Protocol for assessment of potential risk factors for coronavirus disease 2019 (COVID-19) among health workers in a health care setting

Form 1: Initial reporting form for health worker (Day 1)

Unique ID/Cluster number (if applicable):

1. Current status
□ Alive □ Dead □ Unknown/lost to follow-up

2. Data collector information	
Name of data collector	
Data collector institution	
Data collector telephone number	
Data collector email	
Form completion date (dd/mm/yyyy)	___/___/___
Name of data collector	
Data collector institution	

3. Contact identifier information	
First name	
Family name	
Sex	□ Male □ Female □ Not known
Date of birth (dd/mm/yyyy)	___/___/___ □ Unknown
Telephone (mobile) number	
Email	
Address (village/town, district, province/region)	
Country of residence	
Nationality	
Ethnicity (optional)	
Smoker	□ Yes □ No
Occupation in health care facility	□ Medical doctor □ Registered nurse (or equivalent) □ Assistant nurse, nurse technician (or equivalent) □ Radiology/x-ray technician □ Phlebotomist □ Physical therapist □ Nutritionist/dietitian **Other health personnel**: □ Laboratory personnel □ Admission/reception clerks □ Patient transporters □ Catering staff □ Cleaners

4. Adherence to infection prevention and control (IPC) measures information	
What was the date of your most recent IPC training within the health care facility (dd/mm/yyyy)	___/___/___
How much cumulative IPC training (standard precautions, additional precautions) have you had at this health care facility	□ Less than 2 hours □ More than 2 hours
Do you follow recommended hand hygiene practices?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely
Do you use alcohol-based hand rub or soap and water before touching a patient?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely
Do you use alcohol-based hand rub or soap and water before cleaning/aseptic procedures?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely
Do you use alcohol-based hand rub or soap and water after (risk of) body fluid exposure?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely
Do you use alcohol-based hand rub or soap and water after touching a patient?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely
Do you use alcohol-based hand rub or soap and water after touching a patient's surroundings?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely
Do you follow IPC standard precautions when in contact with any patient?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely □ I don't know what IPC standard precautions are
Do you wear PPE when indicated? (PPE includes: medical mask, face shield, gloves, goggles/glasses, gown, coverall, head cover, respirator (for example, N95 or equivalent) and shoe covers)	□ Always, according to the risk assessment □ Most of the time, according to the risk assessment □ Occasionally □ Rarely
Is PPE available in sufficient quantity in the health care facility?	□ Yes □ No □ Unknown

5. Exposures to COVID-19-infected patient	
Date of admission of confirmed COVID-19-infected patient (dd/mm/yyyy)	___/___/___
Have you had close contact with the patient (within 1 metre) since their admission?	□ Yes □ No □ Unknown

- If yes, how many times (total)?	
- If yes, for how long each time?	□ < 5 minutes □ 5–15 minutes □ > 15 minutes
- If yes, did you have prolonged face-to-face exposure (> 15 minutes)?	□ Yes □ No □ Unknown If yes, did you wear PPE? □ Yes □ No □ Unknown If yes, what type? Tick all that apply: □ Medical/surgical mask □ Respirator (for example,FFP2 or N95 masks or equivalent) □ Face shield □ Gloves □ Goggles/glasses □ Gown □ Coverall □ Head cover □ Shoe covers
If you were wearing a medical mask, what type:	
If you were wearing a respirator, was it test fitted?	□ Yes □ No □ Unknown
If you were wearing gloves, did you remove them after contact with the patient?	□ Yes □ No
- If yes, did you perform hand hygiene before contact with the patient?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely If yes: □ Alcohol-based hand rub □ Soap and water □ Water
- If yes, did you perform hand hygiene after contact with the patient?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely If yes: □ Alcohol-based hand rub □ Soap and water □ Water
- If yes, were you present for any aerosolizing procedures performed on the patient?	□ Yes □ No □ Unknown If yes, describe the procedure: If yes, did you wear PPE?

	□ Yes □ No □ Unknown If yes, what type? Tick all that apply: □ Medical/surgical mask □ Respirator (for example,FFP2 or N95 masks or equivalent) □ Face shield □ Gloves □ Goggles/glasses □ Gown □ Coverall □ Head cover □ Shoe covers
- If yes, did you come into contact with the patient's body fluids?	□ Yes □ No □ Unknown If yes, which body fluids: If yes, were you wearing PPE? □ Yes □ No □ Unknown If yes, what type? Tick all that apply: □ Medical/surgical mask □ Respirator (for example,FFP2 or N95 masks or equivalent) □ Face shield □ Gloves □ Goggles/glasses □ Gown □ Coverall □ Head cover □ Respirator (for example, N95 or equivalent) □ Shoe covers
Have you had direct contact with the patient's materials since their admission? *Patient's materials: personal belongings, linen and medical equipment that the patient may have had contact with*	□ Yes □ No □ Unknown
- If yes, which materials?	Tick all that apply: □ Clothes □ Personal items □ Linen □ Medical devices used on the patient □ Medical equipment connected to the patient (ventilator, infusion pump etc.) □ Other:
- If yes, how many times since their admission (total)?	

- If yes, did you come into contact with the patient's body fluids via the patient's materials?	□ Yes □ No □ Unknown If yes, which body fluids: If yes, were you wearing PPE? □ Yes □ No □ Unknown If yes, what type? Tick all that apply: □ Medical/surgical mask □ Respirator (for example,FFP2 or N95 masks or equivalent) □ Face shield □ Gloves □ Goggles/glasses □ Gown □ Coverall □ Head cover □ Shoe covers
- If yes, did you perform hand hygiene before contact with the patient's materials?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely If yes: □ Alcohol-based hand rub □ Soap and water □ Water
- If yes and you were wearing gloves, did you remove them after contact with the patient's materials?	□ Yes □ No
- If yes, did you perform hand hygiene after contact with the patient's materials?	□ Always, as recommended □ Most of the time □ Occasionally □ Rarely If yes: □ Alcohol-based hand rub □ Soap and water □ Water
Have you had direct contact with the surfaces around the patient?	□ Yes □ No □ Unknown
- If yes, which surfaces?	Tick all that apply: □ Bed □ Bathroom □ Ward corridor □ Patient table □ Bedside table □ Dining table □ Medical gas panel □ Other:

- If yes, how many times since their admission (total)?	
- If yes, did you come into contact with the patient's body fluids via the surfaces around the patient?	□ Yes □ No □ Unknown If yes, which body fluids: If yes, were you wearing PPE? □ Yes □ No □ Unknown If yes, what type? Tick all that apply: □ Medical/surgical mask □ Respirator (for example,FFP2 or N95 masks or equivalent) □ Face shield □ Gloves □ Goggles/glasses □ Gown □ Coverall □ Head cover □ Shoe covers
- If yes, did you perform hand hygiene after contact with these surfaces?	□ Yes □ No □ Unknown If yes: □ Alcohol-based hand rub □ Soap and water □ Water

6a. Health worker symptoms	
Have you experienced any respiratory symptoms (sore throat, cough, running nose, shortness of breath) in the period since the patient was admitted?	□ Yes □ No If no, please move on to section 6c
If yes, date of first symptom onset (dd/mm/yyyy)	___/___/___ □ Unknown
Fever (≥ 38 °C) or history of fever	□ Yes □ No □ Unknown If Yes, date ___/___/___ If yes, specify maximum temperature:
6b. Respiratory symptoms	
Sore throat	□ Yes □ No □ Unknown
Cough	□ Yes □ No □ Unknown
Runny nose	□ Yes □ No □ Unknown
Shortness of breath	□ Yes □ No □ Unknown

6c. Other symptoms	
Chills	□ Yes □ No □ Unknown
Vomiting	□ Yes □ No □ Unknown
Nausea	□ Yes □ No □ Unknown
Diarrhoea	□ Yes □ No □ Unknown
Headache	□ Yes □ No □ Unknown
Rash	□ Yes □ No □ Unknown
Conjunctivitis	□ Yes □ No □ Unknown
Muscle aches	□ Yes □ No □ Unknown
Joint ache	□ Yes □ No □ Unknown
Loss of appetite	□ Yes □ No □ Unknown
Loss of smell (anosmia) or taste	□ Yes □ No □ Unknown
Nose bleed	□ Yes □ No □ Unknown
Fatigue	□ Yes □ No □ Unknown
Seizures	□ Yes □ No □ Unknown
Altered consciousness	□ Yes □ No □ Unknown
Other neurological signs	□ Yes □ No □ Unknown If Yes, specify:
Other symptoms	□ Yes □ No □ Unknown If yes, specify:

7. Health worker pre-existing condition(s)	
Pregnancy	□ Yes □ No □ Unknown If Yes, specify trimester: □ First □ Second □ Third □ Unknown
Obesity	□ Yes □ No □ Unknown
Cancer	□ Yes □ No □ Unknown
Diabetes	□ Yes □ No □ Unknown
HIV/other immune deficiency	□ Yes □ No □ Unknown
Heart disease	□ Yes □ No □ Unknown
Asthma (requiring medication)	□ Yes □ No □ Unknown
Chronic lung disease (non-asthma)	□ Yes □ No □ Unknown
Chronic liver disease	□ Yes □ No □ Unknown
Chronic haematological disorder	□ Yes □ No □ Unknown

Chronic kidney disease	□ Yes □ No □ Unknown
Chronic neurological impairment/disease	□ Yes □ No □ Unknown
Organ or bone marrow recipient	□ Yes □ No □ Unknown
Other pre-existing condition(s)	□ Yes □ No □ Unknown If yes, specify:

The following part will be filled out **by study coordinator or equivalent**

8a. Laboratory: Serology testing methods and results:							
Complete a new line for each specimen collected and each type of test done:							
Laboratory identification number	**Date sample collected (dd/mm/yyyy)**	**Date sample received (dd/mm/yyyy)**	**Type of sample**	**Type of test**	**Result (COVID-19 antibody titres)**	**Result date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Serum □ Other, specify:	Specify type (ELISA/IFA IgM/IgG, neutralization assay, etc.):	□ POSITIVE If positive, titre: □ NEGATIVE □ INCONCLUSIVE	___/___/___	□ Yes If Yes, specify date ___/___/___ If Yes, name of the laboratory: □ No

8b. Laboratory: Virology testing methods and results (OPTIONAL)							
Complete a new line for each specimen collected and each type of test done:							
Laboratory identification number	**Date sample collected (dd/mm/yyyy)**	**Date sample received (dd/mm/yyyy)**	**Type of sample**	**Type of test**	**Result**	**Result date (dd/mm/yyyy)**	**Specimens shipped to other laboratory for confirmation**
	___/___/___	___/___/___	□ Nasal swab □ Throat swab □ Nasopharyngeal swab □ Other, specify:	□ PCR □ Whole genome sequencing □ Partial genome sequencing □ Other, specify	□ POSITIVE for COVID-19 □ NEGATIVE for COVID-19 □ POSITIVE for other pathogens Please specify which pathogens:	___/___/___	□ Yes If Yes, specify date ___/___/___ If Yes, name of the laboratory: □ No

9. Status of form completion	
Form completed	□ Yes □ No or partially If No or partially, reason: □ Missed □ Not attempted □ Not performed □ Refusal □ Other, specify: