COVID-19: Primary care quick reference guide

10 April 2020

Case definition of COVID-19 infection

The Ministry of Health develops the case definitions for COVID-19 based on expert advice from our Technical Advisory Group. The criteria are revised frequently. A full explanation of the case definition is found at **www.health.govt.nz/covid19-case-definition.** Note that the suspect case definition is broad, intended to capture all of those who have the disease. This means that many of those who meet the suspect case definition will not have COVID-19.

A suspect case satisfies the following clinical criteria:

Any acute respiratory infection with at least one of the following symptoms: cough, sore throat, shortness of breath, coryza[1], anosmia[2] with or without fever.

Step 1: Infection prevention and control for patient and staff

Patient

A patient that meets the clinical criteria above should be managed as outlined below.

- Provide a surgical mask to the patient and supervise them putting it on – your practice can consider whether this is done at the front desk or whether the patient enters by another entrance.
- Place patient in single room (not in waiting room or treatment room) and shut the door. Provide them with tissues and hand sanitiser. This room can be used by other patients once cleaned.

Staff

Only staff who will be in contact with the patient for more than 15 minutes and within 2 metres, or are undertaking a physical exam or swabbing, need to wear PPE. Reception staff do not need to wear a face mask or any other PPE. PPE for primary care is based on **droplet** and **contact**-transmission precautions, which includes:

- gown or apron
- surgical face mask
- gloves
- eye protection.

[1] Coryza – head cold, eg, runny nose, sneezing, post-nasal drip

[2] Anosmia – loss of sense of smell

See PPE for staff taking nasopharyngeal/throat swabs at **www.health.govt.nz/ppe-health** for more information

PPE should be put on in the following order: hand hygiene, gown, mask, protective eyewear, gloves; and taken off in the following order: gloves, hand hygiene, protective eyewear (if separate from mask), gown, hand hygiene, mask, hand hygiene.

Gloves should be removed and replaced if soiled and hand hygiene performed.

Step 2: Clinical care

- Patients with suspected, probable or confirmed COVID-19 infection, or those under investigation, should be managed medically according to their symptoms and clinical state. They do **not** need to be hospitalised unless clinically indicated and their home care situation is suitable.
- Aerosol generating procedures[3] such as the use of nebulizers should be avoided in primary care.
- Any patients requiring aerosol generating procedures or patients with severe illness should be referred to hospital.

Red flags which should mandate urgent clinical review and potential hospital admission

- Respiratory distress
- Dyspnoea (included reported history of new dyspnoea on exertion)
- Haemoptysis
- Altered mental state
- Clinical signs of shock
- Unable to mobilise without assistance by carers
- Unable to safely provide self-care
- No alternate carers available
- Any other reason that may require hospital admission as assessed by a medical practitioner

Discuss these patients with the on-call medical team, infectious diseases or clinical microbiology service and transfer to hospital, as per your local DHB pathways. Swabs will be obtained in hospital. Ensure safe transit and controlled entry to hospital through liaison with admitting service, and ambulance service if required.

Priority groups for investigation and testing

Ideally all people meeting the suspect case definition for COVID-19, or where the clinician has a high degree of suspicion[4], would be tested to confirm or exclude a diagnosis. The following groups of people have been prioritised for testing at this stage.

[3] Aerosol generating procedures include tracheal intubation, non-invasive ventilation, tracheostomy, bronchoscopy, manual ventilation, sputum induction, high flow nasal oxygen, cardiopulmonary resuscitation.

[4] Some people may not meet the suspect case definition but may present with symptoms such as only: fever, diarrhoea, headache, myalgia, nausea/vomiting, or confusion/irritability. If there is not another likely diagnosis, and they have a link to a recent traveller, a confirmed, or probable case, consider testing.

Suspect cases, where they **or one or more of their household/bubble** meet one or more of the following criteria, should be tested:

- people meeting the clinical criteria who have travelled overseas in the last 14 days, or have had contact, in the last 14 days, with someone else who has recently travelled overseas
- hospital inpatients who meet the clinical criteria
- health care workers meeting the clinical criteria
- other essential workers meeting the clinical criteria if they have had close or casual contact with a probable or confirmed COVID-19 case
- people meeting the clinical criteria who reside in (or are being admitted into) a vulnerable communal environment including aged residential care, or large extended families in confined household/ living conditions
- people meeting the clinical criteria who may expose a large number of contacts to infection (including barracks, hostels, halls of residence, shelters etc).

In addition, testing may be required:

- on advice from the local Medical Officer of Health, when an outbreak or cluster is suspected, or being investigated.

As local testing capacity allows:

- consider suspect cases presenting with new or worsening cough.

These criteria may change as the situation evolves. Testing of individuals who are asymptomatic is NOT recommended unless requested by the local Medical Officer of Health.

Household and other close contacts[5] of those who have tested positive, and who go on to develop symptoms should not be tested unless they meet one of the red flags criteria or are a health care worker.

If swabbing is indicated, use a **single** nasopharyngeal swab (NPS) to swab the nasopharyngeal space. To ensure adequate collection, the swab tip must extend well beyond the anterior nares until some resistance is met. Droplet and contact PPE precautions (as described above) are sufficient.

Step 3: Cleaning

Once a suspect case has been transferred from the primary care premises, a general clean of the room can be undertaken. If the patient uses the toilet, the following cleaning procedures also apply. You do not need a stand-down period before you can use the room again.

- Remove any linen that has been used into linen bags for hot washing.
- Wipe down hard surfaces with detergent and water, then hospital grade disinfectant.
- Remove and discard PPE as clinical waste (taken off in the following order: gloves, hand hygiene, protective eyewear (if separate from mask), gown, hand hygiene, mask, hand hygiene).
- Perform hand hygiene thoroughly to elbows.

Step 4: Management

- Public health units will inform patients and provide information if the result is **positive.** Primary care is responsible for informing patients and providing advice if the result is **negative.**[6]

[5] Definitions of close and casual contact are found here www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-health-advice-general-public/contact-tracing-covid-19

[6] There is additional information for patients who have a negative test available here www.health.govt.nz/covid19-qaa-primary-care#negative

- If the patient does not require hospitalisation, the patient should be requested to self-isolate at home (see **www.health.govt.nz/covid19-self-isolation**).

- Those with positive results, or who do not meet the criteria for testing, must isolate at home till 48 hours after symptoms resolve and at least 10 days after symptom onset.

- Those with negative results must also self-isolate. Provided they are not close contacts, they can be released from self-isolation when they have been symptom-free for 48 hours.

- Close contacts who are symptomatic and test negative still need to complete their 14 days self-isolation. (They should also be reviewed by the public health unit to determine whether repeat testing is required or whether they should be considered a probable case.)

- Any household or other close contacts of suspect cases should be meticulous with physical distancing, hand hygiene and cough etiquette, and immediately isolate and phone Healthline if symptoms develop within 14 days of the last exposure to the suspect case. Household contacts of cases under investigation should behave similarly, and self-quarantine while awaiting test results.

Further advice (including on the management of close contacts of probable and confirmed cases) is available in the Information for Health Professionals on **health.govt.nz/covid-19.**

The Health Act 1956 requires health professionals to notify the Medical Officer of Health on suspicion of notifiable disease. Local public health units will prepare protocols of how primary care can perform this requirement: this may involve e-notification, fax, or email.