

SPECIFIC QUESTIONS ON RISK ANALYSIS COVID-19

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1.1. CONTACTS IN CARS

In the current procedure for contacts of COVID-19 patients, it is stated that:

A person who has travelled with a COVID-19 patient for more than 15 minutes, in any means of transport, sitting within two seats (in any direction) of the patient is considered as a high risk contact.

Masks are hereby not taken into consideration, as opposed to:

A person who has had contact with a COVID-19 patient for more than 15 minutes at a distance of <1.5 m ("face to face"), but with both adequately wearing a mouth mask (nose and mouth covered), is considered as a low risk contact.

This is based on the ECDC recommendation and practice of contact tracing in airplanes and on the fact that especially cars are small and confined spaces (1). There is evidence that contaminations do occur in sharing transport such as taxi's (2–5). In England and Wales, mortality rates involving COVID-19 were higher among taxi drivers and chauffeurs than in other occupations (6).

In The Netherlands, colleagues travelling in a car (in case of contact >15 min) are considered as close contacts for which a quarantine of 10 days is imposed. Wearing a cloth mask does not allow the contact to be downgraded to low risk (7) (expert communication).

However, the statement raises a lot of questions and worries about situations where colleagues (e.g. police) share the same vehicle during working time, possibly leading to a large number of high risk contacts at work.

Proposal:

Sharing a car with friends, family or colleagues is a close contact situation all the time, given the very confined space of a car with difficult assessment of correct ventilation, the probable duration of more than 15 min, the high probability of passengers talking together, the uncertainties of filtration capabilities and correct use of masks.

If a plexi glass is used as a barrier and all passengers have been wearing masks, contacts on different side of the plexi glass can be considered as low risk contacts.

1.2. ASYMPTOMATIC COVID-19 POSITIVE STAFF ON SAME SHIFTS FOR ESSENTIAL FUNCTIONS

A question was raised if it would be allowed for asymptomatic staff to work together on certain shifts, for essential functions other than healthcare.

Proposal:

This cannot be allowed.

There is a risk for other staff working on other shifts to get contaminated (fomites, aerosol transmission).

Some of the elements taken into consideration in the RAG advice on deploying COVID-19 positive healthcare-workers can be repeated:

- Allowing (asymptomatic) infected staff to work is against all basic principles of epidemic/infection control, certainly in times when aerosol transmission seems to increasingly occur.
- The duration of isolation for COVID+ cases in Belgium is already shorter than in many other countries.
- It is important to give clear messages to the public. Exempting certain professions from the obligation to self-isolate in case of a positive test, might jeopardize compliance with self-isolation in the wider population and lead to increased demand of exceptions for other professions/situations too.

In addition, working when being an asymptomatic case is only allowed in health care facilities for essential health care workers under exceptional circumstances, and not for other categories of workers in health care facilities (secretary, cleaner,...) that are less trained or less compliant with barrier measures.

1.3. HEALTH CARE PERSONNEL IN PROLONGED CONTACT WITH CONFIRMED PATIENT

In the current procedure for contacts of COVID-19 patients, in the subtopic Healthcare workers it is stated that:

Health personnel are considered to have a high risk contact if during the care or medical examination of a COVID-19 patient there has been a contact within a distance of 1.5 m, without the use of the recommended personal protective equipment. With the exception of aerosolizing procedures or prolonged exposure to a confirmed patient without a mask, the surgical mask is considered adequate.

This specification was based on the advice about correct use of masks, where FFP2 masks are no longer only advised (if available) in aerosol generating procedures but also in situations of prolonged and close exposure to COVID-19 patients not wearing a surgical mask, e.g. in respiratory physical therapy. However, the above phrase poses problems in settings of for instance practices of physiotherapists or places where people live together with their caregivers, such as centers for people with disabilities or nursing homes. The statement leads to situations where a lot of caregivers are seen as high risk contacts because they were in contact with (presymptomatic) COVID-patients within a distance of 1.5 m, while the patient was not wearing a mask.

The proposal is to provide more tools for a (individual) risk analysis depending on the situation.

Proposal of elements to take into account in the risk assessment of a health worker with prolonged exposure to a COVID-19 patient who was not wearing a mask:

Patient-related

When (if at all) was the onset of symptoms? Patients are most contagious immediately pre- and post-onset of symptoms

What is the nature/severity of the symptoms?

Is the patient able to apply hand, cough and sneezing hygiene?

Was the patient wearing a mask?

Time-based

At least 15 minutes(1) (but to be evaluated in combination with other factors)

Situation-specific

Face to face contact (e.g. difference between foot care and a face to face action, face care, ...)

Respiratory physiotherapy or comparable acts
Has there been direct contact with the patient's body fluids?
Did the contact take place in a poorly ventilated room?
Is it a first infection in the setting or is there a cluster?

Staff related

Which mask is being used by the health worker?
Has hand hygiene always been performed?
Type of care delivered by the person: medical care versus help during eating, education, ...

THIS ADVICE WAS SENT BY MAIL FOR APPROVAL TO THE EXPERTS CONTRIBUTING TO THE TOPICS ON INFECTIOLOGY IN THE RAG. FOLLOWING EXPERTS ACTIVELY ADDED SOME INPUT:

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