

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

17 July 2020

Updates

- The Release from Isolation criteria is being updated to require 72 hours since resolution of acute symptoms instead of 48 hours.
- The section on 'Who should be tested' has been updated, with more information provided on the population groups to be targeted by surveillance testing.

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 support New Zealand's elimination of COVID-19 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 does consider that there are still questions regarding the epidemiology of the virus.

There are separate documents covering **advice for primary health care**.

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, sore throat and anosmia, to shortness of breath and symptoms of pneumonia and severe acute respiratory infection. Most cases in New Zealand have had a mild illness, with approximately six percent having more severe illness requiring hospitalisation. 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 symptoms to date in New Zealand cases are cough, followed by headache, sore throat, and 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 procedures².

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.

Infection prevention to reduce the risk of transmission of acute respiratory infections

- Maintain physical distancing where possible and practical.
- Avoid close contact with people suffering from any symptoms of acute respiratory infection.
- Perform hand hygiene with an alcohol-based hand sanitiser containing at least 60 percent alcohol or wash hands for at least 20 seconds with soap and water, then dry thoroughly. If using sanitiser, ensure that enough is used to cover hands and rub hands together until dry. Always perform hand hygiene after direct contact with ill people or their environment.
- Keep hands away from face (eyes, nose and mouth).
- Facilitate and encourage respiratory hygiene and cough etiquette (cover coughs and sneezes with disposable tissues and place into bin after use, clean/wash and dry hands) or cough into the crook of your arm.
- People with acute respiratory symptoms should stay home if unwell.
- Apply standard precautions for all patients in health and disability care settings. (See the **PPE Frequently Asked Questions**.) All patients with respiratory infections should be provided with a surgical mask upon entry to the facility and if possible, should sit away from other patients in the waiting room or be placed in a single room.

² Refer to the Ministry's PPE guidance and frequently asked questions for further advice on PPE in different situations and a list of Aerosol Generating Procedures (www.health.govt.nz/ppe-health)

These infection prevention measures (as outlined above) are the most important way to stop the spread of respiratory infections, including COVID-19.

Where there is a higher index of suspicion of COVID-19, additional precautions (droplet and contact) should be immediately implemented, with airborne precautions when aerosolised respiratory secretion are generated². Aerosol generating procedures² should not be performed in primary health care.

There is more **infection prevention and control advice** available.

Please refer also to **WHO recommendations on 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

Case definition and criteria of COVID-19 – diagnostic testing

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

The **COVID-19 case definition** has been updated to reflect the current situation in New Zealand, where the greatest risk of re-introduction of COVID-19 and spread is via our border. We are currently in a position where people with an acute respiratory infection are not automatically considered a suspect case.

By revising the definition of who may have COVID-19 we can focus our efforts and resources on identifying those most likely to have it and supporting them to be tested.

People who meet the clinical and Higher Index of Suspicion (HIS) criteria must be tested for COVID-19 and self-isolate while awaiting test results, and the clinician must notify the local Medical Officer of Health.

Children (over six months) who meet both the clinical and HIS criteria should be tested where possible. Discretion should be applied when swabbing those under six months of age. Case definitions may need to be revised but the **current case definitions and criteria** will always be available on the Ministry of Health website.

Testing for surveillance purposes

The symptoms of COVID-19 are similar to many other illnesses. Over winter, most people, are likely to have another illness. However, it is important that, where appropriate, we continue to test people presenting to primary and secondary care who meet the clinical but not the HIS criteria, for surveillance purposes, to ensure that we do not have community transmission.

Children (unless they also meet the HIS criteria) are most likely to have another illness. Clinicians should use their discretion as to whether to test a child under 16 years.

People who meet the clinical but not the HIS criteria, who are tested do not need to self-isolate while awaiting test results. They should follow the advice of their health practitioner regarding staying at home if unwell.

Other conditions that require urgent assessment and management should always be considered alongside COVID-19.

Who should be tested?

The highest priority for testing is for those who meet both the clinical and the HIS criteria.

Others presenting to health services with symptoms consistent with COVID-19 may be tested for surveillance purposes, to help ensure we don't have community transmission in New Zealand, based on the judgement of the clinician.

Among people presenting to primary and secondary care who meet the clinical but not the HIS criteria, clinicians should offer a test for COVID-19 to those from the following population groups:

- those more likely to have severe consequences if they were to contract COVID-19. This group includes: seniors, Māori, Pacific peoples, and those who have significant pre-existing conditions³.
- health care workers and aged care residential staff. All patients in this group with symptoms consistent with COVID-19 should be offered a test.

It is important that clinicians use clinical discretion to determine if those outside the above groups presenting with symptoms consistent with COVID-19 should be offered a test.

Clinicians should be aware that immunocompromised patients may not present with typical symptoms.

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

You can find more information at: <https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-resources-health-professionals/case-definition-covid-19-infection>

How should people meeting the 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.

Specimen may be taken outdoors or in a well-ventilated space (eg, car park), as this also reduces transmission risk.

When collecting nasopharyngeal specimens appropriate PPE should be worn. Refer to **PPE for taking COVID – 19 naso/oropharyngeal swabs**.

When collecting specimens if there is a risk of aerosol generation a N95/P2 respirator should be worn by the health care worker if the person is a confirmed (or probable) COVID-19 case or meets the Clinical and Higher Index of Suspicion (HIS) criteria. 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 where there is a risk of aerosol generation should occur in an airborne infection isolation room if available. Refer to **Personal protective equipment use in health and disability care settings**. 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.

There is a list of activities which may be performed in a PC2 laboratory available, as well as additional precautions in the **WHO biosafety guidelines for handling of SARS specimens**.

³ Examples of significant pre-existing conditions are chronic obstructive pulmonary disease, high blood pressure, heart disease, diabetes

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. 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**.

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 (PHU). Those meeting both the clinical and HIS criteria should be notified to the local Medical Officer of Health, even if they refuse testing, or testing is not done. The notification will be reviewed by the local PHU because further assessment and management may be required.

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

Under the International Health Regulations, 2005, the Ministry will also notify the WHO of a confirmed (or probable) 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 confirmed (or probable) cases and those meeting both the clinical and HIS criteria

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, ideally by phone prior to visit, or by maintaining physical distancing of at least 1 metre while asking.
- All patients with a respiratory infection should be provided with a surgical mask upon entry to the facility and wear until placed in a single room.
- **Infection prevention and control guidance** (standard, contact and droplets) should be followed when managing patients meeting **both** the clinical and HIS criteria for COVID-19.
- Patients meeting **both** the clinical and HIS criteria for COVID-19 should be:
 - managed medically according to their symptoms and clinical state
 - advised to stay in strict isolation until advised otherwise (ie, till confirmed as NOT a case, or deemed to no longer be at risk)
 - notified to the local PHU; if testing is refused or not possible, include detail on notification to the PHU

If they test negative, COVID-19 is not confirmed. In this situation, assessment and management should be based on their clinical presentation (some patients may require further review by public health)

If admission or further assessment is required, the local hospital should be contacted and clearly informed that the patient meets both the clinical and HIS for COVID-19 before the patient is sent.

There's further advice for **primary health care professionals** available.

Management of non-hospitalised COVID-19 cases

All non-hospitalised confirmed (or probable) cases of COVID-19 should remain in strict isolation at home, in their current accommodation, or other appropriate managed quarantine 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 confirmed (or probable) cases should be actively monitored (eg, with daily phone calls) 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 confirmed (or probable) cases is a public health unit responsibility unless there has been clear delegation to another provider. Primary care providers may also provide follow-up of COVID-19 cases to monitor medical needs.

Home care information for cases and care givers is available.

Also available is **interim guidance for health staff implementing home care of people not requiring hospitalisation for COVID-19**.

Management of 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 both the clinical and HIS criteria is advised in these settings.

Patients 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 see **Infection prevention and control procedures for DHB acute care hospitals** and **Personal protective equipment use in health and disability care settings**. Further information can be found at and **WHO recommendations on clinical management of COVID-19**.

Release from isolation of 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.

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 and probable 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

- there has been resolution of symptoms of the acute illness for the previous 72 hours.^{4,5}

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

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 until released from isolation.

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 72 hours^{3, 4}
- they do not have major immunosuppression (such as being within a year of bone marrow transplantation or receiving chemotherapy).

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

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.

Managing relapsing cases

Some cases that met the requirements and were released from isolation re-present shortly afterwards with mild respiratory or other COVID-19 symptoms. The following is recommended:

- there is little value in retesting for COVID-19 as a positive PCR does not mean they are infectious; discuss the need for retesting with local public health unit
- retesting is only recommended if their condition deteriorates and they are hospitalised – it may be because of another condition such as bacterial pneumonia rather than COVID-19
- if they are retested and are PCR positive, they do not need to be isolated. This is because the virus can continue to be detected long after the infectious period is over
- close contacts have no additional quarantine requirements beyond their existing ones, and any new close contacts do not need to be quarantined
- consider testing for other pathogens
- if they have ongoing symptoms and have been deemed non-infectious and able to go back to work or school, a letter can be provided from public health unit declaring this
- case management should be determined by the treating health practitioner based on the likely diagnosis/cause and assessment of likely infectivity.

Managing cases with persistent symptoms

Some cases have persistent symptoms or a prolonged disease course, such as prolonged cough. These cases should be managed on a case by case basis with a decision made on release from isolation following

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.

⁵ Refer also, Management of cases with prolonged illness for further advice.

interdisciplinary case review eg involving the Medical Officer of Health, GP, the clinical microbiologist, and infectious disease physician.

Repeat sampling of respiratory tract secretions for PCR is not recommended for most patients, particularly where the release from isolation criteria are met. In some cases, PCR testing may have a role based in clinical circumstances (eg, major immunosuppression).

Health care workers who are cases

Health care workers who are confirmed (or probable) COVID-19 cases should follow the standard advice for release from isolation. There is no longer a requirement to have two negative PCR tests before returning to work.

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 at a higher risk of being infected.

'Close contact' is defined as any person with the following exposure to a 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 2 metres of a case for 15 minutes or more
- 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; or in a higher-risk closed environment 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).

*The local Medical Officer of Health will determine whether an environment is higher-risk. Considerations include the nature of the gathering, the level of contact between individuals and the ability to observe physical distancing/hygiene measures.

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 primarily staying home and 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, pubs/bars and all public gatherings.

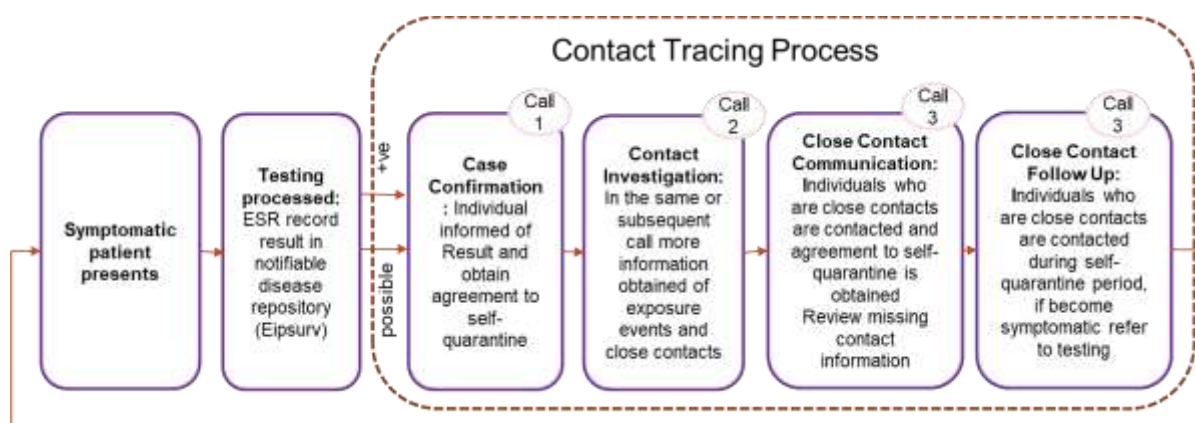
People with recent overseas travel or who are close contacts of confirmed (or probable) cases are expected to self-quarantine for 14 days from the last date of possible exposure (ie, last day overseas or last contact with a confirmed or probable case). Unless granted an exemption, those arriving from overseas will spend at least 14 days in a managed isolation facility (MIF). All overseas arrivals will undergo COVID-19 testing on or around day 3 and day 12 of their stay. If, during their stay, they are confirmed as having COVID-19, then they will be subject to the Release from Isolation criteria. Provided they meet the Release from Isolation criteria and have completed at least 14 days in managed isolation or quarantine, they may be considered to meet the low-risk indicators as outlined in the COVID-19 Public Health Response (Air Border Order) 2020.

If someone has recently travelled overseas or have been a close contact with a confirmed (or probable) case 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 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. If they are in a MIF they will be managed under the border controls and managed isolation process. See further information about the **Border Controls**.

Contact identification and assessment

Contact tracing is an existing practice performed by PHUs to manage infectious notifiable diseases. The high level steps in this process are:

- **case confirmation:** inform an individual of their diagnosis and direct them to self-isolate
- **contact investigation:** determine who the individual could have potentially infected
- **close contact communication:** contact the potentially infected individuals, advising them to self-quarantine and provide health and welfare advice
- **close contact follow-up:** daily communication with the close contact to check if they are developing symptoms. If close contacts become symptomatic with clinical signs consistent with those noted in COVID-19, they should have a clinical assessment to determine if they have now become a case.



Close contact tracing is a time-critical action to isolate a confirmed case of notifiable disease and their close contacts. The National Close Contact Service (NCCS) was established to support PHUs to manage the contact tracing process and is prepared to be scaled up in size and efficiency, if required.

The National Contact Tracing Solution (NCTS) is an IT system that was rapidly developed and stood up on 6 April 2020 to support contact tracing work. The NCTS will be the national repository of data about individuals who have been identified as confirmed (or probable) cases and their close contacts. This information is recorded by and visible to staff across the contact tracing services. The NCTS is being progressively rolled out to PHUs.

Management of contacts

PHUs are responsible for contacting and managing confirmed (and probable) COVID-19 cases and their households. The PHU may choose to manage other close contacts, for example where the individuals or living situations are considered especially vulnerable such as those living in aged residential care. The NCCS is responsible for providing contact tracing services for other close contacts as transferred by the PHUs.

Following initial contact by the NCCS, ongoing monitoring of other close contacts of confirmed (or probable) cases in self-quarantine is undertaken by Healthline for the 14-day period. If a close contact becomes symptomatic, they are referred for testing and back to the PHU for follow-up. All close contacts of a confirmed or probable case (particularly those self-identifying as being a close contact of 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 confirmed (or probable) case. They still need to adhere to any general restrictions due to the Government alert level though.

1. **Household contacts of a person meeting the clinical and HIS criteria** do not need to self-isolate unless there is a high degree of suspicion that the person under investigation is likely to be a case [eg, they are a symptomatic close contact of a confirmed (or probable case)]. Other close contacts will be contacted later if the case is confirmed or probable.
2. **Close contacts of a confirmed (or probable) case** should be counselled about their risk and the symptoms of COVID-19 and be provided with written information (or weblink) about the disease, self-quarantine guidance (including the need to wear a mask when seeking urgent care) and a COVID-19 'All of Government Factsheet for Welfare Support'. Close contacts of confirmed (or probable) cases should be advised to **self-isolate** for 14 days since last exposure with the case. If they have been or are symptomatic, they are immediately referred for testing and to the PHU. **Symptomatic close contacts of confirmed (or probable) cases should be tested for COVID-19.**
3. **Health care workers who are close contacts of a confirmed (or probable) case**
In addition to the advice for close contacts of a confirmed (or probable) case, health care workers who develop symptoms should immediately notify their facility infection control unit. All health care workers should be tested for COVID-19 prior to release from self-quarantine, on around day 12 or 13, even if they have no symptoms. A negative test is required before they can return to work.
4. **Close contacts wanting to transfer or be admitted to an aged residential care facility**
In addition to the advice for close contacts of a confirmed (or probable) case, a close contact wanting to transfer or be admitted to an aged residential care facility should be tested for COVID-19 prior to release from self-quarantine, on around day 12 or 13, even if they have no symptoms. In this circumstance, a negative test is required before they can be admitted to an ARC facility.
5. **Casual contacts of a confirmed (or probable) case**, if identified, 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

A single case within a vulnerable residential institution such as an aged residential care facility, should be considered as a potential institutional cluster. Rapid investigation and case finding should be led by the local Medical Officer of Health in partnership with the facility manager.

In addition to identifying potential sources of infection, it is important to identify any one who may have been exposed to the case while infectious, or where the source is unknown, may have passed it on to the case within the previous 14 days.

Testing of all contacts (staff, residents and visitors) including those who are asymptomatic within this setting as a point in time assessment is appropriate, and recommended, in these circumstances. A negative test does not preclude someone from becoming infectious later in their 14 days since last contact with the case, so they should be appropriately quarantined and closely monitored over the remainder of their quarantine period. Consider testing on day 12 of their quarantine period if there are concerns regarding their ability to recognise and report symptoms.

Read more about the **guidelines for cluster investigation and control**, and when an outbreak in an aged care facility can be considered closed.

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 if they have been overseas or have been in close contact (without appropriate PPE) with a confirmed (or probable) COVID-19 case. They should self-quarantine for 14 days from the date of departure or date of last exposure with the case. Health care workers need to follow the advice for returning to work in the management of contacts section above.

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.

If a passenger is symptomatic on arrival, they will be tested and placed in an approved managed facility for a minimum of 14 days. They will undergo daily monitoring and symptom check.

If a passenger is not symptomatic on arrival, they will be placed in an approved managed facility for a minimum of 14 days and undergo daily monitoring and symptom check. If they remain asymptomatic, they will be tested on around day 3 and day 12 of their quarantine period. If they develop symptoms they will also be tested.

For further information, refer to **COVID-19 Advice for Travellers**.

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

COVID-19

- World Health Organization (WHO) situation updates and advice:
[who.int/emergencies/diseases/novel-coronavirus-2019](https://www.who.int/emergencies/diseases/novel-coronavirus-2019)

APPENDIX 1 – Example of standard operating procedures for contact management of confirmed (or probable) cases

Contact assessment

Identify close contacts, level of contact and contact details with priority given to household, health-care or aged-care associated close contacts and high-risk contacts (those with co-morbidities, pregnant and immunocompromised). Ascertain whether a digital diary or any contact tracing apps have been used and undertake the processes associated with these tools to identify and notify possible contacts.

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 (ie, intensity/duration of exposure)
 - c. time since last exposure (ie, 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 (eg, workplace manager or team lead; school principal; sports team coach) to send a list of people with likely exposure to the case as per their contact tracing registers
 - b. consider text and email for initial immediate contact with follow-up by phone.

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 clinical criteria will require testing.

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 /self-isolation.
- Counsel close contacts about their risk and symptoms of COVID-19; provide them with written information if available.
- Advise that all close contacts must self-isolate 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).

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 including the need to wear a mask if seeking urgent care.
- Close contacts in self-quarantine 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 must be escalated for clinical discussion and/or assessment and testing.
- Advise close contacts in self-quarantine 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 consistent with COVID-19.

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

If individuals under self-quarantine or self-isolation need to see a doctor for any reason (eg, 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 or self-isolation because of COVID-19. They need to wear a mask when receiving any urgent care, to prevent potential transmission to others, even if they do not have symptoms consistent with COVID-19.

Close contacts who are in self-quarantine who are unwell but not requiring urgent medical assessment should contact Healthline.