# Te Whatu Ora

**Health New Zealand** 

# **DRAFT Pre-employment Occupational Health Vaccination Policy**

v0.6

### **Purpose:**

The purpose of this Policy is to eliminate or minimise the risk of harm to workers, patients, and clients from vaccine preventable diseases (see definition below) in so far as reasonably practicable. This Policy is part of a suite of controls aimed at eliminating or minimising the risk of harm to our Workers and others attending our workplaces.

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### Introduction

Vaccination is an evidence-based means of:

- 1. improving immunity against some diseases,
- 2. reducing the personal risk and transmission of certain diseases and
- 3. is part of an overall strategy to reduce harm from diseases in health care settings.

Vaccination is part of an overall strategy to eliminate or minimise risks, in so far as reasonably practicable, which are posed to our workers and members of the public who attend our facilities.

As Health Workers, our employees generally accept vaccination as a science-based intervention to prevent infection from certain diseases. Health workers are also influential in their communities and with whanau as to the benefits of vaccination. The more positive and educational experience health workers have with vaccinations, the wider benefit to community we can expect.

Given our diverse workforce, we recognize there may be situations where a particular staff member declines a vaccine, is unable to become vaccinated or does not become immune to a particular disease following vaccination.

Te Whatu Ora cannot require an individual to be vaccinated, therefore this policy takes a supportive and encouraging approach. Te Whatu Ora has undertaken an assessment of roles in locations in our services and has compared this to the risks arising from disease and vaccination and highlights those roles and departments where vaccination is of greatest benefit.

As with all Health and Safety matters, sometimes an individual assessment will be required. Te Whatu Ora has generally assessed the Health and Safety risk posed by vaccine preventable diseases in the creation of this policy and therefore we set out the general requirements for vaccination at a pre-employment stage to ensure that the risks posed by vaccine preventable diseases are eliminated or minimised in so far as reasonably practicable to allow Te Whatu Ora, and our workers to discharge their obligations under the Health and Safety at Work Act 2015.

### Scope

This Policy applies at pre-employment, for workers new to the organisation, it also applies to all new apprentices, first time students or trainees on clinical placement within Te Whatu Ora, and those gaining work experience or on a work trial.

New employees employed by contractors or sub-contractors, and employees of a labour hire companies are also included. The definition of these workers can be found on page 3 below.

**Appendix 2** contains a list of Vaccine Preventable Diseases impacted by vaccination, which may change over time as situations change or recommendations are updated.

Although this Policy is expected to cover the vast majority of circumstances, specific requirements relating to individual factors or unique workplace exposure scenarios should be considered on a case-by-case basis.

Interpretation of individual laboratory test results, the risks to health and subsequent management of exposure may require consultation and advice from appropriate clinical specialists.

# **Principles**

- Te Whatu Ora are committed to improving, promoting and protecting the health and wellbeing of patients and workers.
- Te Whatu Ora have a duty of care towards patients, which includes taking reasonable precautions to protect them from exposure to vaccine preventable diseases while they are under the care of Te Whatu Ora.
- Te Whatu Ora have obligations and responsibilities under the Health and Safety at Work Act 2015 to manage known risks and protect workers and others from harm. This includes being aware of workers vaccination status or immunity to vaccine preventable diseases that they are potentially exposed to in the workplace. Those covered by this policy who are not yet fully vaccinated should be offered vaccinations in accordance with the risk categorisation guidelines (Appendix 1)
- Te Whatu Ora also has an obligation to respect the legal rights of people and as a public service entity to support to uphold the law.
- Te Whatu Ora workers have an obligation to comply with any reasonable work restrictions ( see note in 3<sup>rd</sup> paragraph above), based on their immunity and vaccination status and level of risk. The same requirements are expected of students, volunteers, contractors and locums with access agreements as Te Whatu Ora employees, in order to control disease transmission risks
- The collection use and disclosure of workers health information will comply with the Privacy Act 2020, the Health Information Privacy Code 2020 and the Human Rights Act 1993

# Definitions

**Immunity** is the biological state of being able to resist disease: the primary objective of vaccination is to induce an immunological memory against specific diseases, so that if exposure to a disease-causing pathogen occurs, the immune response will neutralise the infection before disease can occur. In some cases, rather than preventing disease, a vaccination may lessen the severity of the disease and/or infectivity to others. Immunity may also have been achieved through natural means i.e. via prior infection.

**Vaccine Preventable Disease** refers to an infectious disease for which an effective vaccine exists that may modify the risks of catching and transmitting the disease and reduce the severity of infection. Vaccine Preventable Diseases covered by this policy are set out in Appendix 2.

**Worker** has the same meaning as worker in the Health and Safety at Work Act 2015, however for the purposes of this policy relates solely to new employees or first-time attendees at the workplace and also includes:

- All new apprentices, first time students or trainees on clinical placement within Te Whatu Ora, and
- Those gaining work experience.
- Volunteers
- Contracted employees as defined below.

Workplace has the same meaning as Section 20 of the Health and Safety at Work Act 2015.

**Contracted Workers.** For the purposes of this policy the term "contracted employees" covers the following:

- 1. Workers who are employed by a contractor to work within Te Whatu Ora. Examples would include kitchen, laundry, orderly and security staff employed by Spotless, Compass or similar organisations. The employer of these workers is a related PCBU for the purposes of the health and safety in employment act.
- 2. Workers who work within Te Whatu Ora by means of contracting agents. Examples would include locums excluding those employed by internal Te Whatu Ora locum agencies. The latter are considered directly employed workers.
- 3. Whilst employees of contracted laboratory services are not generally covered by this policy, those who perform phlebotomy and other lab workers who are out and about the hospital as a part of their normal duties will be covered by this policy as a contracted employee.
- 4. Workers with access agreements with Te Whatu Ora. Examples would include lead Maternity Carers and Academic staff who are not also Te Whatu Ora employees.
- 5. Closely dependant contractors whose form of employment is through a contract with a company but where the number of employees of that company is restricted most often to that one person. An example would be where a doctor is contracted to staff a remote ED service, or GP periodically contracted to OHS to manage workload demands.

In the case of these employees, Te Whatu Ora shall review contracts and arrangements with related PCBUs, contracting agents and access agreements to assist as far as able the principles outlined in this policy for Te Whatu Ora's staff to be reflected and upheld by the PCBU, contracting agent or within access agreements. It is the expectation of Te Whatu Ora that those covered by this section shall not be treated differently to workers directly employed by Te Whatu Ora.

Those excluded from this policy include contracted workers who attend Te Whatu Ora premises of facilities for a limited, "one off" function. Examples would include an electrician attending to rewire a single element.

## **Pre-employment screening of workers**

- Reflecting the worker risk assessment profile categories, workers, including students will be made aware of the risks they may be exposed to in their area of work and assessed to determine their level of protection against vaccine preventable diseases. Where appropriate this will include review of vaccination history and serology tests.
- Advice will be given for any recommended vaccines and the reasons for this recommendation. Consent for vaccination will be requested and the implications/restrictions explained of declining the recommendation including potential restrictions on practice. For more detail on specific diseases see Appendix 3.
- Students' access to Te Whatu Ora facilities will depend on their worker risk assessment profile category and where appropriate pre-employment screening, being carried out by the education provider.
   Vaccination/infection screening status will need to be advised to Te Whatu Ora.

### **Responsibilities of managers**

- Actively promote Te Whatu Ora policies on vaccination and immunity as an important part of protection for patients and workers.
- As part of recruitment ensure interviewees are aware of this Policy.
- Ensure that the immunity/vaccination status of workers is considered when making staffing decisions.
- Ensure workers are allowed reasonable time to attend for health assessment and vaccination.
- Assist in determining the potential risk of worker exposure to vaccine-preventable infections and inform Occupational Health Services (OHS) of any potential or actual staff exposures. Should managers have any concerns they should contact OHS for advice.
- Implement risk mitigation steps if individual worker immunity is not achievable. This may involve considerations around use of PPE, work allocation, redeployment or job restriction following discussion with Infection Control, OHS, employee union or representative and senior management.
- Ensure that nursing, midwifery, allied health and medical locum and employment agencies and training
  institutions are aware of this policy regarding immunisation and that they only provide workers who have a
  vaccination status consistent with the provisions of this policy. This also applies to any tertiary education
  providers regarding any students or trainees on clinical placements.

## **Responsibilities of Te Whatu Ora Occupational Health Services**

- Comply with the Privacy Act 2020, the Health Information Privacy Code 2020, the Human Rights Act 1993 and Public Records Act when collecting, using and disclosing employment and health information.
- Promote this policy.
- Provide a health and safety risk assessment and vaccination service for workers.
- Risk assess vaccination needs based on serology and work role.
- Maintain a record keeping system for screening test results and vaccination, immunity status for employees and others who have been vaccinated by OH. Obtain information from staff where these vaccinations have occurred outside of the workplace. Note: OH does not hold records of vaccinations administered elsewhere.
- Provide vaccination details to the National Immunisation Register (NIR) where required by the Ministry of Health (MoH) and with the individual's consent.
- Provide workers with their own vaccination records as requested which they can provide to their primary care provider.

 Where potential risks due to not being fully immunised or immune remain, communicate this risk to the manager so they can consider appropriate workplace work allocation, PPE, deployment and any other relevant restrictions.

## **Decision Making Process**

Where a prospective employee has indicated they have made an informed decision not to have some of the vaccinations recommended for employment the People and Culture representative, hiring manager and Occupational Health will consider the impact of this on the role the applicant has applied for and how it could be accommodated to keep the worker safe and whether the recruitment is able to proceed applying the provisions of the Human Rights Act 1993.

### **References and Consultation**

- 1. Ministry of Health. 2020. Immunisation Handbook 2020. Wellington: Ministry of Health. Retrieved from <a href="https://www.health.govt.nz/publication/immunisation-handbook-2020">https://www.health.govt.nz/publication/immunisation-handbook-2020</a>
- Australian Government. 2019 Australian Guidelines for the Prevention and Control of Infection in Healthcare, Canberra: National Health and Medical Research Council. Retrieved from <u>https://www.nhmrc.gov.au/sites/default/files/documents/infection-control-guidelines-feb2020.pdf</u>
- 3. Health and Safety at Work Act 2015.
- 4. Privacy Act 2020
- 5. <u>Health Information Privacy Code 2020</u>
- 6. Human Rights Act 1993

Information on specific infectious diseases and vaccination was written in consultation with IMAC (The Immunisation Advisory Centre) and cross referenced with what is written on the Ministry of Health NZ website (<u>https://www.health.govt.nz/our-work/diseases-and-conditions/communicable-disease-control-manual</u>) and IMAC websites (<u>https://www.immune.org.nz/vaccines-and-diseases/diseases</u>). In particular consultation was had with Professor Peter McIntyre (IMAC) and Dr Joan Ingram (IMAC).

Literature was consulted on specific topics, however a full list of documents that were used to inform this policy is not given. In regard to COVID 19 vaccination, reference is made to the document produced by the UK Health Security Agency "COVID-19 vaccine surveillance report Week 44" which is a monthly report that contains updated information on vaccine efficacy:

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\_data/file/1115385/Vac cine\_surveillance\_report\_\_\_week-44.pdf

The latest version of this document is up to week 48 published early December and the next is due on January the 12<sup>th</sup>. This and other documentation will be regularly reviewed to inform any amendments/updates to this policy.

# Appendix 1 Risk categorisation

#### Category A: Protection against specified vaccine preventable diseases is expected.

#### Worker has EITHER

Direct physical contact with:

- Patients / clients
- Deceased persons and/or body parts
- Blood, body substances, infectious material or surfaces or equipment that might contain these (e.g., soiled linen, surgical equipment, syringes)

### OR

Contact that would allow the acquisition or transmission of diseases which are spread by respiratory means including workers:

- whose work requires frequent and/or prolonged face to face contact with patients or clients e.g. interviewing or counselling individual clients or small groups, performing reception duties in an emergency/outpatient's department
- whose normal work location is in a clinical area such as a ward, emergency department, outpatient clinic; or
- who frequently throughout their working week are required to attend clinical areas
- All workers working in clinical areas are automatically considered to be "Category A" regardless of duties

Category B: Protection against vaccine preventable diseases is recommended but, the level of risk is no greater than that for the general community.

- Worker has no direct physical contact with patients/clients, deceased persons, blood, body substances, or infectious material or surfaces/equipment that might contain these.
- Normal work location is not in a clinical area
- Only attends clinical areas infrequently and for short periods of time e.g. visits a ward occasionally on administrative duties

# Appendix 2 Vaccination requirements & corresponding restrictions for non-immune/ unvaccinated workers

Vaccine Preventable Disease	Workers affected	Restriction
Measles Mumps Rubella Varicella Pertussis* (*Vaccinated within last 10 years or 5 years for staff working in higher risk areas when community outbreak or significant	Category A	Non-immune (consider vaccination or previous infection) Te Whatu Ora workers in this category should not work in category A roles as defined above without a specific risk assessment of having an unvaccinated person working in these areas. Factors to consider include); the type of department they work in, other risk mitigation factors such as PPE, task restriction, work allocation, health/vulnerability of the worker
increase in local incidence) Sars Co-V-2 (regular vaccinations/ boosters for emerging strains of Sars-CoV-2 when they become available)		If the health facility has a suspected case of any of these diseases, non-immune Te Whatu Ora workers may be excluded from working in relevant clinical areas for a period of time as advised by Infection Control.
Hepatitis B	Category A and any other worker with likely exposure to sharps or needles	Non-convertors and non-immune Te Whatu Ora workers should be counselled regarding precautions to prevent Hepatitis B virus (HBV) and on the need to obtain Hepatitis B Immunoglobulin (HBIG) prophylaxis for any known or possible exposure to Hepatitis B surface antigen (HBsAg) positive blood.
Hepatitis A Tetanus	Health Protection Officers Plumbers Laboratory staff (if exposed to faeces)	Non-vaccinated Te Whatu Ora workers should be restricted in entering areas with suspect contaminated water in environment or plumbing systems.
Seasonal Influenza (Vaccinated annually for the season)	Category A	For Category A workers, it is recommended that workers receive the annual vaccination due to the risk of transmitting the virus to vulnerable patients.

		Unvaccinated staff may be excluded from working in clinical areas where vulnerable patients are located.
	Category B	For Category B workers, the annual vaccination is recommended to reduce the risk of catching the virus in the community and to reduce the risk of transmitting the virus to work colleagues or family.
Meningococcal disease	Laboratory workers if regularly working with Neisseria meningitidis cultures.	

# **Appendix 3 Notes on Individual Diseases**

# Principles to guide the following notes on individual disease management as it applies to the Vaccine Preventable Diseases policy:

- Protecting staff (and other workers), their colleagues, patients/clients and the wider public. This is required under H&SW Act and also is ethically appropriate.
- Minimising medical interventions on staff
- Expediting employment via speed of process and reducing barriers to new staff
- Cost effective
- Evidence based
- Taking a supportive, education based and facilitative approach as a primary objective and only resort to compulsion as a last resort.
- Scalable system i.e. able to meet demand as the demands fluctuate

### MEASLES

**General:** Measles is a viral infection that causes fever, cough, runny nose, and red, watery eyes, commonly followed by a rash that covers the whole body. It can lead to seizures (often associated with fever), ear infections, diarrhoea, and pneumonia. Rarely, measles can cause brain damage or death.

Vulnerable groups: Immunocompromised; Pregnancy – Non-immune are at higher risk of miscarriage / premature labour, low birth weight; Very young children

**Community**: Most of the time Measles is no longer common in the community but prior to vaccination it was very common. Because of that most people born prior to 1969 would have been infected and are now immune. It does (and has recently) cause outbreaks in the community with significant morbidity and mortality (especially in young children and immunocompromised).

**Immunity:** is lifelong after wild infection but has been found to wane after two doses of MMR vaccine. Blood tests for antibodies is available but may be an unreliable method of determining immunity. Evidence of immunity: proof of prior infection; antibody positive against Measles at any stage.

**Vaccination:** Part of childhood vaccination in NZ. After 2 doses of MMR there is over 95% efficacy in children but this wanes in adults.

Incubation period: Usually around 10 days but ranges from 7-18 days.

**Workplace relevance**: This is a highly contagious airborne disease. Immunity protects both the worker and the patients – especially immunocompromised, pregnant and young children. While Measles is not usually common in the community, it not uncommonly is a source of workplace exposures due to a patient having it while in hospital and often it is not diagnosed early. This therefore results in contact tracing and lost time to protect patients during the potential incubation period. It can be a serious disease for pregnant staff and immunocompromised and so is important to protect staff who have contact with patients and public.

**Risk Assessment**: Vaccination is expected for all category A workers but especially for those working in obstetrics, blood and cancer; paediatrics. If a worker declines vaccination they will be offered a consultation with OH to discuss their decision. Immunity status will be recorded and available to their manager. Non-immune workers will be restricted from working with known infected patients. In an outbreak or other high prevalence situation, non-immune workers will also be restricted from working with vulnerable patients groups in Blood and Cancer, Paediatrics and Obstetrics.

Vaccination will be offered to category B staff as health promotion to maximise vaccine cover in the wider community.

### MUMPS

**General**: Mumps causes fever, headache, muscle aches, tiredness, loss of appetite, and swollen and tender salivary glands under the ears. It can lead to deafness, swelling of the brain and/or spinal cord covering, painful swelling of the testicles or ovaries, and, very rarely, death.

Vaccination: Part of childhood vaccination in NZ. After 2 doses of MMR, 85% efficacy.

**Workplace relevance**: This is spread via oropharyngeal secretions and so is not a common hospital occupational disease. Immunisation against this is a useful by-product of being a part of MMR for the worker (who is more likely to contract this from the community especially if in the presence of small children in a social setting or if living in a communal setting such as halls of residence).

### RUBELLA

**General:** Rubella causes fever, sore throat, rash, headache, and eye irritation. It can cause arthritis in up to half of teenage and adult women. If a person gets rubella while they are pregnant, they could have a miscarriage or the baby could be born with serious birth defects

Vulnerable groups: pregnant women

Community: This is no longer common in the community but small pockets of infection can occur.

**Immunity**: May be lifelong and can be tested with antibody levels. Evidence of immunity: documented vaccination; antibodies, proof of prior infection.

Vaccination: Part of childhood vaccination. After 2 doses of MMR there is over 95% efficacy

Incubation period: Usually 16-18 days but ranges from 14 – 23 days

**Workplace relevance**: This is airborne spread but is not common in the hospital setting. Immunity is to protect the worker and patients especially pregnant women to protect the unborn child.

**Risk Assessment**: Vaccination is recommended for all category A staff and expected of those working in obstetrics to help protect their patients. Those who decline vaccination will be counselled and non-immune staff will not be restricted from work unless working with a known infected patient while the worker may become or is pregnant.

## VARICELLA (Chicken Pox)

**General:** Chickenpox is a virus that causes an itchy rash that usually lasts about a week. This can cause serious illness (e.g. encephalitis) and death in a small number of patients and tends to be more severe in adults than in children. Once infected then the virus can be re-activated as shingles in times of relative immunosuppression including stress and in aging populations. This is known as shingles and presents as fatigue and a rash which is usually painful and can lead to long lasting neuralgia and can cause site specific damage e.g. Scarring of the cornea.

Vulnerable groups: immunosuppressed; pregnancy; worse in adults than children.

**Community**: This is not uncommon in the community (incidence in NZ was about 60,000 per year but is less now that vaccination is included in the childhood schedule). However exposure can occur from contact with people with the initial infection or with shingles (the latter being less contagious).

**Immunity**: Is lifelong and it is very rare to get the disease more than once. Most adults will have natural immunity from having had chicken pox in childhood (staff from tropical countries will not necessarily have this same likelihood of childhood infection). Evidence of immunity: Documented evidence of 2 doses of vaccine; History of previous infection is a reliable guide to immunity; serology with positive IgG.

**Vaccination:** Vaccination is now part of the national immunisation schedule but this was a recent change in NZ and so most workers would not be covered by this. The vaccine gives 95% protection after 1 dose but this wanes and 100% protection against severe disease after 2 (90-98% effective against all disease after 2 doses). It can also help if given within 5 days of exposure.

Incubation period: Usually 14-16 days but ranges 10-21 days.

**Workplace relevance**: This is airborne spread from a person with the primary infection and also spread via direct contact with vesicles during infection or with shingles. The worker is more likely to contract chickenpox in the community than the hospital setting especially if around children. Chickenpox in patients or staff has caused significant risk within hospitals and not uncommonly requires contact tracing and standing down of staff for weeks at a time.

**Risk Assessment**: Immunity is mainly to protect the worker since infection is usually symptomatic with an obvious rash and so contact with cases is usually known so transmission from staff to patient can usually be prevented. Vaccination is therefore a recommendation and non-immune workers will only be restricted from contact with those known to be infected.

### PERTUSSIS (Whooping Cough)

**General**: Is a contagious airborne disease that is often mild in adults but in young children and infants it can cause uncontrollable, violent coughing that makes it hard to breathe, eat, or drink. Pertussis can be extremely serious especially in babies and young children, causing pneumonia, convulsions, brain damage, or death and more than 50% of infected infants under 1 year need treatment in hospital and 1-2% of those hospitalised die. In teens and adults it can be very mild but can cause prolonged severe coughing that can disturb sleep for months and occasionally rib fractures and pneumonia.

Vulnerable groups are young children especially the under 1-year olds.

**Community**: The community prevalence is variable and it causes outbreaks each 3-5 yrs. The last 2 epidemics in NZ were between 2011-2013 and 2017-2019.

**Immunity**: Wanes over time from natural infection and more quickly from immunisation. There is no test for immunity in general use.

**Vaccination**: Is part of the immunisation schedule and is given to adults along with Tetanus as the TdaP vaccine. Protection from immunisations starts to wane after the first year of vaccination and so pregnant women are recommended to have the vaccine during every pregnancy to boost antibody levels that are then passed trans placenta to protect their baby in the first months of life. Others are recommended to be vaccinated at least each 10 years and staff working in high-risk areas during an epidemic should be vaccinated if it has been more than 5 years since their last vaccination.

Incubation period: usually 7-10 days but ranging 5-21.

**Workplace relevance**: Airborne spread from adult carriers to children is a significant source of infection and infected staff may be asymptomatic carriers however there is a low risk of transmission if an infected person is not coughing. Infected staff with a cough can therefore be a risk to vulnerable patient groups.

**Risk Assessment**: While workers may catch this at work, vaccination is mainly to protect vulnerable patients. Therefore staff working with vulnerable patient groups (working with young children/infants and in maternity) are expected to be vaccinated against this disease each 10 years and after 5 years during an epidemic. Staff who are not up to date with their booster immunisation should wear an N95 mask for contact with vulnerable patient groups during times of a community outbreak.

### TETANUS

**General:** A reaction to a toxoid derived from Clostridium tetani bacteria, a bacteria found in soil. Tetanus causes painful stiffening of the muscles. Tetanus can lead to serious health problems, including being unable to open the mouth, having trouble swallowing and breathing, or death.

**Immunity and Vaccination**: After three doses most people are immune but repeat vaccination at 10-20 year intervals is required to maintain immunity.

**Workplace relevance**: the vast majority of health care workers are unlikely to contract tetanus at work however if a worker is exposed to soil as a part of their work, vaccination could be given if it has not been kept up to date via regular administration of Tdap which is part of the public health vaccination schedule.

### INFLUENZA (The "flu")

**General:** There are many flu viruses, and their antigens are always changing. This means that protection against one form of the virus may give either no or limited protection against other forms. This can be one reason why the severity of the disease can vary quite widely. Overall the disease can be mild or severe and can lead to death of an infected person.

Vulnerable groups are those with immunosuppression, certain chronic diseases and the elderly.

**Community**: There is always some flu in the community but the numbers increase significantly over the winter months and last through to early spring. Some years there are major changes in the type of strain circulating and this can lead to widespread serious disease and cause serious epidemics and pandemics – e.g. "swine flu", "bird flu" and the 1918-20 pandemic of the "Spanish flu".

**Immunity**: Against a particular strain is effective however the strains are constantly changing so immunity against a currently circulating strain may be poor. However there is often some partial protection against a new strain so long as the antigens are not too different to previous ones. There is no test for immunity for general use and protection relies on annual vaccination.

**Vaccination**: Each year a new flu vaccine is required to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season. Even when the vaccine doesn't exactly match these viruses, it may still provide some protection. Vaccine efficacy varies from one year to the next but when there is a reasonable match with circulating virus it is estimated that between 40-60% effective in preventing a person from needing to see a doctor due to influenza infection.

Incubation period: Usually 1-3 days but ranges from 1-7 days.

**Workplace relevance**: Hospitals patients are generally a vulnerable group however everyone can become seriously unwell even if not in one of the vulnerable groups. Workers are more likely to catch this in the community rather than the workplace (patients and workers) however asymptomatic infection and transmission can occur before symptoms become apparent. Therefore workers can transmit this to patients and their colleagues.

**Risk Assessment**: Hospital patient population is generally a vulnerable group and so would benefit from vaccination of staff to reduce the rate of transmission. Vaccination is an effective tool to reduce transmission and severity of disease so is useful as a workforce tool. Mask use and other infection control measures are also very effective at reducing transmission as was seen during the COVID pandemic when influenza numbers in the community was lower than seen in previous years due to the general infection control measures introduced for COVID. Workers are therefore recommended to be vaccinated and if not then they should be required to wear a medical mask for vulnerable patient contact over times of high community prevalence (generally winter and early spring but this is measured every year).

These procedures are based on the premise of protecting patients and office-based colleagues are not considered. This is because the risk for office-based colleagues within a healthcare setting is no different as compared to a general workplace.

### **HEPATITIS B**

**General**: A serious liver disease. The symptoms range from a mild illness lasting a few weeks, or it can lead to a serious, lifelong illness and liver failure. Hepatitis B is spread when body fluids (such as blood, semen, respiratory secretions etc.) from a person infected with the hepatitis B virus, enters the body of a person who is not infected via contact percutaneously or mucus membranes.

Vulnerable groups: Anyone not already immune can be infected and the rate of those who will develop serious disease is around 10%

Community: It is estimated that about 1-2 % of New Zealanders are carriers of Hepatitis B.

**Immunity**: is lifelong and blood tests for antibodies is necessary to show immunity. Antibody levels above 10 at any time in life indicate lifelong protection against disease.

**Vaccination**: This is part of the NZ vaccination schedule. Routine vaccination sees 85-95% of people protected but the rate is lower in those over the age of 65 years. For those who do not seroconvert after the first course then this is repeated according to an agreed protocol and some will still not become immune.

Incubation period: Usually 60-90 days but ranges between 45-180

**Workplace relevance**: The virus is readily transmitted if a person is exposed to the infected body fluid of a carrier of the virus percutaneously or via mucous membranes. Therefore both the worker and patient involved in a blood body fluid exposure (where the source of the exposure is a carrier of Hepatitis B virus), can get infected. Vaccination of the health care worker will therefore protect primarily themselves but will also protect the patients of workers who perform exposure prone procedures.

**Risk Assessment**: Given the frequent and common potential for exposure to blood and body fluids in the health care industry, the potential for any workers who have contact with patients or blood/body fluids to be exposed to the virus is high. Vaccination is therefore recommended for any workers who have such exposure and is expected for all who perform exposure prone procedures. Those workers who perform exposure prone procedures and are not immune should have two yearly tests for hepatitis B to detect carriers who would be at risk of transmitting the virus. They will also be counselled regarding the risks of BBFE and how to manage an exposure with immunoglobulin etc. If a worker does become infected with, or is a carrier of, Hepatitis B, a risk assessment on their work and potential for transmission to patients will be made by a panel of appropriate specialists (including an Occupational Physician and at least one other specialist doctor including an infectious disease specialist).

### **HEPATITIS A**

**General**: Hep A is a liver disease that tends to be more mild than hepatitis B but occasionally can be severe. It is usually spread through the faecal/oral route from contact with an infected person or when a person unknowingly ingests the virus from objects, food, or drinks that has been contaminated by faeces from an infected person.

A person infected with hepatitis A can transmit the disease to other people even if they do not have any symptoms of the disease.

**Community**: This is quite rare in NZ with an incidence of around 1-2 per 100,000 population and this risk is generally from overseas travel. Occasionally there are outbreaks due to contaminated food.

Immunity: is life long and can be measured with antibody levels.

**Vaccination:** The vaccine is effective in around 95% of cases. Lasts for at least twenty years and possibly a person's entire life.

Incubation period: 15 – 50 days

**Work relevance**: This is not commonly encountered in NZ healthcare industry but may be a risk for those exposed to sewage (plumbers).

Risk Assessment: Given the low risk in NZ, vaccination is recommended only for those workers exposed to sewage.

### COVID -19

**General:** This has been a major focus across the whole world since the beginning of 2020. Symptoms can range from being asymptomatic to a respiratory illness that is often mild however there is also a mortality rate especially in vulnerable groups. There is a proportion of people who develop a post-viral fatigue syndrome often referred to as "long covid".

Vulnerable groups include those over the age of 70, those with immunosuppression, some chronic health conditions and obesity.

**Community**: The community prevalence has decreased significantly from the peak rates seen earlier in 2022 and the severity of the disease has also altered due to the type of strain circulating. The government of NZ has lifted the Epidemic Notice and no longer has requirements to control this infection in the community.

**Immunity**: Immunity can come from previous infection or vaccination but protection from both of these mechanisms wanes over months. Infection or vaccination occurring after the other will boost immunity better than either infection or vaccination alone. Evidence of immunity: proof of primary vaccination and preferably also boosters as recommended by MoH, documented proof of infection and including dates of vaccination and/or infection.

**Vaccination:** Vaccination is freely available to all adults in NZ as a primary course and then as a booster to maximise and maintain protection. Those immunosuppressed require a third dose as the primary course. With the current strain the protection from vaccination is greatest within the first 2 months and wanes after that, such that protection against all infection is poor but vaccination will still give good protection against serious disease.

Incubation period: is usually 3-5 days but ranges from 1-7 days.

**Work relevance**: With the community prevalence over 2022, workers in NZ are more likely to be exposed to the virus in the community than at work unless dealing with patients known to be infected with COVID-19.

**Risk assessment**: NB – The risk assessment process applies for the current strain and vaccine but this would need to be reviewed if there was a significant change in circulating strain. With the current circulating strain and vaccine, the reason to vaccinate health care workers is to protect the worker from serious disease and has little effect on reducing transmission. There are more effective ways of reducing transmission such as hand hygiene, mask use and other infection control precautions. Vaccination of health care workers is therefore expected for all category A staff and is recommended for all staff. Vulnerable workers (those over a "covid age" of 70 according to the ALAMA covid age calculator) who are not immune must be risk assessed before providing direct care to those known or suspected of having COVID-19 infection. Factors to consider for risk assessment include: ability to wear a fit tested N95 grade or better mask; patient contact within 1m and for 15 minutes or more; work space including ventilation, work pace/organisation, risk of aerosols being generated. Generally those workers who are non-immune and are over a covid age of 85 must not provide direct care to patients known or suspected of having COVID-19 infection.

# Appendix 4 Principles to inform vaccination process and understanding

- 1. Vaccines are a proven means of improving immunity from infectious disease. They can stop people getting the disease or reduce the severity of the disease to the individual affected.
- 2. We must be clear on the reasoning for the actions outlined in the policy and the evidenced reasoning for such.
- 3. Not all vaccines have the same impact or rational for use. Each must be taken on its specific merits: tetanus versus Influenza as but one example.
- 4. Not all workplaces are the same and the basis for vaccination prior to working in a specific site or location also needs to be evidence based and reasoned. As an example, we have HIV positive surgeons continuing to operate. There are some restrictions on their practice, but they are still safe practitioners within those parameters.
- 5. It naturally follows that a risk assessment should be carried out appropriate to location of work, disease/vaccine under consideration and individual employee factors. Each instance can be a loaded statement and at some level there will always be generalisations e.g. consider each disease separately but it is reasonable to treat hospitals across the nation the same in terms of risk although acknowledging that some services may be restricted to some centres and not available in others.
- 6. If health and safety is claimed to be the basis of action, whose health and safety should be identified: Patient or Worker. We have identified 4 groups – worker, their colleagues, patients and public at large and all of these groups must be considered. Given health and safety is a risk management system, in what circumstances would action be taken. (Health and Safety claims for basis of action will require schedule of staff Health monitoring/reporting to inform efficacy)
- 7. If the action described in the policy is for some other reason such as to maintain staffing levels or service delivery this should also be clearly articulated and evidenced as necessary.
- 8. The rights of the workers also need to be clearly articulated and considered in policy development. The Bill of Rights, Health Information Privacy Code and Code of Patient Rights make vaccination an individual choice. {Note: The reason a mandate was legislated was because there was no other way of imposing vaccination (or loss of employment) upon people. Recent ID services vs Attorney General Court of Appeal Decision is relevant here}. To undertake a policy that undermines workers' rights at law should not be pursued.
- 9. There <u>may</u> need to be a clear distinction between new employees and current employees. This is difficult to justify on a risk basis and would be due to other reasons such as employment law but there may need to be restrictions placed on existing staff due to safety reasons.
- 10. Immunisation is only one tool: other mitigation strategies such as PPE need to also be considered although a properly constructed policy should use the same reasoning for both. This policy is restricted to immunisation policy and this is clearly only one control measure amongst a suite of others.
- 11. Overall risks must also be assessed. For instance at the time the covid vaccine mandate was introduced, the greatest risk was the spread of covid. Today with widespread community infection (and health workers getting covid in the community, not at work) plus a workforce shortage, the risk is more a lack of workforce rather than unvaccinated workers. This dynamic also impacts advice to training institutions and for students on placement if it is going to reduce training workforce outputs.
- 12. "Assess vaccination needs on serology and work role" is insufficient. What are we trying to protect e.g. tetanus protects the worker from something they are very unlikely to get in the workplace, not the patient, but in what workplace is it necessary to protect that worker, versus the workers right to decline vaccination? And the risk changes over time. For example, what is the value of COVID vaccination being mandated by an employer when the spread is community based? We are not materially protecting the worker from exposure at work or the patient in hospital who is more likely to catch covid from visitors/whanau or in the community before they come to hospital. Covid vaccination in this environment is desired to limit the impact of the disease on the worker so less sick time is required. Where then does the balance lie between a worker's right to be sick, and their right not to be vaccinated? And when we have a workforce crisis, is the risk of less workers greater than the risk of sickness from covid?

- 13. Where staff are not able or decline particular vaccines there should be a supportive approach to enable those workers to continue working whilst managing any risk to worker or patients.
- 14. Vaccine efficacy must be considered. Covid is around 60%, influenza closer to 80%. It appears accepted that 2 vaccines and one booster is equivalent to natural immunity (derived from having been infected). So what is the basis to discriminate against a person with no vaccine but naturally acquired immunity?
- 15. The mandates were a last resort, only activated when a pandemic was raging. Once the pandemic is over they should disappear "ID Services Vs the Attorney General et al: CIB;2021;485;590). To effectively transfer the mandate into policy is therefore unjustified.
- 16. Also need to ensure that hospitals have a structured approach to making access to vaccine programmes (annual flu, whooping cough updates etc) easy for relevant staff e.g. with use of peer vaccinators. That should include a process whereby staff can advise their manager if they have had the vaccine (this may have occurred outside of work), are wanting the vaccine but not yet had it, or have made an informed decision / or based on personal health conditions have declined the vaccine. This way hospital vaccinators can focus on those wanting the vaccine. Staff should also be able to be reimbursed for time and costs if they have had to obtain vaccine outside of work time due to working hours/ lack of easy access to employer vaccination services.

DRAFT Te Whatu Ora Pre-employment Vaccination Policy