

Updated advice for health professionals: novel coronavirus (COVID-19)

8 April 2020

Updates

- Background shortened
- Reordering of some sections
- Updated all sections affected by the update in case definition

As this information is frequently updated, please ensure that you check for the updated health professional advice on Ministry website at health.govt.nz/covid-19

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Introduction

Purpose

The purpose of this document is to provide health professionals, including hospital-based, community-based and public health practitioners, with information on how to identify and investigate any cases of novel coronavirus (COVID-19), as well as how to apply appropriate contact tracing and infection control measures to prevent its spread.

The aim of the guidance is to eliminate COVID-19 in New Zealand by minimising transmission of COVID-19, improving detection and managing all cases.

Information in this document is based on current advice from the World Health Organization (WHO). This guidance has taken into account that there are still questions regarding the epidemiology of the virus.

Separate documents with advice for primary health care are available at health.govt.nz/our-work/diseases-and-conditions/COVID-19-novel-coronavirus/novel-coronavirus-resources-health-professionals

All advice will be updated as more information becomes available.

Background

Coronaviruses are a large and diverse family of viruses which include some known to cause illness in animals and humans, including the common cold, severe acute respiratory syndrome (SARS) and the Middle East respiratory syndrome (MERS).

A novel coronavirus called SARS-CoV-2 caused a cluster of viral respiratory illness (COVID-19) in Wuhan that had not previously been detected in humans or animals. Phylogenetic analysis shows it to be related to SARS CoV, the virus responsible for the SARS pandemic which began in China in 2003¹. On 12 March, the WHO declared COVID-19 a global pandemic.

The clinical signs and symptoms of COVID-19 infection that have been reported range from non-specific respiratory symptoms such as cough, fever and sore throat, to shortness of breath and symptoms of pneumonia and severe acute respiratory infection. Most cases have mild illness, with up to 20 percent having more severe illness requiring hospitalisation (mainly due to pneumonia). The virus has an approximately one percent fatality rate with most of those who have died from the virus to date suffering from pre-existing health problems. The most common reported symptom to date in New Zealand cases is cough, followed by fever.

Local readiness and response plans

District Health Boards (DHBs) have local readiness and response plans in place.

Information for border health operations has been provided through border health advisories.

¹ ecohealthalliance.org/2020/01/phylogenetic-analysis-shows-novel-wuhan-coronavirus-clusters-with-sars

Guidelines for Health Professionals

Spread of infection

The parameters below are provisional estimates based on currently available data and may change as more evidence becomes available.

Incubation period

The incubation period is considered to be from 1-14 days (commonly 3 to 7 days).

Mode of transmission

Transmission is considered to occur primarily through respiratory droplets and secretions. Transmission is likely to occur through virus contact with respiratory mucosa or conjunctivae, either by direct exposure or by transfer on hands from contaminated fomites. The current evidence does not support airborne transmission, except during aerosol-generating procedures which include intubation, suctioning, bronchoscopy, tracheostomy, cardiopulmonary resuscitation.

Period of communicability

The period of communicability is considered to start 48 hours before onset of symptoms and continue until cases meet all of the criteria in the *release from isolation of confirmed or probable COVID-19 cases* section of this guidance.

Minimum precautions to reduce the general risk of transmission of acute respiratory infections

- Avoid close contact with people suffering from any acute respiratory infection.
- Frequent hand-washing and drying (or hand sanitiser if no access to soap and running water), especially after direct contact with ill people or their environment.
- Keep hands away from face (eyes, nose and mouth).
- Everyone should practice cough etiquette (maintain distance, cover coughs and sneezes with elbow, disposable tissues or clothing and wash and dry hands).
- People with acute respiratory symptoms should stay home if unwell.
- Adhere to standard infection prevention and control practices in primary health care. All patients with respiratory infection should be provided with a surgical mask upon entry to the facility. For suspected cases of COVID-19 infection, include contact and droplet precautions, such as personal protective equipment (PPE).
- Aerosol-generating procedures² should not be performed in primary health care.

Infection prevention and control (IPC)

Basic hygiene measures (as outlined above) are the most important way to stop the spread of infections, including COVID-19.

In a health care setting, in addition to basic hygiene measures, standard precautions should apply for all patients.

² Aerosol-generating procedures include nebulizing, intubation, suctioning, bronchoscopy, tracheostomy, cardiopulmonary resuscitation.

As soon as a case of COVID-19 infection is suspected, additional precautions (droplet and contact) should be immediately implemented, with airborne precautions when aerosolized respiratory secretion are generated.²

Infection prevention and control advice is available at health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-novel-coronavirus-resources-health-professionals

Please refer also to WHO recommendations on infection prevention and control during health care when novel coronavirus (nCoV) infection is suspected [who.int/publications-detail-infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected](https://www.who.int/publications-detail-infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected)

Case definition of COVID-19 infection and who should be tested

The Ministry of Health develops case definitions for COVID-19 based on expert advice from our Technical Advisory Group.

There are currently five case classifications; Suspect, Under Investigation, Probable, Confirmed and Not a Case. The case definitions take into account New Zealand's current aim to eliminate COVID-19. This means that our suspect case definition needs to be broad enough to capture all those who may have the disease. As the symptoms of COVID-19 are similar to other viruses, many of those who meet the suspect case definition will not have COVID-19. A new 'Under investigation' case definition has been developed which provides guidance for laboratory testing.

Case definitions may need to be revised but the current case definitions will always be available here along with a list of who should be prioritised for testing:

health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-novel-coronavirus-resources-health-professionals/case-definition-covid-19-infection

The flow chart below is provided as the logic of the case classification differs from other notifiable diseases

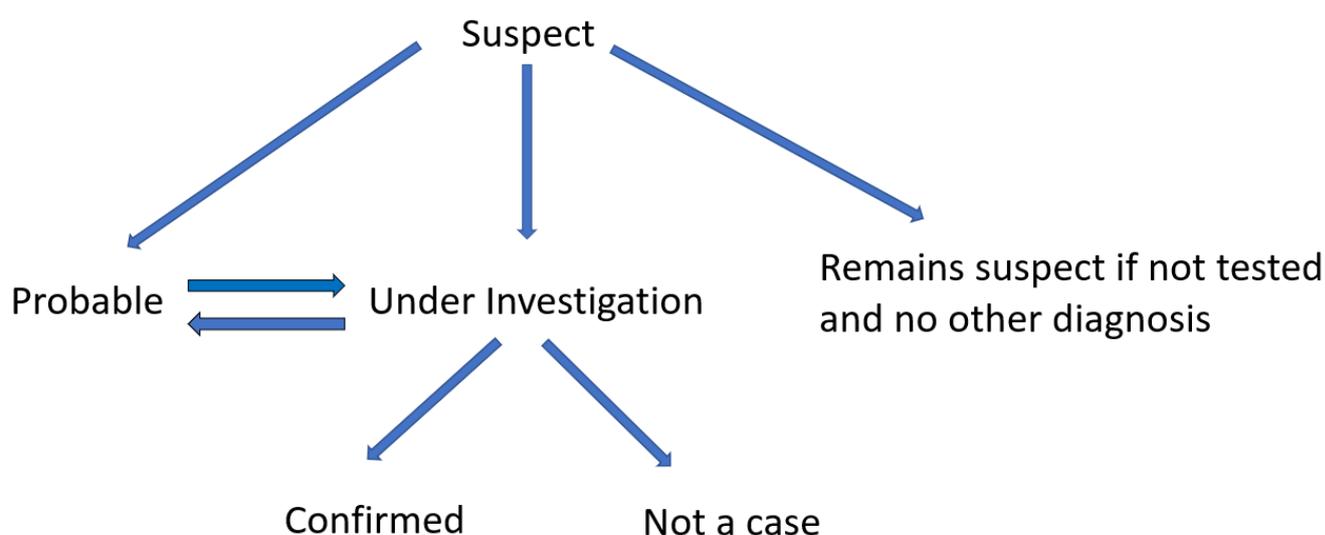


Figure 1 – Flow Chart: Case classification

Laboratory testing for diagnosis of COVID-19 infection

Who should be tested?

Testing should be done for any person meeting the clinical criteria especially those who are among the priority groups for investigation and testing listed here: (<https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-novel-coronavirus-resources-health-professionals/case-definition-covid-19-infection>) or if clinical judgement indicates that testing is warranted.

Clinicians should be aware that immunocompromised patients may not present with typical symptoms so should be considered as a suspected case if they meet the epidemiological criteria.

Clinicians should also maintain a high level of suspicion and consider testing in case of doubt.

Testing in hospitals should always be done in consultation with the infectious disease physician or clinical microbiologist.

How should people meeting the testing criteria be tested?

It is critical that only a single swab is taken for COVID-19 testing.

- Use a single nasopharyngeal swab (NPS) to swab the nasopharyngeal space. If NPS is not available, a single oropharyngeal swab in Universal Transport Medium (UTM) is acceptable
- To ensure adequate collection, the swab tip must extend well beyond the anterior nares until some resistance is met.
- Avoid using dry swabs.
- Place the swab in viral transport media (VTM) and transport to the laboratory.
- Lower respiratory tract samples are better quality samples and less likely to give false negative results but should only be undertaken in a hospital setting with appropriate PPE.
- Repeat testing may be required but will be at the direction of the clinical microbiologist.

Additionally, the specimen may be taken outdoors or in a well-ventilated space (eg, car parking), as this also reduces transmission risk.

In addition to standard precautions, airborne precautions should be followed when collecting specimens if there is a risk of aerosol generation. The collection of specimens should occur in an airborne infection isolation room if available.

For hospitalised patients, routine tests for acute pneumonia should be performed at the same time, including bacterial culture, serology, urinary antigen testing and tests for respiratory viruses, including influenza.

Laboratory staff should handle clinical specimens under PC2 conditions in accordance with *AS/NZS 2243.3:2010 Safety in Laboratories Part 3: Microbiological Safety and Containment*. Any procedure that may generate aerosols should be performed in a Class II biological safety cabinet. For a list of activities which may be performed in a PC2 laboratory as well as additional precautions please refer to the WHO biosafety guidelines for handling of SARS specimens who.int/csr/sars/biosafety2003_04_25/en/

Specific COVID-19 screening and confirmation testing has been available in New Zealand since 31 January 2020.

WHO technical guidance on laboratory testing for COVID-19 can be found on the WHO website who.int/emergencies/diseases/novel-coronavirus-2019/technicalguidance/laboratory-guidance

This guidance includes details on how and which specimens to collect.

Laboratories can also refer to CDC's interim laboratory biosafety guidelines on how to handle specimens from suspected cases in their laboratories cdc.gov/coronavirus/2019-nCoV/lab/lab-biosafety-guidelines.html

Reporting

'Novel coronavirus capable of causing severe respiratory illness' has been added to Section B of Part 1 of Schedule 1 of the Health Act 1956 and is now a notifiable disease (effective from 30 January 2020). Notifiable diseases are required to be reported to the local Medical Officer of Health. Notify cases of COVID-19 through the process established by your local Public Health Unit.

The local Medical Officer of Health / Public Health Unit will enter probable and confirmed case details on EpiSurv.

Under the International Health Regulations, 2005, the Ministry will also notify the WHO of a probable or confirmed case of COVID-19 within 48 hours of identification, by providing the minimum data set outlined in 'Interim case reporting form for 2019 Novel Coronavirus of confirmed and probable cases'.

Management of a suspected, probable or confirmed case

Management on initial presentation

- Rapidly obtain a history of the last 14 days (including a travel and contact history) from any patient with respiratory infection, either by phone prior to visit, or once they have a surgical mask on.
- All patients with respiratory infection should be provided with a surgical mask upon entry to the facility. Infection prevention and control precautions (standard, contact and droplets) should apply and the patient should always wear a surgical mask and be placed in a single room (see infection prevention and control guidance at health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-novel-coronavirus-resources-health-professionals).
- Patients with suspected COVID-19 should be managed medically according to their symptoms and clinical state. They do not need to be hospitalised unless clinically indicated.
- Patients with suspected COVID-19 should be advised to remain in strict isolation until advised otherwise (ie, till 48 hours after symptoms resolve and at least 10 days after symptom onset, till confirmed as NOT a case, or deemed to no longer be at risk).
- If admission or further assessment is required, the local hospital should be contacted and clearly informed that the patient is a suspected case before the patient is sent.

Further advice for primary health care professionals can be found at health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-resources-health-professionals

Interpretation of laboratory results and associated management

Table 1 - Decision matrix for interpretation of COVID-19 cases laboratory results and associated management

SARS-CoV-2 test result	Respiratory panel	Symptoms	Recommended Management
Negative	One or more tests positive	Consistent with alternative diagnosis	No further need for isolation due to COVID-19, however any pre-existing self-quarantine or isolation requirements continue to apply based on alternate diagnosis*
Negative	All negative or not done	Symptoms resolved	No further need for isolation due to COVID-19, however any pre-existing self-quarantine requirements continue to apply*, and recommend they remain in isolation until 48 hours after symptoms have resolved.
Negative	All negative or not done	Symptomatic	If COVID-19 considered unlikely, recommend isolation till 48 hours after symptoms have resolved. Consider discussing with ID physician/clinical microbiologist if COVID-19 still suspected. Consider further upper respiratory test or sputum test/lower respiratory tract specimen test. Assess isolation and self-quarantine based on test results, symptoms and pre-existing self-quarantine advice.
Equivocal	Negative or positive or not done	Symptomatic	Discuss with clinical microbiologist or ID physician. Further testing required. Remains in strict isolation until test results are conclusive. Assess ongoing isolation based on test results,

			symptoms and pre-existing self-quarantine advice.
Positive	Negative or positive or not done	Symptomatic or asymptomatic	Follow confirmed-case process

* A person who is in 14-days self-isolation/self-quarantine due to recent travel or after close contact with a confirmed or probable case should remain in self-isolation/self-quarantine until the end of the 14-day period, irrespective of the SARS-CoV-2 test results

Non-hospitalised COVID-19 cases

All non-hospitalised suspect, confirmed or probable cases of COVID-19 should remain in strict isolation at home, in their current accommodation, or other appropriate community facility until released from isolation. They should be provided with infection prevention and control advice along with advice regarding what to do if symptoms worsen.

Non-hospitalised cases should be actively monitored (eg, with daily phone calls for probable and confirmed, cases and periodic checking in for suspect cases³) for adherence to isolation requirements, for deterioration in clinical status, and to determine when they can be released from isolation. Provision of active monitoring of non-hospitalised probable and confirmed cases is a public health unit responsibility unless there has been clear delegation to another provider.

Home care information for cases and care givers is available at health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus#further

Interim guidance for health staff implementing home care of people not requiring hospitalisation for COVID-19 is available at health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-resources-health-professionals

Hospitalised COVID-19 cases

It is crucial to implement precautionary infection prevention and control measures within hospitals to prevent transmission in health care settings. Given the evidence that human-to-human transmission of SARS and MERS viruses is increased in hospital settings, a cautious approach with patients who meet the suspected case definition is advised in these settings.

Cases under investigation, and probable cases should be accommodated in a single room. If confirmed, they can be cohorted with other confirmed cases.

In addition to standard precautions, contact and droplet precautions should be taken. When performing an aerosol-generating procedure, apply airborne precautions including the use of an airborne infection isolation room (negative pressure room) where possible.

Please refer to WHO recommendations on clinical management of severe acute respiratory infection when COVID-19 is suspected: [who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/patient-management](https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/patient-management)

Release from isolation of suspect, confirmed or probable COVID-19 cases

In all situations, a person cannot be released from isolation unless advised by the health professional responsible for monitoring of their health and wellbeing. In some situations, other criteria may need to be considered such as the number of people they have infected (ie, a 'super shedder'), their occupation and underlying health conditions.

Suspect, confirmed and probable cases of COVID-19 with mild illness who did not require hospitalisation

At the discretion of the health professional responsible for monitoring (currently the public health unit for non-hospitalised probable and confirmed cases), the person can be released from isolation if they meet all the following criteria:

- at least 10 days have passed since the onset of symptoms

³ A solution is under development for monitoring and support for suspect cases (6 April, 2020)

- there has been resolution of all symptoms of the acute illness for the previous 48 hours.⁴

The person and their family/whānau should be advised to continue with hand hygiene and cough etiquette and practice social distancing.

A suspect case who, following investigation and testing, returns a negative test is considered Not a Case. They should be advised to remain in isolation till 48 hours after symptoms resolve. That is, the 10 days requirement and health professional confirmation of release do not apply.

Confirmed and probable cases of COVID-19 with more severe illness who have been discharged from hospital

Confirmed and probable cases that were being cared for in hospital must go into home (or other suitable community facility) isolation on discharge.

The person can only be released from isolation at the discretion of the health professional responsible, based on all the following criteria:

- at least 10 days have passed since hospital discharge
- there has been resolution of all symptoms of the acute illness for the previous 48 hours²
- they do not have major immunosuppression (such as being within a year of bone marrow transplantation or receiving chemotherapy).

People with persistent acute symptoms or fever after 10 days should remain in isolation, pending advice from a clinical microbiologist or infectious diseases physician. For patients with major immunosuppression, advice from the relevant specialist physician should be sought.

The person and their family/whānau should be advised to continue with hand hygiene and cough etiquette and practice social distancing.

Repeat sampling of respiratory tract secretions for PCR is not recommended for most patients, particularly where the above criteria are met. Patients recuperating and being considered for release from isolation for whom these criteria are not met or are in doubt should be discussed with the clinical microbiologist. In some cases, PCR testing may have a role based in clinical circumstances (eg, major immunosuppression or health care workers).

Contact tracing and management

Purpose of contact tracing

The purpose of contact tracing is to prevent potential onward transmission, raise awareness about the disease and its symptoms and support early detection of suspected cases.

Definitions

Close contact

Close contacts are those that are likely to be at a higher risk of being infected.

'Close contact' is defined as any person with the following exposure to a suspect, confirmed or probable case during the case's infectious period, without appropriate personal protective equipment (PPE):

- direct contact with the body fluids or the laboratory specimens of a case
- presence in the same room in a health care setting when an aerosol-generating procedure is undertaken on a case
- living in the same household or household-like setting (eg., shared section of in a hostel) with a case
- face-to-face contact in any setting within two metres of a case for 15 minutes or more

⁴ Some people may have pre-existing illnesses with chronic respiratory signs or symptoms, such as chronic cough. For these people, the treating medical practitioner should make an assessment as to whether the signs and symptoms of COVID-19 have resolved.

- having been in a closed environment (eg, a classroom, hospital waiting room, or conveyance other than aircraft) within 2 metres of a case for 15 minutes or more
- having been seated on an aircraft within 2 metres of a case (for economy class this would mean 2 seats in any direction including seats across the aisle, other classes would require further assessment)
- aircraft crew exposed to a case (a risk assessment conducted by the airline is required to identify which crew should be managed as close contacts).

Casual contact

Any person with exposure to the case who does not meet the criteria for a close contact.

Self-quarantine

Self-quarantine refers to people who are avoiding contact with others because they may have been exposed to COVID-19. Self-isolation would normally refer to people who are avoiding contact with others because they themselves have COVID-19, however, since the start of the outbreak 'self-isolation' has been used by the World Health Organization and others to refer to people who may have been exposed to COVID-19. We will be using the more appropriate term, self-quarantine, in our health professional advice from now on, but appreciate that the public are now more familiar with the term self-isolation, which may continue to be used in public messaging.

Self-quarantine means staying away from situations where someone could infect other people. This means any situation where you may come in close contact with others (such as face-to-face contact closer than 2 metres for more than 15 minutes), such as social gatherings, work, school, child care/pre-school centres, university, polytechnic and other education providers, faith-based gatherings, aged care and health care facilities, prisons, sports gatherings, restaurants and all public gatherings

Patients with recent overseas travel or who are close contacts of confirmed cases are expected to self-quarantine for 14 days from the last date of possible exposure (ie., last day overseas or last contact with a confirmed case).

If someone has recently travelled overseas but does not meet the clinical criteria or has a negative laboratory result, they may still become a case later in their 14 days of self-quarantine. For this reason, they should be advised to remain in self-quarantine for the balance of their 14 days. If they have any deterioration or emergence of new symptoms, they should contact Healthline or phone their GP.

Contact identification and assessment

Identify close contacts and determine whether they would meet the testing criteria in the event they should develop symptoms consistent with COVID-19.

The Ministry of Health has launched the National Close Contact Service (NCCS) to make initial contact with all close contacts (other than those who reside with the case) thought to have been in contact with someone who is a probable or confirmed case of COVID-19. Public Health Units need to provide the NCCS information on the close contacts of people with a confirmed case of COVID-19. They can do this via REDCap or using secure file transfer, or through direct entry into the NCCS.

The NCCS informs close contacts of their potential exposure, ensures they are aware of self-quarantine requirements and provides them with health advice. They also check what assistance they may require and provide contact details to obtain this. Once NCCS has made successful contact with a close contact, their details will be handed over to Healthline for regular follow up through the self-quarantine period.

Management of contacts

1. **Household close contacts of a suspect case who is not being tested**, should be advised to be meticulous with physical distancing, hand hygiene and cough etiquette, and immediately isolate and phone Healthline or their GP if symptoms develop. There are no restrictions on their movements, apart from those that may apply based on the current Government Alert Level.
2. **Household close contacts of a case under investigation** who is being tested at a minimum should be advised to self-quarantine until laboratory results are available. Other close contacts will be contacted later and as relevant if and when laboratory results are available.

3. **Close contacts of a probable or confirmed case** should be counselled about their risk and the symptoms of COVID-19 and if possible be provided with written information about the disease, self-quarantine guidance and a COVID-19 'All of Government Factsheet for Welfare Support'. Close contacts of probable or confirmed cases should be advised to **self-quarantine** for 14 days since last exposure with the case. If they develop symptoms they should immediately notify Healthline and/or their public health unit, and for health care workers, their facility infection control unit. **Symptomatic close contacts of confirmed and probable cases should be tested for COVID-19.**

The PHU is responsible for household contacts only – both the initial conversation and subsequent follow-up. The ongoing monitoring of other close contacts of probable and confirmed cases in self-quarantine is undertaken by Healthline for the 14-day period following initial contact by the NCCS. All close contacts of a confirmed or probable case (particularly an overseas confirmed case) should be reported to the local Medical Officer of Health and the NCCS.

Confirmed and Probable cases who have met the criteria for clearance and release from strict isolation and been cleared by the health professional overseeing their monitoring do not need to then be quarantined if they are a close contact of another probable or confirmed case. They still need to adhere to any general restrictions due to the Government Alert Level though.

1. **Casual contacts of a probable or confirmed case** should be advised to monitor their health for 14 days and to isolate themselves immediately if any symptoms develop and phone Healthline or their GP. For casual contacts with no symptoms there are no restrictions on movements (aside from any that already apply due to the current Government Alert Level. High risk casual contacts (immunocompromised, people with co-morbidities) do not require additional public health follow-up. This group should seek additional information from their health practitioner.

Special situations

Cases in health care or aged-care facilities

Any suspect case in these facilities should be under investigation and tested. If one or more confirmed or probable COVID-19 cases have occurred within a health care or aged-care facility, an outbreak management team should be convened, including a senior facility manager, an infection control practitioner and appropriate clinical staff, in consultation with public health unit staff.

People working in vulnerable settings

There is evidence that human-to-human risk of transmission of coronaviruses is increased in hospital and aged care settings. No health care workers can work in a public setting if they have been overseas or have been in close contact (without appropriate PPE) with a probable or confirmed COVID-19 case in the last 14 days. They should self-isolate for 14 days from the date of departure or last close contact

They should register their details with Healthline if they have not already (call 0800 358 5453 or +64 9 358 5453 for international SIM).

Exposed health care workers who are DHB employees should be discussed with the DHB infection prevention and control and/or occupational health teams.

Management of travellers

Every passenger entering New Zealand is now being screened for COVID-19 on arrival. Passengers are being disembarked in small groups and met by Government officials at the gate. When passengers disembark the plane, health officials will discuss self-isolation and transport arrangements and answer any questions passengers may have.

If passengers have a domestic transit flight, they will not be allowed to connect to that flight.

If a passenger is symptomatic on arrival, they will be tested and placed in an approved isolation facility for 14 days

If a passenger is not symptomatic on arrival, they will be asked to explain their plan for self-isolation and transport arrangements to that place and permitted to on travel if the arrangements are deemed suitable.

People who are close contacts of confirmed COVID-19 cases should be notified to the local public health unit and NCCS, receive daily monitoring of symptoms, self-quarantine for 14 days following last contact with a confirmed case and be provided with information on what they need to do if they develop symptoms.

Where to get further information and advice

Please see the webpages below for the latest information:

- General information for the public: health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus
- World Health Organization (WHO) situation updates and advice: who.int/emergencies/diseases/novel-coronavirus-2019

APPENDIX 1 – Example of standard operating procedures for contact management of probable and confirmed cases

Contact assessment

Identify close contacts, level of contact and contact details with priority given to household, health-care associated close contacts and high-risk contacts (those with co-morbidities, pregnant and immunocompromised).

Prioritising investigation of close contacts

- Identify the quarantine period for people/events.
- Prioritise contacts based on the following:
 - a. likelihood of developing severe disease if infected
 - b. likelihood of becoming infected (i.e. intensity/duration of exposure)
 - c. time since last exposure (i.e. urgency to go into quarantine).

Organising follow-up of close contacts

- Send all contact details to the National Close Contact Service who will undertake the remaining steps below, except in the case of immediate household contacts who *may* continue to be followed up by the Public Health Unit.
- For large contact groups:
 - a. ask a key informant (e.g. workplace manager or team lead; school principal; sports team coach) to send a list of people with likely exposure to the case
 - b. consider text and email for initial contact.

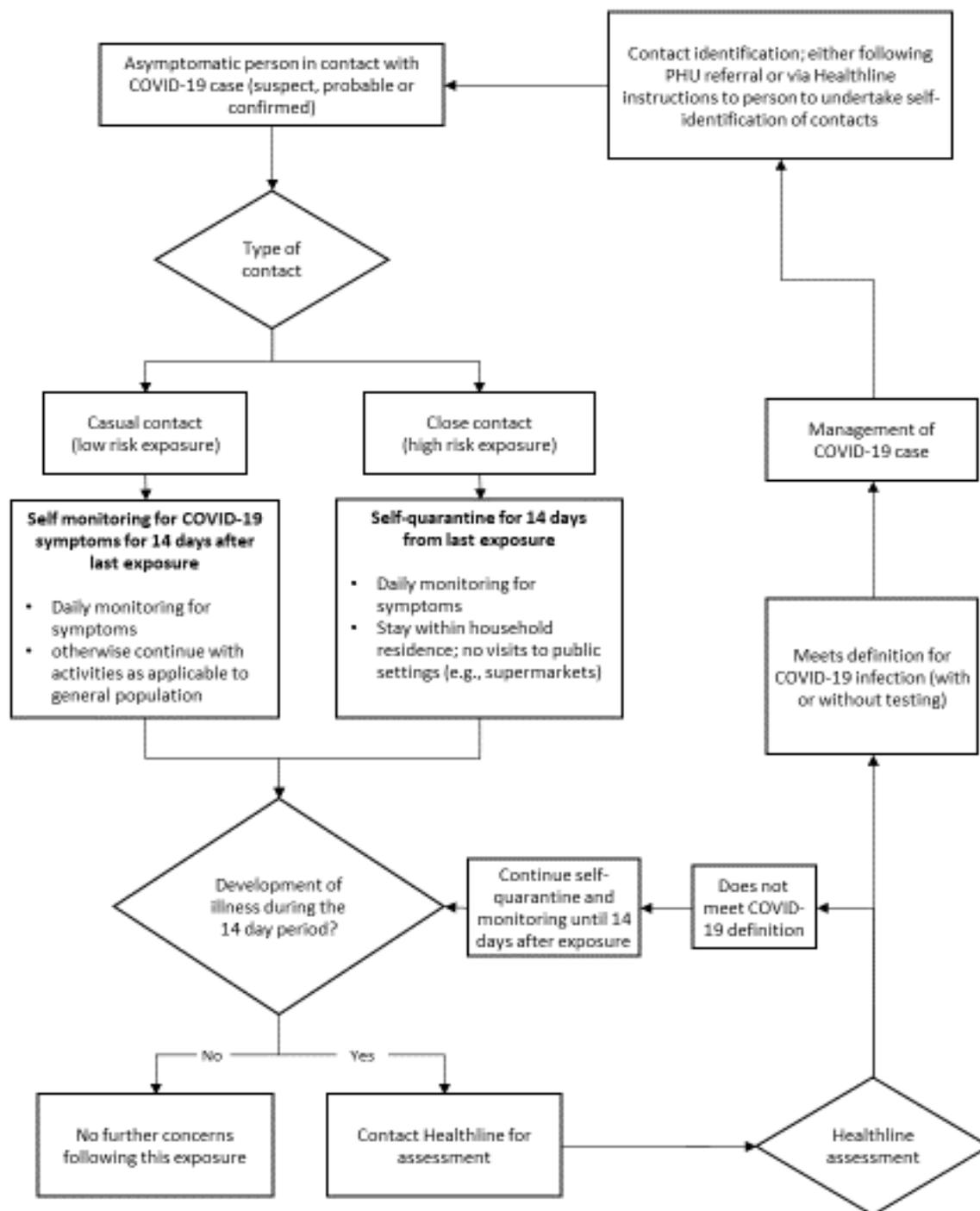
Investigating close contacts

- Initial communication with contact should be made by phone; gather information on symptoms (if any), risk factors for severe illness if infected, needs while in quarantine etc.
- Contacts with apparent symptoms of COVID-19 must be escalated urgently for clinical discussion and/or clinical assessment. Those that meet the suspect case definition will require management as cases.
- Routine laboratory testing for SARS-CoV-2 is NOT required for asymptomatic close contacts
- Close contacts of confirmed cases who are symptomatic should be considered probable cases. Testing is only required if there is uncertainty regarding the diagnosis or it will aid in management of the case and their contacts (e.g. health care worker)
- Close contacts of probable cases should be considered suspect cases and consideration given to testing them especially if they are in the categories prioritised for testing (refer case definitions).

Counselling and education of close contacts

- There is no specific chemoprophylaxis or immunoprophylaxis available for contacts.
- Advise that a negative test during the 14 day incubation period, does NOT mean that they no longer need to stay in quarantine.
- Counsel close contacts about their risk and symptoms of COVID-19; provide with written information if available.
- Advise that all close contacts self-quarantine at home for 14 days from last exposure to a confirmed COVID-19 case and should monitor their health during this 14-day period.
- If an identified close contact has already had COVID-19 and met the criteria for release from isolation, they do not need to undertake any further quarantine (however, any Government Alert Level restrictions still apply).

Figure 1 - COVID-19 contact management algorithm



Adapted from ECDC, "Public health management of persons, including health care workers, having had contact with COVID-19 cases in the European Union." Published 25 February 2020. URL: ecdc.europa.eu/sites/default/files/documents/covid-19-public-health-management-contact-novel-coronavirus-cases-EU.pdf

Quarantine and restriction of close contacts

- Provide contacts with guidance on monitoring health while in self-quarantine.
- Provide contacts with welfare support information.
- Provide advice on infection control for those in self-quarantine.

- Self-quarantined close contacts should be contacted daily for review of the following:
 - a. adherence with self-quarantine
 - b. development of symptoms that may be consistent with COVID-19
 - c. wellbeing while in self-quarantine.
- All those who develop symptoms that may be consistent with COVID-19 or who develop a temperature of 38 degrees Celsius or greater must be escalated for clinical discussion and/or assessment.
- Advise self-quarantined close contacts on the processes for seeking medical care (see below).

Investigation and management of casual contacts

Casual contacts should monitor their health for 14 days and report any symptoms.

There are no restrictions on movements apart from those that apply based on the current Government Alert level. However, casual contacts should be advised to isolate themselves and contact Healthline or their GP if they develop symptoms.

Medical care for individuals in self-isolation/self-quarantine

If individuals under self-quarantine need to see a doctor for any reason (e.g.fever, respiratory symptoms, other illness/injury), they should be advised to phone Healthline or telephone their GP or hospital emergency department before presenting. Patients with severe symptoms should phone 111 and make it clear that they are in self-quarantine because of COVID-19.

Self-quarantined close contacts who are unwell but not requiring urgent medical assessment should contact Healthline.