Consider if data available from the QR code visitor entry data repository will assist with contact tracing information gathering activities. Contact SESLHD Director Nursing and Midwifery Directorate or the Public Health Unit if this data is required.*<br>Correction of title to section 5.<br>Published by Executive Services. |
| July 2021 | 3 | Revised due to updated CDNA COVID-19 SoNG Guidelines v 4.7, updated CEC COVID-19 Infection Prevention and Control Guidelines (v1.4) and updated SESLHD Facility COVID exposure document 9 July 2021. Inclusion of secondary close contacts, airborne precautions, changes in close and casual contact definitions. |
| August 2021 | 4 | Minor Review. Updated appendix D and E to reflect updated advice, at request of Chair, SESLHD IPCC. Approved by Executive Sponsor. |

## 11. APPENDIX A

## 12. APPENDIX B

NSW GOVERNMENT Health

**Protocol for investigation of possible health care worker acquisition of COVID-19 in a health care setting**

Following notification that a health care worker (HCW)[1] has acquired COVID-19[2] in any setting:

1) The LHD/Health service Chief Executive (or Chief Executive of a private health care facility or principal responsible for the practice) and their nominated executive team member will initiate an immediate public health response in accordance with the national Communicable Diseases Network Australia (CDNA) guidelines.

2) The Chief Executive notifies the Deputy Secretary, People, Culture and Governance as the Health Secretary's delegate.

3) IIMS or ims+ incident reports and SafeWork NSW notifications will be made in accordance with the usual processes.

4) An LHD/Health service investigation team will be established and investigation plan developed. The investigation plan will be determined by the initial investigation. The investigation team will include a representative from the relevant public health unit, an infectious diseases specialist, infection control team, clinical governance, and a member of the specialty team (eg: emergency department), with oversight by the Chief Executive. Assistance from Health Protection NSW or the Clinical Excellence Commission can be sought if required to support the investigation team. The team may be expanded as required to undertake contact tracing including using clinicians familiar with the patient cohort.

5) The investigation plan will consider the following:
    a. All possible other sources of COVID-19 outside of the health care setting
    b. Identification of contact with confirmed or suspected COVID-19 patients and staff - an investigation will be undertaken using a standardised HCW infection questionnaire
    c. Results of assessments of close contacts of the HCW, including laboratory testing (COVID-19 PCR and serology as well as other relevant tests)
    d. Identification of those specimens that require urgent COVID-19 genome sequencing – specimens from possible sources and the HCW should be transported urgently to ICPMR-NSW Health Pathology at Westmead Hospital for genomic analysis

6) An investigation report on the likely source of infection will be submitted to Health Protection NSW by the responsible Chief Executive and reviewed by an expert panel.
    a. The investigation team may make use of the expert panel to discuss complex issues.
    b. Expert panel findings will be shared with the LHD/Health service – any lessons should be incorporated into internal infection control or other relevant guidelines and staff training modules.

H20/43888, 4 May 2020

7) The expert panel will comprise:
   a. Ms Carrie Marr, Chief Executive, Clinical Excellence Commission (Chair)
   b. Ms Kathy Dempsey, Program Manager, Healthcare Associated Infections, Clinical Excellence Commission
   c. Professor Lyn Gilbert, Chair – Infection Control Advisory Group & Senior Researcher, Marie Bashir Institute for Emerging Infections and Biosecurity
   d. Professor Bill Rawlinson, Senior Medical Virologist, Director of Serology, Virology and OTDS Laboratories (SAViD), NSW Health Pathology
   e. Nominated representative, Royal Australasian College of General Practitioners (NSW)
   f. Professor Vitali Sintchenko, Director, Centre for Infectious Diseases and Microbiology - Public Health, NSW Health Pathology
   g. Ms Jacqui Cross, Chief Nursing and Midwifery Officer, NSW Health
   h. Dr Marianne Gale, Director, Population and Community Health, SESLHD
   i. Ms Annie Owens, Executive Director, Workplace Relations, NSW Health
   j. Ms Priscilla Stanley, Manager, Public Health Unit, WNSW/FW LHD

The investigation leads at the LHD/Health service will attend to present their findings.

Notes:

1) For this protocol, 'health care worker' refers to all paid and unpaid persons serving in health care settings who routinely enter or work in clinical areas or work with used medical supplies, devices, equipment and clinical waste. It excludes workers in the aged-care and disability services sector.

2) COVID-19 as confirmed by SARS-CoV-2 PCR test.

H20/43888, 4 May 2020

## 13. APPENDIX C –Healthcare Facility Spreadsheet

| Role (Staff /Patient) | MRN | NCIMS No. | First Name | Surname | Contact (Close/Casual/ Secondary Close contacts) | Onset of symptoms | Quarantine End Date | Date Interviewed | Contact Number | DOB | Email Address | Home Address | Symptomatic at time of call | Symptomatic whilst at work | Notes | IIMS Entered | F/U Call | Lost to Follow Up (Y) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
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## 14. APPENDIX D Risk Assessment Matrix - PPE and type of exposure

NSW GOVERNMENT Health

**Health Care Worker COVID-19 Exposure Risk Assessment Matrix** 12 August 2021

NB: All exposure category decisions are based on a local risk assessment

Case = confirmed positive case in a patient, staff member or other

Given current evidence, the risk assessment remains unchanged regardless of vaccination status

| PPE worn during contact between health care worker and case | CONTACT TYPE – See page 2 for more detailed assessment for a breach | | | |
|---|---|---|---|---|
| | No contact | Transient Contact – Low Risk<br>Transient, not face-to-face, limited contact that does not meet the definition of face-to-face contact<br>OR<br>In general, less than 30 minutes in a closed space*<br>*Note: always subject to local documented risk assessment, including assessments of occupational exposures and of the closed space | Medium Risk Scenarios<br>Any face-to-face contact within 1.5 metres and less than 15 minutes<br>OR<br>In general, greater than 30 mins in a closed space<br>OR<br>Based on agreed documented risk assessment including assessments of occupational exposures and of the physical environment | Highest Risk Scenarios<br>Prolonged face-to-face contact within 1.5 metres and greater than 15 minutes<br>OR<br>Aerosol generating behaviours (AGBs e.g. coughing)<br>OR<br>Aerosol generating procedures (AGPs)<br>OR<br>Contact with multiple COVID-19 cases/suspected cases/probable cases |
| 1. No effective PPE worn by staff member or case<br>e.g. no PPE or PPE with major breaches such as mask below nose | Low Risk | Moderate Risk (Depending on risk assessment) OR High Risk (Depending on risk assessment) | High Risk | High Risk |
| 2. Surgical mask only worn by staff member i.e. no eye protection<br>➢ Case no PPE | Low Risk | Low to Moderate Risk (Depending on risk assessment) OR Moderate Risk (Depending on risk assessment) | Moderate Risk | High Risk |
| 3. Surgical mask only worn by staff member i.e. no eye protection<br>➢ Case wearing surgical mask | Low Risk | Low to Moderate Risk | Low to Moderate Risk (Depending on risk assessment) OR Moderate Risk (Depending on risk assessment) | High Risk |
| 4. Staff member in surgical mask and eye protection* with no concerns or breaches<br>➢ Case no PPE<br>*Use of gown/apron and gloves should be risk assessed based on individual incident, exposure to body substance and chances of environmental contamination | Low Risk | Low Risk | Low to Moderate Risk | High Risk |
| 5. Staff member in surgical mask and eye protection* with no concerns or breaches<br>➢ Case wearing surgical mask<br>* See note in Category 4 box | Low Risk | Low Risk | Low to Moderate Risk | Moderate Risk (No AGBs, no AGPs) OR High Risk (Exposure to AGBs, AGPs) |
| 6. Staff member in P2/N95 and eye protection; no breaches<br>➢ Case either with or without PPE<br>* See note in Category 4 box | Low Risk | | | |

| | |
|---|---|
| LOW RISK | Continue to work<br>HCW alert to mild symptoms<br>Test if symptomatic |
| LOW TO MODERATE RISK | Initial test usually not earlier than day 2 post exposure, but can work while result is pending<br>Retest day 5<br>Monitor for symptoms, test if symptomatic<br>Wear a mask at all times on site including staff only spaces |
| MODERATE RISK | Leave workplace immediately and isolate<br>Test as soon as possible, but not before day 2; isolate until day 5 and retest.<br>If both negative, can return to work with repeat testing every 72 hours<br>Clearance/exit test on day 13<br>Monitor for symptoms, test if symptomatic<br>Wear a mask at all times on site, including staff only spaces |
| HIGH RISK | Leave workplace immediately and isolate for 14 days from last exposure<br>Initial test usually not earlier than day 2 post exposure<br>Monitor for symptoms, test if symptomatic<br>Retest day 7 post last exposure<br>Retest day 13 (clearance test)<br>Proof of negative day 13 test is needed to return to work |

* PPE Breach Risk Assessment key principles.

- Perform a risk assessment to determine the level of exposure as applied to COVID-19 suspected/confirmed.

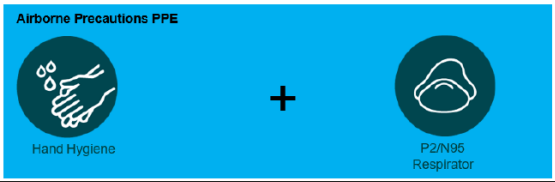
| | | |
|---|---|---|
| LOW RISK BREACH | Breaches in PPE that occur below the neck and managed immediately. E.g. torn glove | Remove from situation<br>Remove Item<br>Perform Hand hygiene |
| MODERATE RISK BREACH<br>INCREASED RISK OF INFECTION | Incorrect use of PPE, incorrect PPE for task<br>Contamination occurs during doffing (occurs above neck) | Remove from situation<br>Remove PPE<br>Perform Hand Hygiene<br>Screening/testing and continuous monitoring |
| HIGH RISK BREACH<br>LIKELY RISK OF INFECTION | Exposure of mucous membranes by direct droplets from confirmed COVID positive. (e.g. spitting in HW face by confirmed COVID<br>Gross contamination during incorrect doffing<br>Contamination occurs during doffing | Remove from situation<br>Remove contamination<br>Remove PPE<br>Closely Monitor, screen/test, consider removing from clinical duties |

Adapted and modified from work developed by AUSMAT Quarantine management and operations compendium for the Howard Springs Quarantine Facility for the Repatriation of Australians at the Centre for National Resilience. National Critical Care and Trauma Response Centre. Darwin 2021.

- **Contact Precautions** protect the HW by minimising the COVID-19 transmission risk from direct physical contact with patients or indirect contact from shared patient care equipment or from contaminated environmental surfaces


- **Droplet Precautions** protect the HWs nose, mouth and eyes from droplets produced by the patient coughing and sneezing


- **Airborne Precautions** protect the HWs respiratory tract from very small and unseen airborne particles that become suspended in the air.




https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0018/644004/COVID-19-IPAC-manual.pdf

## 15. APPENDIX E Staff Contacts of COVID-19

### Management of Staff Contacts of COVID-19

5 August 2021

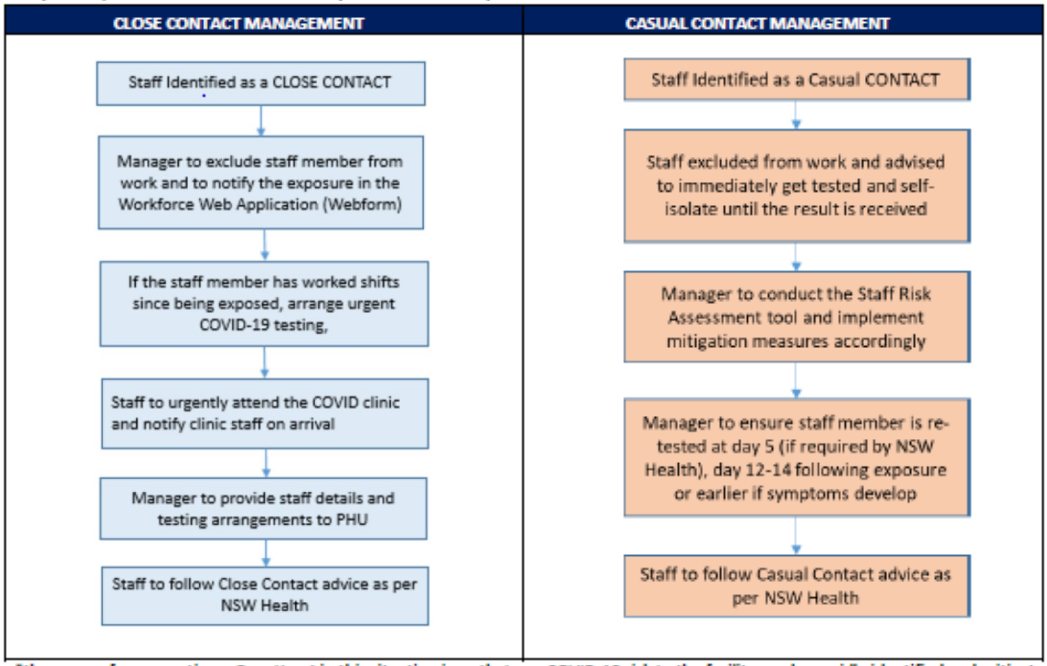
This document is to guide managers in situations where staff are identified as contacts of COVID-19.

Staff identified as a Close Contact must immediately get tested, self-isolate for 14 days and repeat testing on day 7 and day 12.

Staff identified as a Casual Contact must immediately get tested and self-isolate until they receive a negative result. If negative on this initial test, they may return to work, if considered 'essential', following a risk assessment by their manager. All staff Casual Contacts must also have a further COVID test on day 12-14. Depending on the timing of their exposure to COVID-19, some Casual Contacts will also be asked by NSW Health to have a COVID swab on Day 5 (when exposure recognised on day 0-3 and initial test performed before day 5).

Staff identified as a Secondary Close Contact, that is, they live or have closely associated with a Close Contact, must get tested and self-isolate until they receive a negative result *if the close contact's COVID test result will not be available within 4 hours*. If the close contacts COVID result is expected within this timeframe, it is reasonable to await the result before any action is taken given the likely operational impacts. If the close contact's initial swab is negative and they are asymptomatic, then secondary close contacts do not need to take action provided they can effectively isolate from the close contact going forward.

Staff excluded from the workplace may be given alternate duties or an alternate work location during a required period of self-isolation. Special leave may be available if this is not feasible.




*the reason for requesting a GeneXpert in this situation is so that any COVID-19 risk to the facility can be rapidly identified and mitigated

**CONTACTS: Public Health Unit: 9382 8333**

**POWH Clinic: 0418 295 745 SGH Clinic: 0429 446 508 TSH Clinic: 9540 8998 SSEH Clinic: 9382 7842**

**Considerations:**

- In the case that an urgent rapid (GeneXpert) test is required, staff are encouraged to go to POWH or SGH COVID clinic to enable immediate processing (lab on site). If an alternate SESLHD facility clinic is attended, the facility Incident Controller is to liaise with NSW Health Pathology to arrange for urgent processing of the swab/s
- The manager should gather preliminary details about the shifts worked by staff that have been identified as a Close Contact in case the result is positive and further actions become necessary
- Staff identified as a Casual Contact who are in a critical patient role, may have a GeneXpert testing after consultation with an ID physician

SESLHD Population and Community Health Directorate — Produced by South Eastern Sydney Local Health District

## Staff Risk Assessment for COVID Contacts

Current as at 5 August 2021

Any staff member with symptoms must be tested and self-isolate until they receive a negative result. Staff who have travelled to any of the defined places of high concern/contact sites or are otherwise identified as a Close, Casual or Secondary Close Contact are required to follow the associated NSW Health advice.

| | | | |
|---|---|---|---|
| **Staff Name:** | | | |
| **Staff Employee No:** | | **Staff Contact Number:** | |
| **Staff Role:** | | | |
| **Department & Location:** | | | |

### All COVID contacts

| | |
|---|---|
| Contact venue or other COVID-19 exposure: | Date:<br>Location or nature of contact: |
| Latest COVID-19 swab: | Date:<br>Result: |
| Shifts worked since COVID-19 exposure: | Yes/No<br>If yes, dates and locations: |
| COVID-19 Vaccination status: | Yes/No<br>If yes, how many doses: |

### If Close Contact

All Staff Close Contacts must self-isolate for 14 days from exposure and follow testing guidance as per NSW Health.
Ensure staff have received advice on home isolation.

### If Secondary Close Contact *i.e. they live or have closely associated with a Close Contact*

Contact PHU or Infectious Diseases to review COVID-19 testing and assess if the staff member can isolate effectively.
Consider moving to district funded accommodation if unable to isolate from a close contact at home.

Advice from PHU/ID:

### If Casual Contact

| | |
|---|---|
| Is the staff member 'essential' as described below;<br>• Working in a business critical role requiring in person attendance in the workplace?<br>• Are there clinical considerations that require the staff member to be physically at work e.g. risks to patient care or critical clinical service continuity if absent | If Yes – allow to continue to attend work with mitigation measures, after confirming a negative swab result and that the staff member has no symptoms<br><br>If No – permit work from home or alternate duties |

### Summary

| | |
|---|---|
| Staff member can continue to attend the workplace | Yes/No<br><br>If Yes: implement mitigation measures<br><br>If No: alternative arrangement:<br>date of return to the workplace: |

Mitigation measures

- Wear a mask at work
- Monitor exposure site status daily for any change in risk
- Ensure compliance with NSW Health advice regarding testing and isolation
- Notify manager immediately if develops symptoms or is diagnosed with COVID-19

### Approval:

| | | |
|---|---|---|
| Managers name: | Signature: | Date: |

NSW Health Public Health advice: https://www.health.nsw.gov.au/Infectious/diseases/Pages/coronavirus.aspx

## Request for Emergency Accommodation for Covid-19 Related Isolation (SESLHD Staff & General Public)

- There may be need to request accommodation for COVID-19 related isolation. This is most likely to occur when an individual is required to isolate in accordance with Public Health orders and is unable to do so in their current accommodation, or for staff who may need to isolate from housemates to enable them to continue working.

- A person may be considered unable to effectively isolate from others in their current accommodation when:

  i. they share a dwelling with multiple people
  ii. they do not have access to a private bedroom and bathroom in their dwelling
  iii. they do not have the ability to remain separated by 1.5m from other household occupants
  iv. they share a dwelling with a high risk occupant or close contact.

- All individuals (SESLHD staff and general public) requiring accommodation and support will require a referral during business hours (08.30-17.00 Mon-Fri) to the Social Harms of COVID-19 Social Worker (SHoCSW).

- Afterhours and on weekends bookings will be made by referral to the On-Call / Weekend Social Worker of the relevant facility.

- The Social worker will arrange accommodation for the staff member. Currently accommodation is provided at APX World Square at 2 Cunningham St Sydney.

- All cases and high risk close contacts who are unable to isolate effectively at home, as well people who are homeless, or have significant health care needs, mental health issues, or substance use should be referred to SHA.

To request for Emergency Accommodation for COVID-19 Related Isolation, please refer to the following link on the COVID-19 Intranet Page, under Fact Sheets: Request for Emergency Accommodation information for managers

The Social Harms of COVID-19 Social Worker (SHoCSW) can be contacted for assistance

**During business hours 7 days per week**: - SHoCSW M: 0436 420 449

**Monday to Friday only**: SESLHD-COVID-SocialWork@health.nsw.gov.au

**After Hours:** - Contact the switch board of your facility and ask for the afterhours social worker