PRACTICE MANAGEMENT & OPERATIONS

THE AUSTRALASIAN COLLEGE OF DERMATOLOGISTS

Practice Staff

*This guidance is current as of **30 June 2020** and is subject to change. College guidance can be followed to suit individual circumstances and accordingly, some variation in practice is acceptable. Fellows are advised to always refer to government recommendations.*

Visit https://www.dermcoll.edu.au/covid19updates/ for the latest version of this document.

Please note

The following information is general in nature and it is recommended you seek professional advice from your indemnity group or legal counsel. This information does not take into account any specific agreed terms of employment including individualised leave entitlements and other considerations.

Some of the information was sourced from and with the permission of Avant Mutual. To view further detail, please use this link.

Managing staff illness and a COVID-19 safe working environment

The Federal Government has developed practical guidance on working arrangements for the health and aged care workforce during COVID-19. This includes guidance to employers on when staff should or should not attend the workplace and when COVID-19 testing is recommended.

This information pertains to healthcare workers and practice staff regardless of whether they have patient contact.

There may be additional scenarios that are not currently covered by government guidance. Employers should use good judgement in relation to employee illness and consider developing appropriate workplace policies.

To summarise and supplement government guidance, College has prepared management principles for a number of scenarios to assist Fellows in managing a safe working environment for themselves, their staff and their patients. That guidance is at **Appendix A** and covers the following scenarios:

1. A patient attends your practice and is determined by screening procedures to be a potential COVID-19 case
2. A patient attends your practice and is later determined to have COVID-19 at that time.
3. Staff have been in ‘close contact’ with a confirmed case of COVID-19
4. Staff with fever or symptoms of a respiratory infection

It also includes additional notes in relation to asymptomatic staff members; definition of a close contact; close contact, but while using personal protective equipment; the limited nature of Department of Health advice on reuse of PPE and PPE use in daily consulting and case definition.

Staff entitlements

Staff Forced to Self-isolate

Self-isolation is not accounted for under existing laws and there are no specific leave entitlements in place.

Staff who contract COVID-19 are entitled to paid sick leave or other forms of leave if they do not have sufficient sick leave accrued.

Government Mandated Self-isolation

- The usual position is that an employer does not have to pay an employee if the employee is unable to work and is not on some form of paid leave.
- An employee (excl. casual staff) in self-isolation or quarantine, but who is not sick, is not entitled to paid sick leave, but given the unusual circumstances of COVID-19, employers may wish to allow such employees to take paid sick leave.
- An employee is entitled to take paid annual leave or long service leave by agreement with their employer.
- Casual staff are not entitled to paid leave.
- Refer to existing employment contracts for contracted staff.

Practice Mandated Self-isolation

Given the unique circumstances of COVID-19, a practice can require an employee to self-isolate if the practice is concerned that the employee may be a COVID-19 risk. However, the practice must pay the employee their usual wages for the relevant period without deduction from leave entitlements.

Having Enough Staff

Employers cannot cancel or postpone an employee's annual leave unless by agreement with the employee. Refer to Fairwork Act.

Reducing Hours

There are a number of options available if your practice needs to cease operating including:

1. Work from home – Any staff who can perform their duties from home should continue to do so and be paid as per usual.
2. Sick leave – Employees who are sick are entitled to take paid sick leave.
3. Annual leave – By agreement between employee and employer, an employee can take paid annual leave.

Employers can direct staff to take annual leave, however, arrangements must be in line with existing awards.

Refer to links:
Health Professionals and Support Services Award 2010
Nurses Award 2010
Fair Work Ombudsman's coronavirus information on employment

Protecting Against Data Breaches When Staff Work from Home

- Ensure all staff are aware of and are abiding by existing privacy policies
- Ensure staff taking practice hardware (i.e. laptops) home are provided written guidelines about transporting and housing it safely and securely
- Staff should adhere to existing patient confidentiality agreements and ensure no third parties at home can access sensitive information.

Suggested resources:
Chapter 3 in the RACGP's security guidelines
Security guidelines for IT health

Australian Government Support for Businesses

JobKeeper Payments and Cashflow Support for Small and Medium Businesses

The Australian Government is supporting Australian businesses to manage cash flow challenges and retain employees. Assistance includes cash flow support to businesses and temporary measures to provide relief for financially distressed businesses.

This includes:
- Jobkeeper Payments
- Cashflow Support
- Temporary Relief for Businesses in Financial Distress
- Increasing the instant asset write-off

For further information and guidance, please use this link.

Appendix: Principles for practice management of potential or confirmed exposure to COVID-19 cases

This guidance below supplements Federal Government guidance and other material on COVID-19 related practice management. It outlines management principles for potential scenarios.

It covers **four scenarios**:

(1) A patient attends your practice and is determined by screening procedures to be a potential COVID-19 case

(2) A patient attends your practice and is later determined to have COVID-19 at that time.

(3) Staff have been in 'close contact' with a confirmed case of COVID-19

(4) Staff with fever or symptoms of a respiratory infection

It also provides **additional notes** on

(i) Asymptomatic staff member

(ii) Definition of a close contact

(iii) Close contact, but while using personal protective equipment

(iv) Limited Department of Health advice on reuse of PPE and PPE use in daily consulting.

(v) Case definition

This guidance is based on the CDNA National Guidelines for Public Health Units which summarises the case definition for COVID-19 – based on what is currently known about its clinical and epidemiological profile – and provides recommendations for surveillance, infection control, laboratory testing and contact management for coronavirus disease. The latest CDNA National Guidelines are available here: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

Scenarios

(1) A patient attends your practice and is determined by screening procedures to be a potential COVID-19 case:

(a) By your staff before seeing you (e.g. fever 37.5°C or higher / recent overseas travel / recent contact with known COVID-19 case / relevant clinical features).

(b) Staff screening procedures identify no issues, but the dermatologist is concerned of a potential COVID-19 risk.

Recommendation:

(a) If feasible, the patient is advised to immediately leave the premises and self-isolate.

(b) The patient's general practitioner (GP) should be contacted so the patient can be seen either by the GP or a COVID-19 assessment centre.

(c) Contact your local health department immediately and follow up the outcome to determine further action.

(2) A patient attends your practice and is later determined to have COVID-19 at that time.

The infective risk is thought to extend from 48 hours before symptoms, to 14 days after onset of symptoms (in those who are symptomatic). Asymptomatic patients are either pre-symptomatic or truly asymptomatic COVID-19 cases. These cases are also infectious, but for truly asymptomatic COVID-19 cases, their infective period and comparative infectivity is undetermined.

Recommendation:

(a) If the practice is contacted by the Health Department, the Department will dictate what action is required and their advice must be followed.

(b) If the practice is first notified by someone else (for instance, by the patient or a family member):

- The practice must contact the Health Department (preferably their contact tracing team) for further advice.
- The doctor and relevant staff should self-quarantine until the correct procedure is established from the contact tracing team.

Typically, for a 'close contact' (see Notes below for definition) to a COVID 19 patient, the doctor / staff member should quarantine (mandatory 14-days) and **follow the steps in 3 below**.

(3) Staff have been in 'close contact' (see below for definition) with a confirmed case of COVID-19

Recommendation: Staff who have been in 'close contact' (see Notes below for definition) with a confirmed case of COVID-19:

(a) Should quarantine (mandatory 14-day period)

(b) Staff who do not develop COVID-19 symptoms while in quarantine can return to work without medical clearance. Testing for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is not necessary.

(c) Staff who develop symptoms while in quarantine must be tested for SARS-CoV-2.

i. If the result is **negative**, the staff member must remain in quarantine for the full 14 days.

ii. If the test is **positive**, staff must isolate until:

- they are well and afebrile for the previous 72 hours, and
- at least ten days have elapsed from the onset of the acute illness and
- they have clearance from the local Public Health Authority who use situation-dependent criteria.

(4) Staff with fever or symptoms of a respiratory infection

Recommendation: Staff with fever or symptoms of respiratory infection:

(a) should not attend work.

(b) should be tested for SARS-CoV-2.

(c) should isolate while waiting for the result of a SARS-CoV-2 test.

i. If result **negative**, remain at home until well enough to return to work.

ii. If result **positive**, staff must isolate as above

Notes

(i) Asymptomatic staff member:

There is no Departmental advice for an **asymptomatic staff member** who is in significant contact with a febrile person, or one with a likely respiratory infection, not at high risk of having COVID-19.

(a) Common sense would be to recommend the staff member strongly endeavour to have that person tested for COVID-19.

(b) Practice be advised to develop a written procedure for this scenario.

(ii) Definition of a close contact

A close contact is defined as someone who has had:

(a) Face-to-face contact in any setting with a confirmed or probable case, for 15 minutes or more. This is cumulative over the course of one week. It starts from 48 hours before the onset of symptoms in the confirmed or probable case;

(b) Sharing of a closed space with a confirmed or probable case for a prolonged period (e.g. more than 2 hours). This is in the period extending from 48 hours before onset of symptoms in the confirmed or probable case.

(iii) Close contact, but while using personal protective equipment

Current Federal and State Health Department COVID-19 advisory documents state *"Staff who have directly cared for confirmed cases of COVID-19 while using personal protective equipment (PPE) properly can still go to work."*

This is primarily meant for the situation where highly protective PPE is being worn in hospitals, testing clinics or for practitioners seeing patients suspected of having COVID-19. It is not intended to cover unsuspected contact of a dermatologist with a COVID-19 patient during general consulting or procedural work – even if a gown, gloves or mask was worn.

The level of 'proper' PPE would depend on the exact circumstances in terms of the length of time exposed, the nature and closeness of exposure (particularly in terms of possible respiratory or oropharyngeal droplet or aerosol exposure), the exact nature of the PPE and whether the latter was properly disposed of immediately after the exposure. Ideally this would include an N95 respirator or equivalent (different to a standard surgical mask), visor or goggles, disposable droplet impervious gown, headgear and gloves. In many circumstances of common face-to-face dermatology practice, this level of protection would not apply. Ultimately the determination of whether or not the dermatologist or practice staff has complied in a particular situation will be made by the Department's contact tracing team.

(iv) There is no or limited departmental advice on:

(a) **Re-use of PPE**.

Generally it is assumed it is disposable or cleanable.

i. Guidelines on extended use of PPE - see Vic DHHS COVID-19 Infection Control Guidelines – PPE section.

ii. Issues of residual viral RNA / damp masks less effective / deterioration of the product.

(b) **Proper PPE is defined in high-risk situations as above. Beyond this there is only generic advice for its use in daily consulting** regarding:

i. N95 or equivalent respirator vs level 1 or 2 face mask.

ii. The use of visors, goggles, gloves or head-gear.

iii. No advice regarding the utility of daily changing of clothing, scrubs or gowns.

(v) Case definition (CDNC):

The following case definition is taken from the aforementioned CDNA National Guidelines for Public Health Units and is based on what is currently known about the clinical and epidemiological profile of cases of COVID-19 presenting in Australia and internationally. Health authorities are constantly monitoring the spectrum of clinical symptoms and nature of illness. Using a 14 day exposure period will cover the duration of the incubation period in the vast majority of cases.

Confirmed case

A person who:

i. tests positive to a validated specific SARS-CoV-2 nucleic acid test;

OR

ii. has the virus isolated in cell culture, with PCR confirmation using a validated method;

OR

iii. undergoes a seroconversion to or has a significant rise in SARS-CoV-2 neutralising or IgG antibody level (e.g. four-fold or greater rise in titre).[1]

Probable case

A person who has detection of SARS-CoV-2 neutralising or IgG antibody[1] **AND** has had a compatible clinical illness **AND** meets one or more of the epidemiological criteria outlined in the suspect case definition (see below).

Suspect case

Clinical and public health judgement should be used to determine the need for testing in hospitalised patients and patients who do not meet the clinical or epidemiological criteria.

A person who meets the following clinical **AND** epidemiological criteria:

Clinical criteria:

Fever (≥37.5°C)[2] or history of fever (e.g. night sweats, chills) **OR** acute respiratory infection (e.g. cough, shortness of breath, sore throat)[4] **OR** loss of smell or loss of taste.

Epidemiological criteria:

i. In the 14 days prior to illness onset:

- Close contact[5,6] (refer to Contact definition below) with a confirmed or probable case
- International or interstate travel
- Passengers or crew who have travelled on a cruise ship
- Healthcare, aged or residential care workers and staff with direct patient contact
- People who have lived in or travelled through a geographically localised area with elevated risk of community transmission, as defined by public health authorities[7]

ii. Hospitalised patients, where no other clinical focus of infection or alternate explanation of the patient's illness is evident.

Footnotes:

[1] Antibody detection must be by a validated assay and included in an external quality assurance program.

[2] It is recommended that temperature is measured using a tympanic, oral or other thermometer proven to consistently and accurately represent peripheral body temperature.

[3] If the person is a close contact of a probable case, at least one person in the chain of transmission must be a confirmed case.

[4] Other reported symptoms of COVID-19 include: fatigue, runny nose, muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite. Clinical and public health judgement should be used to determine if individuals with sudden and unexplained onset of one or more of these other symptoms should be considered suspect cases.

[5] Testing household contacts of confirmed or probable cases of COVID-19 may not be indicated where resources are constrained. These cases would be considered 'probable cases' (refer to definition above).

[6] In certain high risk outbreak settings, PHU may consider testing asymptomatic contacts to inform management of the outbreak. For a list of settings, refer to high risk settings.

[7] For further information on geographically localised areas with elevated risk of community transmission, refer to the Department of Health website: (https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm)