Coronavirus (COVID-19)
Case and contact management guidelines for health services and general practitioners

DATE 19 January 2021
Version 26
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## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Casual contact</td>
<td>Person believed to be at somewhat increased risk of contracting a communicable disease because of brief contact with an infected person. Defined in section <a href="#">Casual contact</a>.</td>
</tr>
<tr>
<td>Close contact</td>
<td>Person at increased risk of contracting a communicable disease because of prolonged contact with a potentially infected person or a known case. Defined in section <a href="#">Contact definitions</a>.</td>
</tr>
<tr>
<td>Confirmed case</td>
<td>Defined in section <a href="#">Confirmed case</a>.</td>
</tr>
<tr>
<td>Contact tracing</td>
<td>Process of identifying people who are close contacts of a case, and ensuring they are quarantined for the maximum incubation period (14 days) after last close contact with the case.</td>
</tr>
<tr>
<td>COVID-19</td>
<td>Coronavirus disease (the name of the disease); initially referred to as 'novel coronavirus' (2019-nCoV) and often now as just 'coronavirus'.</td>
</tr>
<tr>
<td>DHHS, department</td>
<td>Department of Health and Human Services or its successor, the (Victorian) Department of Health.</td>
</tr>
<tr>
<td>Fomite</td>
<td>Objects or materials likely to carry infection, particularly high touch surfaces.</td>
</tr>
<tr>
<td>HCW</td>
<td>Healthcare worker</td>
</tr>
<tr>
<td>High risk</td>
<td>See sections <a href="#">Priority groups and settings</a>.</td>
</tr>
<tr>
<td>Historical case</td>
<td>Defined in section <a href="#">Historical case</a>.</td>
</tr>
<tr>
<td>Incubation period</td>
<td>Period of time between exposure to the disease and the onset of symptoms. For COVID-19 likely mean incubation period ~5 days, with range of 1-14 days.</td>
</tr>
<tr>
<td>Infectious period</td>
<td>Same as 'communicable period' – period during which an infected person can transmit an infectious agent to a susceptible person. For COVID-19 likely commences 2 days prior to symptom onset, reducing significantly &gt;5 days post symptom onset. See section <a href="#">Infectious period</a> for current definition used in contact tracing and isolation.</td>
</tr>
<tr>
<td>Isolation</td>
<td>Physical separation of people infected with a communicable disease (e.g. COVID-19) from those who are healthy.</td>
</tr>
<tr>
<td>Outbreak</td>
<td>See section <a href="#">Outbreak definition</a>.</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase chain reaction – see section <a href="#">Tests available for COVID-19</a>.</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal protective equipment. Clothing or equipment designed to be worn by someone to protect them from the risk of illness. For COVID-19, this usually means a mask, eye protection, gown and gloves. See <a href="https://www.dhhs.vic.gov.au/personal-protective-equipment-ppe-covid-19">https://www.dhhs.vic.gov.au/personal-protective-equipment-ppe-covid-19</a> for latest recommendations.</td>
</tr>
</tbody>
</table>
| Priority groups and settings | Settings and groups prioritised for public health management include those:  
  - disproportionately affected by adverse health outcomes, or  
  - where outbreaks may have a disproportionate effect on the wider community.                                                                                                                   |
**Quarantine**

Physical separation of people who are well but who may have been exposed to a communicable disease and are potentially infectious, to see if they develop the disease.

**RNA**

Ribonucleic acid – the viral genetic code identified by PCR testing

**Primary close contact**

Defined in section Primary close contact

**SARS-CoV-2**

Severe acute respiratory syndrome coronavirus 2 – the virus that causes COVID-19

**Secondary close contact**

Close contact of a Primary close contact. Defined in section Secondary close contact

**Suspected case**

See section Suspected case

**Transmission**

Spread of an infectious agent from one host (person or animal) to another. COVID-19 is primarily transmitted through direct or indirect contact with respiratory droplets containing the virus, typically produced when an infectious person coughs or sneezes. See Mode of transmission

**Mode of transmission**

The primary modes of transmission of COVID-19 include:

- Direct contact with respiratory droplets
- Indirect contact with fomites
- Airborne spread

**Suspected case**

A person who has been in close contact with a confirmed or probable COVID-19 case and who develops symptoms consistent with COVID-19 within a specified period of time after exposure.
Updated information in these guidelines is highlighted in yellow.

Background

Coronavirus disease (COVID-19), the disease caused by severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), was first identified in Wuhan City, Hubei Province, China in December 2019. Current information on COVID-19 is summarised in a section at the end of this guideline entitled The disease.

Updated epidemiological information is available from the World Health Organization (WHO) and other sources. The Department of Health and Human Services (the department) has up-to-date Victorian data available on its website at <https://www.dhhs.vic.gov.au/coronavirus>.

These guidelines and a range of other resources for health services and general practitioners can be found at the department’s Coronavirus (COVID-19) website. <https://www.dhhs.vic.gov.au/coronavirus>.

A hotline is available for the general public who have questions or concerns – 1800 675 398. There is a wealth of useful information for the public on the department’s website.

Public health response objectives

This situation has evolved rapidly since the start of this year with new clinical and epidemiological information.

The overall objectives of the public health response are to:

- reduce the morbidity and mortality associated with COVID-19 infection through an organised response that focuses on containment of infection.
- rapidly identify, isolate and treat cases, to reduce transmission to contacts, including healthcare, household and community contacts.
- characterise the clinical and epidemiological features of cases in order to adjust required control measures in a proportionate manner.
- minimise risk of transmission in healthcare and residential aged care environments, including minimising transmission to healthcare and residential aged care workers.
- respond rapidly to contain outbreaks through enhanced outbreak response activities.
Checklist for general practitioners

When a patient presents to a general practice or community health service who may be a case of COVID-19, do the following:

1. Provide a single-use surgical mask for the patient to put on.
2. Isolate the patient in a single room with the door closed.
3. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
4. Conduct a medical assessment, asking specifically about:
   - date of onset of illness and especially symptoms or signs of pneumonia
   - contact with confirmed cases of COVID-19 or close contacts of a confirmed case of COVID-19
   - travel history and occupation
   - history of contact with sick people, especially travellers or healthcare facilities
   - work or residence in:
     - Settings with high risk of transmission
     - Higher prevalence groups and settings
   - residence in a geographically localised area with elevated risk of community transmission, see <https://www.dhhs.vic.gov.au/caseLocationsAndOutbreaks>
5. Decide if patient needs:
   - testing for COVID-19 – see Who should be tested for COVID-19?
   - further assessment in an emergency department. Testing and management should be in hospital if pneumonia is suspected or the patient is quite unwell.
   - how will the patient be transferred?

The department does not need to be notified about Suspected cases (Confirmed cases and Historical cases only).

6. If patient is not tested, they should:
   - isolate at home until their acute symptoms have resolved and they feel well,
   - if patient is a close contact of a confirmed case, they must continue to quarantine – see Quarantine

7. If a Suspected case of COVID-19 is unwell enough to need transfer to hospital:
   - if clinically indicated, call Triple Zero (000) and advise that the patient may have suspected COVID-19 infection
   - ambulance transfers do not need to be approved by the department
   - if ambulance transfer is not clinically needed, other transport options include private car driven by the suspected case or an existing close contact (not public transport, taxi or rideshare).

8. Provide a surgical face mask for the patient and driver if being transferred to an emergency department by any means.

9. If a patient is tested by a general practitioner in the community, undertake testing as outlined in Laboratory testing for COVID-19. Ensure arrangements are in place for contacting the patient with the test result – this is the responsibility of the testing clinician.

10. Advise a suspected case that has been tested that they must isolate, and provide a factsheet for suspected cases from the department’s coronavirus website.

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11. **Clean and disinfect** the room according to the [Coronavirus (COVID-19) infection prevention and control guidelines](https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines)

12. When test result is available, if the test is:

   - negative for COVID-19:
     - provide the negative result from the laboratory to the patient
     - manage any other cause of illness you have assessed as requiring treatment
     - symptomatic patients should continue to isolate until their acute symptoms have resolved and they feel well
     - quarantined people must continue to [Quarantine](https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines)
     - advise patient in the normal manner that medical review and repeat testing may be required if symptoms persist or condition deteriorates.

   - positive for COVID-19:
     - notify the department using the [online COVID-19 notification form](https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines) or telephone **1300 651 160**
     - Confirmed cases must continue to isolate until released by the department or their nominated representative, see [Release from isolation of a confirmed case](https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines).

### Checklist for health services

The actions below should be undertaken when a patient presents to an emergency department or urgent care centre who may be a suspected case of COVID-19. See also:

- personal protective equipment (PPE) for health workers is available on the [department’s website](https://www.dhhs.vic.gov.au/personal-protective-equipment-ppe-covid-19)
- [Assessment and streaming in emergency departments and urgent care centres](https://docs.health.vic.gov.au/ewas/temp/covid-daily-matrix.docx)

1. Staff at triage points should wear personal protective equipment for droplet and contact precautions (single-use surgical mask, eye protection, gown and gloves).
2. Triage high risk patients to a separate, isolated waiting area away from low risk patients, staff and general public.
3. Provide a single-use surgical mask for the patient to put on.
4. Isolate the patient in a single room with the door closed.
5. Any person entering the room should don droplet and contact precautions personal protective equipment (single-use surgical mask, eye protection, gown and gloves).
6. Conduct a medical assessment, asking specifically about:
   - the date of onset of illness and especially whether there are symptoms or signs of pneumonia
   - contact with confirmed cases of coronavirus (COVID-19) or their close contacts
   - history of contact with sick people, especially travellers or health care facilities
   - travel history – see [Exposure sites](https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines)
7. Determine whether the patient meets the current criteria for testing – see Who should be tested for COVID-19?

8. If admission is not required and the patient can return to the community:
   a) for patients that do not meet the current criteria for testing for COVID-19 – advise the patient to stay at home until their acute symptoms have resolved and they feel well.
   b) for patients that meet the current criteria for testing - the notifying clinician should advise the patient to isolate at home and avoid contact with other people. Provide a factsheet for suspected cases from the department’s COVID-19 website.
   c) consider advising the patient that admission to hospital and further testing may be required if they deteriorate.
   d) ensure arrangements are in place for the patient to be contacted with the test result – this is the responsibility of the testing clinician and health service.

9. If admission is required:
   a) maintain infection control precautions and actively consider taking multiple samples for testing including from lower respiratory tract specimens.

10. When the test result is available:
   a) if the test is positive for COVID-19, provide the result to the patient. The health service infectious diseases lead, or senior clinician should notify the department either by using the online COVID-19 notification form or by calling 1300 651 160 to confirm that the department is aware of the result and to provide any additional clinical information.
   b) if the test is negative for COVID-19, provide the negative result to the patient and manage any other cause of illness you have assessed as requiring treatment. Stand down suspected COVID-19 precautions for this patient.
   c) consider advising the patient that admission to hospital and further testing may be required if they deteriorate.
Case definitions

**Confirmed case**
A person who tests positive to a validated specific SARS-CoV-2 nucleic acid test;

OR

has the virus isolated in cell culture, with polymerase chain reaction (PCR) confirmation using a validated method;

**Historical case**
A person who:

- undergoes a seroconversion to or has a significant rise in SARS-CoV-2 neutralising or IgG antibody level (such as four-fold or greater rise in titre) **OR**
- has detection of SARS-CoV-2 neutralising or IgG antibody **AND**
- has had a compatible clinical illness **OR**
- epidemiological evidence as below.

**Epidemiological evidence**

- Contact with a known COVID-19 case (confirmed or historical), involving a plausible mode of transmission, at a time when the case was likely to have been infectious.

OR

- International or domestic travel in a geographically localised area with elevated risk of community transmission, including travel on a cruise ship with known COVID-19 transmission on board.

**COVID-19 deaths**

A COVID-19 death is defined for surveillance purposes as a death in a confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death. Where a Coroner’s report is available, these findings are to be observed.

**Outbreak definition**
The department currently defines an outbreak of COVID-19 as:

- A **single** confirmed case of COVID-19 in a resident, staff member or frequent attendee of **Settings with high risk of transmission**

OR

- **Two or more** epidemiologically linked cases outside of a household with symptom onset within 14 days.

See:

- Exposure sites for links to information on current known outbreaks.

**Frequent or infrequent attendee**
Determining whether a person is a frequent or infrequent attendee may be based on...
• the number of visits
• the length of time spent in the setting
• number of contacts within the setting.

Note that transmission within one household does not constitute an outbreak but will become part of an outbreak response if linked to

- Settings with high risk of transmission
- Higher prevalence groups and settings
- Priority settings and groups.

The department may identify other Priority groups and settings where a single confirmed case will trigger an outbreak response. Relevant parties will be informed if this occurs

Contact definitions

Contacts are people at increased risk of contracting coronavirus (COVID-19) because of contact with a potentially infected person, known case or an exposure setting. Determining people to be Primary close contacts, Secondary close contacts or Casual contacts guides public health actions for the different groups.

Primary close contact

A primary close contact is defined as a person who has:

• had face-to-face contact with a confirmed case of coronavirus (COVID-19) during their Infectious period.
• exposure may be any duration depending on risk setting
• shorter durations of contact apply in higher risk situations, such as if there:
  - has already been proven transmission or
  - may be inadequate air exchange in an indoor environment, or
  - are concerns about the nature of contact in the place of exposure, including exposure to shouting or singing
• shared a closed space with a confirmed case of coronavirus (COVID-19) for more than one hour, or
• been exposed to a high prevalence setting or exposure site – see Higher prevalence groups and settings.

A primary close contact may also be determined by the Chief Health Officer or Deputy Chief Health Officer when there is reasonable evidence of exposure to a possible human source or an exposure site. This is particularly important for Priority groups and settings.

Examples of primary close contact include, but are not limited to:

• living in the same household or household-like setting (for example, a boarding school or hostel) – see Settings with high risk of transmission
• direct contact with the body fluids or laboratory specimens of a confirmed case without recommended PPE (droplet and contact precautions)
• a person who spent one hour or longer in the same room (such as a GP clinic or emergency department waiting room, a school classroom)
• a person who spent one hour or longer in the same care facility (such as a residential aged care facility, or disability residential service)
• a person in the same hospital room when an aerosol generating procedure (AGP) is undertaken on the case, without recommended PPE for an AGP (airborne and contact precautions) – see PPE risk matrix
• aircraft passengers who were seated in the same row as the case, or in the two rows in front or two rows behind a confirmed COVID-19 case.
• aircraft crew exposed to a confirmed case – airline should conduct case-by-case risk assessment to identify which crew member(s) should be managed as close contacts. This will include:
  - proximity of crew to confirmed case
  - duration of exposure to confirmed case
  - size of the compartment in which the crew member and confirmed case interacted
  - precautions taken, including PPE worn, when in close proximity to the confirmed case
  - if an aircraft crew member is the COVID-19 case, contact tracing efforts should concentrate on passengers seated in the area where the crew member was working during the flight and all of the other members of the crew.
• cruise ships – close contacts can be difficult to identify. Conduct case-by-case risk assessment to determine passengers and crew to manage as close contacts.

**Higher risk exposures**

These exposures may cause a person to be considered a primary close contact rather than a Casual contact by an officer authorised to exercise public health risk powers:
• a case who is hospitalised (increased severity of infection, increased risk of transmission to others) without the use of appropriate PPE
• an indoor event
• a setting where there is shared use of amenities (such as a toilet or kitchen)
• an indoor setting with multiple shared high touch points (such as a café, restaurant or bar)
  **Settings with high risk of transmission**
• aerosol generating events: Certain behaviours may increase the risk of aerosols being generated and include singing, coughing, sneezing, speaking loudly and aerosol generating procedures in healthcare settings.
• people who are not cooperating with interview for any reason, including for example dementia, intellectual disability or unwillingness to disclose their history or where people cannot reliably recall their exposure (for example, due to intoxication or their age).

**PPE and close contacts**

Consideration should be given to the effective use of an appropriate facemask when assessing whether a person is a primary close contact or a Casual contact. This may not prevent a person being classified as a primary close contact.

**Healthcare workers** and others who have cared for a suspected or confirmed case of COVID-19 are not considered to be close contacts:
• if they have taken recommended infection control precautions
• recommended PPE is droplet and contact precautions for the purposes of this contact definition.
Healthcare workers who are cases

Additional factors may be considered by health services in identifying close contacts of cases who are healthcare workers who have worn a mask at work while infectious. If both the case and a contact are staff members wearing (at a minimum) surgical masks during their interaction, this may not necessarily be considered close contact.

This does not apply to community mask wearing.

Additional factors may include:
- the presence of symptoms in the case
- duration of contact
- distance between the case and contact.

See PPE risk matrix in Healthcare services – management of healthcare workers with suspected or confirmed COVID-19.

The Chief Health Officer and Deputy Chief Health Officer retain the discretion to designate a person a primary close contact.

Secondary close contact

A secondary close contact is defined as a person who:
- has had face-to-face contact in any setting with someone who is a primary close contact of a confirmed case of coronavirus (COVID-19), or
- exposures will have occurred at least 24 hours after the primary close contact was exposed to the case
- exposure may be of any duration, depending on risk as in Higher risk exposures.

For healthcare workers who have cared for a person later identified as a primary close contact, undertake a risk assessment.

If appropriate infection control precautions were taken, including recommended PPE:
- do not automatically quarantine as secondary close contact
- advise to self-monitor
- isolate and test if any compatible symptoms.

A secondary close contact may also be determined by the Chief Health Officer or Deputy Chief Health Officer when there is reasonable evidence of exposure to a possible human source or an exposure site.

Casual contact

A casual contact is defined as a person who:
- has been in the same setting with a confirmed case in their infectious period
- is not a primary close contact.

The Chief Health Officer or Deputy Chief Health Officer may determine a person to be a casual contact when there is reasonable evidence of exposure to a possible human source or a COVID-19 exposure site.

For example: a customer attended a bakery near their home while infectious but asymptomatic. The staff member who assisted the customer briefly is a casual contact.
Priority groups and settings

Priority settings and groups are those that are disproportionately affected by adverse health outcomes. Outbreaks in other groups have a disproportionate effect on the community, including provision of essential services and are therefore prioritised for public health management.

Higher prevalence groups and settings

A patient is considered higher risk for COVID-19 if:

- presenting with acute respiratory tract infection
- presenting with fever without another immediately apparent cause (for example, urinary tract infection or cellulitis)
- they are in Quarantine for any reason, including:
  - they have travelled overseas and have onset of symptoms within 14 days of return
  - they are a Primary close contact or Secondary close contact of a Confirmed case of COVID-19
- they are a resident in an aged care facility where there is an outbreak
- they have lived in or visited a geographically localised area at high risk of exposure – see Exposure sites.

Settings with high risk of transmission

Once a confirmed case of COVID occurs in these settings, the risk of rapid transmission is high.

Places where people reside in groups, for example:

- aged care facilities
- military residential settings
- boarding schools
- boarding houses
- homeless shelters
- correctional facilities
- remote industrial sites with accommodation
- Aboriginal rural and remote communities
- high density residential buildings.

Workplace settings where previous outbreaks have shown large scale amplification, for example:

- schools
- abattoirs
- other low temperature food processing, storage and supply chain facilities
- hotel quarantine
- freight drivers who travel interstate and are required to get tested through the National Freight Movement Protocol
- healthcare services
- aged care facilities
- nightclubs and bars
- workplaces with highly casualised or mobile workforces.
People at high risk of severe disease

For further information on groups who are most at risk of severe illness from COVID-19, see https://www.dhhs.vic.gov.au/clinical-guidance-and-resources-covid-19

- Aboriginal and Torres Strait Islander people 50 years and older with one or more chronic medical conditions.
- People 65 years and older with chronic medical conditions.
- People 70 years and older.
- People with compromised immune systems (see above link on department’s website for details).

Chronic medical conditions

The following chronic medical conditions are of concern in the age groups above:

- Chronic renal failure
- Coronary heart disease or congestive cardiac failure
- Chronic lung disease (severe asthma for which frequent medical consultations or the use of multiple medications is required, cystic fibrosis, bronchiectasis, suppurative lung disease, chronic obstructive pulmonary disease, chronic emphysema)
- Poorly controlled diabetes
- Poorly controlled hypertension.

Critical workforces

Critical workforces in essential services, including:

- emergency response
- law and order
- child protection workers and other social services
- food supply chain
- energy and water.

Other priority settings and groups

Other priority settings not included in lists above, such as:

- childcare centres
- disability day centres
- aged care day centres
- communities with high proportions of culturally and linguistically diverse people
- people experiencing homelessness or housing instability
- remote communities.

Exposure sites

The following websites are useful in the assessment of risk of exposure to COVID for testing and quarantine as close contacts.

Victoria


For current information on:
- known outbreaks
- public exposure sites
- active cases in aged care facilities.

**Australian Capital Territory**

**South Australia**

**New South Wales**

**Northern Territory**

**Queensland**

**Tasmania**

**Western Australia**

**Other countries**
All international locations should be considered as high risk for exposure to coronavirus (COVID-19).
More nuanced assessment for those countries currently considered to be at low risk (‘green zone’) can be found at:

**New Zealand**
Who should be tested for COVID-19?

See also Assessment and management of patients for COVID-19 testing.

**Asymptomatic testing**

People without symptoms should *not* be tested except in special circumstances as directed by the department, such as:

- as part of an outbreak investigation/response (active case finding)
- all primary close contacts and returned international travellers at the start and the end of quarantine as directed by the department.
- prior to surgery as directed by the department
- as part of department-led enhanced surveillance to:
  - investigate how widespread COVID-19 is in the community, or
  - detect and reduce transmission, particularly in Higher prevalence groups and settings and Settings with high risk of transmission.

See also:

Isolation Notification to the department

**Suspected case**

Patients who meet the following clinical criteria should be tested:

Fever OR chills in the absence of an alternative diagnosis that explains the clinical presentation*

OR

Acute respiratory infection (e.g. cough, sore throat, shortness of breath, runny nose, loss of smell or loss of taste)**

*Clinical discretion applies; consider potential for co-infection (e.g. SARS-CoV-2 and influenza).

**Older people may present with other atypical symptoms including functional decline, delirium, exacerbation of underlying chronic condition, falls, loss of appetite, malaise, nausea, diarrhoea and myalgia.

**Other clinical symptoms**

People in the following groups should be tested if they have new onset of other clinical symptoms associated with COVID-19 (such as headache, myalgia, stuffy nose, nausea, vomiting, diarrhoea):

- People at high risk of severe disease
- Higher prevalence groups and settings
- Settings with high risk of transmission

Clinical judgement and reasoning should be used, including consideration of epidemiological risk factors for acquisition and transmission.

See also Symptomatic recovered cases in Cases who have been released from isolation.
Hay fever and asthma

Those with a history of seasonal rhinorrhea, sneezing or cough should seek advice regarding optimising management ahead of the pollen season.

In addition to the public health impact on COVID-19, masks may also provide some benefit for those with allergic rhinitis and asthma. This would not include epidemic thunderstorm asthma as the causative pollen particle sizes are too small in that instance.

Rhinorrhoea

Clinical judgement should be applied in determining whether rhinorrhoea represents COVID-19 (requiring testing) or allergic rhinitis.

Allergic rhinitis is more likely with:
- a history of seasonal rhinitis in previous years at a similar time of year
- concomitant itchy nose and eyes
- response to usual treatment.

Coronavirus (COVID-19) is more likely with:
- other respiratory symptoms (sore throat, cough, anosmia) or
- systemic symptoms – such as fever, myalgia, anorexia
- lack of response to usual allergic rhinitis treatment.

Figure 1: Symptoms of COVID-19 and seasonal allergies and their overlap

*Seasonal allergies do not usually cause shortness of breath or difficulty breathing, unless a person has a respiratory condition such as asthma that can be triggered by exposure to pollen.
Decease people and testing

If there is a suspicion that a deceased person may have had undiagnosed COVID-19 (such as a close contact of a known case or resident of an aged care facility where there is a known outbreak), including on request of paramedics or other first responders, an oropharyngeal and deep nasal swab for COVID-19 PCR testing should be taken, with the consent of the family.

In a community setting, swabs should be performed by the medical practitioner certifying death. The testing medical practitioner should ensure that the results are given to the family, funeral director and any relevant first responders – if negative, this will enable less restrictive funeral practices. Positive test results must also be notified to the department on 1300 651 160, 24 hours a day, to ensure contact tracing occurs.

Tests available for COVID-19

In response to the global increased demand for testing in this public health emergency, many new tests for SARS-CoV-2, the virus that causes COVID-19, have been rapidly developed. These tests fall into the following categories:

Polymerase chain reaction – PCR

The current test of choice (‘gold standard’) for the diagnosis of acute COVID-19 infection in Victoria is a molecular test known as reverse transcription (RT) polymerase chain reaction (PCR). It should be performed on a well-collected combined throat and deep nasal swab or nasopharyngeal swab, and is the test that the national confirmed case definition relies on.

Molecular tests use real-time PCR to look for evidence of the genetic material (ribonucleic nucleic acid – RNA) of SARS-CoV-2. Because these tests directly detect viral RNA, they are an indicator for viral shedding.

A positive PCR result indicates current or very recent infection. SARS-CoV-2 RNA is generally detectable in respiratory specimens from about one day prior to symptom onset, and during the acute phase of infection. Patients may continue to shed viral RNA after their symptoms resolve, but the extent to which this correlates with transmissibility is currently unclear. Clinical resolution (and for some cases two consecutive negative PCR tests) are currently being used as criteria when considering release from isolation. However, this may change as our knowledge of the virus increases.

A negative PCR result means that SARS-CoV-2 RNA was not identified in the sample. Negative results do not preclude SARS-CoV-2 infection, and interpretation of such results should be combined with clinical observations, patient history, and epidemiological information.

Rapid and point of care PCR testing

Most COVID-19 PCR tests are performed in a dedicated laboratory using validated laboratory-based high throughput PCR machines. However, there are also PCR platforms available that offer rapid results (in around an hour) that can be used in either a laboratory or near the site of patient care. The Cepheid GeneXpert (XpertXpress) cartridge system is one example of this type of rapid PCR test that is used in Victoria. However, due to the limited supply of cartridges, it should only be used for suspected COVID-19
cases where their prompt ascertainment (within 1 to 4 hours) will provide a fundamental public health advantage, compared to the conventional PCR-based testing (in 8 to 24 hours).

The GeneXpert platform is not a high throughput platform. Only 1 - 16 tests can be processed per hour by a single operator and this depends on the capacity of the machine. The use of GeneXpert in a COVID-19 outbreak must have authorisation from the Clinical Public Health Command and the supervising Medical Microbiologist at the pathology provider to which the samples are being referred.

Saliva-based PCR testing

Collecting saliva instead of the gold-standard nose-throat or nasopharyngeal swabs is considered an appropriate option for COVID-19 testing in some limited situations. Saliva sampling is less-invasive and can be self-collected, however it is associated with lower sensitivity at detecting the COVID-19 virus compared with than the gold-standard nose-throat swab, with more research required.

Saliva sampling is associated with a lower sensitivity compared to the nose and throat swab (estimated to be 85% sensitive if used in the first 7 days post symptoms onset and deteriorates significantly after that).

Saliva is not recommended if testing is occurring post 7 days of symptoms onset.

The clinical performance of saliva sampling depends on the circumstances in which it is used. The collection technique, the amount of saliva collected, the transport media, and the analytical assay are all factors that can influence sensitivity.

No test is perfect. Caution is required in relying on saliva samples, and clinical discretion is required in interpreting a negative result from saliva-based PCR testing when an infection is suspected.

DHHS only currently endorses the use of saliva sampling as a:

- first-line test in targeted screening – involving repeat high-frequency testing of individuals in a defined target population group.
- last resort option for symptomatic individuals who are unable to undergo a throat-nose swab.

Saliva sampling in targeted screening

Saliva-sampling has been used and endorsed for use in targeted screening in settings with:

- high risk of introduction of virus
- high risk of amplification of transmission.

Saliva is an appropriate and feasible sampling option for targeted asymptomatic screening where individuals will undergo high-frequency repeat testing. In this context, the lower sensitivity of saliva can be offset by repeated testing within the same cohort.

**DHHS does not recommend saliva-based PCR testing for other types of surveillance testing involving a single one-off test. In these cases, throat-nose or nasopharyngeal swabs are recommended.**

The department does not endorse wide-scale and untargeted screening testing. Priorities are articulated through Public Health Directions of the Chief Health Officer or announcements by the Department of Health and Human Services.

Screening testing regimes should include saliva sampling as primary or first-line screening test, with follow-up confirmatory testing performed on a throat-nose swab for definitive diagnosis. Participants with a positive saliva screening test must self-isolate whilst awaiting their confirmatory throat-nose-based PCR test result.
The recommended testing frequency depends on the risk profile of the target population. The greater the frequency the greater the probability an infection is detected and detected early. Testing at least one time per week is the minimum frequency recommended for screening testing. The maximum frequency recommended is five time per week. Currently the department recommends that one test per week is performed with a throat-nose swab and any subsequent tests performed with saliva. The department recommends the use of throat-nose sampling where possible.

Saliva sampling as a last resort option for symptomatic individuals

The throat and nose swab is the gold-standard for COVID-19 testing. This is the upper respiratory specimen from which we are most confident the COVID-19 virus can be detected. However, for some people, the throat/nose swab is not acceptable or possible. This can present a barrier to participating in testing, or can result in unnecessary distress/duress to achieve a test.

Barriers may exist for people experiencing mental health issues, disabilities and/or cognitive impairment, behavioural issues, alcohol and/or substance abuse, social and/or economic exclusion, and mistrust or fear of healthcare services.

In these cases, collecting saliva may be an alternative option, and an important way to enable participation in testing.

The most appropriate sampling approach should be determined by the doctor or health professional overseeing the test. Efforts should first be made to encourage the gold standard option. There are finer and more flexible swabs available, in particular for use in infants and children. Nasopharyngeal swabbing is associated with greater levels of discomfort and pain.

Saliva sampling should only be used within 7 days of symptoms onset.

The decision to use saliva sampling should be made by the treating doctor.

Caution is required in relying on saliva sampling, and clinical discretion is required on any follow-up of a negative result if SARS-CoV-2 infection is suspected.

If a positive result occurs from testing a saliva specimen, confirmatory testing with an oropharyngeal and deep nasal specimen is required for definitive diagnosis of a SARS-CoV-2 infection.

Saliva sampling is being well researched in Victoria. This research is guiding us about how best to use saliva in the COVID-19 response.

Rapid antigen testing

Rapid antigen tests include both point-of-care lateral flow (rapid kit) and laboratory-based assays that detect the presence of SARS-CoV-2 proteins in respiratory tract specimens. In general, rapid antigen tests are less sensitive at detecting the virus than PCR-based assays and quite variable in their test performances.

At present, the department advises against use of rapid antigen tests to diagnose acute SARS-CoV-2 infection in symptomatic persons outside of a research framework, or unless specifically advised by the department.

This is consistent with the joint statement by the Public Health Laboratory Network and the Communicable Diseases Network of Australia (see https://www.health.gov.au/resources/publications/phln-and-cdna-joint-statement-on-sars-cov-2-rapid-antigen-tests).

Evaluation data on rapid antigen tests for COVID-19 are limited, and verification is required before use. The department recommends that health services, residential aged care facilities and other community services do not purchase these tests if approached by suppliers without consultation with the department. Any questions should be sent to COVID-19pathology@dhhs.vic.gov.au

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The Australian Therapeutic Drugs Administration (TGA) has approved some of these SARS-CoV-2 rapid antigen tests for inclusion in the Australian Register of Therapeutic Goods (ARTG) for legal supply in Australia. However, experience with these tests in the Australian context in which there is low infection prevalence is lacking.

The published sensitivity of rapid antigen tests is lower than that of the RT-PCR assay. Their clinical performance depends on the circumstances in which they are used.

Therefore, given the current availability and reliability of high throughput and rapid RT-PCR testing, PCR is the ‘gold standard’ and method of choice for acute COVID-19 diagnosis.

The department is exploring the utility of rapid antigen tests under a research framework with test characteristics being compared to the gold standard, RT-PCR.

Further guidance will be provided to health services when new information is available.

**Serological testing**

Serology tests detect the presence of antibodies (IgA/IgM/IgG) produced against the SARS-CoV-2 virus, the cause of COVID-19 infection. Once an individual is infected with the SARS-CoV-2 virus, a detectable (IgG) antibody response usually takes between 7 and 21 days to develop (Figure 1). The timing, strength and duration of the response vary between individuals.

**Figure 2: The antibody response to a SARS-CoV-2 (COVID-19) infection over time.**

*Reproduced with the permission of the Royal College of Pathologists of Australasia.*

Currently, based on the limited sensitivity of the available serology tests in early COVID-19 infection, serology does not have a role in the acute diagnosis of COVID-19 cases. RT-PCR done on respiratory samples is the best approach to diagnosing acute cases (see below). In addition, very low prevalence of COVID-19 within the community makes an accurate distinction between true positive and false positive results very challenging with the serology tests currently available. However, in limited circumstances, serology may have a role to supplement RT-PCR testing in confirmation of recent exposure to COVID-19 infection as per the current case definition.
It is recognised that serological testing has a potential role in supporting public health measures such as contact tracing, outbreak management and case finding (for example, identifying the missing link in cluster analysis), and population surveillance testing (for example, assessing the seroprevalence of COVID-19 infection, and assisting in providing an estimate of the extent of undiagnosed COVID-19 infection in the community).

Decisions concerning the collection of samples for serology should be made in response to clinical and public health imperatives, and in consultation with the Department of Health and Human Services. If serological testing is deemed indicated or, if requested, serum can be collected from people with positive RT-PCR respiratory samples for assessment of COVID-19 serology. If a sample is collected early in the disease course and returns a negative result, then a repeat serum sample should be collected 14 or more days after onset of illness and marked as ‘convalescent sera’ for paired analysis. If no acute sample was collected, sera collected 14 or more days after symptom onset may also be collected for testing. For contacts of a confirmed case, paired sera collected 4 weeks apart could be useful. These samples should be forwarded to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for storage and confirmatory testing.

The application of serology in the current case definitions is found under the **Historical case** definition.

Additional studies are needed to determine a correlate of protection (that is, which antibodies, and what levels of these antibodies correlate with protective immunity).

**Genome sequencing**

Two variants of the SARS-CoV-2 virus have been identified – one from South Africa (B.1.351) and the other from the United Kingdom (B.1.1.7). These are current variants of concern and while the evidence base is still limited, there is emerging evidence suggesting that these variants may be more infectious. It is unknown whether the variants are associated with worse clinical outcomes. Rapid identification of cases infected with a SARS-CoV-2 variant of concern enables cases to be managed with additional precautions to mitigate the risk to the public (see Confirmed cases infected with a SARS-CoV-2 variant of concern).

In Victoria, all positive PCR samples are being forwarded to the Microbiological Diagnostic Unit for genomic sequencing.

**Transfer, triage and management of patients on arrival to health services**

**High- and low-risk suspected cases**

Suspected cases of coronavirus (COVID-19) are divided into high- and low-risk for the purposes of:

- ambulance transfers
- emergency department management
- PPE use.

**High-risk suspected**

A person who:

- is in quarantine, **OR**
- has a compatible illness with epidemiological risk factors, see: 

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Low-risk suspected

A person who:

- has a compatible clinical illness
- no epidemiological risk factors

See:

- Assessment and streaming in emergency departments and urgent care centres  

Signage and triage of people presenting to health and other services

Diagnosis and management of COVID-19 must be undertaken by medical practitioners in accordance with the current guidelines from the Victorian Department of Health and Human Services. This will occur primarily in general practice and hospitals.

However, to reduce risks to service providers and detect people with COVID-19 risk factors, rapid pre-assessment is indicated by a broader range of service providers prior to the provision of a service. This pre-assessment may include enquiring about recent travel history and relevant symptoms. Only healthcare services who manage unwell patients (such as general practice, hospitals and ambulance services) are expected to assess for symptoms.

See also:

- Physical distancing in emergency departments and urgent care centres  

Patient transfers and destination health service

The following is advice on where patients should be managed:

- patients should be assessed and managed by the health service they present to
- transport of patients to other facilities should be avoided unless medically necessary
- ambulance transfer should be reserved for cases where there is clinical need; alternative means of transport should be used for other cases including a private car driven by the case or an existing close contact (not bus, taxi or ride-share). See also Quarantined people requiring treatment.
- Low-risk suspected, High-risk suspected, or Confirmed cases cases in the community who require assessment or admission at a hospital should be seen and assessed at the nearest emergency department or according to Ambulance Victoria protocols.

Ambulance transfers

Where clinically appropriate Ambulance Victoria can be used to transport any Low-risk suspected, High-risk suspected, or Confirmed cases cases of COVID-19 from:

- ports of entry – by existing arrangements with Ambulance Victoria
• general practice or other settings to an emergency department - call Triple 000 and advise of relevant risk of COVID-19 infection.

Further information:

Arrival to hospital and triage

Upon arrival to the emergency department, patients assessed as Low-risk suspected, High-risk suspected, or Confirmed cases should be triaged to separate isolated sections of the waiting area, away from the general public and provided with a surgical mask. Coronavirus (COVID-19) assessment centres can support the management of high-risk patients if they are in place at the health service.


PPE

All staff at triage points and assessment centres should be wearing the appropriate PPE according to current guidance <https://www.dhhs.vic.gov.au/personal-protective-equipment-ppe-covid-19>

Ambulance triage

Prehospital to hospital transfer process guidance is found at <https://www.dhhs.vic.gov.au/factsheet-prehospital-hospital-transfer-process>

Emergency department admissions

A dedicated floor plan should be established that clearly designates areas assigned for Low-risk suspected, High-risk suspected and Confirmed cases within the emergency department. If able, rostering of staff to these areas to support the separation and rational use of PPE should be considered. Staff should wear appropriate PPE for the area in which they are working. Designated areas for donning and removing PPE should be in place.

See:

Mass respiratory casualty events

In planning for sudden large volumes of respiratory casualties such as may occur during epidemic thunderstorm asthma events, in order to save lives, directors of emergency departments and directors of medical services in urgent care centres should exercise discretion around cohorting suspected and confirmed (COVID-19) patients as well as those with asthma.

Emergency departments and urgent care centres should continue to test appropriate patients for COVID-19 where possible.
Internal patient transfers

Should Low-risk suspected, High-risk suspected and Confirmed cases need to be moved outside of the initial isolation section, they should be transferred using a route that minimises contact with the general hospital population including clinicians (for example, dedicated lift service, external path). Staff involved in patient transfer should wear appropriate PPE. Physical distancing rules apply during all stages of the transfer.

Assessment and management of patients for COVID-19 testing

Medical assessment

For key actions for the assessment of patients for testing, see:

- Checklist for general practitioners
- Checklist for health services

Medical assessment of the patient should focus on the following:

- date of onset of illness and especially whether there are symptoms or signs of pneumonia
- contact with Confirmed cases or Historical cases of COVID-19
- precise travel history and occupation
- history of contact with sick people, travellers, or healthcare facilities
- work or residence in:
  - Higher prevalence groups and settings
  - Settings with high risk of transmission
  - Other priority settings and groups
- Co-morbidities — People at high risk of severe disease.

All patients should attend an emergency department if clinical deterioration occurs.

Isolation

People waiting for test results

People who are tested for COVID-19 should isolate while awaiting results or symptoms have resolved, whichever is longer.

People who were symptomatic at the time of testing for COVID-19 should isolate until COVID-19 is excluded. If their test is negative, they should continue to isolate until the acute symptoms have resolved and they feel well.

People who were asymptomatic at the time of testing for COVID-19 should isolate until COVID-19 is excluded, unless advised otherwise by the department. Those advised by the department that they do not need to quarantine include:
- those tested as part of a surveillance testing or other targeted testing program and
- who are not being tested due to concerns about cases that might have been missed.

See:

- Further information is available in [Healthcare services – management of healthcare workers with suspected or confirmed COVID-19](https://www.dhhs.vic.gov.au/novel-coronavirus-suspected-case-what-you-need-know)

### Exclusion of COVID-19

For patients with fever or respiratory tract infection who are not hospitalised, a single negative oropharyngeal and deep nasal swab (plus sputum if possible) is sufficient to exclude COVID-19 infection.

Repeat testing (especially of lower respiratory tract specimens) in clinically compatible cases should be performed if initial results are negative and there remains a high index of suspicion of infection. In unwell patients, consideration should also be given to a respiratory virus panel test, especially if the first COVID-19 test is negative.

There is no strong evidence to support a required time interval between exclusion swabs or the need for multiple practitioners performing the swab. Health services should apply discretion and consider the need for this on a case by case basis.


### Case management

#### Notification to the department

Confirmed cases and Historical cases must to be notified to the department. Notify as soon as practicable by either:

- using the online COVID-19 notification form, or
- calling 1300 651 160, 24 hours a day.

#### Isolation


Effective isolation from others within the same household or other Settings with high risk of transmission is difficult to achieve. This is likely to affect the duration of quarantine required of close contacts – see Quarantine.

It is a legal requirement for confirmed cases to isolate until cleared by the department or their nominated representative. The current Diagnosed persons and close contacts directions may be found at [https://www.dhhs.vic.gov.au/victorias-restriction-levels-covid-19](https://www.dhhs.vic.gov.au/victorias-restriction-levels-covid-19).
Education

Cases should be educated about the nature of the illness, importance of isolation and infection control measures that prevent the transmission of COVID-19. A fact sheet for confirmed cases is available on the department’s website. Household contacts should be given the close contacts fact sheet.

PCR positive tests in asymptomatic or pre-symptomatic persons

The department may undertake enhanced testing of asymptomatic people in the community (that is, not in an outbreak setting). This may identify asymptomatic or pre-symptomatic PCR positive cases. The following steps should be taken:

- isolate the case while investigations are underway
- confirm interpretation of the test in close liaison with laboratory
- undertake a thorough investigation of the past 4-6 weeks to determine if the individual has recently had clinically compatible symptoms. If historical symptoms are:
  - identified, then for the purposes of contact tracing, the duration of infectivity is regarded as commencing 48 hours prior to symptom onset.
  - not identified, then for the purposes of contact tracing, the case is considered to have been infectious from 48 hours prior to the testing date
- follow the case prospectively for 10 days from the initial test
- if symptoms develop, the case is considered to have been pre-symptomatic. The case and contacts should be managed according to the time of symptom onset.

Clinical management of confirmed cases

This is at the discretion of the treating team and at the present time is supportive care only.

Admission to hospital should occur when medically necessary or when directed by the department in order to reduce the risk of transmission, such as if the case resides in a communal environment. Emerging information suggests COVID-19 may be associated with a delayed deterioration in clinical status in some cases.

Interim clinical guidelines for the management of patients with COVID-19 have been released by the following peak professional bodies:

- The Australasian Society for Infectious Diseases (ASID)
- The Australian and New Zealand Intensive Care Society (ANZICS)

Further advice on clinical management is available from:

- Cochrane Library: Coronavirus (COVID-19):

Inpatient discharge criteria

A confirmed case may be discharged from hospital if all of the following criteria are met:

- a senior member of the treating team (or appropriate consulting team) has determined the patient is clinically improved and well enough to be managed in the community, and
- appropriate infection control measures can be implemented in the community or household setting to ensure risk to other people can be managed
- the department is notified about the pending discharge
A confirmed case in the home or other community setting must remain in isolation until criteria for release from isolation are met.

**Release from isolation of a confirmed case**

Cases must be cleared from isolation by an officer or nominated representative of the department. The clinical or medical lead of the infection prevention or infectious diseases unit of a health service will be considered the nominated representative. The role will be primarily filled by an infectious diseases physician or appropriate officers in a local public health unit. Services without the appropriate clinical or medical lead can be supported by their Cluster Lead health services.

Information on clearance from isolation in the COVID-19 Positive Care Pathways program is available:


**Release from isolation criteria**

**Confirmed cases NOT infected with a SARS-CoV-2 variant of concern**

The following information details the circumstances under which confirmed cases *not infected* with a SARS-CoV-2 variant of concern, as confirmed by whole genome sequencing, can be released from isolation.

**Confirmed cases** can be released from isolation if they meet the appropriate criteria in either point 1, 2, or 3 – whichever is applicable. Significantly immunocompromised cases can be released from isolation if they meet the appropriate criteria in point 1, 2, or 3 and the additional criterion in point 4.

Most cases of COVID-19 will meet criteria for release from isolation that do not require further testing. Healthcare workers and workers in aged care facilities who meet the below criteria can also be released from isolation and do not require further testing to return to work or an at-risk setting.

1. Asymptomatic

Confirmed cases who are asymptomatic can be released from isolation if at least 10 days have passed since the first respiratory specimen positive for SARS-CoV-2 by PCR was taken and no symptoms have developed during this period.

2. Mild illness

Confirmed cases with mild illness (not requiring hospitalisation or admitted to hospital for reasons not directly related to acute COVID-19)

The case can be released from isolation if they meet all of the following criteria:

- at least 10 days have passed since the onset of symptoms; and
- there has been resolution of fever and *substantial improvement of* respiratory symptoms of the acute illness for the previous 72 hours

3. More severe illness

Confirmed cases with more severe illness, that is where hospitalisation was indicated for acute COVID-19, regardless of whether or not the case was actually hospitalised.

a. Resolution of symptoms

Confirmed cases with resolution of fever and respiratory symptoms of acute illness can be released from isolation if they meet all of the following criteria:
- at least 14 days have passed since onset of symptoms, and
- there has been resolution of fever and respiratory symptoms of the acute illness for the previous 72 hours.  

b. Incomplete resolution of respiratory symptoms

Confirmed cases without complete resolution of respiratory symptoms of the acute illness can be released from isolation if they meet both of the following criteria:

- At least 20 days have passed since the onset of symptoms, and
- The case is not significantly immunocompromised.

OR

The case can also be released from isolation if they meet all of the following criteria:

- at least 14 days have passed since the onset of symptoms, and
- there has been substantial improvement in respiratory symptoms of the acute illness (including resolution of fever for the previous 72 hours), and
- the case has had two consecutive respiratory specimens negative for SARS-CoV-2 by PCR taken at least 24 hours apart and at least 11 days from symptom onset.


In addition to meeting the appropriate criteria described in points 1, 2, or 3a above, persons who are significantly immunocompromised and are identified as confirmed cases must meet a higher standard requiring additional assessment. They can be released from isolation when they meet the following additional criterion:

- PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart at least 7 days after symptom onset.

Notes

1 Some people may have pre-existing illnesses with chronic respiratory signs or symptoms, such as chronic cough. Others may have on-going sequelae that result in symptoms such as continuing shortness of breath or post viral cough. For these people, the treating medical practitioner should make an assessment as to whether the respiratory signs and symptoms of acute COVID-19 have resolved.

2 If a case who meets these criteria is additionally swabbed and tests positive, then the case can still be released from isolation based on current evidence from the literature and Australian public health experience that indicates these people are unlikely to be infectious.

3 In patients in which swabs are required to meet release from isolation criteria but where swabs remain positive, additional factors may be considered to determine the need for ongoing isolation, including the clinical scenario and laboratory details (e.g. Ct values, viral culture results). This should be discussed with the treating medical practitioner, the testing laboratory and the department.

4 People who are clinically assessed as being significantly immunocompromised may have a reduced ability to effectively clear SaRS-CoV-2 and a prolonged infectious period. Significantly immunocompromised persons may include, but are not limited to those who:

- have had an organ transplant and are on immune suppressive therapy
- have had a bone marrow transplant in the past 2 years
- are on immune suppressive therapy for graft versus host disease
- have had an active haematological malignancy
have human immunodeficiency virus infection with CD4 T lymphocyte count below 200 cells/mm3

or other conditions specifically noted by the treating medical practitioner.

If the patient has a productive cough due to a pre-existing respiratory illness or other ongoing lower respiratory tract disease, then the sputum or other lower respiratory tract specimens must be PCR negative for SARS-CoV-2. Otherwise upper respiratory tract specimens (deep nasal and oropharyngeal swabs) must be PCR negative.

**Retrospectively identified cases**

If a case is identified retrospectively through serology, clinical and public health judgement should be used in determining case management and whether or not a case requires isolation. If the case had a clinically compatible illness some time ago, it may not be necessary to isolate. If isolation is required, the case can be released from isolation when the appropriate criteria above are met.

**Cases with gastrointestinal symptoms**

Faecal sampling is not recommended as a standard test, however, it may be done for patients with gastrointestinal symptoms. For cases who do have faecal samples tested and remain persistently PCR positive in these samples, after all the release from isolation criteria (above) are met, further or extended precautions and exclusions should be implemented on a case-by-case basis.

- All cases with diarrhoea should be advised not to prepare food for others until 48 hours after symptoms have resolved.
- It is recommended that people whose faecal samples are PCR positive use soap and water for hand hygiene. If this is unavailable, alcohol hand gel should be used.
- Cases who are employed in a role where there is an increased risk of onward transmission (such as healthcare workers, restaurant workers and food handlers), should be excluded from work until 48 hours after any symptoms of diarrhoea have resolved.
- Cases with ongoing diarrhoea or faecal incontinence who may have limited capacity to maintain standards of personal hygiene should be isolated until 48 hours after the resolution of these symptoms.

Patients do not require repeat testing until they are PCR negative in faecal samples. It is recommended that people who remain persistently PCR positive in faecal samples use soap and water for hand hygiene. If this is unavailable, alcohol hand gel should be used.

**Confirmed cases infected with a SARS-CoV-2 variant of concern**

The following information details the clearance process for confirmed cases infected with a SARS-CoV-2 variant of concern as confirmed by whole genome sequencing.

Repeat testing (both PCR and serology) should be sent to the Victorian Infectious Diseases Reference Laboratory.

Serology should be routinely taken at day 12 for all variant cases.

1. **Confirmed cases who are asymptomatic**

   The case can be released from isolation if they meet all of the following criteria

   - at least 14 days have passed since the first respiratory specimen positive for SARS-CoV-2 by PCR was taken and no symptoms have developed during this period
   - The case has had a respiratory specimen negative for SARS-CoV-2 by PCR taken at least 12 days from the first respiratory specimen positive for SARS-CoV-2 by PCR was taken.
2. Confirmed cases who are symptomatic (mild or severe symptoms which resolve)

The case can be released from isolation if they meet all of the following criteria:

- At least 14 days have passed since onset of symptoms; and
- There has been resolution of fever and respiratory symptoms of the acute illness for the previous 72 hours; and
- The case has had a respiratory specimen negative for SARS-CoV-2 by PCR taken at least 12 days from the first respiratory specimen positive for SARS-CoV-2 by PCR was taken

3. Confirmed cases who are symptomatic (mild or severe symptoms which do not resolve)

The case can be released from isolation if they meet all of the following criteria:

- At least 14 days have passed since onset of symptoms; and
- There has been substantial improvement in respiratory symptoms of the acute illness (including resolution of fever for the previous 72 hours); and
- The case has had a respiratory specimen negative for SARS-CoV-2 by PCR taken at least 12 days from the first respiratory specimen positive for SARS-CoV-2 by PCR was taken

4. Significantly immunocompromised persons

In addition to meeting the appropriate criteria described in points 1 or 2 above, persons who are significantly immunocompromised and are identified as confirmed cases must meet a higher standard requiring additional assessment. They can be released from isolation when they meet the following additional criterion:

- PCR negative on at least two consecutive respiratory specimens collected at least 24 hours apart at least 12 days after symptom onset

Notes:

1. Cases should be managed as follows

- If the day 12-13 PCR is negative, the case may be released from isolation, regardless of serology result; or

- If the day 12-13 PCR has a high/long CT in consultation with the responsible authorising pathologist, and spike/neutralising antibodies are present, then the case would be considered non-infectious and can be released from isolation. An expert review panel should be convened if there are concerns with thresholds of the PCR or serology values to decide on release from isolation.

- If the day 12-13 PCR has a high/long CT in consultation with the responsible authorising pathologist, and no seroconversion, a repeat PCR could be performed (to ensure the result was not due to inadequate collection) and serology could be repeated. In these circumstances, an expert review panel should be convened to determine when the case can be released from isolation.
**Cases who have been released from isolation**

Based on a review of current evidence, persons who fulfi l the relevant criteria above are not considered to be infectious. Cases returning to a high risk setting can be released from isolation based on the clinical criteria above and do not need to meet a higher standard or undergo additional assessment before going into any high-risk settings. This includes persons returning to work in a healthcare setting, living in a residential age care setting, being transferred to another hospital or who regularly attend healthcare settings for any other reason.

Specifically, if a person has met the appropriate criteria above, it is not necessary for them to:

- undergo isolation or quarantine in another ward, the facility they are returning to, or any other location, or
- have evidence of any negative test results for SARS-CoV-2 prior to returning to residential aged care or any other setting.

Persons who have been released from isolation should adhere to hygiene and physical distancing measures, as the extent of acquired immunity is unknown.

**Routine testing after release from isolation**

Routine PCR testing post-release from isolation is not recommended unless the person re-develops clinical features consistent with COVID-19 – see Re-exposed recovered cases.

People who have recovered from COVID-19 and have been released from isolation based on the criteria above do not require COVID-19 testing if they are hospitalised for a non-COVID-19 related condition.

**Re-exposed recovered cases**

All recovered cases should continue following community recommendations including physical distancing, hand hygiene and masks where indicated. Health care workers should continue to use appropriate PPE as recommended when caring for COVID-19 patients, or in settings of potential exposure.

**Within 8 weeks – asymptomatic**

If a recently recovered COVID-19 case becomes a close contact of a confirmed case, they do not need to quarantine again if:

- the recovered case is not significantly immunocompromised
- the exposure was less than 8 weeks since the recovered case’s symptom onset (or first positive test if asymptomatic).

Within this 8 week period, recovered cases can continue to attend high-risk settings and do not need to be furloughed from work if re-exposed.

**After 8 weeks or immunocompromised – asymptomatic**

For recovered cases exposed after 8 weeks from their symptom onset (or first positive test if asymptomatic), and immunocompromised recovered cases exposed at any time after release from isolation, consider serology testing in consultation with the microbiologist or virologist at the testing laboratory when making decisions about quarantine and exclusion from the high-risk settings.

**Symptomatic recovered cases**

If symptoms reappear, they should immediately isolate and be retested for SARS-CoV-2. As further evidence becomes available on the duration of immunity, these recommendations may be amended.
Symptomatic past cases who test positive

Symptomatic past cases who test who positive again should be managed as currently infectious COVID-19 cases until determined otherwise.

Usually these cases will go to a departmentally convened Expert Review Panel for consideration of the clinical, epidemiological and laboratory evidence. The panel may request further evidence and will be responsible for a final determination regarding the classification and ongoing management of the person.

Checklist of key actions for the department for confirmed cases

- Confirm the diagnosis with testing laboratory.
- Contact the confirmed case +/- parent/guardian (for cases under 18 years) to collect relevant social, clinical and epidemiological information.
- Identify close contacts and recommend immediate quarantining of any close contacts.
- Identify any potential exposure sites and assess whether any further action is required.
- Undertake all public health response activities including risk communication and sharing of relevant resources.

Checklist of key actions for the clinical team for confirmed cases

- If a patient is in the community at the time of diagnosis and if clinically necessary, the department will organise with the nearest appropriate health service to admit the patient, in order for care to be provided in hospital or via Hospital in the Home.
- For patients who do not require admission to hospital or Hospital in the Home, clinical teams only need to provide patients with the initial feedback of their results, information and counselling and usual advice to seek medical attention if their condition deteriorates. Clinical teams do not need to routinely contact cases unless clinically appropriate.
- Notify the department on 1300 651 160 as soon as possible (within 24 hours) if a patient becomes critically unwell, in the case of intensive care admission, or death.
- Commence list of all healthcare workers and visitors who enter the case’s room. (If the case is at home and being visited by Hospital in the Home only a list of healthcare workers required.)
- Advise healthcare workers who provide care for the case (even with appropriate use of PPE) to self-monitor for symptoms of COVID-19 for 14 days after their last contact with the case.

Communications and media

The department will coordinate communications and media in relation to suspected and confirmed cases of COVID-19. In some instances, the department may – in collaboration with a Victorian health service – request a service to provide media responses in relation to one of more cases associated with that service. A health service should contact the department’s Media Unit with any queries.

Contact management

The department or its nominated representative will conduct contact tracing for confirmed cases in the community and will seek assistance from a health service in relation to any contact tracing required for health service staff.
Quarantine

Quarantine means remaining at home except in cases of emergency. This means a person recommended or required to quarantine:

- must not visit public settings or mass gatherings.
- must not use public transport.
- must not attend settings like health services, residential aged care facilities or educational settings.

This requirement for people who are in quarantine not to attend health services, includes a requirement that they do not visit a family member who is a confirmed case in a Victorian health service.


Groups required to quarantine

Relevant public health directions are on the department’s website <https://www.dhhs.vic.gov.au/victorias-restriction-levels-covid-19>

- **primary close contacts** of confirmed cases until at least 14 days after last close contact with the confirmed case, regardless of any negative test result. See Testing below.
- **secondary close contacts:**
  - **who quarantine in the same household** as a primary close contact(s) remain in quarantine until the primary close contact(s) is cleared from quarantine.
  - **who quarantine independently** in a different household to the primary close contact(s), remain in quarantine until 14 days since the last exposure of the primary close contact to the confirmed case, as long as that secondary close contact does not become a case themselves OR
  - until the primary close contact tests negative, and is symptom free.
- all **travellers** arriving into Melbourne from red zone (higher risk) countries overseas:
  - are quarantined for at least 14 days in hotel rooms and other accommodation facilities after receiving a compulsory Direction and Detention notice.
  - can return to their home states after fulfilling the mandatory quarantine requirements.
- anyone tested as part of an outbreak investigation, unless specifically advised otherwise by the department.
- **Casual contacts** who are tested are only required to quarantine until they receive a negative test result. Casual contacts who are not required to test do not need to quarantine unless advised by the department.

Exemptions to quarantine

Close contacts

Any exception to quarantining of close contacts requires specific exemption from the Chief Health Officer or Deputy Chief Health Officer.

Such close contacts will receive clear instruction from the department if they do not need to quarantine, such as if it is necessary to provide safe staffing in aged care or to maintain critical or essential services.

Travellers

Information on quarantine for returned travellers and related requirements:

Testing during quarantine

Symptomatic quarantined people
People in quarantine who develop symptoms should be tested for COVID-19. If test is negative for COVID-19, they should:

- continue their quarantine period
- be considered for retesting if they deteriorate and require hospitalisation
- be retested prior to being cleared from quarantine, as required by the department, even if symptoms have resolved.

Primary close contacts

Early quarantine testing of primary close contacts
Primary close contacts should be tested at or soon after the time they are identified to:

- detect early infection
- support further contact tracing
- support household contacts to quarantine separately from newly confirmed cases to prevent further exposure
- allow for the immediate release of secondary close contacts who have quarantined independently or in a separate household to the primary close contact.

Testing of primary close contacts before completing quarantine
All primary close contacts are required to be tested prior to the end of their quarantine period (generally at day 11).

Primary close contacts who refuse testing or otherwise fail to be tested on or around day 11 will have their quarantine period extended for up to 10 days. Such people are free to be tested at any time during the 10 day extension and upon return of a negative result will be able to cease quarantine (as long as the initial 14 day quarantine period has finished).

Secondary close contacts
Secondary close contacts themselves are not required to be tested to be released from quarantine.

Casual contacts
Casual contacts only need to be tested if specifically advised to do so by the department.

Returned international travellers
Returned international travellers are tested both early (generally days 0-2) and prior to the end of their quarantine period. The quarantine period of returned travellers will also be extended for up to 10 days if a test is refused. A negative test result will be required prior to the department issuing clearance for a person to exit quarantine.

Quarantined people requiring treatment
If a quarantined person requires assessment or treatment by a clinician during their quarantine period, regardless of whether or not they have symptoms, the following steps should be taken.
The department will advise the quarantined person to:
- wear a single-use face mask
- attend a suitable health facility (such as general practice, emergency department or coronavirus assessment centre) for evaluation
- identify themselves immediately on arrival.

The quarantined person should not wait for advice from the department if they require immediate medical attention.

Where a quarantined person has an illness or injury during their period of quarantine after the step above, the treating clinician will:
- manage the person as a [High-risk suspected] case
- provide a single-use face mask (if the close contact does not already have one)
- use a single room and appropriate PPE
- test for COVID-19.

If the test is positive, the person will be managed as a [Confirmed case]. See [Case management], including [Notification to the department] and [Isolation].

Where the illness is diagnosed as acute respiratory illness:
- if testing for COVID-19 is negative and the treating clinician has diagnosed an acute respiratory illness or an illness that is highly compatible with COVID-19, the close contact may then require a subsequent test at a short period thereafter.
- if the second PCR test is also negative, another test may be conducted on day 14 of the quarantine period.
- they will still need to be monitored for 14 days after their last contact with a confirmed COVID-19 case.
- a negative COVID-19 test result at the end of the quarantine period is still required for release from isolation.

Where the illness is diagnosed as likely to be some other form of infection or is not an infection:
- If testing for COVID-19 is negative and the treating clinician has diagnosed some other infection or a non-infectious cause, then the treating team should consider, in conjunction with an infectious disease specialist, whether testing of relevant specimens such as urine and faeces for COVID-19 might be of value or whether evidence is now clear for an alternative cause, (including legionellosis).
- The quarantined person must continue to quarantine until a full 14 days have expired from date of last close contact with confirmed case and a negative COVID-19 test has been returned at the end of the quarantine period.

**Close contacts**

See [Contact definitions] section for an explanation of who should be considered a primary or secondary close contact of a confirmed case. Note that the department may employ a wider definition of close contact in outbreak investigation, especially in settings that are high risk for transmission or in populations at high risk of adverse consequences of infection.

Close contacts are required to [Quarantine].

See also [Cases who have been released from isolation].
Clearance from quarantine

A letter to confirm that the relevant quarantine requirements have been successfully completed is supplied by the department.

Health services and GPs are not required to provide a certificate of medical clearance.

Potential source (‘upstream’ or ‘acquisition’) contacts

A close contact may also be tested as part of potential source or ‘upstream’ contact tracing, particularly in high risk settings.

Where a confirmed case has no identified source of infection, potential source contact tracing of the ‘first reported case’ (or in an outbreak, index case) should be undertaken. The aim is to identify potential unrecognised chains of transmission and may be particularly useful to identify the source of introduction of disease in a setting where there is potential for rapid transmission (see section High risk settings). In such settings, potential source contact tracing should be done for the ‘first reported case’ or index case.

Potential source contacts:

• are people who had close contact with the case during the time the case is likely to have acquired the infection

• close contact will have occurred between 24 hours and 14 days (usually 5-7 days) before symptom onset in the first reported case

• may be both close contacts and potential source contacts and are required to quarantine – approved exceptions to quarantine will receive clear instruction from the department

• may be unidentified cases, so should be:
  - screened for possible symptoms
  - have their temperature measured
  - undergo PCR testing
  - considered for serological testing if well, and a validated serological assay is available

• if they test positive by PCR, clinical and public health judgement should be used to determine if they are currently infectious

• if deemed to be infectious, they should be managed as any other confirmed case, including rapid contact tracing

• should be assessed as to whether they are likely to be:
  - the primary case who infected the first reported case (index case in an outbreak)
  - a secondary case infected by the first reported case
  - a separate transmission chain.

Primary close contacts

Checklist of key actions for the department

For all primary close contacts the department will:

• Interview the primary close contact to provide advice on quarantine (including restriction on travel) until 14 days from the last contact with confirmed case and to identify secondary close contacts.

• Consider testing early in the quarantine period to determine if the primary close contact is a potential acquisition source for the case and to release secondary close contacts from quarantine where possible.

• Counsel primary close contacts about risk and awareness of potential symptoms.
• Provide a close contact fact sheet
• Make regular contact with the primary close contact to monitor for any symptoms, either through SMS, email or telephone call.
• See also Quarantined people requiring treatment.
• All primary close contacts are required to have testing at day 11 of their quarantine period, regardless of whether or not they display symptoms. When tested, they must complete 14 days of quarantine and return a negative result prior to being released from quarantine. Primary close contacts who refuse testing or otherwise fail to get tested at or around day 11 will have their quarantine period extended by a further 10 days unless they get tested and return a negative result before the 10 day extension has elapsed.
• Provide a clearance from quarantine letter or email.
• If a school or employer requests confirmation directly from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Secondary close contacts

Checklist of key actions for the department

For all secondary close contacts the department will:

• Counsel secondary close contacts about risk and awareness of potential symptoms.
• Advise the secondary close contact to quarantine independently from the primary close contact, in a separate household, to facilitate early release from quarantine based on the outcome of primary close contact testing.
• Provide a close contact fact sheet
• See also Quarantined people requiring treatment.
• There are no testing requirements for secondary close contacts, but testing may be requested as part of acquisition source investigation.
• If a school or employer requests confirmation from the department that the quarantine period has been met, the department will provide evidence with the consent of the individual.

Same household

For secondary close contacts who quarantine in the same household as the primary close contact(s), the department will:

• Advise quarantine (including restriction on travel) until the primary close contact is cleared from quarantine.

Different household

For secondary close contacts who quarantine independently of the primary close contact, in a different household, the department will:

• Advise quarantine (including restriction on travel) until 14 days since the exposure of the primary close contact to the confirmed case, as long as that close contact does not become a case themselves; OR until the primary close contact tests negative, and is symptom free, at least 24 hours after the last contact between the primary and secondary close contacts
• Review early test results for primary close contact to identify whether the secondary close contact can be released from quarantine.

Healthcare workers

Healthcare workers and other contacts who have taken recommended infection control precautions, including the use of recommended PPE, while caring for a confirmed case of COVID-19 are not Coronavirus disease (COVID-19): Case and contact management guidelines for health services & GPs DATE 19 January 2021 – V26

OFFICIAL: Sensitive
considered to be close contacts. However, they should be advised to self-monitor and if they develop symptoms consistent with COVID-19 infection they should isolate themselves. For further information see the section Healthcare services – management of healthcare workers with suspected or confirmed COVID-19 and particularly the Immediate management of a suspected or confirmed case.


Any healthcare workers who is unwell with a compatible illness should not attend work and should seek appropriate medical care. All healthcare workers with fever or symptoms of acute respiratory infection should be tested for COVID-19, as per the testing criteria.

Hospital workers, except if for the purpose of seeking medical attention, must not enter or remain at a hospital in Victoria if:

- the person has been diagnosed with COVID-19, and has not yet met the criteria for discharge from isolation OR
- if the person has travelled/arrived in Australia from any country in the past 14 days OR
- has had known contact with a person who is a confirmed COVID 19 case in the previous 14 days OR
- has a fever or symptoms of acute respiratory infection.

The current Directions and accompanying frequently asked questions can be viewed on the department’s website at <https://www.dhhs.vic.gov.au/coronavirus>.

Healthcare workers who become confirmed cases are not required to meet further criteria before they can return to work in healthcare settings - see Release from isolation of a confirmed case.

Casual contacts

- provide information about their exposure
- ask to self-monitor and seek testing if symptoms develop
- consider asymptomatic testing

Infection prevention and control


This guidance covers issues including:

- healthcare and non-healthcare sector
- standard, transmission, contact and airborne precautions
- personal protective equipment (PPE)
- environmental and equipment management
- care of the deceased.

Further information on PPE is available at https://www.dhhs.vic.gov.au/personal-protective-equipment-ppe-covid-19
Laboratory testing for COVID-19

See [Who should be tested for COVID-19?](#) for current testing criteria.

**Testing advice for clinicians**

Ask symptomatic patients presenting for testing if they have had previous exposure to a known COVID-19 case within the past 14 days – see also [Higher prevalence groups and settings](#), including [Exposure sites](#).

If the patient has been exposed **and** the Outbreak definition is met, treat the test sample as an ‘outbreak sample’.

**Sample labelling**

On request slips:

- provide clinical details
- include the specimen type (e.g. deep nasal/oropharyngeal, partial sample, self-collected, saliva)
- copy results to the patient’s treating physician
- include the patient’s mobile number so that they can be contacted quickly.

**Prioritising specimens for laboratory testing - priority groups and labelling protocol**

This policy guides prioritisation of samples generated from community testing.

COVID-19 testing occurring within health services on in-patients, for the purposes of clinical management is out of scope of this policy. Internal prioritisation of inpatient samples is to be determined by health services in partnership with their pathology providers.

**Table 1: URGENT or PRIORITY samples listed in priority order**

<table>
<thead>
<tr>
<th>Priority 1 (P1)</th>
<th>Definition: URGENT requiring results within 12 hours</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Category 1: Outbreaks and close contacts</strong></td>
<td></td>
</tr>
<tr>
<td>‣ Individuals associated with an outbreak investigation (as requested by the department)</td>
<td></td>
</tr>
<tr>
<td>‣ Close contact (This does not include casual contacts, unless requested by the department)</td>
<td></td>
</tr>
<tr>
<td><strong>Category 2: Hotel Quarantine Program individuals</strong></td>
<td></td>
</tr>
<tr>
<td>‣ Symptomatic and asymptomatic Hotel Quarantine workers</td>
<td></td>
</tr>
<tr>
<td>‣ Symptomatic and asymptomatic Hotel Quarantine guests  Note: prioritisation applies to the Hotel Quarantine surveillance Screening Testing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Note: prioritisation applies to the Hotel Quarantine surveillance Screening Testing</td>
</tr>
<tr>
<td><strong>Category 3: Healthcare workers</strong></td>
<td></td>
</tr>
<tr>
<td>‣ Symptomatic and asymptomatic healthcare workers</td>
<td></td>
</tr>
<tr>
<td>Note: prioritisation applies to the regular surveillance testing of healthcare workers on COVID-19 Wards program.</td>
<td></td>
</tr>
</tbody>
</table>
### Priority 2 (P2)

**Definition:** PRIORITY requiring results within 24 hours

**Category 1: At-risk settings and individuals**
- Symptomatic individuals identified to be from at-risk settings

**Category 2: Requirements from the Department of Health and Human Services**
- Public Health Directions of the Chief Health Officer
- Other departmental directives
- Symptomatic household contacts of workers in Hotel Quarantine and health care workers on COVID-19 Wards programs

**Category 3: Clinical discretion**
- Symptomatic individuals prioritized by the treating clinician at their discretion

Further detail is provided in Table 2 below.

---

*Note: A healthcare worker is someone who works in health settings providing direct care to patients. This includes registered health practitioners, other health practitioners, diagnostic and ancillary staff. Support staff in these settings (such as those in cleaning and workers on the ward) are included for the purposes of this policy. Other health practitioners include those working in dentistry, paramedics, pharmacy, medical imaging and so on.

In the event that a cohort is listed in both P1 and P2 categories, the highest prioritisation requirements will apply.

**Table 2: Detail of prioritised symptomatic testing for at-risk settings and individuals included in P2**

<table>
<thead>
<tr>
<th>At-risk settings</th>
<th>Residential settings*:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Aged care facilities</td>
</tr>
<tr>
<td></td>
<td>Military residential settings</td>
</tr>
<tr>
<td></td>
<td>Boarding schools</td>
</tr>
<tr>
<td></td>
<td>Homeless shelters</td>
</tr>
<tr>
<td></td>
<td>Correctional facilities</td>
</tr>
<tr>
<td></td>
<td>Remote industrial sites</td>
</tr>
<tr>
<td></td>
<td>with accommodation</td>
</tr>
<tr>
<td>Additional residential settings to the outbreak definition:</td>
<td></td>
</tr>
<tr>
<td>Group residential care settings, including disability services</td>
<td></td>
</tr>
<tr>
<td>Accommodation with shared facilities</td>
<td></td>
</tr>
</tbody>
</table>

\* Places where people reside in groups

<table>
<thead>
<tr>
<th>Occupational settings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workplace settings where previous outbreaks have shown large scale amplification, e.g.:</td>
</tr>
<tr>
<td>Port-of-entry workers (airports, ports, interstate transport hubs, etc)</td>
</tr>
<tr>
<td>Abattoirs and other low temperature food processing and storage facilities</td>
</tr>
<tr>
<td>Educational settings</td>
</tr>
<tr>
<td>Workers in the defined residential settings</td>
</tr>
<tr>
<td>Persons required to maintain essential services and critical infrastructure (e.g. Energy, water, social</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Community settings:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aboriginal and Torres Strait Islander communities</td>
</tr>
</tbody>
</table>
Requirements from the Department of Health and Human Services

The Department may announce specific Public Health directions or priorities depending on the epidemiology at the time.

At the clinical discretion of the referring doctor

Consideration could be given to:
- An individual’s clinical risk of severe illness
- Interaction with work sites where workers are unable to undertake physical distancing or where outbreaks have been identified in the past
- Residential context, including high-density living
- Workplaces with highly casualised workforces

NOTE: Prioritization does not apply to pre-operative testing.

This policy should be read in combination with detailed guidance elsewhere in the Case and Contact Management Guidelines for Health Services and General Practitioners for most up-to-date definitions and management guidance regarding (1) close contacts, (2) outbreak definition, (3) high risk settings, and (4) contact management - testing.

Guidance for clinicians regarding priority sample labelling

To ensure priority samples are fast-tracked for testing in laboratories, please follow below instructions for labelling:

1. The outside of the sample bag must be labelled and marked URGENT (P1) or PRIORITY (P2)
2. The sample should be labelled with the patient’s name and date of birth and marked as P1 or P2.
3. The pathology slip and/or Test Tracker Registration must be clearly labelled and marked as URGENT (P1) or PRIORITY (P2) sample. A statement to clearly identify the reason why the sample is urgent, or priority is also required. Detailed labelling instructions are outlined in the table below:
4. Where an outbreak has been issued with an identifier, this should be included in the labelling on the pathology slip or Test Tracker registration.

<table>
<thead>
<tr>
<th>Priority Group</th>
<th>Detail labelling information</th>
</tr>
</thead>
</table>
| P1             | P1 – OUTBREAK (including outbreak ID if established)  
|                | P1 – CONTACT                 
|                | P1 – HQ                      
|                | P1 – HC WORKER               
|                | P1 – DHHS REQUIREMENT        |
| P2             | P2 – SETTING                 
|                | P2 – DHHS REQUIREMENT        
|                | P2 – CLIN DISCRETION         |

5. Samples should then be forwarded on for laboratory testing under normal processes.
Guidance for clinicians regarding priority sample labelling

The prioritisation category and reason should also be included in the ELR or report to the department.

All P1- URENT and P2 - PRIORITY samples must be prioritised for testing in laboratories. All laboratory testing results are turned around within time recommended below.

<table>
<thead>
<tr>
<th>Priority Group</th>
<th>Detailed labelling information</th>
<th>Recommended turnaround time</th>
</tr>
</thead>
</table>
| P1             | • P1 – OUTBREAK *(including ID)*  
                 • P1 – CONTACT  
                 • P1 – HQ  
                 • P1 – HC WORKER  
                 • P1 – DHHS REQUIREMENT | Less than 12 hours |
| P2             | • P2 – SETTING  
                 • P2 – DHHS REQUIREMENT  
                 • P2 – CLIN DISCRETION | Less than 24 hours |

Specimens for testing

A number of Victorian laboratories are undertaking testing for COVID-19 in Victorians. There can be significant pressure on supply of swabs and reagent kits for COVID-19 testing as well as laboratory capacity.

Specimen collection for COVID-19 testing – combined oropharyngeal and deep nasal swab

- Use only one swab when testing, unless testing for other respiratory viruses is indicated (for example, multiplex PCR) and your local testing laboratory is unable to undertake this on the same specimen. Contact your laboratory to clarify if an additional specimen needs to be collected.

  The recommended upper respiratory specimen is the combined oropharyngeal and bilateral deep nasal swab.

- Nasopharyngeal sampling, which is deeper and less comfortable, is no longer recommended.
- Sampling both sites optimizes the chances of virus detection.
- Please remember to indicate the specimen type on the Pathology Request.
- If nasopharyngeal sampling is being performed, ensure the swab is suitable. If the swab is too large revert to a combined oropharyngeal and bilateral deep nasal sampling technique.

Guidance from the Public Health laboratory Network on laboratory testing for SARS-CoV-2 can be found at <https://www1.health.gov.au/internet/main/publishing.nsf/content/Publications-13>

For initial diagnostic testing for COVID-19, the department recommends collection of the following samples:

1. upper respiratory tract specimens.
2. lower respiratory tract specimens (if possible).
3. salivary specimens (in certain circumstances)
4. serum, where possible (to be stored for later analysis at VIDRL).
Respiratory specimens

Collection of upper respiratory specimens is recommended for all patients – these would be oropharyngeal and deep nasal to optimise the chances of virus detection. Nasopharyngeal sampling, which is a deeper and less comfortable, is no longer recommended.

In some circumstances both the nasal & throat sample may not be possible. In these circumstances we recommend that if a partial sample is collected it still be tested. Note on the pathology referral form what specimen was collected.

In addition, lower respiratory specimens (sputum, if possible) are recommended for patients with a productive cough. For PPE recommendations, see Coronavirus (COVID-19) infection prevention and control guidelines, available on the department’s website.

If the patient has severe symptoms suggestive of pneumonia, for example, fever and breathing difficulty, or frequent, severe or productive coughing episodes then airborne and contact precautions should be observed. This means that a P2 respirator must be used instead of a single-use surgical mask.

Patients with symptoms suggestive of pneumonia should be managed in hospital, and sample collection conducted in a negative pressure room, if available. If referral to hospital for specimen collection is not possible, specimens should be collected in a single room. The door should be closed during specimen collection and the room left vacant for at least 30 minutes afterwards (cleaning can be performed during this time by a person wearing PPE for airborne and contact precautions).

Salivary specimens

Saliva sampling is only recommended in the scenarios presented in the Saliva-based PCR testing section.

Not all laboratories are able to perform testing on saliva samples. Contact your laboratory provider to find out if they are able to test saliva specimens.

There are two specimen collection methods available.

Swab method

Should be collected using either the Copan eSwab or the Meditech 3D Printed Swab (Honey dipper).

The participant is directed to place the swab in their mouth and suck on the swab for 30 seconds until they feel that it is completely coated/saturated.

The participant then opens their mouth to remove the swab and places it into the tube, breaking off the excess shaft of the swab at the dint/red marker.

A video demonstration of appropriate saliva specimen collection can be found at: <https://www.youtube.com/watch?v=ws39aLpX17s&feature=youtu.be>

Dribble pot

A secondary method of dribbling into a straw or container may be used if swabs are unavailable or this method is preferred. Caution must be taken to produce the correct volume and a viable sample if using this method.

There is no specific container or “kit” to collect saliva. The standard specimen collection pot used for urine is appropriate. Consideration should be given to the spill risk and potential contamination of the outside of the container. The size of the container should be sufficient to ensure at least 2ml of saliva is collected.

- At least 2mls of saliva needs to be collected
- The patient should collect saliva in their mouth and spit carefully and slowly into the container. This could be done repeatedly over a 30-minute period until the 2ml is collected.

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Serum and other specimens
See section on Serological testing.

The department is continuously reviewing whether there is a requirement for other specimens such as stool or urine to be sent to VIDRL. At the current time this is not routinely recommended in cases of respiratory illness.

Specimen collection and transport
- Specimens should preferably be collected by a health professional.
- A self-collected swab, partial swab, or saliva specimen should be clearly labelled and indicated on the pathology referral form.

Preparation for specimen collection
- Obtain the following equipment:
  - Personal protective equipment (PPE). For PPE recommendations, see Coronavirus (COVID-19) Infection Prevention and Control guidelines on the department’s website.
  - A single swab for oropharynx and deep nasal sampling (one swab per patient only – unless your laboratory requires a second swab for other respiratory virus testing).

Sampling both the oropharynx and deep nose is recommended to optimise the chances of virus detection; both sites should be sampled with a single swab
- Use a swab with a synthetic tip (e.g. Dacron® or Rayon; flocked preferred) and aluminium or plastic shaft. Do not use calcium alginate swabs or swabs with wooden shafts, as they may contain substances that inactivate some viruses and inhibit PCR testing.
- Swabs should be placed in transport medium, which may be viral transport medium (VTM) or Liquid Amies.
- Label tube appropriately (patient’s ID number, specimen type and swab date). Request slips should include clinical details identifying high-risk patients and healthcare workers.

Specimen collection process

Upper respiratory tract
Collection of upper respiratory specimens (that is, deep nasal and oropharyngeal samples) can be performed using droplet and contact precautions.

- Stand slightly to one side of the patient to reduce exposure to respiratory secretions should the patient cough or sneeze.
- Swab the oropharynx (throat) first: swab tonsillar beds and the back of the throat, avoiding the tongue (see figure 1).
- Using the same swab, sample the deep nasal area (see figure 2):
  - using a pencil grip and while gently rotating the swab, insert the tip to a depth according to age (below, or until resistance is met), into the nostril, parallel to the palate, to absorb mucoid secretion.
    - 1.5 cm if 2-6 years
    - 2 cm if 6-12 years
- 2-3 cm if >12 years to adult
- rotate the swab several times against the nasal wall.
- withdraw the swab and repeat the process in the other nostril. To conserve swabs the same swab that has been used to sample the oropharynx should be utilised for nasal sampling

- Place the swab(s) back into the accompanying transport medium. Avoid repeated freezing and thawing of specimens.
- At the completion of the specimen collection process, remove all PPE and perform hand hygiene after removing gloves and when all PPE has been removed. See How to take off your PPE poster on the department’s website <https://www.dhhs.vic.gov.au/how-put-and-take-your-ppe>.
- Clean room after sample collection - droplet and contact precautions PPE must be worn when cleaning the room. See the COVID-19 infection prevention and control guidelines https://www.dhhs.vic.gov.au/covid19-infection-control-guidelines for further information. Note that, for droplet and contact precautions, the room does not need to be left empty after sample collection.

![Swabbing the oropharynx](image1.png)

**Figure 3: Swabbing the oropharynx**

![Swabbing the deep nose](image2.png)

**Figure 4: Swabbing the deep nose**

**Self-collected nasal (both nostrils) and oropharyngeal swab**

If there are barriers to a health-professional collected swab, a self-collected swab may be a more acceptable option. Supervision and guidance from a health professional is recommended.

A health professional supervised parent/guardian/trusted carer collected swab may be an option for children and adults who cannot tolerate a health professional collected swab and are unable to perform a self-collected swab themselves.
• The request form should identify that the specimen has been self-collected.
• If a person does not choose self-collection or does not feel comfortable about their ability to self-collect, sampling should be performed by a trained healthcare worker using PPE.

Note:
• Self-collected swabs are not appropriate for patients with severe symptoms or in hospital settings (such as emergency departments and wards). In these situations, collection of a specimen should be performed by a trained healthcare worker using appropriate PPE.
• Self-collection should only be offered to people over 18 years of age who are considered to have the capability to perform the test correctly and safely.

Guiding documents on the use of self-collected swabs

These can be found at:
• Public Health Laboratory Network – PHLN guidance on laboratory testing for SARS-CoV-2
• Communicable Diseases Network Australia – COVID-19 SoNG

Lower respiratory tract

If possible, obtain lower respiratory tract specimens as they are likely to contain the highest virus loads, based on experience with SARS and MERS coronaviruses

• **Sputum** – have the patient rinse the mouth with water and then expectorate deep cough sputum directly into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C. If sending to Victorian Infectious Diseases Reference Laboratory (VIDRL), send on an ice pack.
• **Bronchoalveolar lavage, tracheal aspirate** – collect 2-3 mL into a sterile, leak-proof, screw-cap sputum collection cup or sterile dry container. Refrigerate specimen at 2-8°C - if sending to VIDRL, use ice pack.

Blood

Blood (serum) for storage for serology at a later date:

• Children and adults: collect 1 tube (5-10mL) of whole blood in a serum separator tube.
• Infant: a minimum of 1ml of whole blood is needed for testing paediatric patients. If possible, collect 1ml in a serum separator tube.

There are no special requirements for transport of samples. They can be transported as routine diagnostic samples for testing (that is, Biological substance, Category B).

Referral of positive samples

All positive samples are to be labelled as “POSITIVE SAMPLE FOR STORAGE” and couriered to the Victorian Infectious Diseases Reference Laboratory (VIDRL) for ongoing storage and genomics.

Handling of specimens within diagnostic laboratories

All diagnostic laboratories should follow appropriate biosafety practices, and testing on clinical specimens, including for other respiratory viruses, should only be performed by adequately trained scientific staff.
Current advice from the WHO is that respiratory samples for molecular testing should be handled at Biosafety Level 2 (BSL2), with the US CDC recommending that the following procedures involving manipulation of potentially infected specimens are performed at BSL2 within a class II biosafety cabinet:

- aliquoting and/or diluting specimens
- inoculating bacterial or mycological culture media
- performing diagnostic tests that do not involve propagation of viral agents in vitro or in vivo
- nucleic acid extraction procedures involving potentially infected specimens
- preparation and chemical- or heat-fixing of smears for microscopic analysis.

**Indeterminate test results**

Indeterminate test results have been reported from a number of Victorian laboratories. These are usually samples that have had one gene detected in the assay but not both genes.

Indeterminate results may be referred to VIDRL for further testing, although these samples should be considered as positive. Confirmatory testing may not be possible as the sample may already be low titre and degradation due to processing may mean that VIDRL’s PCR may not be sufficiently sensitive to offset loss of titre in the sample.

Cases with indeterminant results should be managed as Confirmed cases. If the treating clinician feels that the pre-test probability for COVID-19 is low, another sample may be collected for further testing. If the second sample tests negative, the department will discuss the case with the treating doctor and the testing laboratory to determine whether the case should continue to be managed as a confirmed case.
Healthcare services – management of healthcare workers with suspected or confirmed COVID-19

Summary
This guidance outlines the roles and responsibilities of healthcare services in the event of a suspected or confirmed case or suspected or confirmed outbreak of COVID-19 among staff (and/or patients). It is primarily intended for use by hospitals but could be applied to other healthcare settings where appropriate.

Healthcare worker definition
For the purposes of this guide, healthcare workers are defined as people in contact with patients or the patient space.
Includes:
• staff who enter the patient’s room or cubicle such as doctors, nurses and cleaners
• frontline administrative staff.
Not included:
• Staff who work in non-clinical areas and who do not enter patient rooms.

Outbreaks in healthcare settings
See Outbreak definition
In a healthcare setting, epidemiological links include staff who work in the same ward or patients who are cared for by the same staff member.
Note that healthcare services are Settings with high risk of transmission so a single confirmed case of coronavirus (COVID-19) is classed as an outbreak. This requires immediate control measures and the active involvement (resources permitting) of the Department of Health and Human Services (the department).

Roles and responsibilities

Directions
Hospital Visitor Directions that restrict entry into hospitals to minimise the risk of spreading COVID-19 among hospital patients and staff are currently in place. See:

Role of Department of Health and Human Services (the department)
The department will assist with:
• Performing a situation assessment and confirming the presence of an outbreak, if appropriate.
• Notifying the employer if a staff member attended work while potentially infectious.
• Providing advice on measures to prevent further transmission in the workplace.
• Providing other specialist public health advice on other topics as needed.
• Conducting interviews with confirmed cases (or their next of kin or healthcare provider where relevant) and contact tracing in parallel with and supported by the healthcare service’s investigation.
• Consolidating information collected by the department with that obtained by the healthcare service.
• Information management of test results and clinical information of close contacts and confirmed cases in their case and contact database.
• Making daily contact with cases (through text message, email or telephone call) until they meet criteria for release from isolation of a confirmed case.
• Monitoring outbreaks.

See:

Role of healthcare service

In the event of a confirmed case or confirmed outbreak involving a staff member or patient, the healthcare service is responsible for the following:

• Immediate Notification to the department.
• Nominating a staff member (usually the infection prevention and control lead) to be the point of contact with the department.
• Performing a rapid assessment of risk in the workplace and commence workplace contact tracing – see Rapid workplace risk assessment and contact tracing.
• Implementing immediate infection prevention and control measures - see Control of exposure risks to staff and patients.
• Assessing whether practices are aligned to policies and procedures in order to identify potential breaches and shortfalls.
• If the healthcare worker has worked while infectious, the healthcare services in which they worked is to perform thorough contact tracing of all patients, staff and visitors who have been in close contact with the case during their infectious period.
• Informing these people that they have been in close contact with a case and provide them with the necessary advice and information. While the healthcare service will need to identify all close contacts, the department can assist with contacting them.
• Providing the department with the information obtained from their risk assessment and contact tracing.
• Maintaining an up-to-date case and contact list and sending this to the department at agreed times (such as every second day, depending on the situation). Use the department’s Close contact spreadsheet template.
• Organising Testing during quarantine for appropriate contacts.
• Notifying the Case and Contact Sector Lead in the department on 1300 651 160 as soon as possible (within 24 hours) if a confirmed case becomes critically unwell, requires intensive care admission or dies, or in the event of additional suspected or confirmed cases.
• Providing psychological support to the healthcare worker if required.
• Engaging with and sharing findings of internal review of confirmed cases with Safer Care Victoria Coronavirus disease (COVID-19): Case and contact management guidelines for health services & GPs

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Role of the treating doctor / doctor who has requested COVID-19 testing

- It is the responsibility of the testing doctor (and the testing laboratory) to notify the department of any confirmed case of COVID-19 – see Notification to the department.
- It is the responsibility of the treating doctor to inform the case of their test result and advise them of the appropriate actions they must take such as isolation, and if required, medical treatment.

Role of Safer Care Victoria

Safer Care Victoria is responsible for the oversight of quality and safety in Victorian health services. This includes a role in supporting and assisting health services to review clinical incidents.

In the event of a confirmed case or confirmed outbreak involving a staff member or patient, Safer Care Victoria has a responsibility for:

- providing guidance and support to health services regarding review processes and where required participation in conducting reviews for a confirmed case or outbreak.
- to share findings for the purpose of learning with the health sector and the Department of Health and Human Services.
- to update any relevant Safer Care Victoria guidance based on findings and recommendations of review.

Safer Care Victoria can be contacted by phone on 1300 650 172 or email at info@safercare.vic.gov.au.

Healthcare service staff responsible for managing a case or an outbreak

A single confirmed case (either a staff member or patient) in Settings with high risk of transmission such as healthcare requires the active involvement of the department. Where there is an infection prevention and control (IPC) unit or an infectious diseases department, they should be involved as soon as possible. Ideally, a member of staff from the IPC team should be designated the outbreak lead as the point of contact between the healthcare service and the department.

The outbreak lead should:

- Coordinate contact tracing, particularly in staff and patients of the healthcare service.
- Keep a case list of confirmed cases, suspected cases and deaths, and a close contacts list.
- They should update the department regularly (timeframe to be agreed between the department and the IPC outbreak lead) and email the updated case list through where necessary.
- The Case and Contact Sector Lead in the department must be notified immediately on 1300 651 160 (including after hours) if:
  - an outbreak is suspected
  - a new confirmed case of COVID-19 is identified
  - a death due to confirmed or suspected COVID-19 occurs.

Responsibilities of the healthcare service as an employer

Employers (including healthcare services) have a duty to provide and maintain, as far as is reasonably practicable, a working environment that is safe and without risks to health. This includes a responsibility to:

- identify whether there is a risk to health of employees from exposure to COVID-19 at their workplace.
implement appropriate measures to reduce or eliminate risk (for example, by implementing physical distancing initiatives, providing adequate facilities or products to enable good hand hygiene, and providing appropriate personal protective equipment and training on how to use it).

- facilitate testing of employees who meet current testing criteria for COVID-19.
- ensure employees understand when to stay away from the workplace.
- advise employees of the requirement to quarantine for at least 14 days following return from overseas travel OR contact with a confirmed case of COVID-19 without adequate infection control precautions.

When should a healthcare worker be tested?

All healthcare workers who meet the criteria for testing as described on the COVID-19 website <https://www.dhhs.vic.gov.au/assessment-and-testing-criteria-coronavirus-covid-19> should be tested. Surveillance testing may also be carried out for staff in COVID wards as advised by the department.

When testing healthcare workers, doctors are reminded to clearly mark pathology slips with ‘Urgent – P1’ to ensure the swabs can be easily identified for priority testing, and to include the healthcare worker’s mobile number so they can be promptly contacted. See Prioritising specimens for laboratory testing - priority groups and labelling protocol

Healthcare workers should NOT be their own testing or treating doctor.

Immediate management of a suspected or confirmed case

Any healthcare worker who meets the testing criteria for COVID-19 should be advised to isolate immediately and testing for COVID-19 should be facilitated. While they are awaiting test results they should remain in isolation until they have been notified of the test result and the appropriate course of action is subsequently determined. The following steps should be taken by the healthcare service:

- Ensure that the staff member is currently isolating.
- If the staff member is not currently in self-isolation, they must remove themselves from the workplace immediately with the least possible risk of transmission to others. This may include the following:
  - If possible:
    - wear a single-use surgical mask
    - avoid public transport and return home immediately without detour
    - take a private car
    - if not driving, sit in the rear seat
    - minimise contact with any other persons and practice strict physical distancing.
- Ensure that the staff member has had testing arranged.
- Ensure they have the appropriate information. Inform them that they must remain in isolation until they have been notified of the test result and they must not attend work during this time.
- Consider whether the member of staff shares a house with other healthcare workers or older or vulnerable people. In these circumstances it may be preferable for the case to isolate in another location to reduce the risk of transmission. They may be eligible for free accommodation provided by the department. Contact covid19.hcwaccom@dhhs.vic.gov.au.
- If the healthcare worker was tested for COVID-19 within your institution and returns a positive result, ensure that the doctor requesting the test has notified the department of the confirmed case (notifications should be directed to 1300 651 160).
- Instruct any healthcare worker diagnosed with COVID-19 to remain in self-isolation until cleared by the department and encourage them to seek urgent medical attention if they become very unwell.

Rapid workplace risk assessment and contact tracing

A rapid assessment of the workplace risk should be performed as soon as is practicable following identification of a confirmed case in a staff member. Nominate a dedicated member of staff to manage staff COVID-19 cases and to serve as a point of contact between the department and the healthcare service. The point of contact in the department will be an appointed member of the Case, Contact and Outbreak Management Team.

For a full list of actions and processes which should be undertaken in the event of a confirmed case in a staff member, please see the checklist below.

Immediate actions

- Perform a rapid workplace risk assessment and contact tracing, using the “Checklist for healthcare service when there is a confirmed case in a staff member” below. Ensure you provide the department with the completed “Close contact spreadsheet” as soon as possible.

Ongoing actions

- Maintain an outbreak case list using the “Close contact spreadsheet”.
- Provide the department with regular updates; - how frequently this will be required depends on the level of risk and size of the outbreak.
- Consider enhanced surveillance for symptoms of COVID-19 within the workplace and among patients other than the identified contacts.
- Notify the department of any COVID-related deaths as soon as possible, including after hours.
- Ensure that confirmed cases who are healthcare workers do not return to work until they have met the release from isolation of a confirmed case criteria.
- Ensure that close contacts who are healthcare workers do not return to work until the department has determined that their quarantine period has ended.

Case interview and contact tracing

Infectious period and close contacts

The department will conduct a comprehensive case interview with all confirmed cases to confirm the date and timing of symptom onset as well as their infectious period. This does not preclude the health services from doing their own interview and urgently instituting appropriate isolation of close contacts.

- Cases are considered infectious from 48 hours prior to symptom onset until they meet the criteria for release from isolation.
The health service should compile a list of people who the case has been in close contact with while infectious using the Close contact spreadsheet template.

- See Contact definitions for determining Primary close contact and Secondary close contacts.
- A review of medical records/charts may be helpful to determine what staff/patients are possible contacts.
- If it is difficult to ascertain the level of contact that staff have had with a confirmed case, a risk assessment should be performed, and the names of these staff recorded by the health service. Decisions on close contact status may need to be considered on a case-by-case basis.
- Consideration should be given as to whether a potential close contact is immunocompromised and may be more likely to become infected with shorter periods of exposure.

Ensure all sections of the spreadsheet are completed including accurate and up to date contact information for all close contacts.

If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed.

**PPE risk matrix**

Where the contact and/or case are using PPE, a risk assessment should be performed to determine whether the contact should be designated as a close contact. Factors that may be considered include:

- case details: presence of symptoms and timing of exposure in relation to symptom onset
- contact details: physical distancing, length of exposure time either directly to the case or within a shared environmental space
- PPE: use of PPE by the case, appropriate PPE use and any reports or suspicion of PPE breaches
- environment: if aerosol generating procedures were performed, use of shared equipment and use of communal spaces (for example, tea rooms or work stations)
- staff mobility: if staff work across multiple facilities or are highly mobile within the facility (such as security guards or cleaning staff)

<table>
<thead>
<tr>
<th>During Infectious period</th>
<th>Aerosol generating procedures</th>
<th>Primary close contact</th>
<th>Environmental contamination and/or working in COVID-19 treatment or testing facility</th>
<th>Casual contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contact PPE:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>No PPE</td>
<td>High risk</td>
<td>High risk</td>
<td>Individual risk assessment</td>
<td>Individual risk assessment</td>
</tr>
<tr>
<td>Surgical mask only</td>
<td>High risk</td>
<td>High risk</td>
<td>Individual risk assessment</td>
<td>Low risk</td>
</tr>
<tr>
<td>Mask and eye protection only</td>
<td>High risk</td>
<td>Individual risk assessment</td>
<td>Individual risk assessment</td>
<td>Low risk</td>
</tr>
<tr>
<td>Other PPE concerns, e.g. incorrect doffing</td>
<td>High risk</td>
<td>Individual risk assessment</td>
<td>Individual risk assessment</td>
<td>Low risk</td>
</tr>
</tbody>
</table>
### Source of infection

Consider whether the staff member’s infection may have been acquired within your health service (via another patient or staff member) or via an external exposure event.

- Ask whether the healthcare worker has had contact with anyone with apparent or reported fever or acute respiratory symptoms in the 14 days prior to their symptom onset (i.e. as a potential source of infection).
- Consider whether the staff member engaged in any recent aerosol generating procedures (AGPs) that may have increased their exposure risk.
- Consider whether the staff member may have had a breach of personal protective equipment (PPE) which may have led to an exposure.
- Document any recent travel (international or domestic) and consider whether the staff member had been in close contact with any confirmed cases prior to diagnosis.
  - Determine whether the staff member was in quarantine at the time of symptom onset.
  - Document date from which staff member has been in isolation/quarantine.
  - Document attendance at any other sensitive settings during the staff member’s infectious period (from 48 hours prior to onset of symptoms until appropriately isolated) including: other healthcare services, clinics, education or learning centres, residential and aged care facilities, correctional facilities or attendance at patients’ homes for home visits.
- If the source of the infection is unclear, or there are concerns that there has been widespread exposure from an index case, consider widespread testing for staff and patients.

### Workplace risk assessment

As part of the risk assessment, the following should be taken into consideration:

- Whether the case was infectious while at the workplace.
- Whether cleaning and disinfection of certain areas are required.
- Whether closure of certain areas is required to facilitate cleaning and allow for the investigation to be completed.
- Whether there are at risk/vulnerable patients for which enhanced surveillance for symptoms and possibly enhanced use of PPE could be considered (e.g. immunocompromised patients).

### Control of exposure risks to staff and patients

The following actions should be taken immediately to reduce the risk of exposure to staff and patients:
- Ensure staff are adhering to current guidelines relating to the use of PPE in healthcare settings and that appropriate PPE is accessible. See <https://www.dhhs.vic.gov.au/personal-protective-equipment-ppe-covid-19>
- Arrange for thorough cleaning and disinfection of areas which may pose an infection risk.
- Remove healthcare worker/staff close contacts from the workplace and advise them to quarantine for 14 days from last close contact with the case.
- Testing of close contacts should be undertaken early in quarantine for potential source contacts as well as on day 11, or if the close contact develops symptoms of COVID-19.
- Place any patients identified as close contacts into quarantine (for 14 days from last close contact with the case) and ensure that droplet and contact precautions (or airborne and contact precautions for AGPs) are followed when caring for these patients.

Checklist for healthcare service when there is a confirmed case in a staff member

This process should be managed by the IPC lead, who can delegate the following activities to members of the outbreak management team with the support of local staff.

<table>
<thead>
<tr>
<th>Checklist</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Detection and confirmation of case(s)</strong></td>
</tr>
<tr>
<td>Support staff with fever or acute respiratory infection to isolate. Facilitate testing for symptomatic staff or potential source contacts where possible. Confirm diagnosis.</td>
</tr>
<tr>
<td>Determine the symptom onset date and determine whether the staff member attended work during the infectious period.</td>
</tr>
<tr>
<td><strong>Management of case(s)</strong></td>
</tr>
<tr>
<td>Ensure that the staff member is currently isolating and reiterate that they should not return to work until they meet the release from isolation of a confirmed case criteria.</td>
</tr>
<tr>
<td>Ensure the staff member knows where to seek psychological support as well as medical advice if they become more unwell.</td>
</tr>
<tr>
<td>Facilitate clearance testing for the staff member where possible.</td>
</tr>
<tr>
<td><strong>Contact tracing</strong></td>
</tr>
<tr>
<td>Enter the staff member’s details in the “Close contact spreadsheet” template.</td>
</tr>
<tr>
<td>If you have identified multiple confirmed cases within your institution, ensure each confirmed case has a separate form/tab completed. Ensure accurate contact details for each person you record in the spreadsheet.</td>
</tr>
</tbody>
</table>
Immediately compile a list of all **staff** (paid and unpaid) who may be contacts of the staff member. Check rosters, sign-in sheets and other records as necessary. Liaise with staff member’s manager and medical workforce.

Immediately compile a list of all **patients** who may be contacts of the staff member. Check ward lists, admissions, discharges and transfers for the relevant ward / department.

Immediately compile a list of all **visitors** who may have been exposed to the staff member. Check visitor sign-in sheets and other records.

**Review medical records** to determine if the staff member documented contact with patients.

From the above lists, identify **potential close contacts** from the available evidence (see definition of close contact above).

Discuss with the staff member (case) to **confirm** the type and duration of contact they had with the above contacts and identify any further people who qualify as **close contacts** of the case.

Record all information in the case and contact spreadsheet and provide this to a case and contact officer (CCO) at the department.

### Quarantine contacts and isolate cases

For all close contacts of the confirmed case identified within the healthcare setting (staff members, patients or visitors):

- Notify them that they have been identified as a contact of a confirmed case and inform them of the next steps required (please note that an employer cannot disclose confidential information about the confirmed case, and should only notify close contacts that they have been identified as a close contact with a confirmed case).
- Distribute close contact information as provided by the department, including information on psychological support.

For staff members and visitors, additionally:

- Ensure they are excluded from work and are **in quarantine for at least** 14 days after last contact with the case.
- Encourage them to seek testing if they develop symptoms and further medical advice if they become more unwell.

For patients, additionally:

- Implement droplet and contact precautions, including if patient is readmitted during quarantine/ isolation period
- Advise isolation at home if already discharged
- Facilitate testing if they develop symptoms
Keep a record of each close contact and when they were informed of their potential exposure.

**Implement infection control measures**

- Quarantine patients who are close contacts of the case (cohort patients if necessary).
- Consider temporary closures (e.g. rooms, wards) to facilitate investigation of the positive case and allow terminal cleaning. This decision can be made in consultation with the department.
- Implement droplet and contact precautions (e.g. masks, gloves, gowns, eye protection) for all patients identified as a case or close contact of a case.
- Provide PPE outside rooms / wards / facility.
- Display sign outside rooms / wards.
- Reinforce standard precautions (hand hygiene, cough etiquette) throughout facility.
- Increase frequency of environmental cleaning (minimum twice daily where there are confirmed cases in patients).

**Monitor/update**

- Arrange for daily symptom check and observations for inpatients who are close contacts.
- Arrange prompt testing for those who develop symptoms of COVID-19 whilst in quarantine as a close contact.
- Arrange for clearance testing of close contacts at day 11 of their quarantine period.
- Ensure the IPC lead is informed of all positive results as soon as possible.
- The IPC lead must update the department (via the designated contact) on an agreed basis (daily, every second day, etc.) or when there is a significant issue (e.g. a cluster, a death).
- Update the case list with both positive and negative test results.

**Notify**

- Contact the department on **1300 651 160**, when there is an outbreak or a COVID-related death (24 hours, 7 days a week).
- Email case and contact spreadsheet to [publichealth.ccom@dhhs.vic.gov.au](mailto:publichealth.ccom@dhhs.vic.gov.au)
- Keep patients, staff and families informed.

**Restrict**

- Restrict movement of staff between areas of facility.
- Avoid patient transfers if possible.
Restrict visitors where practical and in compliance with most recent direction on hospital visitors (if applicable).

Consider cohorting of staff (during shift work).

Do not allow healthcare workers to return to work until they have met the DHHS healthcare worker clearance criteria.

**Declare and review**

Declare the outbreak over when there have been no new cases for a defined period of time (in consultation with the department).

Review and evaluate case and outbreak management – amend outbreak management plan if needed.

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### The disease

#### Infectious agent

Severe Acute Respiratory Syndrome coronavirus 2 (SARS-CoV-2) has been confirmed as the causative agent. Coronaviruses are a large and diverse family of viruses that include viruses that are known to cause illness of variable severity in humans, including the common cold, severe acute respiratory syndrome (SARS-CoV), and Middle East Respiratory Syndrome (MERS-CoV). They are also found in animals such as camels and bats.

First termed 2019 novel coronavirus (2019-nCoV), the virus was officially named severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) 11 February 2020. The disease it causes is now called coronavirus disease (COVID-19).

#### Reservoir

It is highly likely that the virus has come from an animal source. Genomic analysis suggests that bats appear to be the reservoir of SARS-CoV-2 but the intermediate host has not yet been identified.

#### Mode of transmission

Human-to-human transmission of SARS-CoV-2 is predominantly via droplets and fomites from an infected person.

There is some evidence that COVID-19 infection may lead to intestinal infection and virus can be present in the faeces of infected persons. Additionally, airborne transmission of COVID-19 may occur during aerosol-generating procedures. Despite this, current evidence does not support faecal-oral or airborne spread as major drivers in transmission; however, aerosol-generating procedures should be undertaken with appropriate precautions (refer to the current Coronavirus (COVID-19) infection prevention and control guidelines).

Estimates for the basic reproductive number ($R_0$) of SARS-CoV-2 range from 2–4, with $R_0$ for confined settings, e.g. cruise ships, at the higher end of this range. Estimates of the effective reproductive number
(R<sub>eff</sub>) vary from between settings and at different time points are dependent on a range of factors, including, public health interventions such as isolation, quarantine and physical distancing to limit close contact between people.

**Incubation period**

The median incubation period is estimated to be 5 to 6 days, with a range of 1 to 14 days.

**Infectious period**

Evidence on the duration of infectivity for COVID-19 infection is evolving. Epidemiological data suggests that the majority of transmission occurs from symptomatic cases; however, pre-symptomatic and asymptomatic transmission also occurs. Viral loads appear to be highest at the time of symptom onset and decreased quickly within 7 days.

As a precautionary approach, cases are considered to be infectious:

- from **48 hours prior to onset of symptoms until they meet the criteria for release from isolation**.
- **At the discretion of the public health unit, longer infectious periods (such as up to 72 hours before illness onset) may be considered in high risk settings**.

**Infection control precautions** should be applied throughout any admission and until the department or its nominated representative has released the confirmed case from isolation as per the section Release from isolation of a confirmed case.

**Clinical presentation**

For 80% of cases, COVID-19 presents as a mild illness. Common signs of COVID-19 infection include respiratory symptoms, fever, cough, shortness of breath and breathing difficulties. Other symptoms include sore throat, coryzal symptoms, headache, fatigue, myalgia, anosmia, dysgeusia, chills and vomiting.

The elderly population may present with atypical symptoms of COVID-19 including functional decline, delirium, exacerbation of underlying chronic conditions, falls, loss of appetite, malaise, nausea, diarrhoea and myalgia.

In more severe cases, infection can cause pneumonia, severe acute respiratory syndrome and multi-organ failure (including renal failure). Severe and fatal outcomes occur more frequently in the elderly and individuals with comorbid conditions. Some individuals remain asymptomatic. In summary, the clinical spectrum varies from mild cases, through to severe acute respiratory infection (SARI) cases.

For confirmed cases reported globally, the case fatality rate is approximately 3.5%; however, this is likely an overestimate for the Australian health setting. The true case fatality rate for COVID-19 is difficult to estimate due to variable case ascertainment, especially in regards to mild cases, and the impact of health systems on patient outcomes. Mortality of cases is, to a significant extent, determined by individual risk factors and healthcare quality and access. Based on surveillance data notified as of 13 October 2020, the crude Victorian case fatality rate is 4.0% (810 deaths/20,295 confirmed cases).

**Information resources**

It is important that health professionals consult this website frequently, as case definitions and content of this guideline change regularly during the response to this outbreak.

Keeping informed of emergencies affecting the health sector and critical public health issues impacting your work is made easier if you:

- [Subscribe now](#) to information including Chief Health Officer updates and emergency advice from the Department of Health and Human Services.
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