



2019 Novel Coronavirus (COVID-19)  
Public Health Management of cases and contacts  
Yukon Communicable Disease Control  
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# Interim Guidance: Public Health Management of Cases and Contacts Associated with Novel Coronavirus (COVID-19) in the Community

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## Background

Yukon Communicable Disease Control (YCDC) has adapted this interim guidance document from the Public Health Agency of Canada (PHAC) for the public health management of human illness cause by the novel coronavirus (COVID-19) and BC Centre for Disease Control (BCCDC) Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (COVID-19) in the community.

Coronaviruses were first identified as human pathogens in the 1960's, with seven now known to infect humans including SARS-CoV-2 (commonly known as COVID-19) (1). Common coronaviruses include OC-43, HKU1, 229E, NL63; these cause illnesses ranging from common colds to severe respiratory illnesses. Other coronaviruses have emerged in recent years: SARS-CoV (2002) and MERS-CoV (2012). COVID-19, initially seen in Wuhan, China, in late 2019, was declared a global pandemic in January 2020 by the World Health Organization. There have been recognized mutations leading to variants of the virus which may possible implicate transmission and case management. Information on new SARS-CoV-2 variants of public health concern is constantly emerging. Further information on variants can be found from these sources:

BC Centre for Disease Control: <http://www.bccdc.ca/health-info/diseases-conditions/covid-19/about-covid19/variants>

Centers for Disease Control and Prevention: <https://www.cdc.gov/coronavirus/2019ncov/transmission/variant.html>

PHAC: <https://health-infobase.canada.ca/covid-19/epidemiological-summary-covid-19-cases.html#VOC>

The strategy outlined in the guidance is aligned with goal of risk mitigation and is based on the assumption that the virus is primarily spread while the case is symptomatic. This guidance is based on current available scientific evidence and expert opinion and is subject to change as new information on the clinical spectrum, transmissibility, and epidemiology becomes available. It builds upon relevant Canadian guidance developed for the current and previous coronavirus outbreaks (e.g. MERS CoV and SARS-CoV), in addition to available guidance from the World Health Organization (WHO) (2).

This guidance is based upon current knowledge and it should be understood that it is subject to change as new data become available and new developments arise with this new virus. SARS-CoV-2 has and will continue to develop mutations; after many significant mutations the virus becomes a variant. A variant of concern (VOC) is identified when it escalates disease transmission or severity; becomes undetectable by tests; or impacts the effectiveness of vaccines or treatments (3).

This guidance is set in the Yukon context and is based on the available scientific evidence and expert opinion. In interpreting and applying this guidance, it is important to recognize that the health, disability, economic, social, or other circumstances faced by some individuals and households may limit their ability to follow the recommended measures (3). Furthermore, unique situations may require some discretion in adjusting these guidelines which are meant to be supportive, not prescriptive. This may necessitate adapted case management and contact responses by YCDC.

This guidance should be read in conjunction with relevant territorial legislation, regulations, organizational policies as well as provider scope practice. In Yukon, all aspects of management related to COVID-19 are coordinated by YCDC and Yukon's Chief Medical Officer of Health (CMOH) and/or the Deputy Chief Medical Officer of Health (DCMOH). For the purpose of this document Medical Officer of Health (MOH) will be used for all MOHs practicing in Yukon.

## Goals

The objectives of this guideline are:

- Promote prompt identification and reporting of probable and confirmed cases of COVID-19 and contacts
- Management of cases and contacts
- Supplement existing guidelines provided by the Public Health Agency of Canada related to case and contact management in the community.

## Epidemiological Characteristics

<p>Clinical Characteristics</p>	<ul style="list-style-type: none"> <li>Reported illnesses have ranged from infected people with mild to no symptoms, to severe illness, including death. Symptoms absent at the onset of illness may develop over time with disease progression. Based on available data, neither the absence nor presence of signs or symptoms are accurate enough to rule disease in or out (3). As such people suspected of having COVID-19 should be tested to rule in or out this diagnosis (4).</li> <li>At this time the progression seems to include initial symptoms that may be quite mild with worsening symptoms during the second week</li> <li><u>Common symptoms</u> (5) (&gt;50%) include: Fever, chills, cough, shortness of breath/difficulty breathing, fatigue, loss of appetite, loss of taste and/or smell</li> <li><u>Less common symptoms</u> (5) (&lt;50%) include: sputum production, muscle aches, chest pain, diarrhea, nausea/vomiting, headache, dizziness, sore throat</li> <li><u>Rare</u> (5) (&lt;10%): confusion, runny nose, fainting, skin manifestations</li> <li>WHO estimates that of all cases 82% will experience mild illness, 15% severe illness, and 3% critical illness. This is similar to the data that has been compiled from Canadian cases.</li> <li>15% of infected people are asymptomatic (6) (7) (8) (9) (10), up to 36% of children are asymptomatic (11), and those over the age of 65 and/or with medical conditions (5) may have atypical presentations.</li> </ul>
<p>Treatment</p>	<p>See below</p>
<p>Period of Incubation</p>	<p>Mean: 5 days, Median: 5-7 days, Range: 2-14 days for public health purposes. The Omicron variant of concern, which is the dominant strain in YT at this time, has a shorter median incubation period of 3 days (range 0-8 days) (48-51). A very small proportion of individuals would still be incubating at 14 days, likely about 1%, perhaps up to 6.7% (52).</p>
<p>Human to Human Transmission</p>	<ul style="list-style-type: none"> <li>Contact &amp; droplet which vary in size from large droplets that fall to the ground rapidly (within seconds or minutes), to smaller droplets (i.e., aerosols) which linger in the air under some circumstances, such as within settings with poor ventilation (3)</li> <li>Fomites (duration of virus survival could be days); however, current evidence does not support fomites as a substantial source of transmission.</li> <li>Consider potential fecal-oral transmission</li> </ul>
<p>Zoonotic Transmission</p>	<ul style="list-style-type: none"> <li>Reported transmission from mink to humans in the Netherlands.</li> <li>There is currently no evidence that other domestic animals are a source of transmission.</li> <li>At this time, there is evidence that bats, cats, dogs, mink, ferrets, hamsters, mink, non-human primates, tree shrews and rabbits have some level of susceptibility to infection with SARS-CoV-2 and may develop illness.</li> </ul>
<p>Period of Communicability</p>	<ul style="list-style-type: none"> <li>Period of communicability is considered 48 hours prior to onset of symptoms and at least 10 days after onset of symptoms. Contact tracing efforts should consider all individuals, with whom a case had contact prior to isolation, beginning up to 48 hours prior to the case developing initial symptoms.</li> <li>Period of communicability and discontinuation of isolation depends on the patient and setting. See text for further discussion.</li> <li>Coughing may persist for weeks, <b>this does not mean</b> the individual is infectious, nor is self-isolation needed.</li> </ul>
<p>Diagnostics</p>	<p>See <a href="#">Surveillance Case Definitions</a></p>
<p>Immune response and reinfection</p>	<p>Following infection, more than 90% of individuals will develop IgM and IgG antibodies within weeks of symptom onset (12). As stated by the Public Health Agency of Canada guidelines, the relationship between antibody levels and the level of protection against reinfection remains undetermined, as well as the role of cellular immunity in preventing reinfection (including cross-protective immunity) following exposure to common coronaviruses. See section on <a href="#">reinfection</a>.</p>

## Surveillance Case Definitions

Surveillance Case Definitions (13)		Reportable to YCDC
<b>PUI</b> (person under investigation)	A person for whom a laboratory test for COVID-19 has been ordered or is expected to be ordered.	No
<b>Probable</b>	<p>A person who:</p> <ol style="list-style-type: none"> <li>Has symptoms compatible with COVID-19 (See <a href="#">clinical characteristics</a>) <b>AND</b> Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) OR was exposed to a known cluster or outbreak of COVID-19 <b>AND</b> Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed or the result is inconclusive <b>OR</b> Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset <b>OR</b></li> <li>Had a POC NAAT <b>OR</b> POC antigen test for SARS-CoV-2 and the result is preliminary (presumptive) positive <b>OR</b></li> <li>Had a validated POC antigen test for SARS-CoV-2 and the result is positive</li> </ol>	Yes
<b>Confirmed</b>	<p>A person with confirmation of infection with SARS-CoV-2 documented by:</p> <p>The detection of at least one specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory) <b>OR</b></p> <p>The detection of at least one specific gene target by a validated point-of-care (POC) nucleic acid amplification test (NAAT) that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing) <b>OR</b></p> <p>Seroconversion or diagnostic rise (at least four-fold or greater from baseline) in viral specific antibody titre in serum or plasma using a validated laboratory-based serological assay for SARS-CoV-2</p>	Yes

**Note:** Definitions above reflect surveillance criteria and does not reflect clinical criteria where testing for COVID-19 is recommended and reporting to MOH/YCDC is required, as soon as possible.

Case definitions and exposure criteria are subject to change. YCDC assigns classification using the most recent PHAC definitions for affected area.

Published case definitions can be found at: [www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/healthprofessionals/national-case-definition.html](http://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/healthprofessionals/national-case-definition.html).

Front line health care providers must notify YCDC of any possible cases where further follow up, including testing, may be clinically warranted (as well as all, PUI, suspect, probable or confirmed) in accordance with territorial reporting requirements under Yukon's [Reportable Disease List](#) & the [Public Health and Safety Act](#). See [Contact](#) section for contact numbers.

YCDC/MOH may provide overall coordination with health care providers for the management of the case and establish communication links with all involved health care providers. Based on clinical need, hospital admission may be recommended for any suspected, probable or confirmed cases whose clinical condition requires acute care to ensure effective isolation and appropriate monitoring of illness. On a case by case basis, MOH may recommend hospitalization based on additional factors such as anticipated disease trajectory, co-morbidities, access to health care services in one's home community and logistics associated with transportation to acute care services. In circumstances where coordination is required with other provincial or territorial jurisdictions for contact tracing or case management, YCDC will coordinate with all other CDC offices.

YCDC will document all investigations in Panorama, using the UDF and existing core functionality (i.e., risk factors, signs/symptoms). YCDC will report all confirmed cases of COVID-19 nationally to the PHAC using defined PHAC processes and case report forms, available at [www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirusinfection/health-professionals/2019-nCoV-case-report-form-en.pdf](http://www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirusinfection/health-professionals/2019-nCoV-case-report-form-en.pdf)

## Clinical Management

At this time, treatment is mainly supportive, though antivirals and monoclonal antibodies may be recommended for high risk cases. Other treatments are available for severe disease in hospitalized individuals. Supportive treatment should be based on the patient's clinical condition at the discretion of the primary health care provider. Guidance on the [clinical management](#) of severe acute respiratory infection when a case of COVID-19 is suspected is available from the WHO (14).

At this time, there is no evidence to suggest that the period of communicability is different in the pediatric population compared to the adult population. Therefore, public health follow-up in pediatric cases mirrors that of adult cases.

## Epidemiology Management Definitions

### COVID-19 Illness Severity Criteria (applies to children and adults)

Asymptomatic illness: Cases with no COVID-19 compatible symptoms at the time of testing, and who do not develop symptoms during their isolation (if they develop compatible symptoms, they should be reclassified in the appropriate category based on severity of illness).

Mild to moderately severe illness: Cases that do not reach the threshold for severe illness. If a patient was admitted to the hospital for reasons unrelated to their COVID-19 illness, they should not automatically be considered as having severe COVID-19 illness.

Severe to critical illness: Individuals for whom COVID-19 causes any one of the following: experienced oxygen saturation below 94% on room air, pneumonia, hypoxemic respiratory failure, multiple organ dysfunction, or septic shock (15) (16) hospitalized because of the severity of COVID-19 illness (hospitalization in those who have COVID-19 can be for other reasons than COVID-19 severity of illness, e.g. for a surgical procedure, for relief of LTC capacity, for another medical condition).

### Level of Immune Compromise

Mildly immune compromised: Those with mild immune compromising conditions, such as diabetes, end-stage renal disease, advanced age, are treated the same as those without immune compromising conditions.

Moderately immune compromised (15) (17) individual with one or more of the following:

- Persons on chemotherapy for solid organ cancer (as determined by the most responsible physician [MRP])
- Human Immunodeficiency Virus (HIV) with a CD4 count of 50 -  $\leq 200$  cells/mm<sup>3</sup> (inclusive)
- Combined primary immunodeficiency disorder



- Any person taking a biologic/immunomodulatory therapy, prednisone of >20 mg/day (or equivalent dose) for ≥14 days, tacrolimus, sirolimus, mycophenylate, methotrexate, or azathioprine.

Based on their clinical judgement, MRPs may determine that there are other diagnoses and/or medications not listed above that support considering patients as moderately immune compromised. Consult an infectious disease specialist as needed.

Severely immune compromised (17) (18) (19) (20) (21) individuals with one or more of the following (in consultation with the most appropriate care provided if needed):

- Bone marrow transplant
- Chronic lymphocytic leukemia
- Lymphoma
- Hypogammaglobulinemia
- Human Immunodeficiency Virus (HIV) with a CD4 count of < 50 or AIDS
- Chimeric antigen receptor T-cell therapy
- Use of rituximab

There may be other diagnoses or a combination of diagnoses and/or medications that support considering patients as severely immune compromised. Current evidence may not have demonstrated prolonged live viral shedding with such diagnoses and/or medications yet. Thus, clinical judgement remains important to determine if these patients should be considered as severely immune compromised to determine their communicability period.

### **Period of Communicability**

The period of communicability is dependant on the level of immune compromise and severity of symptoms. It considered as 48 hours prior to onset of symptoms up to 10 days after onset of symptoms. Live viral shedding may occur for longer in those with illness of greater severity (e.g., admitted to hospital directly due to COVID-19) and those who are severely immunocompromised, and the period of communicability may extend to 20 days after onset of symptoms in these groups. For a small number of individuals within these groups (~ 2%), live viral shedding may extend beyond 20 days, with the maximum known duration being 32 days (22) (23) (24) (25) (15).

### **Reinfection**

Following infection, more than 90% of individuals will develop IgM and IgG antibodies within weeks of symptom onset (12). As stated by the Public Health Agency of Canada guidelines, the relationship between antibody levels and the level of protection against reinfection remains undetermined, as well

as the role of cellular immunity in preventing reinfection (including cross-protective immunity following exposure to common coronaviruses). However, this might be affected by the emergence of variants of concern with mutation enabling immune escape. As explained by the US CDC (26) "Reinfection with a SARS-CoV-2 variant virus has been reported in Brazil, the U.K., and South Africa. The risk of reinfection may be increased in the future with exposure to SARS-CoV-2 variant virus strains that are not neutralized by immune antisera, such as one recently described in South Africa." The risk of reinfection also depends on the nature of exposure to an infectious case of COVID-19. The use of prevention strategies can lower the risk of transmission and reinfection.

A recent PHAC review indicates that the time to reinfection can vary from 15 days to more than 220 days, with a median time to reinfection below between approximately 60 to 80 days (27). For confirmed reinfection, studies suggest the risk is decreased by more than 95%, while studies of suspected reinfection suggest 83 to 94% protection. Most studies conclude that the vast majority of individuals with prior infection are at very low risk of reinfection in the first 6 months, and likely protected for longer.

Some studies indicate the relative risk of reinfection is significantly lower in those with detectable antibodies, even several months after infection (28) (29). Those who did not seroconvert may not have the same degree of protection from reinfection as those with high titers of antibodies; older age, duration of symptoms, and the number of symptoms correlate with higher IgG responses after primary infection, while an immune-compromised status, and older age in some studies, is correlated with a lower antibodies response.

There are too few cases to determine the clinical presentation in a second infection and how it may differ. To date, there has not been any evidence of antibody-dependent disease enhancement observed.

As serological testing for the detection of SARS-CoV-2 antibodies becomes more widely available, the results are expected to provide further insight into the questions on reinfection and the duration of immunity

**A repeat test resulting as positive is highly unlikely to indicate a new infection (30) in the first 45 days since recovery and is unlikely in the first 90 days following recovering.** For clients who continue to be symptomatic, or have new symptoms with a positive test it is important to consider other differential diagnoses such as long COVID-19 or underlying immune compromise.

### **Diagnostic Testing**

Yukon is conducting COVID-19 diagnostic testing for individuals with compatible symptoms when warranted as part of a clinical assessment. Up to date laboratory testing guidelines for clinical purposes can be found on the [Yukon Health Professionals](#) page.

Asymptomatic testing is not routinely recommended, but can be useful in specific circumstances as determined by YCDC/MOH. Canadian guidelines suggest that asymptomatic testing of close contacts may be warranted to interrupt more chains of transmission. YCDC/MOH may recommend testing for

individuals who are part of a public health investigation of a case, cluster or an outbreak, regardless of symptom profile.

Point-of-care (POC) testing may assist in addressing the gaps in access to timely COVID-19 testing. Use of POC testing such as Abbott ID Now™ continues to be evaluated in the COVID-19 response, as well as the role of serology and genomic testing. **POC testing has different sensitivity and specificity compared to the gold standard PCR tests**, including a potential to miss early or late infections. Some may need confirmatory testing. As always, the COVID-19 test result must be interpreted in the clinical context of the patient and exposure history. If a POC test results negative but the client is symptomatic, client should isolate and retest in 2-3 days if signs and symptoms persist or have a PCR collected after the POC test. Refer to Yukon guidelines on use the use of Abbott ID testing.

At this time, PCR lab-based testing is recommended for individuals in conjunction with a clinical assessment. See current Yukon COVID-19 PCR testing recommendations available at <https://yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals>.

Individuals who are not in need of clinical assessment and can manage their symptoms at home are able to self-test with an at-home test. Specific information regarding the use of at-home antigen tests, interpretation of results and additional recommendations can be found at [Yukon.ca/covid19](https://yukon.ca/covid19). These tests are for personal use only, and may not be regarded as proof or documentation of COVID-19 disease unless conducted and recorded by a healthcare provider. Please note that individuals who have tested positive with an at-home test but experience either severe symptoms (such as severe difficulty breathing, chest pain, feelings of confusion, or fainting/loss of consciousness), worsening or non-resolving symptoms, or who have pre-existing conditions that may be exacerbated by COVID-19 should still present to a healthcare provider for assessment. Upon presentation, PCR testing may be recommended for follow-up based on the clinical assessment even if the patient reports a previous positive at-home test.

For individuals who have symptoms that are compatible with COVID-19 but do not need to be assessed by a healthcare provider, it is recommended that they stay at home until:

- their fever has been gone for 24 hours without the use of antipyretics; AND
- it has been at least 48 hours since their last episode of vomiting and/or diarrhea; AND
- their other symptoms feel like they have noticeably improved, and none of their symptoms are getting worse.

Please note that it is not required that people be completely symptom free to resume their normal activities. After a viral infection, some people may have symptoms that linger (such as a cough), but that does not mean they need to stay home until symptoms go away completely.

### Discontinuation of Isolation in Congregate Healthcare Settings

Cases are considered 'recovered' when they have met the criteria for removal of isolation. Discontinuation of isolation for confirmed cases can be complex depending on the clinical scenario but it is ultimately based on the potential risk of transmission to others. When multiple isolation requirements apply for one individual, for example: being co-infected with 2 or more organisms which require isolation precautions, the longest isolation period will always apply.

Table 2. Recommended criteria for ceasing isolation of cases to use in conjunction with definitions in infectious period section.

Recommended isolation period for congregate healthcare settings	Population
<p><b>At least 5 days</b> after the date of symptom onset or specimen collection, whichever is earlier or applicable, and;</p> <ul style="list-style-type: none"> <li>Symptoms have improved; Fever has resolved for 24 hours without the use of fever-reducing medications</li> </ul>	<ul style="list-style-type: none"> <li>General population, regardless of illness severity or immune status, when residing in or admitted to a congregate healthcare setting (i.e. long term care facilities, or hospital settings)</li> </ul>

**Coughing may persist for several weeks, so a cough alone does not mean the individual is infectious.**

**Please note that a negative at-home rapid antigen test is not required for cases to leave isolation. Instead, the end of a case's isolation is determined by when they meet all of the above criteria.**

Additional factors that are considered when determining end of isolation include:

- infection or possible infection with a variant of concern (VOC)
- activities of the recovering individual
- close contact with vulnerable populations (e.g., infants, seniors, immunocompromised etc.)
- ability to follow infection prevention measures (e.g., hand hygiene etc.)
- feasibility of obtaining negative NP swabs
- potential risk of understaffing in health care facilities
- other individual and situation-specific factor

### **Test-Based Cessation of Isolation**

In general, repeat laboratory testing (e.g., a negative test result) as the basis for discontinuing home isolation is not recommended. In exceptional circumstances, a test-based strategy might be considered, at the discretion of the MOH.

## Case Management in the Community (Confirmed, Probable, PUIs)

Most persons can be safely and effectively managed in the community setting providing the patient is clinically stable. Although this purpose of this document is the public health management, it is important to note the importance of a collaborative approach to care, including that of primary care providers, who will continue to lead the care of chronic and acute illnesses within the isolation period that may or may not be exacerbated by COVID-19 infection. When appropriate, respective First Nations Governments may also be involved for supports.

If a case has not been assessed by a HCP prior to identification, a thorough assessment should be undertaken at baseline or if symptoms progress, see [Appendix A](#). Abnormal findings should be communicated to the primary health care provider or MOH based on the concern identified. For instance, clients experiencing changes in pre-existing chronic conditions while on self-isolation should have this communicated to their primary health care provider for further discussion and management, while changes in respiratory status assumed to be related to COVID-19 should be communicated to the primary care provider and MOH for further discussion including possible diagnostic imaging.

The following measures and activities are recommended for all persons investigated for COVID-19:

- Individuals should remain isolated at home or a suitable alternative environment if isolating at home is not possible. It is important that cases who do not require hospital-level care convalesce in a suitable environment where effective isolation can be maintained and appropriate monitoring (e.g., for worsening of illness) can be provided. Considerations for a suitable environment will depend on the individual and their living situation; and may vary depending on the sex, gender, or other socioeconomic or identity factors of the case.
- Individuals will routinely be followed by passive surveillance; however, active surveillance may be considered at the discretion of the MOH. Cases may be followed by active daily monitoring of the case's health status for the duration of illness. Active daily monitoring (or variation of) will be completed by YCDC staff as well as by Primary Care Nurses and/or Community Health Nurses if cases are in rural communities.
- Individuals should be provided standardized information included in the client hand out: [Information about the novel coronavirus \(COVID-19\) Self-isolating at home](#). This handout should be reviewed in detail by the HCP allowing for questions and demonstrated comprehension. When possible, education should involve other household members. Standardizing information includes:
  - What is novel coronavirus (COVID-19)
  - How to self-isolate
  - Daily monitoring
  - Personal hygiene
  - How to prevent the spread of infection to household contacts or the community

- How to care for the case as safely as possible
- Where and when to seek medical attention

See current testing recommendations. Include exposure/travel history with specimens being sent. Refer to Laboratory guidance for specimen collection found on the Yukon Government website [novel coronavirus information for health professionals](#) page.

### Home Based COVID-19 Tests

Yukon government as well as other local agencies provide access to free home based COVID-19 tests in addition to those accessed through a private market. At this time, many of these are rapid antigen tests (RAT). However, the use of rapid molecular tests may also be available. It is important to note that the sensitivity, specificity of these tests differ from that of lab based molecular tests and can vary widely from product to product. **Within the context of widespread community transmission of COVID-19, the likelihood of a positive test reflecting true infection is high, while the utility of a negative results, specifically in the presence of symptoms or repeat testing is suboptimal and should be interpreted with caution. Persons meeting this criteria, specifically HCPs or those working in vulnerable settings, SHOULD NOT use a negative RAT in the context of symptoms and widespread community transmission to continue to present within the workplace.** Persons reporting a positive home-based RAT are strongly encouraged to follow up with their family doctor, emergency department or community health centre if there are any pre-existing health concerns that may be exacerbated or result in a high risk of morbidity and mortality or any medical emergency.

In conjunction with the surveillance definitions, patient reported positive RAT do not need to be reported to YCDC.

### How to Care for the Case as Safely as Possible

#### Healthcare workers

- For healthcare workers providing health care services in the home, virus-specific guidance for acute health care settings is applicable (31) (32).
- In addition to [Routine Practices](#), healthcare workers should follow Contact and Droplet precautions, including eye protection, when within two meters of the case. Toilets should be flushed with the lid down. See [Appendix B](#) for further discussion.
- Aerosol-generating medical procedures should be avoided in the home as much as possible.
- If aerosol-generating medical procedures (e.g., case is receiving nebulized therapy) are necessary, the use of [Additional Precautions](#), including using a fit-tested N95 respirator with eye protection, is recommended. Healthcare providers should follow existing facility/organizational direction on aerosol-generating medical procedures. PICNet IPC guidance has developed updated information for [AGMP in health care settings](#) specific to COVID-19. This can also be found on the BCCDC website on the [Novel coronavirus \(2019nCoV\)](#) page for reference.

- When possible, allow for adequate ventilation.
- Medical equipment should be cleaned, disinfected or sterilized in accordance with [Routine Practices](#) (such as Accel InterVention™ wipes, one step surface cleaner and disinfectant).
- Wherever possible, only household members who are essential for communication with staff should be present during visit (33). They should remain 2m from staff and wear a medical mask. As household member is a contact to client, staff should wear appropriate PPE if a 2m distance cannot be ensured. Depending on household situation, it may be recommended for entire household to wear a mask and remain 2m away from staff during visit (if tolerated).

#### For caregivers and others sharing the living environment

- If direct contact care must be provided, the case should wear a surgical/procedure mask, or if not available, use a non-medical mask or facial covering (e.g., cloth mask, dust mask) or cover nose and mouth with a tissue at all times and follow respiratory etiquette.
- The caregiver providing direct contact care to the case should also wear a procedure/surgical mask and eye protection when within two metres of the case and perform hand hygiene after contact.
- Anyone who is at higher risk of developing complications from infection should avoid caring for or come in close contact with the case. This includes people with underlying chronic or immunocompromising conditions (2).
- When possible, allow for adequate ventilation.

#### **Self-Isolation Considerations for Cases and Contacts**

The location where a person will self-isolate may be determined by YCDC or their rural health care provider in conjunction with the case/contact. 'Case' refers to confirmed and probable cases. When determining the location, several factors to determine the suitability of the home setting:

##### Severity of illness

Mild symptoms that do not require hospitalization, taking into consideration their baseline health status including older age groups, or chronic underlying or immunocompromising conditions that may put them at increased risk of complications from COVID-19. The ill person should be able to monitor their own symptoms and maintain respiratory etiquette and hand hygiene. Cases with underlying co-morbidities associated with risks for severe COVID-19 disease may require additional or ongoing management. As such, engagement with the most responsible care provider should occur to support holistic management of cases within the isolation period.

##### Suitable home care environment

In the home, the case should stay in a room of their own so that they can be isolated from other household members. Children's psychological needs still need to be tended to, including physical



contact and comfort from a caregiver. It might also be impossible to prevent interaction between young siblings. If residing in a dormitory, such as at a post-secondary institution or where there is overcrowded housing, efforts should be made to provide the case with a single room (e.g., relocate any other roommates to another location) with a private bathroom. Consult YCDC for any concerns or problem solving surrounding appropriate self-isolation as soon as possible.

#### Cohorting cases in co-living settings (e.g., those living in university dormitories, work camps, shelters, overcrowded housing)

Special consideration is needed to support cases in these settings when self-isolating. Consult YCDC, for support. If it is not possible to provide the case with a single room and a private bathroom, efforts should be made to cohort ill persons together. If there are two cases who reside in a co-living setting and single rooms are not available, they could share a double room.

#### Access to supplies and necessities

There should be access to food, water, heating fuel, and supplies (i.e. medication) for the duration of the period of self-isolation. Ideally, there should have access to running water for both drinking and sanitation, however within the context of rural and remote Yukon this may not be feasible or appropriate. Those residing in remote and isolated communities may wish to consider having additional supplies, as well as food and medications usually taken, if it is likely that the supply chain may be interrupted or unreliable. Special consideration is needed to support persons within these contexts.

#### Risk to others in the home

Household members with conditions that put them at greater risk of complications of COVID-19 (e.g., underlying chronic or immunocompromising conditions, or the elderly) should not provide care for the case and alternative arrangements may be necessary. For breastfeeding mothers: considering the benefits of breastfeeding and the insignificant role of breast milk in transmission of other respiratory viruses, breastfeeding can continue. If the breastfeeding mother is a case, she should wear a medical mask, or if not available, a non-medical mask or facial covering (e.g., homemade cloth mask, dust mask, bandana), when near the infant, practice respiratory etiquette, and perform hand hygiene before and after close contact with the infant. Other cases in the home, e.g., non-breastfeeding parent or other caregiver should refrain from contact with the infant with the breastfeeding mother and infant isolating as a unit.

#### Psychosocial considerations

HCPs should encourage individuals, families and communities to create a supportive environment for people who are self-isolating to minimize stress and hardship associated with self-isolation as the financial, social, and psychological impact can be substantial. Obtaining and maintaining public trust are key to successful implementation of these measures; clear messages about the criteria and justification for and the role and duration of self-isolation and ways in which persons will be supported during the self-isolation period will help generate public trust. For Indigenous Peoples, mandatory

isolation away from home due to COVID-19 may trigger re-traumatization based on the history of forced removals. There is also the potential for new trauma if their ability to practice cultural and/or spiritual activities is limited.

#### Access to care

While it is expected that persons isolating at home will be able to provide self-care and follow the recommended preventative measures, some circumstances may require care from a household member (e.g., the case is a child). The caregiver should be willing and able to provide the necessary care and monitoring for the case with appropriate precautions in place.

### **Self-Care While Convalescing**

#### Treatment

At this time, there are limited treatments for COVID-19. Cases should review options for potential treatment with their primary healthcare provider. The case should rest, eat nutritious food, stay hydrated with fluids like water, and manage their symptoms. Over the counter medication can be used to reduce fever and aches. Vitamins and complementary and alternative medicines are not recommended unless they are being used in consultation with a licensed healthcare provider.

#### Monitor temperature regularly

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

#### Maintain a suitable environment for recovery

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

#### Stay connected

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

### **Contact Tracing**

While contact tracing has been an effective mechanism to prevent the spread of COVID-19 in the past, it is not currently an effective tool in preventing transmission with current variants. It is also notable that contact tracing is not done for most common respiratory pathogens, e.g. influenza, RSV, enterovirus, for the same reasons.

With the emergence of more transmissible variants with shorter incubation periods (the period between contracting the virus and becoming infectious), it is more challenging to find contacts through contact tracing. Seroprevalance studies in BC and other regions show that only a fraction of all cases are known. Therefore, contact tracing cannot be done on many cases, which reduces the effectiveness of the intervention. At this point in time, YCDC is primarily completing contact tracing only in outbreak situations, though cases are encouraged to let their own close contacts know that they have been exposed.

If close contacts are identified for a case, close contacts are advised to monitor for symptoms of COVID-19 and isolate only if symptoms occur. A close contact includes those who have had contact with a symptomatic/COVID-19 positive individual 48 hours prior to symptom onset (or test date if individual is asymptomatic) and until they start self-isolating, and meeting at least one of the following:

#### **Definition of a close contact**

- Anyone who has been within 2 meters of a case for more than 15 minutes cumulatively in a day
- Anyone who is exposed to the infectious body fluids of a case
- A healthcare worker who provided direct physical care to a case, or a laboratory worker handling COVID-19 specimens, without consistent and appropriate use of recommended PPE and infection prevention and control practices.
- Anyone who lived with a case before the case started isolation, or if the case is unable to isolate adequately in the household setting anyone who lives with the case during his or her isolation period; or
- Anyone who has direct physical contact with a case, including the case's caregiver, an intimate partner or a child receiving care from the case even if not residing in the same household as the case.
  - The caregiver should reduce their risk of COVID-19 infection by wearing a medical mask if available (preferred), or a well-constructed and well-fitting non-medical mask, when providing direct care, or within 2m of the case. They should also use appropriate eye protection. However, in most cases, this will not be sufficient to avoid the classification of the exposure as high-risk.
  - There are scenarios where someone with COVID-19 has to take care of dependents, or dependents with COVID-19 need care from someone without it. Psychological needs of children need to be attended too, frequently including physical contact and comfort from a caregiver. It might be impossible to prevent all interaction between young siblings.
- Others, as determined by the MOH/YCDC.

As part of the individual risk assessment, consideration is given to the duration of the contact's exposure (e.g., a longer exposure time likely increases the risk), the case's symptoms (coughing or

severe illness likely increases exposure risk) and whether exposure occurred in a health care setting when determining implementation of level of contact.

All Close Contacts (regardless of vaccination status)
<ul style="list-style-type: none"><li>• Self-monitor for the appearance of symptoms consistent with COVID-19</li><li>• Follow recommended public health measures and orders</li><li>• If symptoms occur, it is recommended to isolate away from others, particularly within the home or co-living setting as quickly as possible; put on a medical mask if available (preferred), or well-constructed and well-fitting non-medical mask</li><li>• Follow <a href="#">YT testing guidelines</a> for testing recommendations</li></ul>

### Contact Tracing in Outbreak Situations

In an outbreak context, contact tracing and management also serves the purpose of active case finding during an investigation. Where an outbreak is suspected, YCDC may adopt a situation specific definition for those at high risk of exposure (i.e., "close contact") to help efficiently target their contact investigation and case finding efforts.

Outbreaks may have a significantly higher impact in some populations due to their vulnerabilities or their potential for widespread transmission (34).

### Community Based Measures

A number of community-based measures may be implemented to minimize the risk of community transmission of COVID-19. These measures can be found on the PHAC website:

<https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/public-health-measures-mitigate-covid-19.html>



2019 Novel Coronavirus (COVID-19)  
Public Health Management of cases and contacts  
Yukon Communicable Disease Control  
4 Hospital Rd., Whitehorse, YT Y1A 3H8  
Phone: (867) 667-8323 Fax: (867) 667-8349

## Contact Numbers

This guidance has been approved by the current MOH and is subject to change.

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## Appendix A – Clinical Assessment

Initial assessment should include:

Detailed information specific to COVID-19 including: signs/symptoms severity and onset, travel history, work/school/community involvement, contacts (if appropriate).

General health history including previous medical history, current HCP, treatment, allergies, current medications (OTC, traditional/herbal and prescribed), alcohol/drug use.

Different populations will present with different clinical presentations. 36% of children present asymptotically and the elderly and those with medical conditions may have atypical presentations (11).

1. Focused interview
  - Ask relevant questions related to dyspnea, cough/sputum, fever, chills, chest pain with breathing (see [Clinical Characteristics](#) for full list).
2. Vital signs including O2 saturation with a pulse oximeter
3. Detailed respiratory assessment (initial assessment or change in symptoms)
  - Inspect
    - For use of accessory muscles and work of breathing
    - Configuration and symmetry of the chest
    - Respirations for rate (1 minute), depth, rhythm pattern
    - Skin colour of lips, face, hands, feet
  - Auscultate (anterior and posterior) lungs for breath sounds and adventitious sounds
    - Fine crackles (rales) may indicate asthma and chronic obstructive pulmonary disease (COPD).
    - Coarse crackles may indicate pulmonary edema.
    - Wheezing may indicate asthma, bronchitis, or emphysema.
    - Low-pitched wheezing (rhonchi) may indicate pneumonia.
    - Pleural friction rub (creaking)
4. Assess adherence to self-isolation
5. Report and document assessment findings, immediately upon return to the facility

See <https://opentextbc.ca/clinicalskills/chapter/2-5-focussed-respiratory-assessment/> for more information including stethoscope placement and adult reference ranges.

## Appendix B - PPE

For the most up to date recommendations see PPE information at [yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals](http://yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals)

Depending upon the intake process for new clients there may be two opportunities to perform a risk assessment (23) (24) (25)

- While booking an appointment, questions regarding potential infectiousness should be asked, such as whether the individual has symptom compatible with COVID-19 infection. Include questions on home environment including other occupants. Consider eliciting information to support effective donning & doffing of PPE as well as alerting patient/family that PPE will be in use by the HCP. This risk assessment should be ongoing for all interactions.
- Upon arriving within the home the initial risk assessment should be confirmed or adapted. During a home visit, a more complete health history is usually performed by using information as well as interviewing the client.

Routine Practices include (33) (31)

- Hand hygiene (i.e., using alcohol-based hand rub (ABHR) of at least 70%)
  - before entering the client/patient/resident's room
  - after exiting the client/patient/resident's room
- After taking off and disposing of personal protective equipment.
- Examination procedures that minimize contact with droplets/aerosols (e.g., sitting 2 metres away and next to rather than in front of a coughing client/patient/resident when taking a history or conducting an examination).
- Client/patient/resident should be provided a mask or if unable to tolerate one, be advised to practice respiratory etiquette when coughing or sneezing.

Droplet/Contact Precautions include (33) (31)

- At a minimum: gloves, gown, medical mask and eye protection with any contact to a suspect or confirmed case or high risk contact. Use of N95 mask may be used based on a staff point-of-care risk assessment (PCRA).
- Facial protection covering the nose and mouth including eye protection when within **two metres of the client/patient/resident**. Regular glasses are insufficient and do not meet the requirement of eye protection. Goggles or a face shield is required. Personally-owned and non-single use eyewear may be cleaned by the individual after each use.



- In non-acute settings, gloves and gown are **required** for activities that involve direct care where the health care provider's skin or clothing may come in direct contact with the clients or items in the client's room or bed space or when within **two metres of the**

**client/patient/resident.** Gloves and gown, if worn, must be removed and hands cleaned immediately following the activity for which they were used. In the context of COVID-19 consideration can be given to donning contact precautions in the home, outside of the 2 metre area based on [point of care risk assessment](#). This includes the capacity to implement and adherence to self-isolation at home, number of persons in the home, size of the home, symptoms and age of the client.

- After the health care provider has completed care **and is greater than two metres distance** from the client/patient/resident, must remove PPE in a manner that does not contaminate themselves or the environment. Removed PPE and other waste generated during the health care of the patient at home should be placed in a waste bin with a lid and remain in the home for routine disposal.
- Wear contact/droplet PPE for the duration of the visit if there are household contact present or if the client is not confined to an enclosed room.
- See guidelines for Contact and Droplet precautions- personal protective equipment - Donning & Doffing available at [yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals](http://yukon.ca/en/health-and-wellness/health-concerns-diseases-and-conditions/find-information-health-professionals)

Additional considerations:

- Only bring in essential equipment for visits. Staff bags for professional purposes can be brought in the home (35), placed on a solid elevated surface (i.e. those containing important paperwork and tools). We recommend following droplet precautions: keep bag outside 2 metre range and remove items that will be required for direct client care (e.g. stethoscope).
- Communal or shared equipment should be cleaned and disinfected after use and can be place back into the homecare bags after use. If additional cleaning is required, consider initial clean within the home and placing objects into a plastic bag within the home care bag for secondary cleaning (if required) upon retuning to the facility. (36)
- If a health care provider believes that his/her hands have become contaminated during any stage of PPE removal, hand hygiene must be performed before proceeding further. Sinks that patients/residents use may be heavily contaminated and should not be used by health care providers for hand hygiene (35). If visibly soiled and running water is available, the sink may be used, provided it is followed immediately by use of ABHR (36) (35).
- Gloves are not a substitute for hand hygiene; caregivers must perform hand hygiene before and after putting on and taking off gloves. Reusable utility gloves may be used; however, they must be cleaned with soap and water and decontaminated after each use with a diluted bleach solution (100 ml bleach to 900 ml of water).

- Face masks (surgical/procedure masks) provide a physical barrier that help prevent the transmission of the virus from an ill person to a well person by blocking large particle respiratory droplets propelled by coughing or sneezing. However, using a mask alone is not guaranteed to stop infections and should be combined with other prevention measures including respiratory etiquette and hand hygiene.
- Applying a consistent approach to putting on and taking off a mask are key in providing overall protective benefits.