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

Interim Guidance: Public Health Management of Cases and Contacts Associated with Novel Coronavirus (COVID-19) in the Community

Contents

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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.

The strategy outlined in the guidance is aligned with a containment goal (i.e. to reduce opportunities for transmission to contacts in the community) and is based on the assumption that the virus is primarily spread while the case is symptomatic. This 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. This guidance 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)[1].

This guidance is also based upon current knowledge and it should be understood that guidance is subject to change as new data become available and new developments arise with this new virus; furthermore, unique situations may require some discretion in adjusting these guidelines which are meant to be supportive, not prescriptive.

This guidance should be read in conjunction with relevant territorial legislation, regulations, organizational polices 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 either CMOH or DCMOH.

Epidemiological Characteristics

Clinical Characteristics	• Reported illnesses have ranged from infected people with mild to no symptoms, to people being severely ill including death.
	• Suggestion that initial symptoms may be quite mild with worsening symptoms during the second week
	• Mild symptoms may include:
	  o Low-grade fever, cough, malaise, rhinorrhoea, fatigue, sore throat, gastro-intestinal symptoms such as nausea, vomiting, and/or diarrhoea.
	• more severe symptoms may include:
	  o any of the above as well as fever, shortness of breath, difficulty breathing and/or chest pain.
	• WHO reported that of all cases, 81% will experience mild illness, 14% severe illness, and 5% critical illness; these estimates are based on 72 314 cases in China as of Feb 18, 2020.

Treatment	• Supportive care
Period of Incubation	• Mean: 5.2 days • Range: 2-14 days • 14 days for clinical purposes
Mode of Transmission	• Contact & droplet spread o Direct close contact; fomites (duration of virus survival could be days). Transmission reported among family members and friends who took care of infected persons and in staff not wearing appropriate personal protective equipment. • Consider Fecal-oral transmission • No evidence that domestic animals (livestock or pets) are a source of transmission. At this time there is evidence that cats, ferrets, hamsters, and dogs have some level of susceptibility to infection with SARS-CoV-2 and may develop illness. Transmission from domestic animals to people has not been reported. However, it cannot be rules out given the early transmission in a live animal marker in China. • Possibly airborne when performing aerosol generating procedures (e.g. intubation, bronchoscopy); although, airborne transmission has not yet been demonstrated in human cases
Period of Communicability	• Period of communicability is considered to be as soon as symptoms appear and at least 10 days after onset of symptoms. It is possible that people infected with COVID-19 may be infectious before showing significant symptoms. However, based on currently available data, the people who have symptoms are causing the majority of virus spread. • Viral shedding may occur for longer in the immunocompromised and pediatric populations. • As such, for the purpose of contact tracing, trackback period should include 2 days prior to symptom onset • Discontinuation of isolation depends on the patient and setting. See text for further discussion.
Diagnostics	• 3-site PCR developed at BCCDC PHL including confirmatory testing at BCCDC

Surveillance Case Definitions

Surveillance Case Definitions[3]		Reportable YCDC
PUI (person under investigation)	A person for whom a laboratory test for COVID-19 has been ordered or is expected to be ordered.	Yes
Suspect case	A person with symptoms that include two or more of: • Fever (signs of fever) • Cough (new or exacerbated chronic) • Sore throat • Runny nose • Headache **AND** • Meets the exposure criteria* **OR** • Had a close contact** with a probable case of COVID-19	Yes
Probable	A person (who has had a laboratory test): • with fever (over 38 degrees Celsius) or new onset of (or exacerbation of chronic) cough **AND** • who meets the COVID-19 exposure criteria* **AND** • in whom laboratory diagnosis of COVID-19 is inconclusive. A person (who has not had a laboratory test): • with fever (over 38 degrees Celsius) or new onset of (or exacerbation of chronic) cough **AND** • close contact** with a confirmed case of COVID-19 **OR** • lived in or worked in a closed facility known to be experiencing an outbreak of COVID-19 (e.g., long-term care facility, prison).	Yes
Confirmed	A person with laboratory confirmation of infection with the virus that causes COVID-19 performed at a community, hospital or reference laboratory (NML or a provincial public health laboratory) running a validated assay. This consists of detection of at least one specific gene target by a NAAT assay (e.g. real-time PCR or nucleic acid sequencing).	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.

***Exposure criteria**

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

- Travelled to an affected area (including inside Canada)
  OR
- Had close contact** with a person with acute respiratory illness who traveled to an affected area (including inside Canada) within 14 days prior to their onset of illness
  OR
- Participated in a mass gathering identified as a source of exposure (e.g., conference)
  OR
- Had laboratory exposure to biological material (e.g. primary clinical specimens, virus culture isolates) known to contain COVID-19

Other factors that raise the index of suspicion should also be considered.

****Close contact**

A close contact is defined as a person who provided care for the patient, including healthcare workers, family members or other caregivers, or who had other similar close physical contact or who lived with or otherwise had close prolonged contact with a probably or confirmed case while the case was ill.

Note: Case definitions and exposure criteria are subject to change. YCDC assigns classification using the most recent PHAC definitions for affected area, exposure criteria as well as confirmed, probable, and suspect. Current case definitions and exposure criteria can be found at www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/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 Reportable Disease List & the Public Health and Safety Act. See Contact section for contact numbers.

YCDC/MOH will 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.

YCDC will document all investigations in Panorama, using the UDF and existing core functionality (i.e.,

risk factors, signs/symptoms). YCDC will report all probable and confirmed cases of COVID-19 nationally to the PHAC within 24 hours of notification using defined PHAC processes and case report forms, available at www.canada.ca/content/dam/phac-aspc/documents/services/diseases/2019-novel-coronavirus-infection/health-professionals/2019-nCoV-case-report-form-en.pdf

Clinical Management

At this time, there is no specific treatment for cases of COVID-19 infection. However, 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[4].

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

Persons can be safety and effectively managed in the community setting providing the patient is clinically stable. Care in the community will be supported by YCDC (Whitehorse) or Community Nursing (rural Yukon) to actively follow cases.

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:

- should remain isolated at home
- will routinely be followed by passive surveillance; however, active surveillance may be considered at the discretion of the MOH. Cases must be followed by active daily monitoring of the case's health status for the duration of illness.
- should be provided standardized information included in the client hand out: *Information about the novel coronavirus (COVID-19) Self-isolating at home* and *Information about the novel coronavirus (COVID-19) for caregivers* (*if appropriate*) 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 for Whitehorse, rural Yukon as well as enhanced testing recommendations for long term care facilitates and Whitehorse emergency shelter for current recommendations and processes. 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.

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[5].

- 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 (2019-nCoV) page for reference.
- Medical equipment should be cleaned, disinfected or sterilized in accordance with Routine Practices (such as Accel InterVention™ wipes, one step surface cleaner and disinfectant).

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[6].

Caregivers of cases and PUI should have the standardized information included in the client hand out: *Information about the novel coronavirus (COVID-19) for caregivers* and reviewed in detail by the HCP allowing for questions and demonstrated comprehension.

Self-care while convalescing

Treatment

At this time, there is no specific treatment for COVID-19. The case should rest, eat nutritious food, stay hydrated with fluids like water, and manage their symptoms. Over the counter medication can be used to reduce fever and aches. 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.

Discontinuation of isolation

Discontinuation of isolation for confirmed cases will occur on the direction of MOH. This may include a non-test based strategy or a test based strategy. Both approaches require resolution of fever (without use of fever-reducing medication) AND improvement in symptoms (respiratory, gastrointestinal, and systemic).

Factors that are considered include:

- severity and length of disease
- activities of the recovering individual
- close contact with vulnerable populations (e.g., seniors, immunocompromised etc.)
- ability to follow infection prevention measures (e.g., hand hygiene etc.)

- feasibility of obtaining negative NP swabs
- individual factors (e.g. pediatric and immunocompromised individuals may shed for longer)
- potential risk of understaffing in health care facilities
- other individual and situation-specific factors

The following table describes a suggested approach for various groups of COVID-19 cases and the strategies are further defined below. If an individual falls into more than one category, then the more stringent strategy should be applied.

Group of COVID-19 cases	Preferred strategy	Alternate strategy
Mild disease	Non-test-based strategy	n/a
Severe disease, e.g., ICU	Test-based strategy	Non-test based strategy
Immunocompromised	Test-based strategy	Non-test based strategy
Risk of exposure to vulnerable populations (e.g. LTC facility) except health care workers	Test-based strategy	Non-test based strategy
Health care workers	As directed by the MHO	

Description of the strategies:

1. Test based strategy:
    a. Resolution of fever without use of fever-reducing medication; AND
    b. Improvement in symptoms (respiratory, gastrointestinal, and systemic); AND
    c. Two negative NP swabs collected at least 24 hours apart

2. Non-test-based strategy:
    a. At least 14 days have passed since onset of symptoms; AND
    b. Fever has resolved without use of fever-reducing medication; AND
    c. Symptoms (respiratory, gastrointestinal, and systemic) have improved

Generally, within the community setting, cases managed at home, are required to self-isolate for 14 days after the onset of their symptoms. After 14 days, if their temperature is normal for greater than 48 hours and they feel better, they can return to their routine activities. Coughing may persist for several weeks, so a cough alone does not mean they need to continue to self-isolate for more than 14 days.

Discontinuation of isolation in special groups require MOH review and often utilize a test-based strategy. Discontinuation of isolation in such groups will require a case-by-case review.

Contact identification and management

Considering the context for this guidance is containment of the virus, close contacts of confirmed and

probable cases occurring in Canada should be identified and managed as per the recommendations in this document and an individual risk assessment by the MOH, until the containment objective is achieved or a new objective becomes necessary (e.g., if sustained person to person transmission is occurring in the community).

For the purpose of contact tracing, the trace back period should be 2 days prior to onset of sign/symptoms consistent with COVID-19 infection.

Contact isolation can be difficult to manage with multiple exposures and when overlaid with additional direction such as 14-day self-isolation for travellers. In such cases the highest level of protection (ie self-isolation versus self-monitoring) and longest duration will supersede.

Contacts who are asymptomatic will be advised to self-isolate or self-monitor depending on the exposure risk see following table. If the contact is/becomes symptomatic they will be required to self-isolate along with all members of their immediate household. In this scenario, persons who have a negative COVID-19 testing during this incubation period, will be required to complete the 14-day self-isolation period irrespective of negative test results.

Information about COVID-19 disease in children is limited, but children appear to have reduced severity of illness compared to adults[12]. This, coupled with challenges in eliciting mild sign/symptoms in a pediatric population, lends itself to aggressive self-isolation and contact management within a household setting. In scenarios where the child and not the caregiver was exposed, testing of symptomatic adults within the household, in the absence of symptoms in the child is recommended.

As transmission may occur from asymptomatic laboratory confirmed cases, consider tracing contacts from 2 days before through the 14 days after the date on which the sample was taken which led to confirmation of the asymptomatic case.

Within the context of a transmission in a household setting, individuals may be identified as contact multiple times. Often, in such scenarios the whole home will be place on isolation and removed from isolation as a group. Outside of this context, lab-confirmed cases with a subsequent exposure after recovery will be assessed on a case-by-case for the requirement to self-isolate.

The following table provides guidance on risk assessment of contacts and corresponding public health management. If a contact belongs to more than one risk category, the highest risk category should apply. The risk categories are not absolute and may be modified by the MOH in consideration of other factors including but not limited to, use of Personal Protective Equipment (PPE), duration of the contact's exposure (e.g., a longer exposure time likely increases the risk), the case's symptom severity (coughing or severe illness likely increases transmission risk), as well as persons who engage in high-risk settings or situations, e.g. daycares, health care, extremes of age, immunocompromised etc.

Yukon Communicable Disease Control
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Phone: (867) 667-8323 Fax: (867) 667-8349

Risk stratification and management for contacts (of confirmed cases)

Risk level	Description	Management - 14 days post last exposure	
		Isolation level / contact responsibilities	**Public health responsibilities**
High risk	• Close contacts [1]	• Self-isolation[2] at home for 14 days post last exposure • Daily self-monitoring[3] • Take & record temperature • If symptomatic, continue isolation and report to public health. If symptoms are severe, e.g. shortness of breath, call ahead and go to the nearest emergency department.	• Active daily monitoring of contacts[4] • Manage as probable or suspect case if symptomatic[5] • If testing for COVID-19 is negative, continue self-isolation for 14 days post contact
Medium risk[6]	• Non-close contacts- those who do not meet a high-risk definition; e.g. household contacts who consistently use PPE or who were not within 2 metres of the case • All incoming travellers, including those from the US & other locations in Canada, but outside of YT are required to self-isolate and complete a self-isolation plan. • Airline contacts (see p 11)	• Non-close contacts –> daily self-monitoring[3] • All incoming travellers –> self-isolation[2] and self-monitoring[3] • Airline contacts-> daily self-monitoring[3] or self-isolation[2] and self-monitoring[3] depending on flight plan • If symptomatic, continue to self-isolate and contact YCDC (Whitehorse) or the rural community health center	• If tested in acute care or medical clinic: YCDC (Whitehorse) or health center (rural) will contact client to confirm self-isolation is in place and again when lab results available. • Active daily monitoring generally not required, may be considered at the discretion of the MOH • Manage as probable or suspect case if symptomatic[5] • If testing for COVID-19 is negative, continue self-isolation for the duration of the 14 days post contact/landing
Low / No risk	• Interactions with a case that do not meet any of the high, medium, categories such as walking by the person or briefly being in the same room	• Follow action recommended for the entire population	• Individual advice if required

See definitions for all footnotes on following pages

[1]Definition of a high risk close contact

For the purpose of identifying the appropriate individuals for public health monitoring, a high risk close contact is defined as a person who:

- provided care for the case, including healthcare workers, family members or other caregivers, or who had other similar close physical contact without consistent and appropriate use of personal protective equipment, OR
- who lived with or otherwise had close prolonged* contact (within 2 metres) with a probable or confirmed case while the case was ill, OR
- had direct contact with infectious body fluids of a probable or confirmed case (e.g., was coughed or sneezed on) while not wearing recommended PPE, OR
- has been identified by MOH as a possible contact.

*As part of the individual risk assessment, consider the duration of the contact's exposure (e.g., a longer exposure time likely increases the risk), the case's symptoms (coughing or severe illness likely increases exposure risk) and whether exposure occurred in a health care setting.

[2]Self-isolation within the home/community setting means:

- Avoiding situations where the person could infect other people.
- The person should not use public transportation including buses or taxis.
- As much as possible, the person should limit contact with people other people. They should avoid having any visitors to their home, but it is okay for friends, family or delivery drivers to drop off food. The person can also use delivery or pick up services for errands such as grocery shopping.
- See client hand out *Information about the novel coronavirus (COVID-19) Self-isolating at home,* and *Information about the novel coronavirus (COVID-19) for caregivers* *(if appropriate)* for more details.

[3]Daily self-monitoring means:

- Self-monitor for the appearance of symptoms, particularly fever and respiratory symptoms such as coughing or shortness of breath. Reinforce the importance of reporting "mild" symptoms.
- Take and record temperature daily and **avoid the use of fever reducing medications** (e.g., acetaminophen, ibuprofen). These medications could mask an early symptom of COVID-19; if these medications must be taken, advise MOH.
- Stay in an area where health care is readily accessible in case symptoms develop.
- Self-isolate within the home as quickly as possible should symptoms develop, and contact the health care provider indicated. If symptoms are severe, (e.g., shortness of breath), call ahead

and go to the nearest emergency department. When presenting to a health care facility, wear a mask or if that is not readily available, cover nose and mouth with a tissue. Inform the facility that you are being investigated for COVID-19.

[4]Active daily monitoring

- Daily contact with client for ongoing assessment of signs or symptoms. See UDF in panorama or internal active daily monitoring form.

[5]Manage as probable or suspect case if symptomatic

- From an infection prevention and control perspective, such individuals should be managed as a case. If transferring from the community to an acute care facility, it will be important to notify EMS services (if appropriate) and the receiving facility prior to arrival to ensure appropriate measures are in place.

[6]Exemptions for essential service workers in medium risk category

- Several groups are considered essential for the continued functioning of the health care system, public safety and the transportation of essential goods. Generally, essential services are those considered critical to preserving life, health and basic societal functioning. For example, this includes first responders to life threatening events, health care workers who are essential to delivering patient care and life-saving services, critical infrastructure workers such as drinking water, hydro, internet and natural gas and workers who are essential to supply society with critical goods such as food and medicines.

  After a discussion with their manager and a risk assessment, those workers who *have returned from travel* and are deemed *essential* may return to work. **However**, they are required to take additional precautions to reduce the risk to their patients, colleagues and public. Precautions within in the workplace include:

  - Daily self-monitoring for the development of signs or symptoms (fever, cough, or difficulty breathing)
  - Wear a surgical mask at all times and in all areas of your workplace
  - Follow closely infection prevention and control protocols including attentive hand hygiene and use of personal protective equipment when providing patient care
  - Limit close contact with other health care workers and avoid sharing same spaces when possible
  - Avoid close contact with others when traveling to/from work and between shifts
  - Self-isolate at home when not required at the workplace.

  They must self-monitor for 14 days, and if they develop symptoms, should self-isolate immediately, contact 811 and their employer.

Contact tracing for airplane passengers
Contact tracing for all airplane passengers will be co-ordinated by YCDC at the direction of MOH.

At this time there is no specific PHAC recommendation for contact tracing for airline passengers. The European Centre for Disease Prevention and Control (ECDC) has recommended the ECDC Risk assessment guidelines for infectious diseases transmitted on aircraft (RAGIDA): Middle East Respiratory Coronavirus (MERS-CoV)[7] be used in response to the current 2019-nCoV outbreak, until new evidence becomes available.

Decisions related to contact tracing air travellers who may have been exposed to a case of COVID-19 on a flight should be made on a case by case basis by the MOH. Contacts will be notified, at the direction of the MOH, based on the case's classification (e.g., confirmed) and the type and severity of symptoms during the flight. As there is no direct evidence at present regarding transmission risk in relation to flight duration, these recommendations apply regardless of the length of the flight.

Contact tracing efforts should focus on those seated within a 2 metre radius of the case, as this is the accepted exposure risk area for droplet transmission. Where possible an aircraft seat map will be requested by YCDC to best target contact tracing efforts.

Contact tracing in order to identify passengers in the exposure risk area should occur if a COVID-19 confirmed case was symptomatic during the flight, and if it can be conducted within 14 days of the flight.

Contact tracing efforts should focus on:

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

See BCCDC Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (2019-nCoV) in the community for further discussion.

Community based measures

A number of community-based measures can and will 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

Contact Numbers

Dr. Brendan E. Hanley MD CCFP (EM) MPH
Chief Medical Officer of Health, Yukon
204 Lambert Street, 4th Floor, Whitehorse, PO Box 2703 (H-2)
Telephone:
Office: (867) 456-6136
Cell: (867) 332-1160
Fax: (867) 667-8349

Dr. Catherine Elliott MD MHSc FRCPC
Deputy Chief Medical Officer of Health, Yukon
#4 Hospital Road, Whitehorse, YT Y1A 3H8
Telephone:
Cell: (867) 335-0546
Fax: (867) 667-8349

Yukon Communicable Disease Control
Hours: Monday- Friday (08:30 to 16:30)
#4 Hospital Road, Whitehorse, YT Y1A 3H8
Telephone:
Local (867) 667-8323
Within Yukon 1-800-661-0408, ext. 8323
Fax: (867) 667-8349

Whitehorse General Hospital
#5 Hospital Road, Whitehorse, YT, Y1A 3H7
Telephone: (867) 393-8700
Fax: (867) 393-8772

WGH Laboratory telephone: (867) 393-8739

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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.

1. Focused interview
    - Ask relevant questions related to dyspnea, cough/sputum, fever, chills, chest pain with breathing (see Active daily monitoring 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

Depending upon the intake process for new clients there may be two opportunities to perform a risk assessment[8,9,10]

1. While booking an appointment, questions regarding potential infectiousness should be asked, such as whether the individual has a fever, cough or other respiratory symptoms. 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.
2. 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[1,6,8,.9,10,11.]

- Hand hygiene (i.e., using alcohol-based hand rub (ABHR) of at least 70%)[1,6,8,.9,10,11]:
  - 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 next to rather than in front of a coughing client/patient/resident when taking a history or conducting an examination.)[1,8,9]
- Client/patient/resident advised to practice respiratory etiquette when coughing or sneezing. [1,6,8,.9]

Droplet/Contact Precautions include[1,6,8,.9,10,11]

- Facial protection covering the nose and mouth including eye protection when within **two metres of the client/patient/resident.**[1,6,8,9] 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[8]

- 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.**[1,6,8,9,10,11] 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 including, implementation 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.[5] 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.[1,8,9,11]
- See guidelines for Contact and droplet precautions- personal protective equipment - Donning & Doffing available at https://yukon.ca/en/novel-coronavirus-hp

Additional considerations:

- Home care bags can be brought in the home[11], placed on a solid elevated surface.[10] With respect to droplet precautions, removing items that will be required for direct client care (ie stethoscope), should be removed from the bag outside of the 2 metre patient range, with the bag staying outside this 2 metre range is recommended.
- Communal or shared equipment should be cleaned and disinfected after use and can be place back into the homecare bags after use. [5,8, 10, 11] 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.[11]
- 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.[8] If visibly soiled and running water is available, the sink may be used, provided it is followed immediately by use of ABHR.[8,11]
- 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 (20 ml bleach to 1 litre 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.