Interim Guidance Public Health Measures

Managing Novel Coronavirus (COVID-19) Cases and Contacts in Community

Situation

The strategy outlined in this guidance is intended to focus on case and contact management to mitigate the health impacts of COVID-19 on Manitobans. This guidance is set in the Canadian context and is based on the available scientific evidence and expert opinion. In interpreting and applying this guidance, it is important to recognize that the health, disability, economic, social, or other circumstances faced by some individuals and households may limit their ability to follow the recommended measures. This may necessitate adapted case management and contact responses in some situations.

This document is based on the Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus from the Public Health Agency of Canada¹. Information on the situation is evolving. This guidance will be updated as further information becomes available.

Background

First identified in the 1960s, there are now seven known coronaviruses that can infect people. While four of these cause mild-to-moderate illness in humans, recently discovered viruses such as SARS (severe acute respiratory syndrome) and MERS-CoV (Middle East Respiratory Syndrome Coronavirus) can cause severe illness. On January 12, 2020, the World Health Organization confirmed China’s detection of a novel coronavirus (COVID-19) with significant

¹ PHAC. Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (COVID-19) (February 6, 2020)
health impacts. Early information suggest that common symptoms include fever (> 90%), malaise, dry cough (80%), shortness of breath (20%) and respiratory distress (15%).

Current case numbers can be found on the Johns Hopkins coronavirus website (www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6)

Surveillance Case Definitions

Surveillance case definitions are provided for the purpose of standardized case classification and reporting. They are based on the current level of epidemiological evidence and uncertainty, and public health response goals, and are subject to change as new information becomes available.

These surveillance case definitions are not intended to replace clinician or public health practitioner judgment in individual patient management or testing, or for the purpose of infection control triage. For current screening and testing advice, please refer to https://manitoba.ca/asset_library/en/coronavirus/screening_tool.pdf

Suspect case – A person with symptoms that include two or more of:
- Fever (signs of fever)
- Cough (new or exacerbated chronic)
- Sore throat
- Runny nose
- Headache, AND

Meets the exposure criteria OR Had close contact with a probable case of COVID-19.

Note: COVID-19 may present as a co-infection with other pathogens. At this time, the identification of one causative agent should not exclude COVID-19 where the index of suspicion may be high.

Probable case – A person who
- has a fever (> 38°C), AND/OR
- has new onset of (or exacerbation of chronic) cough or difficulty breathing, AND
- meets exposure criteria, AND
- for whom laboratory diagnosis of COVID-19 is:
  - inconclusive (inconclusive is defined as a positive test on a single real-time PCR target or a positive test with an assay that has limited performance data available),

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- NAATs must be validated for detection of the virus that causes COVID-19.
- An indeterminate result on a real-time PCR assay is defined as a late amplification signal in a real-time PCR reaction at a predetermined high cycle threshold value. This may be due to low viral target quantity in the clinical specimen approaching the limit of detection (LOC) of the assay, or may represent nonspecific reactivity (false signal) in the specimen. When clinically relevant, indeterminate samples should be investigated further in the laboratory (e.g. by testing for an alternate gene target using a validated real-time PCR or nucleic acid sequencing that is equally or more sensitive than the initial assay or method used) or by collection and testing of another sample from the patient with initial indeterminate result.

**OR**

- A (un-tested)person with:
  - Fever (over 38 degrees Celsius), **AND/OR**
  - Cough (new or exacerbated chronic); **AND**
  - Close contact\(^3\) with a confirmed case of COVID-19, **OR**
  - Lived in or worked in a closed facility known to be experiencing an outbreak of COVID-19 (e.g., long-term care facility, correctional facility)

**Confirmed case** – A person with

- laboratory confirmation of infection with the virus that causes COVID-19 performed at a community, hospital or reference laboratory (NML or a provincial public health laboratory) running a validated assay, or performed in a community facility with approved point of care testing (e.g. GeneXpert). This consists of detection of at least one specific gene target by a NAAT assay (e.g. real-time PCR or nucleic acid sequencing).

**Note:**

- nucleic acid amplification tests must be validated for detection of the virus that causes COVID-19. Positive laboratory tests during early stages of testing (e.g. first 10 positive tests) at a non-reference laboratory require additional testing at a reference laboratory for confirmation.
- laboratory tests are evolving for this emerging pathogen, and laboratory testing recommendations will change accordingly as new assays are developed and validated.

**Exposure Criteria:**

In the 14 days before onset of illness, a person who:

\(^3\) A close contact is defined as a person who provided care for the patient, including healthcare workers, family members or other caregivers, or who had other similar close physical contact or who lived with or otherwise had close prolonged contact with a probable or confirmed case while the case was ill. Prolonged exposure is defined as lasting for more than 15 minutes.
• Traveled to an affected area (including inside Canada). OR
• Participated in a mass gathering identified as a source of exposure (e.g., conference) OR
• Close contact with a person with acute respiratory illness who has been to an affected area within 14 days prior to their illness onset OR
• Laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19.

Factors that raise the index of suspicion should also be considered. Other exposure scenarios not specifically mentioned here may arise and may be considered (e.g. history of being a patient in the same ward or facility during a nosocomial outbreak of COVID-19).

Laboratory Testing

• In addition to routine investigations relevant to the patient’s symptoms and care, testing for COVID-19 requires a nasopharyngeal (NP) swab placed in viral transport medium, or performed in a community facility with approved point of care testing (e.g. GeneXpert). If such a specimen is being collected for ILI or presumed viral RTI, then a second swab is not required.
• For samples being sent to CPL, include the following information on the CPL General Requisition: relevant symptoms, priority group/reason for test, outbreak code if applicable, and request for COVID-19.
• More severely ill patients may also require deep lung specimens be submitted, such as sputum, ETT secretions or broncho-alveolar lavage specimens.
• Serological testing to investigate immune response to COVID-19 infection is not yet available for clinical use in Manitoba. Serological assays have been developed to detect the host antibody response to COVID-19. At this time, serological assays can only determine past exposure to COVID-19. Given the variable test performance and the uncertainty of true disease prevalence, caution needs to be taken when interpreting results from serological assays. There is no current role for serologic tests in case and contact management.
• The Respiratory Virus Infections Working Group of the Canadian Public Health Laboratory Network has developed laboratory testing best practices for COVID-19 and has updated its protocol on microbiological investigation of emerging respiratory pathogens, including severe acute respiratory infections.4,5

Contact Definitions

**Period of communicability** - The period extending from 48 hours prior to the development of overt symptoms in the case until the case is classified as no longer infectious.

Note that the extent to which asymptomatic and pre-symptomatic transmission of COVID-19 is occurring is unclear. There is sufficient evidence to suggest that pre-symptomatic transmission is occurring, but based upon the current epidemiological evidence, it is not known whether truly asymptomatic transmission is also occurring and whether pre-symptomatic transmission is a major driver of transmission. The evidence base on this subject continues to evolve rapidly.

**Discontinuing home isolation:** An individual who has been placed on home isolation can stop home isolation 10\(^7\) days after the onset of their first symptom provided they are afebrile and have improved clinically. Absence of cough is not required for those known to have chronic cough or who are experiencing reactive airways post-infection. For asymptomatic cases, isolation can be discontinued if at least 10 days have passed since the specimen collection date of the confirmatory laboratory sample. In general, repeat laboratory testing (i.e., a negative test result) as the basis for discontinuing home isolation is not recommended.

**This criteria does not apply to hospitalized patients.** Decisions on discontinuing isolation should be made in conjunction with the case’s health care providers, considering both the clinical and laboratory findings. Information on discontinuing precautions in hospitalized cases can be found in the COVID-19 Specific Disease Protocol (Provincial) – Acute and Community Settings - [https://sharedhealthmb.ca/files/IPC-acute-care-manual-provincial.pdf](https://sharedhealthmb.ca/files/IPC-acute-care-manual-provincial.pdf)

**Health Care Workers (HCWs):** Those who work in health care settings may need to meet additional requirements before returning to their workplace. For cases that are HCWs, public health should notify and consult with regional occupational health at the end of the home isolation period to determine any additional requirements before the HCW returns to the workplace. In general, HCWs can return to work without laboratory testing 10 days after the onset of their first symptom provided they are afebrile and have improved clinically for at least 72 hours. If symptoms remain, consult Occupational Health on return to work guidance, which may include laboratory testing if symptoms continue to persist. Further information on return to work can be found at: [https://sharedhealthmb.ca/files/covid-19-screening-tool-hcw-symptomatic.pdf](https://sharedhealthmb.ca/files/covid-19-screening-tool-hcw-symptomatic.pdf)

**Close contact** – A person who, within the period of communicability

- provided care for the case, including HCWs, family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment, OR
- who lived with or otherwise had close prolonged* contact (within 2 metres) with a probable or confirmed case while the case was ill, OR

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\(^6\) Evidence is limited on transmission of the infection during the incubation period or during asymptomatic infection. There are a small number of case reports suggesting asymptomatic transmission can occur.

\(^7\) Manitoba previously used 14 days of isolation post symptom onset. Evidence supports limiting to 10 days post-symptom onset, and is consistent with current national guidance.
• had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended personal protective equipment.

*As part of the individual risk assessment, consider the duration of the contact’s exposure (e.g., a longer exposure time likely increases the risk), the case’s symptoms (coughing or severe illness likely increases exposure risk) and whether exposure occurred in a health care setting. Prolonged exposure is defined as lasting for more than 15 minutes.

Public Health Management of Cases

Suspect, probable and confirmed cases well enough to be managed at home

Epidemiologic evidence suggests that the majority of people who develop COVID-19 will have mild illness and will not require care in a hospital. Cases whose clinical condition does not require hospital care may be cared for in the home environment as long as effective isolation and appropriate monitoring (i.e., for worsening of illness) can be provided. The location where a person will isolate will be determined by their healthcare provider and public health.

Considerations for a suitable environment will depend on individual or household living situations and may vary depending on the sex, gender, or other socioeconomic or identity factors of cases. Cases should be isolated away from others in the home or co-living setting, including household members (i.e. not to go out unless directed to do so to seek medical care, not to take public transportation to seek medical care and to avoid contact with others).

When determining the location, several factors to determine the suitability of the home setting are described below.

• Ability to self-manage: Symptomatic and asymptomatic cases should be able to monitor themselves for symptoms, maintain proper personal hygiene practices (i.e., hand hygiene, respiratory etiquette, clean and disinfect high-touch surfaces) and isolate away from others (See Appendix 1), which will be impacted by:
  o Household social and economic circumstances such as insecurity, violence or abuse;
  o Inadequate housing conditions (e.g. lack of access to clean water and appropriate supplies), economic barriers (e.g., inability to purchase larger quantities of needed supplies at one time, unstable employment or inflexible working conditions);
  o Individual skills, abilities and vulnerabilities such as difficulty reading, speaking, understanding or communicating, physical or psychological difficulty undertaking preventive activities and using protective equipment, need for assistance with personal or medical care activities or supplies, or need for ongoing supervision.
  o Social or geographic isolation such as lacking family or community contacts for support or residing in an area with reduced access to services or supports;
The ability for the case to access plain-language instructions in the appropriate languages on:

- **Severity of illness.** The case is exhibiting mild symptoms that do not require hospitalization, taking into consideration their baseline health status and the presence of risk factors for severe disease or outcomes (i.e., older adults, chronic medical conditions, immunocompromised, or obesity (BMI of 40 or higher)). Instructions should be provided on self-monitoring of symptoms and when/how to seek medical care.

- **Household configuration.** Cases will be in varying household configurations that may hinder their ability to isolate themselves. This includes single-parent households, and multi-generational households with shared child care and elder care responsibilities. It also includes situations where child care is shared between two homes. In this context, the children should remain in the household that does not have a case for the duration of the self-isolation.

- **Suitable home care environment.** In the home, the case should stay in a room of their own so that they can be isolated from other household members. If a separate room is not feasible, ensure that shared spaces are well ventilated (e.g. windows open, as weather permits) and that there is sufficient room for other members of the home setting to maintain a two-metre distance from the case whenever possible. If the ill person is sleeping in the same room as other persons, it is important to maintain at least 2 meters of separation from others (e.g. separate beds and have people sleep head-to-toe, if possible). If a separate bathroom is not available, the bathroom should be cleaned and disinfected frequently.

- **Cohorting cases in co-living settings (e.g. those living in university dormitories, shelters, overcrowded housing).** Special consideration is needed to support cases in these settings when isolating. If residing in a dormitory, such as at a post-secondary institution or where there is overcrowded housing, the preferred option is to provide the case with a single room (e.g. relocate any other roommates to another location) with a private bathroom. If it is not possible to provide the case with a single room and a private bathroom or to relocate the case outside of the home, ensure that shared spaces are well ventilated (e.g., windows open, as weather permits) and that there is sufficient room for other members of the home setting to maintain a two-metre distance from the case. If the case cannot be isolated in their own room, hanging a sheet from the ceiling to separate the ill person from others may be considered. If the ill person is sleeping in the same room as other persons, it is important to maintain at least 2 metres distance from others (e.g. separate beds and have people sleep head-to-toe). If a separate bathroom is not available, the bathroom should be cleaned and disinfected frequently. Efforts should be made to cohort ill persons together. If there are two cases who reside in a co-living setting and single rooms are not available, they could share a double room. Note that confirmed positives can be cohorted together. However, do not cohort confirmed positives with symptomatic individuals waiting for test results (or not being tested). Cases in these settings are a priority to move to alternate accommodations.
• **Access to supplies and necessities.** The case must have access to food, running water/hand hygiene supplies, drinking water, and supplies (see Supplies for the home when isolating in appendix A) for the duration of the period of isolation. Those residing in remote and isolated communities may wish to consider stockpiling the needed supplies, as well as food and medications usually taken, if it is likely that the supply chain may be interrupted or unreliable.

• **Risk to others in the home.** Household members with conditions that put them at greater risk of complications of COVID-19 (e.g. older adults, underlying chronic or immunocompromising conditions, or obesity (BMI of 40 or higher) should not provide care for the case, and alternative living arrangements for the household member(s) or case may be necessary. This could include temporarily relocating these individuals or the case outside of the home to a location determined by public health, such as a designated hotel. For breastfeeding mothers: considering the benefits of breastfeeding and that the virus has not been found in breastmilk, breastfeeding can continue. If the breastfeeding mother is a case, she should wear a medical/procedure mask when near the baby or if not available, a non-medical mask or facial covering (e.g., homemade cloth mask, dust mask, bandana) when in close contact with the baby, especially during feeding. The mother should adhere to respiratory etiquette, and perform hand hygiene as well as washing the mother’s chest/breast area before and after close contact with the baby. Never place a mask on a child under two years of age.

• **Access to care.** While it is expected that the case/convalescing at home will be able to provide self-care and follow the recommended preventative measures, some circumstances may require care from a household member (e.g. the case/is a child). The caregiver should be willing and able to provide the necessary care and monitoring of the case, and be prepared to self-isolate (quarantine) for 14 days from the last known contact with the case.

• **Psychosocial Considerations:** Public health should encourage individuals, families and communities to create a supportive environment for people who are isolating to minimize stress and hardship associated with isolation as the financial, social, and psychological impact can be substantial. Obtaining and maintaining public trust are key to successful implementation of these measures; clear messages about the criteria and justification for and the role and duration of isolation or self-isolation (quarantine) and ways in which persons will be supported during the isolation or self-isolation (quarantine) period will help generate public trust. Additional information on the psychological impacts of COVID-19 is available.

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9Quarantine is also referred to publicly as ‘self-isolation’. This document will use ‘self-isolation (quarantine)’ to refer to quarantine recommendations for people who are well but have been potentially exposed to COVID-19. The term ‘isolation’ will refer to recommendations for individuals with symptoms that are suspected of having, or known to have, COVID-19.
Alternative Isolation Accommodations are available in Manitoba and recommended for cases and contacts that cannot be suitably isolated within their home or living arrangements. Further information is available at https://sharedhealthmb.ca/covid19/providers/alternative-isolation-accommodations/.

For cases being cared for in the home environment, the following measures and activities are recommended. Refer to Appendix A Instructions for Self-Isolating the home or co-living situation.

- Public Health to conduct active daily monitoring of the case’s health status for duration of illness (and until they have met the criteria for discontinuing isolation) or until laboratory investigation has ruled out COVID-19 infection. Refer to the Temperature Self-Monitoring Form adapted from the Winnipeg Regional Health Authority for specific guidance. Suspect cases should be advised to self-isolate until results are known and advised to call Health Links if symptoms worsen. Active daily monitoring of suspect cases does not need to occur unless the individual becomes a case.

**Discontinuation of home isolation**

An individual who has been placed on home isolation can stop home isolation using the following criteria:

- For symptomatic cases:
  - at least 10 days have passed since onset of first symptom,
  - the case did not require hospitalization,
  - the case is afebrile and has improved clinically,
  - absence of cough is not required for those known to have chronic cough or for those who are experiencing reactive airways post infection.

- For asymptomatic cases:
  - at least 10 days have passed since the specimen collection date of the confirmatory laboratory sample.

- In general, repeat laboratory testing (i.e., a negative test result) as the basis for discontinuing home isolation is not recommended.

- Those who work in health care settings may need to meet additional requirements before returning to their workplace. For cases that are HCWs, public health should notify and consult with Occupational Health at the end of the home isolation period to determine any additional requirements before the HCW returns to the workplace. In general, HCWs can return to work without additional laboratory testing 10 days after the onset of their first symptom provided they are afebrile and have improved clinically for at least 72 hours. If symptoms remain, consult Occupational Health on return to work guidance, which may include laboratory testing if symptoms continue to persist.

- Clients on home isolation with worsening symptoms should have a prompt clinical assessment. Note that clinical deterioration has more commonly occurred around 8 to 10 days post-symptom onset.

- Anyone with persistent symptoms at day 10 (e.g. fever, increasing shortness of breath, fatigue), aside from a reactive airway cough, should have a prompt clinical assessment.
Individuals who remain symptomatic at day 10 should also continue on active daily monitoring until symptoms have resolved for 24 hours (72 hours for HCWs).

- Provide public health advice to the case and household (or co-living setting) contacts on individual measures including self-monitoring, infection prevention and control, and environmental cleaning of the home setting. See Appendix A.
- The client should be instructed to cancel or notify any service providers that regularly come into the home.

Infection Prevention and Control

**Healthcare Workers**

- For healthcare workers providing health care services in the home, virus-specific IPC guidance for acute health care settings is applicable.
- In addition to routine practices, healthcare workers should follow Contact and Droplet precautions when within two metres of the case. See provincial coronavirus resources for staff at [https://www.gov.mb.ca/health/coronavirus/index.html](https://www.gov.mb.ca/health/coronavirus/index.html)
- For aerosol-generating medical procedures\(^{10}\) (e.g., case is receiving nebulized therapy) the use of additional precautions, including using a N95 respirator, is recommended. See [https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf](https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf)
- Medical equipment should be cleaned, disinfected or sterilized in accordance with routine practices.

**Caregivers and others sharing the living environment**

- If direct contact care must be provided, the case should wear a surgical/procedure mask and follow respiratory etiquette.
- The caregiver providing direct contact care to the case should also wear a procedure/surgical mask and eye protection when within two metres of the case and perform hand hygiene after contact.
- Masks should not be touched or handled during use. If the mask gets wet or dirty with secretions, it should be changed immediately. After discarding the mask, hand hygiene should be performed.
- Direct contact with body fluids, particularly oral, and respiratory secretions should be avoided. Use disposable gloves to provide oral or respiratory care, and when handling stool, urine and waste, if possible. Perform hand hygiene following all contact.
- Anyone who is at higher risk of developing complications from infection should avoid caring for or come in close contact with the case. This includes people with underlying chronic or immunocompromising conditions.

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\(^{10}\) Aerosol-generating medical procedures (AGMPs): AGMPs are medical procedures that can generate aerosols as a result of artificial manipulation of a person’s airway. There are several types of AGMPs which have been associated with a documented increased risk of tuberculosis (TB) or SARS transmission: Intubation and related procedures (e.g. manual ventilation, open endotracheal suctioning), Cardiopulmonary resuscitation, Bronchoscopy, Sputum induction, Nebulized therapy, Autopsy, Non-invasive positive pressure ventilation (CPAP, BiPAP). [https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf](https://sharedhealthmb.ca/files/N95-respirator-FAQ-for-managers.pdf)
Persons caring for a case should limit their contact with other people as much as possible and monitor themselves for any signs of illness for 14 days from last close contact.

Additional provincial Infection Prevention and Control guidance documents are available at https://sharedhealthmb.ca/covid19/providers/ipc-resources/

Clinical Management/Treatment

The treating health care provider will provide clinical management of the case (whether in the home or in an acute care setting) based on their condition and at the discretion of the health care provider. Remdesivir (Veklury) is the only drug currently authorized in Canada for treatment of cases of COVID-19. Canadian guidance on the clinical management of patients with moderate to severe COVID-19 is available. https://www.ammi.ca/Content/Clinical%20Care%20COVID-19%20Guidance%20FINAL%20April2%20ENGLISH%281%29.pdf

HCWs providing care for a case should follow relevant guidance developed for infection prevention and control including Routine Practices and Additional Precautions11,12, and COVID-19-specific infection prevention and control (IPC) guidance13. Any aerosol-generating medical procedures (AGMP), such as nebulized medications, should be avoided in the home environment. If an AGMP is required, consideration should be given to transferring the case to hospital due to the need for Additional Precautions.

Testing Individuals After Death

In the interest of identifying all deaths related to COVID-19 and to better understand the burden of disease in Manitoba, collection of a post-mortem nasopharyngeal (NP) swab for COVID-19 testing should be considered if the following are true:

Part A: Prior testing

1) The deceased did not have a NP swab positive for COVID-19 prior to death
OR

2) The deceased did not have two or more NP swabs negative for COVID-19 in the past week

AND

Part B: Symptoms or cause of death

1) Death was preceded by influenza-like illness (ILI), upper or lower respiratory tract infection, or any symptoms compatible with COVID-19, even if very mild
OR

2) Cause of death is unclear

If a previous swab was positive, no further testing is required.


12 https://sharedhealthmb.ca/covid19/providers/


2020-08-12
Process for acquiring the NP swab:
For deaths occurring in a health care facility:

- If the death is reportable to Office of the Chief Medical Examiner (OCME), the NP swab can be obtained without prior permission from the OCME, unless the death is a homicide or suspicious in nature with police involvement. It should be communicated to the OCME that the swab has been taken when the death is reported.
- If the death is not reportable to the OCME, follow facility processes for post-mortem procedures.

For deaths occurring outside of a health care facility:

- Current process by OCME for deaths reportable to their office should continue. The OCME has been bringing in every decedent with any indication of ILI, respiratory difficulty, exposure to a known COVID-19 case, recent travel, etc. for an external examination and acquisition of NP swab.

Public Health Management of Contacts

In an effort to help prevent or reduce the spread of COVID-19 in Canada, the entire population has been asked to:

- when outside of the home, practice physical distancing from others,
- avoid crowded places,
- self-monitor for symptoms of COVID-19, and
- isolate themselves within the home-setting should symptoms develop and follow instructions provided by public health, including testing if symptomatic.

Close contacts of confirmed and probable cases occurring in Canada should be identified and managed as per the recommendations in this document, to the extent possible.

The purpose of contact management is:

1. to facilitate rapid identification of new cases and to reduce community spread by:
   - identifying and isolating any symptomatic contacts as quickly as possible; and
   - reducing the opportunity for transmission to others in the community from those with infection but without symptoms or with mild symptoms that may go unnoticed, and by providing contacts with information regarding infection prevention and control measures they should follow, and what to do if they develop symptoms.
2. to gain a better understanding of the epidemiology of this coronavirus.

Contact tracing should include:

- identifying people who were in contact with a symptomatic case starting 48 hours prior to the case developing a symptom consistent with COVID-19.
- identifying people who were in contact with a laboratory confirmed asymptomatic case starting 48 hours prior to the day their positive specimen was collected.
An individual risk assessment conducted will identify the contact’s exposure risk level and to determine the required level and parameters of self-isolation (quarantine), and public health actions for the 14-day monitoring period.

Public Health should attempt to identify, notify, and direct all contacts to self-isolate (quarantine) as soon as possible, ideally within 24 hours of notification of a confirmed or probable case. A provincial target has been established to notify 90% of contacts within one day of case notification.

A contact who develops symptoms compatible with COVID-19 within the monitoring period should be managed as a suspect case.
- If laboratory testing is conducted and the test results are negative for the virus that causes COVID-19, the individual is no longer a managed as a case, but should continue to self-isolate (quarantine) until 14 days from last exposure since they are still a contact of a case. The contact may be considered for re-testing if they have worsening /progression of symptoms.
- If laboratory testing is not conducted, the contact, who is now being managed as a suspect or probable case, after completing at least 10 days of home isolation may need to resume self-isolation (quarantine) until 14 days from last exposure since they are still a contact of a case and not a lab confirmed case themselves.

Laboratory testing is recommended for contacts who remain asymptomatic 5 to 7 days after the last exposure to the case. If negative, they should continue to self-isolate (quarantine) until 14 days from last exposure. Additional laboratory testing should be advised if the contact subsequently develops symptoms. If positive, the contact should be managed as a laboratory confirmed case. If the contact is asymptomatic and identified more than 7 days after the last exposure to the case, they should be tested as soon as possible.
Depending on exposure risk level, there are three categories of contacts (high, medium or low). Table 1 Categories of contacts by exposure risk level describes the risk level, provides isolation and contact management advice as well as associated public health actions\(^{14}\).

See additional resources which include:
- The Temperature Self-Monitoring form
- The Novel Coronavirus Screening Tool for Public Health and Health Links

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<tr>
<th>Risk Level</th>
<th>Description of Risk Level(^{15})</th>
<th>Isolation Level/ Contact actions</th>
<th>Public health authority (PHA) actions</th>
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<tbody>
<tr>
<td>High</td>
<td>1) Close contact(s) of a case:</td>
<td>a. Self-isolate (quarantine)(^{17}) at home for 14 days from last unprotected exposure</td>
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<td>c. Self-monitor for the appearance of symptoms consistent with COVID-19.</td>
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<td>workers, family members or other</td>
<td>d. Take and record temperature daily and avoid the use of fever reducing medications (e.g., acetaminophen, ibuprofen) as much as possible. These medications could mask an early symptom of COVID-19; if these medications must be taken, advise public health.</td>
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<td>caregivers), or who had other</td>
<td>e. Follow measures outlined in COVID-19 self-isolation factsheet.</td>
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<td>f. Isolate within the home setting as quickly as possible should symptoms develop, and contact Health Links or public health for further direction, which will include:</td>
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<td>(e.g. intimate partner) without</td>
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<td>was symptomatic and not self-</td>
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<td>isolating, OR</td>
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<td>had direct contact with</td>
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<td>infectious body fluids of a case</td>
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<td>(e.g., was coughed or sneezed</td>
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<td>on) without the appropriate</td>
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\(^{15}\) Adapted from Public Health Ontario. Public health management of cases and contacts of novel coronavirus (COVID-19) in Ontario February 12, 2020 (version 4.0).

\(^{16}\) As part of the individual risk assessment, consider the duration of the contact’s exposure (e.g., a longer exposure time likely increases the risk), the case’s symptoms (coughing or severe illness likely increases exposure risk) and whether exposure occurred in a health care setting. Prolonged exposure is defined as lasting for more than 15 minutes.

\(^{17}\) In general, self-isolation means that a contact stays in their home and does not go out, and avoids being within the same room with others within the home setting. If this cannot be avoided, a distance of at least 2 metres should be maintained from others.
For contacts of suspect cases:

<table>
<thead>
<tr>
<th>Level</th>
<th>Description</th>
<th>Actions</th>
<th>Monitoring</th>
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| Low/No risk | 1) Only transient interactions (e.g., walking by the case or being briefly in the same room) or unknown but possible transient interaction due to the occurrence of local community transmission | - Follow actions recommended for the entire population  
- No monitoring required | - Provide community level information  
- Provide individual advice, if required |
| Medium    | 1) **Non-close contact:**  
- provided direct care for the case, (including health care workers, family members or other caregivers) or who had other similar close physical contact **with consistent and appropriate use of personal protective equipment** and the case was self-isolating OR  
- who lived or otherwise had prolonged contact **but was not within 2 metres** of a case up to 48 hours prior to symptom onset or while the case was symptomatic and self-isolating | **Self-monitor** for symptoms for 14 days following their last contact.  
Follow actions recommended for the entire population.  
- Self-isolation is not required.  
- Self-isolate as quickly as possible should symptoms develop, and contact Health Links or public health for further direction, which will include:  
  - where to go for care,  
  - appropriate mode of transportation to use, and  
  - IPC precautions to be followed.  
If it is an emergency and the case is unable to contact public health or Health Links in advance, instruct the case to call 911 and report travel/contact history.  
- Avoid close contact with individuals at higher risk for severe illness | - No active monitoring |

**For contacts of suspect cases:**

- use of recommended personal protective equipment,  
- where to go for care,  
- appropriate mode of transportation to use, and  
- IPC precautions to be followed.  
Instruct to wear a surgical/procedure mask if attending a health care facility. If it is an emergency and the case is unable to contact public health or Health Links in advance, instruct the case to call 911 and report travel/contact history.
• Identification and assessment of contacts may be deferred pending the results of initial laboratory testing if results are anticipated with 48 hours. During this time, asymptomatic contacts of suspect cases do not need to self-isolate until results are known.
• Contacts known to be symptomatic should be referred for immediate investigation and managed as a suspect case.

Persons possibly exposed through travel
As of March 25, 2020, all travellers incoming to Canada are subject to mandatory quarantine (self-isolation) enforceable through an emergency order under the Quarantine Act: Minimizing the Risk of Exposure to COVID-19 in Canada - Order (Mandatory Isolation). Therefore, all incoming travellers without symptoms are required to quarantine (self-isolate) at home (or another designated location) where they will have no contact with vulnerable people for 14 days following their arrival to Canada. In addition, domestic travellers from outside Manitoba may also be recommended to self-isolate for 14 days if arriving from a destination that is not excluded by current Public Health Orders. Travellers should:

• Follow good respiratory etiquette and hand hygiene practices.
• Wear a non-medical mask or face covering while travelling to the place of quarantine,
• Self-monitor for the appearance of symptoms consistent with COVID-19.
• Take and record temperature daily and avoid the use of fever reducing medications (e.g., acetaminophen, ibuprofen) as much as possible. These medications could mask an early symptom of COVID-19.
• Isolate within the quarantine setting as quickly as possible should symptoms develop, and follow directions provided by public health, which will include:
  o where to go for care (if required),
  o appropriate mode of transportation to use, and
  o IPC precautions to be followed.
  o Arrange to have someone pick up essentials like groceries or medication, or order deliveries,
  o Not have visitors,
  o Stay in a private place (i.e., yard or balcony) for fresh air,
  o Keep a distance of at least 2 metres from others

According to the Order, asymptomatic travellers who develop symptoms while in the 14 day quarantine period must extend quarantine to 14 days following the appearance of symptoms. Exemptions from the mandatory quarantine due to travel outside of Canada have been made for certain individuals who provide essential services as long as they are asymptomatic. Included are individuals who cross the border regularly to ensure the continued flow of goods and essential services, or those who provide other essential services to Canadians (e.g., health care workers, truck drivers, airplane crews).

These individuals should:
  o follow good respiratory etiquette and hand hygiene practices
  o practice physical distancing from others, and avoid settings where physical distancing is not possible

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- self-monitor for symptoms of COVID-19, and
- isolate within the home-setting should symptoms develop
- take appropriate precautions to protect close contacts who are at highest risk of serious complications from COVID-19 (i.e., people older than 60 years and those living with chronic conditions), including the requirement to self-isolate for 14-days prior to visiting persons in an acute care or long-term care facility.

Exemptions from self-isolation for travel outside Manitoba and guidelines to follow have also been established and can be found in the current Public Health Orders [https://www.gov.mb.ca/covid19/soe.html](https://www.gov.mb.ca/covid19/soe.html).

Health Care Workers (HCW): In general, HCW’s should self-isolate and not work in health care settings for 14 days after travel to locations that require self-isolation in Public Health orders after return to Manitoba.

- Exceptions should be provided for HCW’s who reside in another country/province and travel regularly into Manitoba for essential work (including remote fly-in communities).
- If staff are deemed to be essential for service (essential is defined by the number of staff required to perform the service), management/human resources should consult with occupational health to perform a risk assessment, taking into account the type of work, exposure to high risk clients, and the travel exposure to determine if an exemption can be made.
- If deemed essential, HCWs must self-monitor for symptoms, including monitoring their temperature twice a day, and wear continuous PPE for the duration of their shift and self-monitoring period. The HCW must immediately remove themselves from work if any symptoms develop, self-isolate and notify Occupational Health. When not at work, they should self-isolate at home for the full 14 day period.

Any traveller who develops symptoms compatible with COVID-19 within the 14-day mandatory self-isolation (quarantine) period should be considered and managed as a suspect case.

- If laboratory testing is conducted and the results are negative for COVID-19, the individual is no longer considered a suspect case but must continue their mandatory self-isolation (quarantine) for the remainder of the 14-day monitoring period as per the emergency order, and 24 hours after symptoms have resolved. The traveller may be considered for re-testing if they have worsening /progression of symptoms.
- If laboratory testing is not conducted, the symptomatic traveller should extend their quarantine 14 days from the appearance of symptoms (as per the [Mandatory Isolation Order](https://www.gov.mb.ca/covid19/soe.html)). On day 14, if they still have a fever or have not clinically improved, their eligibility to discontinue home isolation should be assessed by the local public health.
- If the symptomatic traveller requires transfer to acute care or further medical assessment, they should call ahead to the receiving facility to ensure the appropriate IPC measures are in place.

**Health Care Workers**

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**Self-isolation (quarantine):** Health care workers (HCW’s) who are potentially exposed (as per above contact and travel guidance) should self-isolate (quarantine) for 14 days after the last exposure.

- If the HCW develops symptoms, they should be referred for testing. If positive, follow guidance for HCW’s who are cases. If negative, they need to continue self-isolating (quarantine) until their 14 day period is completed, and 24 hours after symptoms are resolved.
  - If a false negative result is suspected due to compatible clinical symptoms and clear history of exposure, Occupational Health may advise isolation for 10 days after symptom onset and 24 hours after symptoms are resolved, if this exceeds the 14 days self-isolation (quarantine) period.
- If staff are asymptomatic and deemed to be essential for service (essential is defined by the number of staff required to perform the service), and have not been specifically identified as a close contact but are potentially exposed, the HCW could continue to work if continuous PPE is utilized, with twice daily screening for symptoms while at work. When not at work, they should self-isolate for 14 days after the last exposure.

**HCW’s with No Exposure History:** Health care workers who have no exposure history and develop symptoms, should be referred for testing. If positive, follow guidance for HCW’s who are cases. If negative, they could return to work 24 hours after symptoms are resolved in consultation with Occupational Health regarding return to work. If there are exceptional circumstances where a false negative result is suspected, occupational health may advise isolation for 10 days after symptom onset and 24 hours after symptoms are resolved. If the HCW is not tested, they should not return to work until 10 days after symptom onset and 24 hours after symptoms are resolved.

**Management of Individuals with Respiratory Symptoms in the Community without Exposures (not Self-Monitoring or Self-Isolating)**

All individuals who have symptoms, should isolate at home for 10 days after symptom onset, and until symptoms are resolved for 24 hours. Isolation is recommended to lower the chance of spreading the illness to other people. Testing of all symptomatic individuals is recommended. If testing exceeds laboratory capacity, priority populations for testing will be established. If the COVID-19 test results are negative, individuals should stay home until symptoms have resolved for 24 hours. If they have travelled or been exposed to a case, they should continue to self-isolate (quarantine) for the remainder of the 14-day period.

**Contact tracing for airplane passengers**
Decisions related to contact tracing individual air travellers/crew who may have been exposed to a confirmed case of COVID-19 on a flight should be made based on a risk assessment conducted by the public health authority to which the case is notified, considering the:

- the type and severity of symptoms during the flight.
- current messaging to all international travellers - specifically that they must enter into a legally mandatory 14 day quarantine (self-isolation) period starting the day they enter Canada
- timing of notification and likelihood of getting sufficient passenger contact information (i.e., within 14 days of flight),
- incremental benefit of individual communication to those seated within 2 metres of the case versus public communication of the flight number (with or without identification of the section of the plane where the case was seated).

There is no direct evidence at present that contacting individual air travellers/crew has facilitated early case finding. Nor is there evidence regarding transmission risk in relation to flight duration.

Should public health determine that contact tracing individual air travellers is warranted, the Public Health Agency of Canada’s Interjurisdictional Notices team can assist in obtaining a flight manifest; however, it should be noted that flight manifests are not kept indefinitely and do not contain contact information on all travellers. Public health may be required to provide a letter citing their authorities under the Public Health Act in order to obtain the manifest. If contact tracing is not feasible, a public advisory to notify the public of the potential exposure may be considered.

Contact tracing efforts should focus on those seated within a 2 metre radius of the case, as this is the accepted exposure risk area for droplet transmission.

Contact tracing efforts oriented towards individual air travellers/crew should, at a minimum, focus on:

- passengers seated within two metres of the index case AND
- crew members serving the section of the aircraft where the index case was seated AND
- persons who had close contact with the index case, e.g. travel companions or persons providing care.

Public health may wish to request the aircraft seat map from airlines to best target the contact tracing efforts. If the seat map isn’t available, public health may wish to trace economy class passengers seated in the 5 seats surrounding the case in all directions, up to and including 3 rows in front and 3 rows behind the case. In business class, due to seat spacing this may only involve tracing passengers in the 2 surrounding rows due to the space between seats. Public health may also wish to confirm that the case sat in the assigned seat for the duration of the flight, and ask about the case’s movements during the flight.

Public health could consider expanding the scope of their contact tracing for individual travellers if the case had severe symptoms, such as persistent coughing and sneezing, or had diarrhea or
vomiting during the flight. Alternatively, public health could consider publicly communicating the flight number and possibly the section of the plane where the case was seated, as long as it does not reveal the identity of the case.

In the event that a crew member is a confirmed case and was symptomatic during the flight, passengers seated in the area served by that crew members, as well as the other crew members, should be included in any individually-oriented contact tracing efforts.

**Process for Notification and Posting of Affected Flights with COVID-19 Cases**

Regional Health Authority / Regional CD Coordinator:

1. **Consider period of communicability**: Flights are considered affected if the case flew during the period of communicability, which includes 48 hours prior to symptom onset. For asymptomatic cases, consider up to two days prior to date of specimen collection.

2. **Document flight details in PHIMS and indicate that information is for public posting**: Create a transmission event for each flight and include the following details:
   a. Airline(s)
   b. Flight number(s)
   c. Departing city/airport
   d. Destination city/airport
   e. Flight date(s)
   f. Seat number(s)
   g. Clearly indicate “FOR PUBLIC POSTING” within the transmission event “exposure location name”

Epidemiology and Surveillance Unit, MHSAL:

3. **Routinely monitor PHIMS** for travel-acquired cases and affected flights through routine surveillance processes (flag will be the instructions for public posting).

4. **Email** affected flight details to PHAC and request notification to airlines on behalf of MHSAL.

5. **Email draft notice to region (CD coordinator) for confirmation**.

6. **Notify** MHSAL Communications via email for posting to provincial website and inclusion in the daily bulletin once confirmation received from airline(s)/PHAC: [https://manitoba.ca/covid19/flights.html](https://manitoba.ca/covid19/flights.html). The following information is posted on the website:
   a. Airline
   b. Flight number
   c. Departing and destination airports
   d. Flight date(s)
   e. Affected rows (generally 3 rows in front and 3 rows behind the case)


**Process for Notification and Posting of Public Exposures**

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Regional Health Authority:

1. The determination on whether notification of a public exposure is required is made by the Region (CD Coordinator in consultation with the MOH). Consider the following:
   - Ensure the exposure is within the period of communicability
   - Assess the potential for close prolonged contact with unknown or unidentified contacts.
     - Transient interactions while shopping would not generally warrant a public notification unless close prolonged contact was identified.
     - Prolonged periods of time in one public location would increase risk (e.g. employee)
     - Multiple cases present in the location would increase risk (e.g. family cluster)
   - Consider use of PPE or non-medical masks and whether appropriately used. This would not be the primary consideration due to inability to confirm proper use, but may influence the decision if exposure is considered lower risk.
   - If subsequent cases are identified from the same exposure location, consider updating the notification.

2. Determine whether notification of the Chief Occupational Medical Officer is required. (e.g. workplace action is required, or is a sensitive occupation (e.g. temporary foreign worker, meat processing plant). Most public exposures from investigations identified on the weekend can wait until the next business day for notification, unless identified as high risk and/or requiring more immediate public notification. All public notifications should occur as soon as possible once details confirmed on regular business days.

3. **Document public exposures in PHIMS and indicate that information is for public posting:** Create a transmission event for each public exposure (in addition to all other exposures) that includes details on location, date, and time of exposure. Clearly indicate within the transmission event “exposure location name” that the exposure is: “FOR PUBLIC POSTING”. This determination is made by the Region (CD Coordinator in consultation with the MOH).

Epidemiology and Surveillance Unit, MHSAL:

1. **Routinely monitor PHIMS** for transmission events that require public posting through routine surveillance processes (flag will be the instructions for public posting).
2. **Email draft notice to region (CD coordinator) for confirmation.**
3. **Coordinate** with MHSAL Public Health and Communications to notify and request posting public exposure to provincial website and inclusion in the daily bulletin:
   - [https://manitoba.ca/covid19/updates/flights.html#event](https://manitoba.ca/covid19/updates/flights.html#event).

**Reporting Cases and Contacts**

**Surveillance objectives:**
• To rapidly identify laboratory-confirmed cases, in order to isolate and treat them, and prevent transmission to their contacts.
• To identify contacts in order to ensure appropriate public health interventions are put into place, such as symptom monitoring.
• To describe the epidemiology of COVID-19 infection in Manitoba, in order to characterize cases, identify risk factors for transmission, and guide public health action.

Cases:

• The Clinical Notification of Reportable Diseases and Conditions Form only needs to be completed and sent to MHSAL in the event of the death of a probable or lab-confirmed case of COVID-19.
• All investigations of COVID-19 cases should be entered into PHIMS in real time utilizing the MHSU-6683 COVID-19 Case Investigation Form to guide data entry. Organizations who do not have access to the PHIMS investigation module should complete and submit the MHSU-6683 COVID-19 Case Investigation Form within 2 working days post confirmation of diagnosis.

Contacts:

• All known close contacts to probable and confirmed cases should be identified and documented within 24 hours, and must be reported to the MHSU with 48 hours of a confirmed case. The method of symptom surveillance should be identified – self-isolation, symptom monitoring (active, passive), education only.
• All travellers or contacts from identified high risk exposures (e.g. outbreak settings, cruise ships, repatriated individuals) that are recommended to self-isolate at home should also be reported within 48 hours of identification. Returning travellers from these areas will be identified and contact details forwarded for public health follow-up and education on self-isolation.
• Contacts can be entered in PHIMS directly, or reported using the Case report form. When referred through the Manitoba Health Surveillance Unit (MHSU), the MHSU will enter contact investigations in PHIMS when processed for regional referral, and close the investigation when the contact form is received and entered.
• Organizations can document ongoing symptom monitoring in either PHIMS, or their regional system. If a contact becomes symptomatic, the contact should be reported as a new case following case definitions.

Surveillance Definitions:

Recovered: A case is recovered when:
  • Isolation has been discontinued OR
  • Precautions have been discontinued (for hospitalized and facility-based cases)

Fatal:
Death due to COVID-19:
A death resulting from a clinically compatible illness, unless there is a clear alternative cause of death that cannot be related to COVID disease (e.g., trauma). There should be no period of complete recovery* from COVID-19 between illness and death.

Death not due to COVID-19:
A death in an active COVID-19 case with an alternative cause of death that cannot be related to COVID disease (e.g., trauma).

*note “recovery” in this context means no residual effects or complications from COVID-19, and does not refer to the status of “recovered”, which refers to clients who are off isolation precautions and are no longer considered infectious.

Active:
A case is active when:
• Case is currently in isolation OR
• Case is currently under precautions (for hospitalized and facility-based cases)

PHIMS Reporting:
Cases are considered “active” unless there is a recorded Status Assessment of “Recovered” or “Fatal” within the client’s investigation. A date must be recorded for all statuses.
APPENDIX A: Instructions for Isolating a case in the home or co-living setting

Isolating in the home setting

Stay at home

The case (confirmed, probable, or suspect) should isolate themselves in the home setting for a minimum of 10 days from the onset of symptoms. The criteria for discontinuing home isolation includes: at least 10 days have passed since onset of first symptom or laboratory confirmation of an asymptomatic case, the case did not require hospitalization, the case is afebrile and has improved clinically.

Staying at home means:

- Not going out unless directed to do so (i.e. to seek medical care)
- Not going to school, work, or other public areas
- Not using public transportation (e.g. buses, subways, taxis)

Personal protective measures for infection prevention and control

The case should follow good respiratory etiquette and hand hygiene practices.

Respiratory etiquette

Respiratory etiquette describes a combination of measures intended to minimize the dispersion of respiratory droplets when coughing, sneezing and talking.

- Cover coughs and sneezes with a medical/procedure mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana) or tissue. Dispose of tissues in a lined waste container and perform hand hygiene immediately after a cough or sneeze
  OR
- Cough/sneeze into the band of your arm, not your hand

Hand hygiene

Hand hygiene refers to hand washing or using an alcohol-based hand sanitizer and actions taken to maintain healthy hands and fingernails. It should be performed frequently with soap and water for at least 15-20 seconds:

- Before and after preparing food;
- Before and after eating;
- After using the toilet;
- Before and after using a medical/procedure mask
- After disposing of waste or handling contaminated laundry;
- Whenever hands look dirty.

Handwashing with plain soap and water is the preferred method of hand hygiene, since the mechanical action is effective at removing visible soil and microbes.
If soap and water are not available, hands can be cleaned with an alcohol-based hand sanitizer (ABHS) that contains at least 60% alcohol, ensuring that all surfaces of the hands are covered (e.g. front and back of hands as well as between fingers) and rub them together until they feel dry.

When drying hands, disposable paper towels are preferred, but a dedicated reusable towel may be used and replaced when it becomes wet.

**Monitor your symptoms.**

The case should monitor their symptoms and immediately report worsening of symptoms to Health Links or public health for further assessment. If it is determined that transfer to an acute care facility is required, instructions will be provided regarding transportation (e.g. by ambulance or private vehicle). If calling an ambulance, the dispatcher should be notified that the case may have COVID-19. If the person is transferred by private vehicle, the receiving facility should be notified to ensure that appropriate infection prevention and control measures are in place. During travel, the ill person should wear a medical/procedure mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana), if tolerable or cover their nose and mouth with a tissue. Those transporting the ill person should use appropriate personal protective equipment when within 2 metres of the ill person (details below).

**Limit contact with other people.**

The case should avoid being in close proximity (within 2 metres) of other people, including household members and visitors who do not have an essential need to be in the home, with the exception of individuals providing care or delivering supplies or food.

When interactions within 2 metres are unavoidable, these should be as brief as possible, and the case should wear a medical mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana). If possible, the ill person or caregiver should arrange to have supplies dropped off at their front door to minimize direct contact. If the case must leave the home setting, a mask should be worn.

**Masks**

Medical masks (surgical or procedure masks) provide a physical barrier that helps prevent the transmission of the virus from an ill person to a well person by blocking large particle respiratory droplets propelled by coughing, sneezing and talking. However, using a mask alone is not enough to stop transmission and must be combined with other prevention measures including physical distancing, respiratory etiquette and hand hygiene.

The following steps will help to ensure masks are used effectively:
- Medical masks are recommended for cases of COVID-19 and for any household member providing direct care to a case; the coloured side of the mask should be worn facing out.
- N95 respirators must be reserved for health care workers and should not be used for by a case or household caregivers.
- If medical masks are not available for home use, non-medical masks or facial coverings, (e.g. homemade cloth masks, dust mask, bandanas) worn by the ill person, if tolerable, to cover their mouth and nose may prevent respiratory droplets from contaminating others or landing on surfaces. These non-medical masks may also be worn by any household member providing care to a case. Children under 2 years of age should not wear a mask. Children ages 2 years and above should wear a child-sized medical mask or if not available, a non-medical mask or cloth face covering adapted to their size where feasible.
- Before putting on a mask, wash hands with soap and water or ABHS.
- Cover mouth and nose with mask and make sure there are no gaps between your face and the mask, press the mask tight to your face using your fingers to secure along the perimeter of the mask, pressing firmly over the bridge of your nose. After putting on a new mask, wash hands again with soap and water or ABHS.
- Avoid touching the mask while using it; if you do, clean your hands with soap and water or alcohol-based hand sanitizer.
- Replace the mask with a new one as soon as it is damp or dirty with secretions. Do not re-use single-use masks.
- Non-medical masks should be carefully removed and replaced when soiled or damp and laundered in hot water and then dried thoroughly.
- To remove the mask, remove both straps from behind the ears or untie from behind head. Do not touch the front of mask, and ensure that the front of the mask does not touch your skin or any surfaces before you discard it in a waste container or place it in a hamper for laundering. Wash hands with soap and water or ABHS.

**Limit contact with animals**

There have not been any reports of pets transmitting the SARS-CoV-2 virus to humans. However, there have been several reports of infected humans spreading the virus to their pet dog or cat. It is still not clear how often this happens and under what circumstances. From the limited information available, it appears that some animals can get sick, therefore, it is recommended that the case also refrain with contact with pets and, if possible, have another member of the household look after them. If this is not possible, practice good hand hygiene before and after touching animals, and their food/supplies, as well as good respiratory etiquette. Restrict the pet's contact with other people and animals outside the household while the case is in isolation.

**Avoid Sharing Personal Household Items**

The case should not share personal items with others, such as toothbrushes, towels, washcloths, bed linen, cigarettes, unwashed eating utensils, drinks, phones, computers, or other electronic devices.

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In the event that the case must prepare food for others (e.g. single parent with young children), the case should perform hand hygiene before and after, adhere to respiratory etiquette, including wearing a mask, during meal preparation.

**Clean all high-touch surfaces**

Disinfectants can kill the virus making it no longer possible to infect people. High-touch areas such as toilets, bedside tables and door handles should be cleaned daily using approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada.

- While most disinfectants will work against coronavirus, Health Canada has created a list of hard-surface disinfectants that are supported by evidence demonstrating that they are likely to be effective and may be used against SARS-CoV2.
- Always read and follow the directions on the label to ensure safe and effective use, including information about how long the surface should be visibly wet to be disinfected.
- You can also find more information on all other approved disinfectants and other drug products on Health Canada’s searchable Drug Product Database

When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution. Follow instructions for proper handling of household (chlorine) bleach. Be sure to prepare the solution fresh, when you are intending to use it, and only dilute bleach in water (and not with additional chemicals). Check the labelled intended use - some bleaches, such as those designed for whitening laundry, may not be suitable for disinfection. Ensure the product is not past its expiration date. Disinfectants, household cleaners, and bleach are meant to be used to clean surfaces. Never use these products on the skin or internally (e.g. by swallowing or injecting these products) as this could cause serious harm.

Find more information on Health Canada's website about using household chemicals safely and protect yourself and your family from poisonings when using disinfectants, household cleaning products and bleaches.
If they can withstand the use of liquids for disinfection, high-touch electronics such as phones, computers and other devices may be disinfected with 70% alcohol (e.g. alcohol prep wipes) following recommended manufacture contact time.\textsuperscript{18}

Disposable gloves should be used when cleaning or handling surfaces, clothing, or linen soiled with body fluids. Dormitories and co-living settings where ill persons are convalescing should be cleaned and disinfected daily.

Toys and other objects children may have contact with that may have been contaminated by a case should be cleaned and disinfected daily.

All used disposable contaminated items should be placed in a lined container before disposing of them with other household waste.

**Self-care while convalescing**

**Treatment**

At this time, there is no specific pharmaceutical treatment for COVID-19. The case should rest, eat nutritious food, stay hydrated with fluids like water, and manage their symptoms. Over the counter medication can be used to reduce fever and aches. If using vitamins or alternative medicines, the case should check with their healthcare provider whether they should continue use while awaiting test results.

**Monitor temperature regularly.**

The case should monitor their temperature daily, or more frequently if they have a fever (e.g., sweating, chills), or if their symptoms are changing. Temperatures should be recorded and reported to public health as per its instructions. If the case is taking acetaminophen (e.g. Tylenol) or ibuprofen (e.g. Advil), the temperature should be recorded at least 4 hours after the last dose of these fever-reducing medicines.\textsuperscript{19}

**Maintain a suitable environment for recovery.**

The environment should be well ventilated and free of tobacco or other smoke. Ventilation can be improved by opening windows and doors to the outside, as weather permits.


\textsuperscript{19} The peak effect of temperature reduction was found to be 2.5-3.0 hours after ingestion for both acetaminophen and ibuprofen treatments in a systematic review of antipyretic effect of ibuprofen and acetaminophen in children. Wahba H. The antipyretic effect of ibuprofen and acetaminophen in children. Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy. 2004 Feb;24 (2):280-4.
Stay connected.

Staying at home and not being able to do normal everyday activities outside of the home can be socially isolating. Public health can encourage people who are isolating themselves at home to connect with family and friends by phone or computer.

Precautions for household members (e.g. caregivers, roommates) to reduce risk of transmission to others in the home

For caregivers of a case, it is important to take appropriate steps to protect yourself and others in the home environment from contracting COVID-19.

- **Perform Regular hand hygiene.** The ill person and the household members should perform hand hygiene regularly.
- **Practice good respiratory etiquette** followed by hand hygiene.
- **Limit the number of caregivers.** Ideally, the ill person should be able to care for themselves. Caregiving within 2 meters of the ill person should be limited to one person. Household members with risk factors for severe disease or outcomes (i.e., older adults, chronic medical conditions, immunocompromised, or obesity (BMI of 40 or higher)) should not provide care for the case and should stay elsewhere if feasible.
- **Prevent exposure to contaminated items and surfaces.** Do not use personal items that belong to the case such as toothbrushes, towels, washcloths, bed linen, cigarettes, unwashed eating utensils, drinks, phones, computers, or other electronic devices. The lid of the toilet should be down before flushing to prevent contamination of the environment.
- **Frequent cleaning and disinfecting.** High-touch areas such as toilets, bedside tables and door handles should be cleaned daily using approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution.
- **Disposing of waste.** All used disposable contaminated items should be placed in a lined container before disposing of them with other household waste.
- **Use precautions when doing laundry.** Contaminated laundry should be placed into a laundry bag or basket with a plastic liner and should not be shaken. Gloves and a surgical/procedure mask should be worn when in direct contact with contaminated laundry. Clothing, linens and non-medical masks belonging to the ill person can be washed together with other laundry, using regular laundry soap and hot water (60-90°C). Laundry should be thoroughly dried. Hand hygiene should be performed after handling contaminated laundry and after removing gloves. If the laundry container comes in contact with contaminated laundry, it can be disinfected using approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit
number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution.

- **Use of personal protective equipment.** If household members have direct contact with the case, they should wear a medical/procedure mask or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana) and eye protection when within two meters and should perform hand hygiene after contact. Caregivers should wear disposable gloves when in direct contact with the ill person, or when in direct contact with the ill person’s environment as well as soiled materials and surfaces. Hand hygiene should be performed before putting gloves on and after removing them.

- Use of personal protective equipment. Household members, who have direct contact with the case, should wear a medical mask, or if not available, a non-medical mask or cloth face covering (i.e., constructed to completely cover the nose and mouth without gaping, and secured to the head by ties or ear loops) and eye protection when within two metres and should perform hand hygiene after contact. Caregivers should wear disposable gloves, if available, when in direct contact with the ill person, or when in direct contact with the ill person’s environment as well as soiled materials and surfaces. Hand hygiene should be performed before putting gloves on and after removing them.

### Eye Protection

Eye protection is recommended to protect the mucous membranes of the eyes during case care or activities likely to generate splashes or sprays of body fluids including respiratory secretions.

- Eye protection should be worn over prescription eye glasses. Prescription eye glasses alone are not adequate protection against respiratory droplets.
- Protective eye wear should be put on after putting on a mask.
- After applying eye protection, gloves should be donned (see above).
- To remove eye protection, first remove gloves and perform hand hygiene. Then remove the eye protection by handling the arms of goggles or sides or back of face shield. The front of the goggles or face shield is considered contaminated.
- Discard the eye protection into a plastic lined waste container. If the eye protection is not intended for single use, clean it with soap and water and then disinfect it with approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5 % sodium hypochlorite, to give a 0.1 % sodium hypochlorite solution, a
store bought disinfectant, or if not available, a diluted bleach solution of one part bleach to 9 parts water, being mindful not to contaminate the environment with the eye protection.

- Perform hand hygiene.

**Gloves**

Disposable single use gloves, if available, should be worn when in direct contact with the ill person, cleaning contaminated surfaces, and handling items soiled with body fluids, including dishes, cutlery, clothing, laundry, and waste for disposal. Gloves are not a substitute for hand hygiene; caregivers must perform hand hygiene before and after putting on and taking off gloves.

- Gloves should be removed, hand hygiene performed, and new gloves applied when they become soiled during care.
- To remove gloves safely, with one of your gloved hands pull off your glove for the opposite hand from the fingertips, as you are pulling, form your glove into a ball within the palm of your gloved hand. To remove your other glove, slide your un gloved hand in under the glove at the wrist and gently roll inside out, and away from your body. Avoid touching the outside of the gloves with your bare hands.
- Gloves must be changed and hand hygiene performed when they are torn.
- Discard the gloves in a plastic-lined waste container.
- Perform hand hygiene.
- Double-gloving is not necessary.

Reusable utility gloves may be used; however, they must be cleaned with soap and water and decontaminated after each use with approved hard-surface disinfectants that have a Drug Identification Number (DIN). A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved hard surface disinfectants are not available, for household disinfection, a diluted bleach solution can be prepared in accordance with the instructions on the label, or in a ratio of 5 millilitres (mL) of bleach per 250 mL of water OR 20 mL of bleach per litre of water. This ratio is based on bleach containing 5% sodium hypochlorite, to give a 0.1% sodium hypochlorite solution.
Supplies for the home when self-isolating

- Medical mask, or if not available, a non-medical mask or facial covering, (e.g., homemade cloth mask, dust mask, bandana) for case and others in the home
- Disposable Gloves
- Eye protection
- Thermometer
- Fever-reducing medications
- Running water
- Hand soap
- Alcohol based hand sanitizer (ABHS) containing at least 60% alcohol.
- Tissues
- Waste container with plastic liner
- Regular household cleaning products
- Approved hard-surface disinfectants that have a Drug Identification Number (DIN). or if an approved hard surface disinfectant is not available, bleach containing 5 % sodium hypochlorite, and a separate container for dilution.
- Alcohol (70%) prep wipes or cleaners suitable for cleaning high-touch electronics (e.g., phones)
- Regular laundry soap
- Dish soap
- Disposable paper towels

Core personal public health practices

With no targeted therapies or vaccine currently available, core personal public health practices are recommended for the entire population for the duration of the pandemic to help to reduce the spread of COVID-19 in Canada. These practices include:

- Staying informed, being prepared and following public health advice;
- Practicing good hygiene (i.e., frequent hand hygiene, avoid touching face, respiratory etiquette, disinfect frequently touched surfaces);
- Maintaining a physical distance of at least 2 metres from others as much as possible when outside of the home (i.e. from non-household members);
- If symptomatic/feeling ill, staying at home and away from others – not going to school/work and following jurisdictional/local public health advice;
- If at higher risk of severe disease or outcomes, staying at home as much as possible;
- Wearing a medical mask if experiencing symptoms and in close contact with others in the home setting or if going out to access medical care; if a medical mask is not available, a non-medical mask (NMM) or cloth face covering should be worn;
- Wearing NMM or cloth face covering for periods of time when it is not possible to consistently maintain a two-metre physical distance from others, particularly in crowded public settings
- Reducing personal non-essential travel.