COVID-19: Primary care quick reference guide

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Key points/updates for clinicians:

- It is critical that all patients presenting with symptoms consistent with COVID-19 are offered a test.
- All COVID-19 assessment and tests should be free of charge to the patient.
- The case definition, clinical criteria and Higher Index of Suspicion (HIS) criteria are unchanged, see Appendix 1 of this document.
- The drive to also test all patients presenting with symptoms consistent with COVID-19 is part of our broader disease surveillance.
- Nasopharyngeal swabbing is the preferred and superior method for COVID-19 testing. However, in some situations and with proper technique, oropharyngeal swabs can be used.
- Self-isolation requirements while test results are pending reflect Alert Levels. See below for more detail.

Step 1: Infection prevention and control for patient and staff

Detailed IPC guidance for workers can be found **here**.

In particular, see the documents **Alert Level 2: risk assessment** and **Alert Level 3: risk assessment** **for people with unknown COVID-19 status.**

In summary, in the general practice and primary care setting, a patient that has symptoms consistent with COVID-19 (see Appendix 1) should be managed as outlined below:

The Patient

- Provide a surgical mask to the patient to wear whilst waiting assessment.
- Encourage cough and respiratory etiquette.
- Ensure they are at least 1 m away from others or move them into a single room if available. If using a single room, provide the patient with tissues and hand sanitiser, and shut the door. This room can be used by other patients once cleaned.

Staff

Maintaining physical distancing and performing hand hygiene are key infection prevention and control principles. Standard Precautions should be applied at all times during care. For more information on the Standard Precautions, see the **PPE Frequently Asked Questions**.

- If staff cannot maintain 1m physical distancing, or are undertaking a physical exam/procedure, they should wear a surgical mask as part of droplet precautions. Reception staff do not need to wear a face mask or any other PPE.

- If a patient with clinical and HIS criteria requires urgent or other clinical care/procedure before their COVID-19 status is known, and 1m physical distancing cannot be maintained, refer to **PPE guidance when caring for a COVID-19 case**

Note that if the patient does not have clinical symptoms consistent with COVID-19, but is a close contact of a probable or confirmed case/has travelled overseas in the last 14 days, and physical distancing is not possible, staff should wear a surgical mask.

Step 2: Clinical care

- Patients with probable or confirmed COVID-19 infection, or those under investigation, should be managed medically according to their symptoms and clinical state. If their home care or managed facility situation is suitable, they do **not** need to be hospitalised unless clinically indicated.
- Aerosol generating procedures[1] should be avoided in primary care.
- Any patients requiring aerosol generating procedures or patients with severe illness should be referred to hospital.

Red flags which should mandate urgent clinical review and potential hospital admission

- Respiratory distress
- Dyspnoea (included reported history of new dyspnoea on exertion)
- Haemoptysis
- Altered mental state
- Clinical signs of shock e.g. low blood pressure, fainting
- Unable to mobilise without assistance by carers
- Unable to safely provide self-care
- No alternate carers available
- Any other reason that may require hospital admission as assessed by a medical practitioner.

Discuss these patients with the on-call medical team, infectious diseases or clinical microbiology service and transfer to hospital, as per your local DHB pathways. Swabs will be obtained in hospital. Ensure safe transit and controlled entry to hospital through liaison with admitting service, and ambulance service if required.

Testing

Who to test

1. Our current surveillance response requires that **all patients presenting with symptoms consistent with COVID-19 are tested.** The assessment and swabbing for these patients are at no charge to the individuals.

[1] Aerosol generating procedures include tracheal intubation, non-invasive ventilation, tracheostomy, bronchoscopy, manual ventilation, sputum induction, high flow nasal oxygen, cardiopulmonary resuscitation. Note: the use of nebulisers in primary care is not advised for patients with both clinical and HIS criteria.

2. Our **essential groups** for community testing are:

Who	Test
Has symptoms of COVID-19 and meets the higher index of suspicion (HIS) criteria. Has, in the 14 days prior to illness onset: • had contact with a confirmed or probable case • had international travel • had direct contact with a person who has travelled overseas (eg Customs and Immigration staff, staff at quarantine/isolation facilities) • worked on an international aircraft or shipping vessel • cleaned at an international airport or maritime port in areas/conveniences visited by international arrivals, or • any other criteria requested by the local Medical Officer of Health	Test and notify the Medical Officer of Health. The individual must self-isolate while test is pending, irrespective of Alert Level.
Meets the HIS criteria, and has one or more of the following: fever, diarrhoea, headache, myalgia, nausea/vomiting, or confusion/irritability, and there is not another likely diagnosis.	Test and notify the Medical Officer of Health. The individual must self-isolate while test is pending, irrespective of Alert Level.
Has symptoms of COVID-19. Does not meet HIS criteria but is: • Healthcare worker • Aged care worker	Test
Has symptoms of COVID-19. Does not meet HIS criteria but is at greater risk of poor health outcomes if they were to contract COVID-19: • Māori • Pasifika • Seniors • Pre-existing conditions (for example: chronic obstructive pulmonary disease, high blood pressure, heart disease, diabetes.)	Test
Asymptomatic border worker groups. This includes those who work at Managed Isolation and Quarantine Facilities	Test if they present with a referral/letter
Asymptomatic New Zealand-based air crew	Test if they present with a referral/letter*

*More information on requirements for international airline crew is available here https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-information-specific-audiences/covid-19-resources-border-sector/covid-19-aviation-sector

More extensive testing, including testing of people who are asymptomatic, may be required on advice from the local Medical Officer of Health.

Personal Protective Equipment (PPE) required for testing

Personal Protective Equipment (PPE) for taking COVID-19 nasopharyngeal or throat swabs provides this guidance.

The PPE recommended when taking a swab reflects both Standard Precautions, and transmission-based precautions (droplet and contact), which includes:

- gown or apron
- surgical face mask
- eye protection, such as goggles or a face shield. (Prescription glasses are not classed as eye protection. Remember to clean reusable eye protection between uses.)
- gloves

This PPE guidance applies to **all patients who have symptoms consistent with COVID-19 (irrespective of HIS criteria), and to all people with HIS criteria (irrespective of symptoms).**

PPE should be put on in the following order: hand hygiene, gown, mask, protective eyewear, gloves; and taken off in the following order: gloves, hand hygiene, protective eyewear (if separate from mask), gown, hand hygiene, mask, hand hygiene.

How to test

A nasopharyngeal swab placed into a viral transport media (VTM) will obtain the optimal specimen and is the preferred collection method for both symptomatic and asymptomatic testing.

An oropharyngeal swab may be considered for those unable to tolerate a nasopharyngeal swab. If an oropharyngeal specimen is collected, it is recommended that a deep nasal specimen is also collected at the same time as this will ensure adequate virus is obtained.

An oropharyngeal on its own should only be taken if deep nasal specimen is not tolerated. Oropharyngeal specimens (without a deep nasal specimen) should only be taken in the first few days of their illness when the viral load is likely to be highest. Oropharyngeal specimens should not be taken if there are no symptoms as they are unlikely to collect an adequate amount of virus.

There is more information on specimen collection available **here**.

Managing relapsing cases

Some people that meet the requirements to be released from isolation have re-presented with mild respiratory symptoms later. Retesting is only recommended if their condition deteriorates and they are hospitalised. Otherwise there is little value in retesting for COVID-19 as a positive PCR does not mean they are infectious. Testing for other pathogens should be considered.

Step 3: Cleaning

Once the patient has been transferred from the premises, a general clean of the room can be undertaken. You do not need a stand-down period before you can use the room again. If the patient uses the toilet, the following cleaning procedures also apply.

- After the patient has left the room, if not already wearing don PPE - plastic apron and gloves.
- Remove any linen that has been used into linen bags for hot washing.
- Wipe down surfaces with detergent and water, then hospital grade disinfectant.
- Remove and discard PPE as clinical waste.
- Perform hand hygiene.

Step 4: Management of patients

- At Alert Levels 3 and 4, all people who meet the clinical criteria who are tested should self-isolate while awaiting test results. Only those meeting the HIS criteria need to be notified to the Medical Officer of Health Unit.

- At Alert levels 1 and 2, only people who have symptoms and meet the HIS criteria, need to self-isolate while awaiting test results. They should follow the advice of their health practitioner regarding staying at home if unwell.

- At any Alert Level, anyone who meets the clinical and HIS criteria should be tested, self-isolate while awaiting test results and be notified to the Medical Officer of Health.

- Those who meet the HIS criteria who are asymptomatic do not need to self-isolate while waiting for test results, unless they are advised otherwise, for example if they are a close contact of a confirmed case.

- Public health units will inform patients and provide information if the result is **positive.** Primary care is responsible for informing patients and providing advice if the result is **negative**, according to local protocols.[2]

- Those with positive results will be followed up by the local public health unit and receive daily monitoring. They need to receive clearance from the health professional responsible for daily monitoring before they can come out from isolation. This will occur at least 10 days after symptom onset and at least 72 hours after acute symptoms resolve.

- Those patients with negative results but who meet HIS criteria must remain at home while they have symptoms. If there is a high degree of suspicion that they may have COVID-19 (eg very close contact with a case), the test may be repeated – discuss with the Medical Officer of Health. Provided they are not close contacts of a confirmed or probable case, or have had recent overseas travel where pre-existing isolation requirements continue to apply, they can discuss when they are fit to return to work with their General Practitioner or primary care provider.

- **All patients (whether positive or negative) may need ongoing general practice and primary care support, depending on the severity of their illness and other comorbid conditions.**

The Health Act 1956 requires health professionals to notify the Medical Officer of Health on suspicion of notifiable disease. Local public health units will prepare protocols of how primary care can perform this requirement: this may involve e-notification, fax, or email. Patients who are confirmed or probable cases, those with both clinical and HIS criteria, and those with atypical symptoms without another diagnosis and HIS criteria, need to be notified to the Medical Officer of Health.

Information regarding the management of close contacts is detailed in the **Case Definition** and in the **Updated Advice for Health Professionals documents**.

[2] There is additional information for patients who have a negative test available here www.health.govt.nz/covid19-qaa-primary-care#negative

APPENDIX ONE

The case definition no longer defines all who should be tested for COVID-19. The case definition identifies those with a higher risk of having COVID-19 and outlines the reporting and self-isolation requirements for those with symptoms who meet the higher index of suspicion criteria.

Please refer to the **testing guidance** for advice on who to test. The testing guidance will be regularly updated, however, those with symptoms who meet the higher index of suspicion criteria should always be the highest priority for testing.

Case definition of COVID-19 infection

The Ministry of Health develops the case definitions for COVID-19 based on expert advice from our COVID-19 Technical Advisory Group. The criteria are revised frequently. A full explanation of the case definition is found **here**.

There are criteria ('Higher Index of Suspicion', HIS) to provide guidance around risk assessment (see below). However, as part of our surveillance strategy, some groups of people without HIS criteria will also be tested for COVID-19.

The clinical symptoms consistent with COVID-19 remain the same:

Any acute respiratory infection with at least one of the following symptoms: new or worsening cough, sore throat, shortness of breath, coryza[3], anosmia[4] with or without fever.

'Higher Index of Suspicion' (HIS) criteria for COVID-19 include (in the14 days prior to illness onset):

- contact[5] with a confirmed or probable case
- international travel
- direct contact with a person[6] who has travelled overseas (eg Customs and Immigration staff, staff at quarantine/isolation facilities)
- worked on an international aircraft or shipping vessel
- cleaned at an international airport or maritime port in areas/conveniences visited by international arrivals, or
- any other criteria requested by the local Medical Officer of Health.

[3] Coryza – head cold e.g. runny nose, sneezing, post-nasal drip.

[4] Anosmia – loss of sense of smell.

[5] Refer **Advice for Health Professionals** for close contact criteria.

[6] Excludes household and community contacts of aircrew.