

# Interim Guidance Public Health Measures

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

### Situation

There are ongoing outbreaks of a novel coronavirus (COVID-19) in China, with spread of cases to countries in Asia, Europe, Australia, United States and Canada. Chinese officials confirmed human-to-human transmission, though further evidence is required to determine how efficiently or sustainably this virus spreads between people. Additional travel related COVID-19 cases are anticipated, hence preparations to manage persons under investigation in community are required.

The strategy outlined in this guidance document is for containment (i.e. to reduce opportunities for transmission to contacts in the community), and is based on the assumption that the virus is primarily spread while the case is symptomatic. 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 Canada<sup>1</sup>. There are gaps in the understanding of infectivity of COVID-19 cases and transmission modes. 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

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<sup>1</sup> 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%).<sup>2</sup>

Current case numbers can be found on the Johns Hopkins coronavirus website ([www.arcgis.com/apps/opsdashboard/index.html#/bda7594740fd40299423467b48e9ecf6](http://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](https://manitoba.ca/asset_library/en/coronavirus/screening_tool.pdf)

### **Person under investigation (PUI) –**

A person with fever and/or cough who meets the exposure criteria and for whom a laboratory test for COVID-19 has been or is expected to be requested.

*Note: There is limited evidence on the likelihood of COVID-19 presenting 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),
  - negative (if specimen quality or timing is suspect), or
  - positive but COVID-19 not confirmed by the National Microbiology Laboratory (NML) or a provincial public health laboratory by a validated nucleic acid amplification test (NAAT).

**OR**

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<sup>2</sup> Hui, D. S., Azhar, E., Madania, T. A. et al 2020. Continuing COVID-19 epidemic threat of novel coronavirus to global health – the latest 2019 novel coronavirus outbreak in Wuhan, China. *International Journal of Infectious Diseases*, 91; 264-266 ([https://www.ijidonline.com/article/S1201-9712\(20\)30011-4/fulltext](https://www.ijidonline.com/article/S1201-9712(20)30011-4/fulltext)).

- A (un-tested) person with:
  - Fever (over 38 degrees Celsius), **AND/OR**
  - Cough (new or exacerbated chronic); **AND**
  - Close contact<sup>3</sup> 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 reference laboratory (NML or a provincial public health laboratory), and consists of positive nucleic acid amplification tests (NAAT) on at least two specific genome targets or a single positive target with nucleic acid sequencing.

*Note:*

- *nucleic acid amplification tests must be validated for detection of the virus that causes COVID-19*
- *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:

- Traveled to an affected area (The number of countries now reporting cases of COVID-19 has expanded and continues to change on a daily basis, including within 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. If such a specimen is being collected for ILI or presumed viral RTI, then a second swab is not required.
- Include the following information on the CPL General Requisition: travel history, relevant symptoms, and request for COVID-19.

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<sup>3</sup> 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.

- More severely ill patients may also require deep lung specimens be submitted, such as sputum, ETT secretions or broncho-alveolar lavage specimens.
- There is currently no serological test for the COVID-19 virus.

## Contact Definitions

***Period of communicability***<sup>4</sup> - 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 14 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.

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.

**HCW's:** Those who work in health care settings may need to meet additional requirements before returning to their workplace. For cases that are health care workers, 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, health care workers can return to work without laboratory testing 14 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.

**Laboratory Criteria:** For situations where the recommendation for discontinuing home isolation does not apply, such as for hospitalized patients, the Canadian Public Health Laboratory Network recommends two consecutive negative tests for the virus that causes COVID-19, at least 24 hours apart be considered as laboratory evidence that the case is no longer communicable; at a minimum collect NP swabs, with consideration for both NP and throat swabs at all sampling times to maximize sensitivity for detecting the virus.

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

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<sup>4</sup> 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.

- provided care for the case, including healthcare workers, 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
- 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.

Adapted from the US Centers for Disease Control and Prevention: Interim Guidance for Healthcare Professionals, Criteria to Guide Evaluation of Patients Under Investigation (PUI) for COVID-19, accessed January 29, 2020

*\*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.*

## Public Health Management of Cases

### **Persons under investigation, and probable and confirmed cases well enough to be managed at home**

Early epidemiologic evidence suggests that the majority of people who develop COVID-19 will have mild illness and may not require care in a hospital. Cases/PUI 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 self-isolate will be determined by their healthcare provider and public health. When determining the location, several factors to determine the suitability of the home setting are described below.

- **Severity of illness.** The case/PUI is exhibiting mild symptoms that do not require hospitalization, taking into consideration their baseline health status including older age groups, or chronic underlying or immunocompromising conditions that may put them at increased risk of complications from COVID-19. The ill person should be able to monitor their own symptoms and maintain respiratory etiquette and hand hygiene
- **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 residing in a dormitory, such as at a post-secondary institution or where there is overcrowded housing, efforts should be made to provide the case/PUI with a single room (e.g. relocate any other roommates to another location) with a private bathroom. 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/PUI whenever possible. If it is difficult to separate the case/PUI physically 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 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/PUIs in co-living settings (e.g. those living in university dormitories, shelters, overcrowded housing).** Special consideration is needed to support cases/PUIs in these settings when self-isolating. If it is not possible to provide the case/PUI with a single room and a private bathroom, efforts should be made to cohort ill persons together. If there are two cases/PUIs who reside in a co-living setting and single rooms are not available, they could share a double room. Cases in these settings are a priority to move to alternate accommodation if available.
- **Access to supplies and necessities.** The case/PUI should have access to food, running water, drinking water, and supplies (see Supplies for the home when self-isolating in appendix A) for the duration of the period of self-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. underlying chronic or immunocompromising conditions, or the elderly) should not provide care for the case/PUI and alternative arrangements may be necessary.
  - For breastfeeding mothers: considering the benefits of breastfeeding and the insignificant role of breast milk in transmission of other respiratory viruses, breastfeeding can continue. If the breastfeeding mother is a case, she should wear a medical/procedure mask when near the baby, practice respiratory etiquette, and perform hand hygiene as well as washing the mother's chest/breast area before and after close contact with the baby<sup>5</sup>.
- **Access to care.** While it is expected that the case/PUI 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/PUI is a child). The caregiver should be willing and able to provide the necessary care and monitoring for the case/PUI.
- **Psychosocial Considerations:** Public health should encourage individuals, families and communities to create a supportive environment for people who are self-isolating to minimize stress and hardship associated with self-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 quarantine and ways in which persons will be supported during the quarantine period will help generate public trust.

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<sup>5</sup>WHO. Home care for patients with suspected novel coronavirus (nCoV) infection presenting with mild symptoms and management of contacts. [Online] 4 February 2020. [Accessed on 7 February 2020] [https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-\(ncov\)-infection-presenting-with-mild-symptoms-and-management-of-contacts](https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts)

For cases/PUI 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. PUI's should be advised to self-isolate until results are known and advised to call Health Links if symptoms worsen. Active daily monitoring of PUI's does not need to occur unless the individual becomes a case,
- An individual who has been placed on home isolation can stop home isolation 14 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. Note that this criteria does not apply to hospitalized patients. Those who work in health care settings may need to meet additional requirements before returning to their workplace. For cases that are health care workers, 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, health care workers can return to work without laboratory testing 14 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. Provide public health advice to the case/PUI 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/PUI. See Provincial coronavirus resources for staff at <https://www.gov.mb.ca/health/coronavirus/index.html>
- For aerosol-generating medical procedures<sup>6</sup> (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>

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<sup>6</sup> 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

- 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/PUI should also wear a procedure/surgical mask and eye protection when within two metres of the case/PUI 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/PUI. This includes people with underlying chronic or immunocompromising conditions.
- Additional guidance is available in the WHO's Home care for patients with suspected novel coronavirus (COVID-19) infection presenting with mild symptoms and management of contacts.<sup>7</sup>
- Persons caring for a case/PUI 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.

## Public Health Management of Contacts

Considering the context for this guidance is containment of the virus, close contacts of confirmed and probable cases occurring in Canada should be identified and managed as per the recommendations in this document until the containment objective is achieved or a new objective becomes necessary (e.g., if sustained person to person transmission is occurring in the community). An individual risk assessment conducted will identify the contact's exposure risk level and to determine the required level and parameters of isolation, and public health actions for the 14-day monitoring period.

The purpose of contact management is:

- primarily to facilitate rapid identification of new cases and to support containment by identifying and isolating any symptomatic contacts as quickly as possible; and

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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>

- reducing the opportunity for transmission to others in the community from those with mild symptoms that may go unnoticed, and by providing contacts with information regarding infection prevention and control measures they should follow, as well as what to do if they develop symptoms;
- and secondly, to gain a better understanding of the epidemiology of this novel coronavirus

## Exposure Risk Categories and Recommended Public Health Actions

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<sup>8</sup>.

See additional resources which include:

- The Temperature Self-Monitoring form  
[https://manitoba.ca/asset\\_library/en/coronavirus/temperature.pdf](https://manitoba.ca/asset_library/en/coronavirus/temperature.pdf)
- The Novel Coronavirus Screening Tool for Public Health and Health Links  
[https://manitoba.ca/asset\\_library/en/coronavirus/screening\\_tool.pdf](https://manitoba.ca/asset_library/en/coronavirus/screening_tool.pdf)

Table 1. Categories of contacts by exposure risk level			
Risk Level	Description of Risk Level <sup>9</sup>	Isolation Level/ Contact actions	Public health authority (PHA) actions
	<p><b>1) Close contact(s) of a case:</b></p> <ul style="list-style-type: none"> <li>• <u>provided care</u> for the case (including health care workers, family members or other caregivers), or who had other similar close physical contact (e.g. intimate partner) <b>without consistent and appropriate use of recommended personal protective equipment, OR</b></li> <li>• who <u>lived with or otherwise had close prolonged</u><sup>10</sup> <u>contact</u></li> </ul>	<p>a. Self-isolate<sup>11</sup> at home for 14 days from last unprotected exposure</p> <p>b. Follow good respiratory etiquette and hand hygiene practices.</p> <p>c. Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms such as coughing or shortness of breath.</p>	<ul style="list-style-type: none"> <li>• Active daily monitoring of contacts for symptoms. Refer to the Temperature Self-Monitoring Form for specific guidelines.</li> <li>• A close contact who develops symptoms compatible with COVID-19 within the monitoring period should be considered a PUI and from an IPC perspective should be managed as a case.</li> </ul>

<sup>8</sup> Adapted from Public Health Ontario. At-a-Glance Risk Levels and Precautions for COVID-19. February 2020.

<sup>9</sup> 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).

<sup>10</sup> 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.

<sup>11</sup> 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.

<p><b>High</b></p>	<p>(within 2 metres) with a case while the case was symptomatic and not self-isolating, <b>OR</b></p> <ul style="list-style-type: none"> <li>• had direct contact with infectious body fluids of a case (e.g., was coughed or sneezed on) without the appropriate use of recommended personal protective equipment, <b>OR</b></li> <li>• Airplane crew and passengers seated within 2 meters of a symptomatic case. See section <b>Contact Tracing for Airplane Passengers</b>.</li> </ul>	<p>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.</p> <p>e. Follow measures outlined in COVID-19 self-isolation factsheet.</p> <p>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:</p> <ul style="list-style-type: none"> <li>○ where to go for care,</li> <li>○ appropriate mode of transportation to use, and</li> <li>○ 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.</li> </ul>	<ul style="list-style-type: none"> <li>• If laboratory testing is negative for the virus that causes COVID-19, the individual is no longer a PUI, but should continue to self-isolate until 14 days from last exposure.</li> <li>• If transferring the symptomatic person from the community to an acute care facility, notify the receiving facility prior to arrival to ensure appropriate IPC measures are in place.</li> <li>• Contact PHAC to obtain the flight manifest for contact tracing by public health.</li> </ul>
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<p><b>Medium</b></p>	<p>1) <b>Non-close contact:</b></p> <ul style="list-style-type: none"> <li>provided care for the case, (including health care workers, family members or other caregivers) or who had other similar close physical contact <b>with consistent and appropriate use of personal protective equipment</b> and the case was self-isolating <b>OR</b></li> <li>who lived or otherwise had prolonged contact <b>but was not within 2 metres</b> of a case while the case was symptomatic and self-isolating</li> </ul>	<p><b>Self-monitor</b> for symptoms for 14 days following their last contact.</p> <ol style="list-style-type: none"> <li>Self-isolation is not required.</li> <li>Self-isolate as quickly as possible should symptoms develop, and contact Health Links or public health for further direction, which will include: <ul style="list-style-type: none"> <li>where to go for care,</li> <li>appropriate mode of transportation to use, and</li> <li>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.</li> </ul> </li> <li>Avoid crowded public spaces and places where rapid self-isolation upon onset of symptoms may not be feasible.</li> <li>Avoid close contact with individuals at higher risk for severe illness</li> </ol>	<ul style="list-style-type: none"> <li>No active monitoring</li> <li>Any contact who develops symptoms within the monitoring period should be considered a PUI and from an IPC perspective should be managed as a case. If test is negative, individual is no longer a PUI, but should continue to self-isolate until asymptomatic for 24 hours. Then self-monitor for 14 days from last exposure</li> <li>If transferring a PUI from the community to an acute care facility, it will be important to notify the receiving facility prior to arrival to ensure appropriate IPC measures are in place</li> </ul>
<p><b>Low/No risk</b></p>	<p>1) <u>Only transient interactions</u> (e.g., walking by the case or being briefly in the same room)</p>	<ul style="list-style-type: none"> <li>No monitoring required</li> </ul>	<ul style="list-style-type: none"> <li>No action required</li> </ul>

***For contacts of persons under investigation***

- Identification and assessment of contacts may be deferred pending the results of initial laboratory testing if results are anticipated within 48 hours. During this time asymptomatic contacts of persons under investigation 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 person under investigation.

***Persons possibly exposed through travel***

Decisions regarding the management of travellers who may have been unknowingly exposed to the virus that causes COVID-19 while travelling should take into consideration:

- The location(s) of travel – The location of travel serves as indicator of likelihood of having come into contact with a case during travel and therefore risk of having had an exposure to the virus. Whether a PHAC Level 3 Travel Health Notice (i.e., “avoid all non-essential travel”) is in effect for any the travel locations is a key consideration.  
Note: The level of travel health notice is based on a risk assessment that takes into consideration several variables including but not limited to the epidemiology of the disease in the country, trends, control measures and surveillance systems in place.
- The setting the traveller will be returning to in Manitoba – The setting the traveller will be returning to in Manitoba helps assessment of the potential impact/consequences of the traveller introducing or spreading the virus in their work or school setting. Depending on the type of work, for example caring for elderly patients in a health care setting, or maintaining critical infrastructure, transmission of the virus in these settings could increase the risk of severe cases, health care delivery disruption and/or societal disruption.
- Local situation – The current epidemiology, response goal (i.e. containment or mitigation), demographics, health care delivery and critical infrastructure resources and surge capacity are also important considerations.

All of these considerations together with analysis of the potential positive and negative impacts of a recommendation should inform the measures implemented for returning travellers.

Table 2 describes recommendations for travellers who have travelled outside of Manitoba in the previous 14 days. All measures should start upon arrival in Manitoba and continue for a period of 14 days.

- Any traveller who develops symptoms compatible with COVID-19 within the 14 day monitoring period should be considered a PUI and from an IPC perspective should be managed as a case. If laboratory testing is negative for the virus that causes COVID-19, the individual is no longer a PUI, but should self-isolate/self-monitor for the remainder of the 14 day monitoring period. If transferring the symptomatic person from the community to an acute care facility, notify the receiving facility prior to arrival to ensure appropriate IPC measures are in place.

Travel location	Traveller type	Traveller actions	PHA actions
Any country/area outside of Manitoba	Health care providers and those working in health care settings	<ul style="list-style-type: none"> <li>• Self-isolate (ideally at home) for 14 days following arrival in Manitoba</li> <li>• Follow good respiratory etiquette and hand hygiene practices.</li> <li>• Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms such</li> </ul>	<ul style="list-style-type: none"> <li>• In general, HCW's should self-isolate and not work in health care settings for 14 days after travel.</li> <li>• Exceptions should be provided for HCW's who reside in another country/province and travel regularly into</li> </ul>

		<p>as coughing or shortness of breath.</p> <ul style="list-style-type: none"> <li>• Isolate within the home setting as quickly as possible should symptoms develop, and contact Health Links for further direction, which will include: <ul style="list-style-type: none"> <li>○ where to go for care,</li> <li>○ appropriate mode of transportation to use, and</li> <li>○ IPC precautions to be followed.</li> </ul> </li> </ul>	<p>Manitoba for essential work (including remote fly-in communities).</p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• If deemed essential, HCW must self-monitor for symptoms, including monitoring their temperature twice a day, and wear a mask 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.</li> <li>• Any HCW who develops symptoms within the monitoring period should be considered a PUI and from an IPC perspective should be managed as a case. If test is negative, individual is no longer a PUI, but should</li> </ul>
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			continue to self-isolate for 14 days from returning from travel, and until asymptomatic for 24 hours.
	Critical infrastructure workers	<ul style="list-style-type: none"> <li>• Self-isolate (ideally at home) for 14 days following arrival in Manitoba</li> <li>• Follow good respiratory etiquette and hand hygiene practices.</li> <li>• Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms such as coughing or shortness of breath.</li> <li>• Isolate within the home setting as quickly as possible should symptoms develop, and contact Health Links for further direction, which will include: <ul style="list-style-type: none"> <li>○ where to go for care,</li> <li>○ appropriate mode of transportation to use, and</li> <li>○ IPC precautions to be followed.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• In general, critical infrastructure workers should self-isolate and not work for 14 days after travel.</li> <li>• Exceptions should be provided for workers who reside in another country/province and travel regularly into Manitoba for essential work, as well as workers involved in movement of goods and people.</li> <li>• Work with industry to ensure measures in place to assess all drivers, including commercial drivers, crossing our shared border and for directing drivers that exhibit signs of COVID-19 to the appropriate officials.</li> <li>• If staff are deemed to be essential for service (essential is defined by the number of staff required to perform the service and must be more than an inconvenience), 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</li> </ul>

			<p>exemption can be made.</p> <ul style="list-style-type: none"> <li>Any critical infrastructure worker who develops symptoms within the monitoring period should be considered a PUI and from an IPC perspective should be managed as a case. If test is negative, individual is no longer a PUI, but should continue to self-isolate for 14 days from returning from travel, and until asymptomatic for 24 hours.</li> </ul>
Primary and secondary school students and staff and daycares	<ul style="list-style-type: none"> <li>Self-isolate (ideally at home) for 14 days following arrival in Manitoba</li> <li>Follow good respiratory etiquette and hand hygiene practices.</li> <li>Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms such as coughing or shortness of breath.</li> <li>Isolate within the home setting as quickly as possible should symptoms develop, and contact Health Links for further direction, which will include: <ul style="list-style-type: none"> <li>where to go for care,</li> <li>appropriate mode of transportation to use, and</li> <li>IPC precautions to be followed.</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Communicate message through public messaging.</li> <li>No active monitoring.</li> <li>Any traveler who develops symptoms within the monitoring period should be considered a PUI and from an IPC perspective should be managed as a case. If test is negative, individual is no longer a PUI, but should continue to self-isolate for 14 days from returning from travel, and until asymptomatic for 24 hours.</li> </ul>	
All other travellers	<ul style="list-style-type: none"> <li>Self-isolation is recommended.</li> <li>Self-monitor for symptoms for 14 days following arrival in Manitoba.</li> </ul>	<ul style="list-style-type: none"> <li>No active monitoring</li> <li>Communicate message through public messaging.</li> <li>Employers should follow this guidance.</li> </ul>	

		<ul style="list-style-type: none"> <li>• Self-isolate as quickly as possible should symptoms develop, and contact the Health Links for further direction, which will include where to go for care, the appropriate mode of transportation to use, and IPC precautions to be followed</li> <li>• Avoid crowded public spaces and places where rapid self-isolation upon onset of symptoms may not be feasible. Examples of crowded public spaces and places include mass gatherings, such as concerts and sporting events.</li> <li>• Avoid close contact with individuals at higher risk for severe illness.</li> </ul>	<ul style="list-style-type: none"> <li>• Any traveler who develops symptoms within the monitoring period should be considered a PUI and from an IPC perspective should be managed as a case. If test is negative, individual is no longer a PUI, but should continue to self-isolate for 14 days from returning from travel, and until asymptomatic for 24 hours.</li> </ul>
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## Health Care Workers

**Self Isolation:** Health Care Workers (HCW's) who are potentially exposed (as per above contact and travel guidance) should self-isolate for 14 days. If the HCW develops symptoms, including a cough, runny nose, fever or sore throat, they should be referred for testing. If positive, follow guidance for HCW's who are cases. If negative, they need to remain on self isolation until their 14 day period of self-isolation 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 self-isolation for 14 days after symptom onset.

**HCW's with No Exposure History:** Health care workers who have no exposure history and develop symptoms, including a cough, runny nose, fever or sore throat, 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 self-isolation for 14 days after symptom onset. If the HCW is not tested, they should not return to work until 14 days after symptom onset.

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

**During period of time with no to limited evidence of community transmission in Manitoba:**

Individuals who have symptoms, including a cough, runny nose, fever or sore throat, should self-isolate at home until all symptoms are completely resolved. Self-isolation is recommended to lower the chance of spreading the illness to other people.

Health care workers who have symptoms, including a cough, runny nose, fever or sore throat, should self-isolate at home until a minimum 24 hours after all symptoms are completely resolved. Consideration should be given to early institution of the recommendation to self-isolate for 14 days after symptom onset when there is early evidence of potential community spread. Health care workers should be prioritized for testing as lab capacity allows. They could return to work 24 hours after symptoms are resolved if the test is negative in consultation with occupational health regarding return to work.

**Once community transmission is established in Manitoba:**

All individuals who have symptoms, including a cough, runny nose, fever or sore throat, should self-isolate at home for 14 days after symptom onset. Self-isolation is recommended to lower the chance of spreading the illness to other people. Health care workers and critical infrastructure workers should be prioritized for testing as lab capacity allows. They could return to work 24 hours after symptoms are resolved if the test is negative in consultation with occupational health regarding return to work.

***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 (e.g., to self-isolate, avoid crowds and public places etc.),
- 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 the public health authority determine that contact tracing individual air travellers is warranted, the Public Health Agency of Canada's Office of Border and Travel Health 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 authorities may wish to request the aircraft seat map from airlines to best target the contact tracing efforts. If the seat map isn't available, PHAs 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 authorities 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 authorities 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, the public health authority 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.

## 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:

- Urgent same day reporting is required for all persons under investigation using the MHSU 0013 Clinical Notification of Reportable Diseases and Condition form.

- 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 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 high risk exposures 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 through airport screening and contact details forwarded for public health follow-up and education on self-isolation. Other high risk exposure scenarios may also be identified where self-isolation is recommended (e.g. cruise ship exposure).
- 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 – person under investigation.

## APPENDIX A: Instructions for Self-Isolating in the home or co-living setting

### Self-Isolation in the home setting

#### Stay at home

The case/PUI should isolate themselves in the home setting until advised by public health that isolation can be discontinued. 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/PUI 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 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 hand sanitizing 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.
- Avoid touching their eyes, nose, and mouth with unwashed hands.

**Monitor your symptoms.**

The case/PUI 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/PUI 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 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/PUI 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/PUI should wear a medical/procedure mask. 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/PUI must leave the home setting, a medical or procedural mask should be worn.

**Medical/Procedure Masks**

Face masks (medical or procedure masks) provide a physical barrier that may help prevent the transmission of the virus from an ill person to a well person by blocking large particle respiratory droplets propelled by coughing or sneezing. However, using a mask alone is not guaranteed to stop infections and should be combined with other prevention measures including respiratory etiquette and hand hygiene.

Applying a consistent approach to putting on and taking off a mask are key in providing overall protective benefits. The following steps will help to ensure masks are used effectively:

- Before putting on a mask, wash hands with soap and water or alcohol based hand sanitizer. The mask should be worn with the coloured side facing out.
- 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. 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.
- To remove the mask, remove both straps from behind the ears. 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 immediately in a closed waste container. Wash hands with alcohol-based hand rub or soap and water.

**Limit contact with pets.**

Due to the theoretical possibility that animals in the home could be infected by COVID-19, it is recommended that cases also refrain with contact with pets, if possible.

**Avoid Sharing Personal Household Items**

The Case/PUI 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.

**Clean all high-touch surfaces**

High-touch areas such as toilets, bedside tables and door handles should be cleaned daily using a store bought disinfectant, or if not available, a diluted bleach solution (0.5% sodium hypochlorite, see above) that remains wet for 1 minute. 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) that remains wet for 1 minute.<sup>1</sup>

Disinfectants can kill the virus making it no longer possible to infect people. 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.

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 treatment for COVID-19. The case/PUI 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/PUI should check with their healthcare provider whether they should continue use while awaiting test results.

**Monitor temperature regularly.**

The case/PUI 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/PUI 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.<sup>12</sup>

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<sup>12</sup> 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.

**Maintain a suitable environment for recovery.**

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

**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 prevent transmission to others in the home**

For caregivers of a case/PUI, 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.
- **Prevent exposure to contaminated items and surfaces.** Do not use personal items that belong to the case/PUI 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 a store bought disinfectant, or if not available, a diluted bleach solution (0.5% sodium hypochlorite) or regular household cleaners
- **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 and linens 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 a store bought disinfectant, or if not available, a diluted bleach solution (0.5% sodium hypochlorite, see above).

- **Use of personal protective equipment.** If household members have direct contact with the case/PUI, they should wear a medical/procedure [mask](#) 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.

## Eye Protection

Eye protection is recommended to protect the mucous membranes of the eyes during case/PUI 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 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 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 ungloved 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 a store bought disinfectant, or if not available, a diluted bleach solution of one part bleach with nine parts water (to make a 0.5% sodium hypochlorite solution).

## Supplies for the home when self-isolating

- ✓ Medical/Procedure Masks 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
- ✓ Bleach (5% sodium hypochlorite) and a separate container for dilution.
- ✓ Alcohol (70%) prep wipes
- ✓ Regular laundry soap
- ✓ Dish soap
- ✓ Disposable paper towels

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<sup>1</sup> Kampf G, Todt D, Pfaender S, Steinmann E. Persistence of coronaviruses on inanimate surfaces and its inactivation with biocidal agents, Journal of Hospital Infection <https://doi.org/10.1016/j.jhin.2020.01.022>