COVID-19

Te Mana Ora protocol

This protocol is based on Manatū Hauora-Ministry of Health's advice and information on the Ministry of Health, World Health Organization and Unite against COVID-19 websites[1, 2,3], and the Communicable Diseases Network Australia COVID-19 National Guidelines for Public Health Units[4].

Protocol users should check those documents and websites for any recent updates. Links in this document point to the specific pages of each site wherever possible.

Te Mana Ora-specific content is in green.

Recently updated content is in blue.

Contents

1. Associated documents

Te Whatu Ora Waitaha Canterbury policies and procedures:

- Māori Health policy
- Te Reo Māori policy
- Tikanga policy
- Interpreter procedure

Te Mana Ora's COVID-19 procedures, forms, checklists, orders, letters, etc., and reference documents from the Ministry of Health and other agencies are available via the following link:

- COVID-19 document library
- Using Interpreting Services and Translation of Written Material / Te Ratonga Whakamārama procedure
- Privacy/Nohotapu Whakahaere Rorohiko Tika procedure
- Contact details for COVID-19 external agencies

2. The illness

Epidemiology

SARS-CoV-2 is the infective agent that causes COVID-19. SARS-CoV-2 is a novel coronavirus that was first identified in humans in Wuhan, China, in December 2019. On 12 March 2020 the World Health Organization declared COVID-19 a global pandemic.

Like other viruses, SARS-CoV-2 evolves over time, often with minimal impact on its properties. Some mutations, however, affect the properties in a way that pose an increased risk to public health. The WHO Technical Advisory Group on SARS-CoV-2 Virus Evolution (TAG-VE) monitors for such variants to determine if they meet the definition of a Variant of Interest (VOI) or a Variant of Concern (VOC). The Ministry of Health no longer provides regular New Variants Updates. However, ESR create regular reports on viral genomic surveillance on their COVID-19 Genomics Insights Dashboard. The Ministry of Health's "Current cases" webpage shows up-to-date information on the New Zealand COVID-19 situation.

Clinical description

The most common symptoms of COVID-19 are fever, cough, shortness of breath, sore throat and loss of smell or loss of taste. Other non-specific symptoms of COVID-19 include fatigue, headache, runny nose, acute blocked nose (congestion), muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite.

Incubation

The median incubation period of ancestral strains of SARS-CoV-2 is **5 to 6 days**, with a range of **1 to 14**. Studies have shown **shorter** incubation periods for both Delta and Omicron VOCs than ancestral SARS-CoV-2. The Ministry of Health website currently states: *symptoms tend to arise around two to five days after a person has been infected but can take longer to show.*

Transmission

SARS-CoV-2 is primarily transmitted by exposure to infectious respiratory droplets and particles. Exposure occurs primarily through three routes:

- Inhalation of respiratory droplets and aerosolised particles.
- Deposits of respiratory droplets and particles on mucous membranes (mouth, nose, eyes).
- Touching of mucous membranes with hands directly contaminated with virus-containing respiratory fluids or indirectly by touching surfaces contaminated with virus-containing respiratory fluids.

Communicability

For public health purposes the period of communicability is considered to start **48 hours before onset of symptoms** and continue for 7 days after the day of symptom onset.

For **asymptomatic** cases, the presumed infectious period is considered to start 48 hours before the first positive test. In general, if the asymptomatic case has had a recent negative PCR test they may be assumed to have been non-infectious at least until that swab was taken.

Transmission of SARS-CoV-2 can occur in pre-symptomatic and asymptomatic people and can continue as long as they shed whole live viruses. Nucleic acid amplification testing (NAAT) is not an effective measure of infectiousness as it can detect viral fragments that do not correlate with infectiousness. Studies have instead used viral cultures to estimate the duration of infectiousness for SARS-CoV-2. For the ancestral strains of SARS-CoV-2, people with mild-to-moderate illness were highly unlikely to be infectious more than 10 days after symptom onset. The infectious period, however, can vary based on individual factors and the VOC. Individuals with severe disease or who are significantly immunocompromised may have prolonged infectious periods.

Prevention

Vaccine information is available on the Ministry website.

Treatment

Current information about COVID-19 therapeutics is available in a series of pages on the Ministry website.

Paxlovid (Remdesivir) is an oral treatment which may be prescribed to people who have been diagnosed with COVID-19, have symptoms, and are at a higher risk of hospitalisation including Māori and Pacific peoples, those with complex health needs, the elderly and unvaccinated populations, and people with disabilities. The position of

the Therapeutics Technical Advisory Group (TAG), established by the Ministry of Health, is that Molnupiravir is no longer recommended for treatment in non-hospitalised patients. Access criteria for Paxlovid™ are set by Pharmac. Further information about oral agents is available on the Ministry website and on HealthPathways.

Long COVID[i]

Long COVID is considered as experiencing symptoms of COVID-19 after 12 weeks of infection. It is estimated one in 10 people feel symptoms of long COVID 12 weeks after infection. Symptoms of long COVID may include low energy and fatigue, shortness of breath and cough, headaches, low mood, difficulty concentrating (brain fog), ongoing chest pains, racing pulse, aches and pains in muscles, ongoing changes to sense of smell and taste, and poor quality of sleep.

Information about long COVID is available on the Unite against COVID-19 website, HealthPathways, and the Te Whatu Ora website.

A clinical rehabilitation guideline for people with long COVID is available on the Ministry website.

3. Notification

Although medical practitioners are legally required to notify all notifiable diseases to the medical officer of health, in practice this is not expected for COVID-19, and advice on Hospital and Community HealthPathways has been updated. Case records are created in EpiSurv (see 7. Information systems & processes), however, these do not create an 'e-notification' prompt.

Te Mana Ora may receive hospital death notification emails directly, as well as ERMS referrals and coroner autopsy notifications of deaths. At Te Mana Ora, the monitoring for, and actioning of, death notifications is currently completed by the COVID-19 Coordinator. The procedure for Te Mana Ora staff to respond to **death** notifications is available via the COVID-19 document directory.

4. Case definition

Clinical criteria

Common symptoms of COVID-19 are similar to colds or influenza. A person may have one or more of the following symptoms.

Common symptoms:

- new or worsening cough
- sneezing and runny nose
- fever
- temporary loss of smell or altered sense of taste
- sore throat
- shortness of breath
- fatigue/feeling of tiredness.

Less common symptoms of COVID-19 may include diarrhoea, headache, muscle aches, nausea, vomiting, malaise, chest pain, abdominal pain, joint pain or confusion/irritability. These almost always occur with one or more of the common symptoms.

Laboratory criteria

Definitive laboratory evidence

SARS-CoV-2 detected from a clinical specimen using a validated nucleic amplification acid testing (NAAT) OR by a Rapid Antigen Test in a health care setting.

Suggestive laboratory evidence

SARS-CoV-2 detected through a self-reported rapid antigen test where the quality of result cannot be verified.

[i] Advice from COVID-19 Response Update 15 March 2022 (COVID-19 Group, DPMC)

Case classification

The majority of cases are no longer actively followed up. Therefore, clinical and epidemiological criteria are not included in the case definition provided in the Communicable Disease Control Manual. (Note, however, that in an outbreak investigation a symptomatic contact may still be considered a confirmed case if they meet the outbreak case criteria.)

Confirmed case

A confirmed case has definitive laboratory evidence AND has not been a confirmed or probable case in the previous 28 days.

Probable case

A probable case has suggestive laboratory evidence AND has not been a confirmed or probable case in the previous 28 days.

Under investigation case

A case that has been notified where information is not yet available to classify it as confirmed, probable or not a case.

Not a case

A case under investigation who doesn't meet the definition of a confirmed or probable case.

Reinfection

The latest evidence shows that reinfection with COVID-19 can occur within a short period of time. Reinfection will become more likely as new variants spread in the community.

When someone tests positive for COVID-19 and it has been 29 or more days since the last infection, it will be categorised as reinfection (same advice and support as for a new infection).

COVID-19 Death

A COVID-19 death is reported when COVID-19 is determined to have been the underlying cause of death or a contributory cause of death. This can range from death not related, for instance someone with COVID-19 who dies in a car accident; to COVID-19 being a contributing cause, for example when someone dies with an existing health condition combined with COVID-19; and to COVID-19 being recorded as the cause of death.

All deaths where someone has died within 28 days of being reported as having a positive test result for COVID-19 are now reported.

5. Testing

There are currently no mandatory testing requirements in Aotearoa New Zealand.

People who have **symptoms** that meet the clinical criteria for COVID-19 should be tested.

People may also be tested when they are **asymptomatic,** and they are household contacts of confirmed (or probable) cases.

A PCR test, involving a **swab from the nasopharynx,** is the most effective way of detecting the presence of SARS-CoV-2. While nasopharyngeal swabbing is the "gold standard", an **oropharyngeal with bilateral anterior nares** swab is acceptable for both surveillance and diagnostic testing for those who cannot tolerate nasopharyngeal swabbing.

Rapid antigen tests, often abbreviated 'RATs', are generally taken with a front of nose swab and detect the presence of specific proteins on the outer portion of the virus, such as the spike protein. RATs require a higher quantity of the virus to be present in the sample than other COVID-19 testing methods. As a result, RATs are **less sensitive** at detecting cases, especially in asymptomatic people or people who are early in their infectious period.

The advantage of RATs is that they give a result quickly, which assists with rapid risk assessment and reduces the amount of time a positive individual is active in the community. RATs can be conducted in a laboratory, a health setting, or in the community e.g., at home. Detailed information on RATs from the Te Whatu Ora website.

Information on RAT testing in the community is available on the Unite against COVID-19 website.

Saliva PCR testing has been used for asymptomatic surveillance testing in some workers. Any positive test needs follow up confirmation with nasopharyngeal PCR (or oropharyngeal and bilateral anterior nasal if unable to tolerate nasopharyngeal).

Serology may be useful in determining historical cases, but interpretation can be difficult in vaccinated individuals and should be discussed with a microbiologist.

Whole genome sequencing is undertaken by ESR. Urgent WGS can be requested via covid.urgentwgs@esr.cri.nz. ESR are actively monitoring this address and will provide urgent sequencing services upon request. Please note that they no longer have staff on-call to provide this service after hours or on weekends, so they are only able to accommodate samples received between 8am-4pm on week days.

This *may* be required if the person:

- had overseas travel history to areas where there are identified VOCs;
- people who are hospitalised with COVID-19 infection; and
- priority population groups who are at higher risk of producing a mutation of the virus, that creates a new variant.

Further testing information is available.

- Ministry of Health website's Case definition and clinical testing guidelines.
- Information on ESR's wastewater testing programme is also available.
- Unite against COVID-19 website's advice on further testing of people who have had COVID-19.
- Te Whatu Ora's testing strategy.

6. Cultural and social context

Cultural, social, work and home environments affect any person's risk of contracting a communicable disease, the likely impact of that disease on them, and their likelihood of passing the infection on others. Keep these factors in mind at every point of your investigation and follow-up.

- Request an interpreter if needed.
- Consider the potential impact of cultural, social, work or home factors on a person or family's ability or willingness to provide information and/or follow public health advice.
- Tailor your advice to the situation.
- Seek advice yourself if unsure. Talk to:
    - Te Mana Ora's Māori Relationships Manager or Pacific Relationships Manager or Communicable Diseases Manager for advice on community and primary care support people or agencies.
    - Ngā Ratonga Hauora Māori for Maori patients at Christchurch Hospital or Christchurch Women's hospital.
- If appropriate, and with the case and/or contact's permission, seek the assistance of family or other community members, community leaders, and/or support agencies if required.
- Te Mana Ora has worked with Māori and Pasifika partner agencies to facilitate support for Māori and Pasifika cases and contacts.

7. Information systems & processes

Disestablished processes:

- The MSD COVID line has been disestablished, however, COVID-19 cases who require welfare support may still be able to access supports through the generic MSD support line, where their needs will be assessed.
- The Reach service had been disestablished nationally. This removes their function of the follow up of 'potentially vulnerable' or 'high risk' cases, identification of 'high risk location' exposure events through case interviews, as well as referrals to Care in the Community ("the Hub") for welfare or uncontactable case.

Current processes:

- When a person returns a positive laboratory test for COVID-19, case records are created in EpiSurv, NCTS (the National Contact Tracing Solution). RATs self-reported by cases via their My COVID Record or 0800 222 478 also create NCTS and EpiSurv case records.
- The input of these cases in NCTS generates a record in CCCM (COVID Clinical Care Management). The CCCM will interact with NES (National Enrolment Service) which identifies if the person positive for COVID-19 is enrolled at a GP practice/primary care provider in New Zealand.
  - If they have a GP practice their primary care provider will be notified via HealthLink.
  - If they are not enrolled in a GP practice, there is an automatic referral to Care in the Community ("the HUB").
- The input of these cases into NCTS also automatically generates a text to the case (from the Ministry of Health), this prompts the cases to complete a health screen. If they have any chest pain or shortness of breath or meet the criteria for a 'potentially vulnerable case', there is an automatic referral to the HUB.
- High risk exposure events are identified through the self-serve form (same process as the health screen), upon identification of these (some residential housing, faith-based places of worship, ARCs, Marae and Tangihanga) they are automatically allocated to the local public health unit via NCTS.

Under review:

- The high-risk exposure section of the self-serve form is currently under review (as of 20 September 2023), with a proposal to cease the collection of this information and thus the subsequent creation and delegation of high-risk exposure events to public health units. For current exposure event process, see Exposure events.
- The ongoing role of the HUB in COVID-19 case management is under review (as of 10 October 2023), with the possibility that the HUB's COVID-19 function will be disestablished. However, should this occur, their current roles and responsibilities will not fall to the Public Health Unit.

HealthScape should continue to be used to record non-COVID traveller illness incidents, airport incidents and breaches, and agency interactions.

Manual entry into EpiSurv is no longer required for PHUs.

The Ministry of Health should be advised of the **death** of a person with COVID-19. The COVID-19 coordinator checks the CPHOps email daily for death notifications and ensures the Ministry protocol for reporting deaths is followed.

WHO will be notified of probable and confirmed cases through the National Focal Point for International Health Regulations (i.e., the Office of the Director of Public Health, Ministry of Health).

8. Management of case

There are currently no mandatory isolation requirements in Aotearoa, New Zealand.

Actions for cases and contacts are summarised in Appendix 1 and Appendix 2.

Confirmed and probable cases

Currently, most reported cases have self-tested with a RAT and self-notified. Community cases who are tested with PCR are notified by text. Investigation and management are "self-service".

There are no longer community isolation facilities.

Infectious period and isolation

"**Day zero**" is the date of the onset of symptoms or the date of a positive COVID-19 test (if the person remains asymptomatic), whichever is the earliest.

Cases are considered **infectious** for the **two days preceding** their "day zero". However, if a case has had a negative swab within the 48hrs preceding their "day zero" they may be considered not infectious until the time of that swab.

Cases are recommended to isolate for a minimum of **5 full days** after their "day zero". If their symptoms are resolved and they feel well, case can return to normal activities on day 6. If cases are still symptomatic after 5 days, it is recommended that they stay home until recovered (for a maximum of 10 days). Additional RATs are

not required after testing positive. If the case is concerned, they may still be infectious after isolating for 5 days, then testing negative with a RAT provides a good indication that unlikely to be infectious.
It is recommended that the case avoids contact with other household members if possible, during isolation, wear mask and physical distance in shared spaces.

If case needs to leave home during 5-day isolation period, it is recommended to take precautions to prevent transmission:

- Wear a mask whenever leaving the house.
- Should not visit a healthcare facility (except to access medical care), an aged residential care facility, or have contact with anyone at risk of getting seriously unwell with COVID-19.

It is recommended for the case to wear a mask if visiting a healthcare facility or an aged residential care facility, or if in contact with anyone at risk of getting seriously unwell with COVID-19 up until 10 days after symptoms started or positive test.

Advice for people with COVID-19 is available on the Ministry of Health website.

Clinical care

GPs are responsible for clinical care of any COVID-19 patients in the community, and guidance is available on Community HealthPathways. Primary care providers will be notified of cases from their practice via HealthLink.

Hospitalised cases

Advice for clinical management of hospitalised COVID-19 cases is available on the Ministry website. There is no specific requirement for COVID-19 clearance to be able to discharge a patient from hospital; standard COVID-19 isolation recommendations apply.

Recovered cases

Further COVID-19 testing of cases is **not recommended for 28 days following onset** of infection. All cases should be advised to seek a supervised RAT if new symptoms develop at any stage after 28 days following onset of infection. Detailed advice is available here.

The current guidance from the Ministry of Health for getting a COVID-19 vaccine if you have had COVID-19 is to wait 6 months after testing positive before getting any COVID-19 vaccination. However, those at high risk of severe disease if they do catch COVID-19 again, are advised to talk to their doctor, nurse, or healthcare provider for advice on timing of their next dose, as it might be appropriate for them to receive their COVID-19 vaccine sooner than 6 months.

9. Management of contacts

Definitions and actions for cases and contacts are summarised in Appendix 1 and Appendix 2. Specific advice must be referred to for **healthcare** worker exposures.

Contacts are not actively managed by public health services and are recommended to self-monitor for symptoms and test as recommended.

Contact Classification

Close contact – household

- Normally share a residence with case (either on a permanent or part time, or shared custody basis), and
- Spent at least one night or day (more than 8 hours) in that residence while case was infectious.
- Includes shared houses and flats, travellers in shared holiday accommodation (e.g., hotel room or campervan).
- Don't normally reside with the case but have spent a night together in the same room.

Close contact – other

- Live in same group accommodation with case*.
- Had contact with case during their infectious period.

Casual contact

- Any person with exposure to the case who does not meet the criteria for a Close contact.

* e.g., halls of residences, boarding houses, hostels, backpackers, transitional housing or similar.

Contact management

Household contacts are recommended to:

- test with a RAT each day for 5 days from the day that the first case in the household tests positive
- wear a mask outside home for the duration of testing, particularly around vulnerable people (e.g. elderly or immunocompromised), on public transport, or in crowded indoor places
- continue with daily life provided no symptoms and a negative RAT result each day for 5 days
- continue with daily tests up to 5 days if symptomatic. If all test negative no need for further tests; stay at home until 24 hours after symptoms resolve
- avoid or minimise contact with the case(s) in the household as much as possible while they are isolating
- continue daily RATs if a final daily test is negative, but newly symptomatic, until symptoms resolve or up to a maximum of a further 5 days. The contact should stay at home until recovered (for a maximum of 10 days).
- self-isolate for at least 5 days, as a case, if any RAT result is positive (from date symptoms developed or date of test if asymptomatic, whichever comes first)

If a positive case enters a household part way through the case's isolation period (e.g. student returning from hostel to home, or shared care situations), the new household contacts should test for 5 days from the date of entry of the case (5 days from exposure)

Daily testing does not restart if additional members of the household are identified as cases within the initial case's isolation period.

If a new case is identified in the household:

- ≤10 days since the initial case was released from isolation, other household contacts do not need to test daily for 5 days. If symptoms develop, stay home and test. If a test is negative, continue daily RATs until symptoms resolve or up to a maximum of a further 5 days. Stay at home until 24 hours after symptoms resolve;
- >10 days after the initial case was released from isolation: other household contacts (except those who became cases) do need to test daily for 5 days.

Note: cases whose onset of COVID-19 infection was within the last 28 days are not considered household contacts if there are further cases in their household and are not recommended to test. If ≥29 days since the onset of COVID-19 infection and someone in the household tests positive, then testing for 5 days as a household contact is recommended.

"Close contact – other" are recommended to:

- self-monitor for symptoms for 10 days.
- stay at home and test with a RAT immediately if symptoms develop at any time during the 10 days. If test is negative, recommend RATs continue daily until symptoms resolve or up to a maximum of 5 days. Stay at home until 24 hours after symptoms resolve.

Advice for people who are contacts is available on the Ministry of Health website.

10. Exposure events

Public health units have discretion to continue to manage **high-risk exposure events**. Te Mana Ora is not routinely following up COVID-19 exposure events.

As outlined in Section 7, exposure events are automatically allocated to the local public health unit via NCTS, in Te Mana Ora this is monitored by the COVID-19 coordinator. If follow up is required, guidance for specific settings and institutions is saved in the CPH COVID-19 Document Directory.

Actions for high-risk exposures are currently under review as of 20 September 2023, with a proposal to cease the collection of this information and thus the subsequent creation and delegation of high-risk exposure events to public health units.

11. Cluster and outbreak management

Most local clusters or outbreaks are now managed by the setting they occur in. If further public health support is required, consider the following:

- assess the priority of the setting and Te Mana Ora's capacity to support an outbreak response.
- establish a cluster co-ordinator and a lead medical officer of health as soon as the outbreak is identified.
- consider forming an immediate response team, including Infection Prevention & Control staff and management from the affected facility, if the cluster is in a vulnerable setting (aged residential or disability care or Corrections facility).
- identify a "point of contact" and clear communication lines for the affected household, institution, business or community.
- support development of an outbreak response plan for the setting, including accessing appropriate welfare and manaakitanga support.
- liaise with the affected institution, infection prevention and control staff, primary care, and the Ministry of Health.

12. Other control measures

Disinfection

Clean and disinfect surfaces and articles soiled with respiratory secretions or faeces, using a product with antiviral activity. For further details, see Ministry of Health cleaning and disinfection advice.

13. Legislation and enforcement

Legislative framework

Relevant legislation that pre-dated COVID-19 includes:

- Health Act 1956, which sets out the roles and responsibilities of individuals to safeguard public health. Part 3 of the Act grants powers to medical officers of health while an Epidemic Notice remains in force. These powers are available for the management of all scheduled infectious diseases, including COVID-19 where appropriate.
- New Zealand Bill of Rights Act 1990 that protects the rights of people.
- Health and Safety at Work Act 2015 that imposes obligations to secure the health and safety of workers and workplaces.
- Privacy Act 2020, which outlines the protection of an individual's right to privacy of personal information, including the right of an individual to access their personal information, while recognising that other rights and interests may at times also need to be taken into account.

Revoked and inactive legislation – Orders/Notices

The Epidemic Notice expired on 20 October 2022, and Health Act section 70 powers are now inactive, in the absence of approval for use by the Minister of Health. Any further activation is subject to the processes set out in section 70.

The COVID-19 Public Health Response (Authorisation of COVID-19 Orders) notice 2022 expired 20 January 2023. This was made by the Prime Minister under section 8(c) of the Act on 18 October 2022, to authorise the use of COVID-19 orders in relation to:

- Self-isolation requirements for COVID-19 cases;
- Point-of-care test requirements; and
- Mask requirements in health service premises.

The COVID-19 Public Health Response (Self-isolation Requirements and Permitted Work) Order 2022 required COVID-19 cases to self-isolate for 7 days. This was revoked on 15 August 2023.

14. Staff wellbeing and support

Investigation and management of COVID-19 cases and contacts can be challenging for staff in many ways. All staff are encouraged to prioritise their own wellbeing and the wellbeing of their colleagues, and to seek support when they need it and encourage others to do the same.

15. References and further information

1. Ministry of Health. Novel coronavirus COVID-19. 2020; Available from: https://www.health.govt.nz/our-work/diseases-and-conditions/novel-coronavirus-COVID-19

2. World Health Organisation. *Coronavirus*. 2020; Available from: https://www.who.int/health-topics/coronavirus

3. New Zealand Government. *Unite against COVID-19*; Available from: https://covid19.govt.nz/

4. Australian Government Department of Health. *Coronavirus Disease 2019 (COVID-19) CDNA National guidelines for public health units*; Available from: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm

5. Te Whatu Ora | Health New Zealand. *Communicable Disease Control Manual*; Available from: https://www.tewhatuora.govt.nz/for-the-health-sector/health-sector-guidance/communicable-disease-control-manual/covid-19/

Appendix 1: Te Whatu Ora case and contact management table (15 August 2023)

Te Whatu Ora
Health New Zealand

COVID-19: Case and contact management

Effective from 15 August 2023 (version 10.0)

New Zealand Government
Te Kāwanatanga o Aotearoa

Category	Description	Actions for the Case or Contact	Actions for health providers
Healthcare workers who are cases or contacts should follow instructions from their employer and/or refer to Guidance for return to work for healthcare workers			
Not a contact	General public and surveillance testing	• Asymptomatic: self-monitor for symptoms • Symptomatic: test with a rapid antigen test (RAT). Stay at home until 24 hours after symptoms resolve. If RAT is negative and symptoms persist/worsen, test again with a RAT 48 hours after the negative test. If symptoms resolve, no need for a further test	• None

Close contact	Household contacts:
	• normally share a residence with case (either on a permanent or part time, or shared custody basis), **and**
	• spent at least one night or day (more than 8 hours) in that residence while case was infectious
	• includes shared houses and flats, travellers in shared holiday accommodation (e.g., hotel room or campervan)
	• don't normally reside with the case but have spent a night together in the same room
		• Recommended to test with a RAT each day for 5 days, from the day that the first case in the household tests positive
		• Wear a mask outside home for duration of testing particularly around vulnerable people (e.g., elderly or immunocompromised), on public transport or in crowded indoor places
		• Continue with daily life provided no symptoms and a negative RAT result each day for 5 days
		• If symptomatic, recommended to continue with daily tests up to 5 days and if all tests negative no need for further tests; stay at home until recovered (for a maximum of 10 days)
		• Avoid or minimise contact with the case(s) in the household as much as possible whilst they are isolating
		
		• If final daily test is negative, but **newly** symptomatic, recommend daily RATs continue until symptoms resolve **or** up to a maximum of a **further 5 days**. Stay at home until recovered (for a maximum of 10 days)
		• If any RAT result is positive, recommend at least 5 days self-isolation as a case (from date symptoms developed or date of test if asymptomatic, whichever comes first)
		• If a positive case enters a household partway through the case's isolation period (e.g., student returning from hostel to home, or shared care situations), the new household contacts should test for 5 days **from the date of entry** of the case (5 days from exposure)
		• Daily testing **does not** restart if additional members of the household are identified as cases within the initial case's isolation period
		• If a new case is identified in the household:
		  ▪ ≤10 days of the initial case being released from isolation: other household contacts **do not** need to test daily for 5 days. If symptoms develop, stay home and test. If test is negative, recommend RATs continue daily until symptoms resolve **or** up to a maximum of a **further** 5 days. Stay at home until 24 hours after symptoms resolve
		  ▪ >10 days after the initial case was released from isolation: other household contacts (except those who became cases) **do** need to test daily for 5 days	

	Cases with an onset of COVID-19 infection within the last **28 days**, are not considered household contacts and are not recommended to test. If **≥29 days** since the onset of COVID-19 infection and someone in household tests positive, daily testing for 5 days as a household contact is recommended.		
	All other close contacts: • live in same group accommodation with case[1] • had contact with case during their infectious period	• Known contacts notified directly by the case, their workplace or education settings • Self-monitor for symptoms for 10 days • If symptoms develop at any time during the 10 days, stay at home and recommend test with a RAT immediately. If test is negative, recommend RATs continue daily until symptoms resolve **or** up to a maximum of 5 days. Stay at home until 24 hours after symptoms resolve	• None
Case	Confirmed case if PCR or RAT in healthcare setting or Probable case if self-reported RAT	• PCR or RAT positive; upload RAT result to My Covid Record (or call the helpline at 0800 222 478 and choose option 1); • Notified by text message if positive. • Complete online contact tracing form, if possible • Day 0 is when symptoms developed or date of test if asymptomatic, whichever comes first • Recommended to self-isolate at home for a minimum of 5 days. • If needing to leave home during 5 day isolation period, take precautions to prevent transmission. Wear a mask whenever leaving the house. Should not visit a healthcare facility (except to access medical care), an aged residential care facility, or have contact with anyone at risk of getting seriously unwell with COVID-19. Avoid contact with other household members if possible during isolation; wear mask and physical distance in shared spaces • If still symptomatic after 5 days, recommended to stay home until recovered (for a maximum of 10 days). • Additional RATs are not required after testing positive. If concerned may still be infectious after isolating for 5 days, then testing negative with a RAT provides a good indication that unlikely to be infectious. • If symptoms resolved and feel well, can return to normal activities. Recommended to wear a mask if visiting a healthcare facility or an aged residential care facility, or if in contact with anyone at risk of getting seriously unwell with COVID-19 up until 10 days after symptoms started or positive test.	• Facilitate access to antiviral therapeutics • Support management of outbreaks in residential settings as required
	If ≤28 days following onset of infection, no further self-testing for COVID-19 is recommended. If ≥29 days since previous infection take a RAT if new COVID-19 like symptoms develop or if identified as a household contact. Reinfection is unlikely but possible with new variants. If RAT is positive, follow usual advice for cases. If RAT is negative but symptoms persist, repeat RAT 48 hours later. If RAT is negative, not a new case; stay at home until 24 hours after symptoms resolve.		

[1] e.g. halls of residences, boarding houses, hostels, backpackers, transitional housing or similar

Appendix 2: Te Whatu Ora contact risk assessment table (15 August 2023)

Contact risk assessment

The following table should be used to guide assessment and management of contacts exposed during a case's infectious period. The infectious period starts two days before their symptom onset or the date they were tested (if they have no symptoms) and finishes once they have completed their isolation.
The following table is **NOT** for:

- household contacts - are defined and managed as per page 1
- contacts who work in healthcare - refer to **Guidance for return to work for healthcare workers**

NOTE: An individual public health risk assessment should be carried out for contacts in residential facilities including aged care, correctional centres or other settings where cases and contacts interact frequently with people at high risk of severe illness.

	Type of interaction	Examples	Face covering worn by case[2]	
			Yes[3]	No or unknown
Close range contact (within 1.5m of case)	Direct contact with respiratory secretions or saliva (indoors or outdoors) **OR** Face to face contact with a case who is forcefully expelling air/secretions **FOR ANY DURATION OF TIME REGARDLESS OF FACE COVERING USE**	Singing, shouting, coughing, sneezing Active play in close proximity (heavy breathing related to exertion) Kissing, spitting, hongi, sharing cigarettes or vapes	**Close contact**	**Close contact**
	Indoor face to face contact for more than **15 minutes**	Having a conversation, sitting across a table from someone, eating together, playing together	**Not a contact**	**Close contact**
	Non-face to face contact for more than **1 hour** in an indoor space	Sitting or playing near someone	**Not a contact**	**Close contact**
Higher risk indoor contact (more than 1.5m away from case and no close-range contact)	Indoor contact in a small space without good airflow/ventilation* for more than **15 minutes**	Small offices, toilet blocks Close contact businesses such as hairdressers Buses, trains, taxis School classrooms, restaurants, cafes, bars	**Not a contact**	**Close contact**
	Indoor contact in a moderate sized space without good airflow/ventilation for more than **1 hour**	Bars and pubs, Social gatherings, church sessions Indoor, high intensity sports, Gyms and indoor recreation settings	**Not a contact**	**Close contact**
Low risk contact (no close-range contact or higher risk indoor contact)	Large indoor settings (bigger than 300m^2) if none of the criteria above are present	School and community halls, exhibition centres, hardware stores, supermarkets	**Not a contact**	**Not a contact**
	Smaller indoor venues (less than 300m^2) with good air flow-ventilation for up to 2 hours	Well ventilated rooms/offices (e.g., windows open)		
	Brief indoor contact regardless of distance from case	Conversations <15 mins Passing each other in the corridor, sharing an elevator Collecting takeaways, click & collect services	**Not a contact**	**Not a contact**
	Contact in outdoor spaces **FOR ANY DURATION OF TIME**	Most outdoor recreation activities, including outdoor dining Non-contact outdoor sports, petrol station forecourts		
*Good air flow and ventilation is required to prevent virus particles accumulating in an indoor space. Good ventilation/airflow can be achieved by keeping windows open.				

[2] For masks to be effective, it is important they are of sufficient quality (medical or multilayer cloth masks) are worn. Mask breaks are recommended to improve compliance over a workday. Masks should be changed if they become wet or dirty.

[3] Consistent use of a mask by a case will minimise the likelihood that other people are close contacts. Short time periods without wearing a mask (less than 15 minutes) will not change the categorisation of other contacts in the same space, unless the case was coughing, sneezing or shouting at the time.

16. Document Control

Protocol review task	Responsibility	Date completed
Advise team of review (and planned timeframes).	PHS	24/01/20
Document owner to commence a new draft directly into a new EDMS version.	PHS	24/01/20
Review Ministry of Health (MoH) advice, literature, other protocols, and write draft update.	PHS	25/01/20
Update Fact Sheet (or source link from Manatū Hauora | Ministry of Health website).	PHS	n/a
Send drafts to MOsH, CD, Team Leader, and HPO for feedback.	PHS	25/01/20
Update drafts further as required.	PHS	n/a
Send final drafts to Com Dis MOH.	PHS	n/a
Com Dis MOH sign-off.	Com Dis MOH	25/01/20
Send final drafts to Clinical Director for approval.	Com Dis MOH	25/01/20
Clinical Director approval (via EDMS authorisation workflow task).	CD	V1, 25/01/20
Complete **electronic** document control tasks incl. header; footer; EMDS metadata. Check Te Mana Ora P&P site page links work. Create .pdfs (for external links), and save to: • Protocols – Y:\CFS\Quality\Archive\Protection\IntranetPROTOCOLS • Fact Sheets – Y:\CFS\Quality\Archive\Protection\FactSheets Above folders are checked once a week and new documents are uploaded to: • Protocols – Surveillance (PHU server) website and MS Teams on-call documentation group • Fact Sheets – CPH (Te Mana Ora) website or links are checked to MoH website.	QC	V46, 20/10/2023
Update **paper** copies (on-call folder/ vehicle).	HPO	n/a
Advise operational/ regional staff of update, summarising any substantial changes (text highlighted in blue in document).	QC	V46, 20/10/2023
When new information is required to be added, the document owner opens the current EDMS version and commences editing. A review workflow may be used for major updates.	PHS	ongoing
Updates v1-v28: a variety of updates reflecting latest Ministry advice.	PHS/ CD	V1, 06/04/20 – V28, 27/08/21
Minor update v29: added information about Delta variant. Removed previous Appendix 5 with now outdated "weak positive" scenarios. Added links to Auckland outbreak documentation.	PHS/CD	V29, 16/09/21
Major update v30: new information from CDNA guidelines. Extensive new advice on case and contact management from Ministry in response to Auckland-centred outbreak. Added section on outbreak/cluster management. Removed some detailed advice no longer considered relevant.	PHS/CD	V30, 16/11/21
Minor update v31: further updates to Ministry Rainbow chart. Added Ministry advice re hospitalised patients and persistent symptoms. Reorganised Case Management section. Included ARPHS advice on recovered cases. New appendix with key details summary. Further reduction in other detail.	PHS/CD	V31, 22/11/21
Major update v32: extensive changes to MoH advice, plus Omicron information.	PHS/CD	V32, 24/12/21
Minor update v33: corrected error in p25 version of Table 1. No change to "blue" colouring.	PHS/CD	V33, 10/01/22
Minor update v34: wide-ranging updates for Omicron.	PHS/CD	V34, 26/01/22
Major update v35: wide-ranging updates for Omicron Phase 2.	PHS	V35 21/02/22
Major update v36: wide-ranging updates for Omicron Phase 3.	PHS	V36, 24/02/22
Major update v37: wide-ranging updates for Omicron Phase 3.	PHS	V37, 10/03/22
Minor update v38: amended Order, changes in isolation period, discrepancy between legal and website isolation requirements noted.	PHS	V38, 14/03/22
Minor update v39: updated Ministry POL-002 tables, Ministry clarification re post-COVID vaccination and post-COVID testing, re-isolation of household members after further household cases, information about long COVID.	PHS	V39, 18/03/22
Minor update v40: updated advice about post-COVID-19 booster vaccination delay, updated MoH deaths reporting protocol, removed advice for cases and contacts to avoid high-risk settings until Day 10, new Appendix 4 with MoH end-to-end process, MoH reinfection guidance added, updated advice for clearance from isolation of hospitalised case.	PHS	V40, 13/05/22
Minor update v41: updated "rainbow diagram", links to new CPH and MoH deaths reporting procedures, rearranged case classification and removed reference to Higher Index of Suspicion cases (finally), as per MoH website changes; MoH clarification about close contact definition for internal travellers.	PHS	V41, 26/05/22
Minor update v42: updated "rainbow diagrams" and references to guidance on testing for possible COVID-19 reinfection. Updates in "The illness" section to reflect CDNA guidelines June update. Added PHU "discretion" to follow up exposure events.	PHS	V42, 29/07/22
Major update v43: removal of traffic light framework and contact quarantine requirements.	PHS	V 43, 22/07/22
Minor update v44: October changes noted in legislation section.	PHS	V44, 25/11/22
Minor update notes v45: added Pacific Relationships Manager into Cultural and Context section.	QC	V45, 16/02/2023
Major update v46: update on Reach, MSD COVID-19 line and the HUB services. Update of legal requirements for case isolation – no longer any mandatory isolation requirements. Updates includes updated "rainbow diagrams". Updated case definitions to reflect the Communicable Disease Control manual (NZ) COVID-19 chapter.	PHS	V46, 20/10/2023