

ADDENDUM 1: COVID-19

ADDENDUM TO THE POLICY: SUSPECTED OR CONFIRMED NOVEL RESPIRATORY VIRUS: MANAGEMENT OF A PATIENT

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1. BACKGROUND

Coronaviruses are a large group of viruses that are common amongst animals. In rare cases these viruses can be transmitted from animals to humans to cause zoonotic diseases. The viruses usually cause mild to moderate upper respiratory tract illness, similar to a common cold, but may also cause serious infections or complications. SARS-CoV-2, a novel coronavirus, likely originating from a bat, with undefined intermediate animal host, has recently been discovered in humans. Person to person transmission is rapid causing large community outbreaks across the globe. The virus infects and locally colonises the human nasopharynx and upper respiratory tract, later affecting the lower respiratory tract leading to pneumonia, respiratory failure and sometimes death (variable case fatality rates reported 1-5%). The disease caused by this virus is called coronavirus disease (COVID-19).

The median incubation period for COVID-19 is estimated to be 4-5 days with an interquartile range of 2-7 days. Based on patients' viral shedding patterns and on epidemiological modelling, patients appear to be infectious for 2-3 days prior to the onset of symptoms, and the transmission of pre-symptomatic infections may be substantial. The basic reproductive number for the virus is approximately 2.2 (meaning that on average each person spread the infection to two others).

The purpose of this document is to provide guidance to healthcare facilities and healthcare workers based on the recommendations from the World Health Organization (WHO) and the National Institute for Communicable Diseases (NICD). These guidelines may change as more information becomes known about the disease.

2. TRANSMISSION

The virus infects and locally colonises the human nasopharynx and upper respiratory tract, later affecting the lower respiratory tract leading to pneumonia, respiratory failure and sometimes death (variable case fatality rates reported 1-5%), depending on the severity of the disease. The majority of infections are mild to moderate, not requiring hospitalisation.

There are two known routes of transmission (WHO recommendations¹)

- **Droplet route:** Via **respiratory droplets** produced via sneezing, coughing or directly inhaled during close contact with the affected person
- **Contact route:** Via respiratory droplets landing on **environmental surfaces** surrounding the infected person (also known as the patient zone and the health zone) which are then transferred through contact with **contaminated hands** to a person's face and mucous (eyes, nose and mouth)

Airborne transmission only takes place during aerosol generating procedures (AGP) when in close proximity.

3. CORONAVIRUS DISEASE (COVID-19)

3.1 CLINICAL PRESENTATION

Eighty one percent of symptomatic patients develop mild disease, an estimated 14% develop severe disease (with hypoxaemia, dyspnoea and tachypnoea) while 5% become critically ill (with respiratory failure, septic shock and/or multiorgan dysfunction). The main clinical signs and symptoms are the following:

- Fever (may or may not be present)
- Cough
- Myalgia, sore throat, nausea, vomiting and diarrhoea (in less than one fifth of patients)
- **Loss of smell and loss of taste**
- Difficulty in breathing (identified in only a few patients)
- Bilateral infiltrates on chest X-rays (Chest CT scans are more sensitive)
- Lymphopaenia may be present.

Atypical manifestations are increasingly being recognised, including large vessel strokes in young patients, unexplained abdominal pain, various dermatological manifestations, and a multisystem inflammatory syndrome in children.

Treatment is supportive. The differential diagnosis is broad. Consider the possibility of influenza (Southern Hemisphere influenza season will begin in May or June), bacterial pneumonia, tuberculosis, Pneumocystis jirovecii (PCP) if immunosuppressed, and manage accordingly.

Patients with underlying illness and the elderly appear to be at increased risk of severe illness.

3.2 CLINICAL CRITERIA FOR A SUSPECTED CASE

It is important to note that the case definition might change as the situation evolves. The latest case definition is available on the NICD website as well as the Mediclinic COVID-19 intranet site:

<https://www.nicd.ac.za/>

Case definition as at 25 May 2020

| Suspected COVID-19 case definition |
|---|
| <p>Any person presenting with an acute respiratory tract infection (≤ 14 days) or other clinical illness compatible with COVID-19, OR</p> <p>an asymptomatic person who is a close contact¹ of a confirmed² case</p> <ul style="list-style-type: none"> ○ Symptoms include ANY of the following respiratory symptoms: ○ Cough ○ Sore throat ○ Shortness of breath ○ Loss of sense of smell (anosmia) ○ Alteration in the sense of taste (dysgeusia) ○ With or without other symptoms (which may include fever, weakness, myalgia, or diarrhoea) <p>Note: Asymptomatic close contacts should not be routinely tested despite meeting the suspected case definition. However, testing may be indicated in certain circumstances (e.g. institutions such as care homes).</p> |

Figure 1: Case definition (NICD Quick Reference Guide 25 May 2020)

¹Close contact:

- A person having had **face-to-face contact (<1 meter)** or been in a **closed space** with a confirmed COVID-19 case for **at least 15 minutes**. This includes, amongst others:
 - All persons living in the same household as a COVID-19 case
 - People working closely in the same environment as a case
 - A healthcare worker or other person providing direct care for a COVID-19 case, while not wearing recommended personal protective equipment (PPE) (e.g. aprons, gowns, gloves, N95 respirator, eye protection)
 - A contact in an aircraft sitting within two seats (in any direction) of the COVID-19 case,
 - Travel companions
 - Persons providing care
 - Crew members serving in the section of the aircraft where the case was seated.

²Confirmed case:

- A person with laboratory confirmation of SARS-CoV-2 infection (using an RT-PCR assay), irrespective of clinical signs and symptoms. **Symptomatic cases are considered infectious from 2 days before symptom onset to 14 days after symptom onset.**

3.3 SPECIMEN COLLECTION AND DIAGNOSIS OF COVID 19

Specimen collection poses a risk of aerosol production. **Airborne precautions in addition to contact and standard precautions** should be implemented (N95 respirator, eye protection, gloves and a gown or apron). Try to limit exposure. It is recommended that the person attending to the patient should collect the specimen. All specimens must be handled as potentially infectious.

Good quality specimens (e.g. containing sufficient cells and secretions), the appropriate packing and transport (e.g. keep the virus viable and detectable) is essential. Ensure specimens are stored correctly, at the right temperature (2-8°C in a cooler box with ice packs) whilst awaiting for transport to the laboratory. Specimens have to be sent as soon as possible.

| Transport time to testing laboratory | |
|--|---|
| <2 days: can use dry swab (no transport medium needed) and can be transported at ambient temperature | >2 days: transport in UTM, preferably at 2-8°C. If UTM is not available, can use normal saline as an alternative. |

Figure 2: Specimen Transport requirements (NICD Clinical Management Guidelines 18 May 2020)

Consult the latest NICD Quick Reference Guide for the procedure on how to collect the specimens:
<https://www.nicd.ac.za/>

SARS-CoV-2 is diagnosed by means of reverse transcriptase polymerase chain reaction (RT-PCR) molecular test. Samples to be sent are:

- Upper respiratory tract samples – nasopharyngeal (preferred) or
- Other swabs that may be sent if a nasopharyngeal swab is not possible are: Oropharyngeal, nasal mid-turbinate or anterior nares
- Lower respiratory tract samples, where available, send sputum, tracheal aspirates, or bronchoalveolar lavage fluid. Lower respiratory tract samples may have a higher sensitivity than upper respiratory tract samples
- **Sputum induction is not recommended**
- **Antibody-based (serological test) are not currently recommended for the diagnosis of acute COVID-19**

A single negative test result, especially if from the upper respiratory tract, does not exclude infection. Repeat sampling and testing using lower respiratory tract specimens is recommended for cases with severe disease or those in whom COVID-19 is strongly suspected, particularly in hospitalised patients.

A number of factors could lead to a false-negative result including:

- Poor sampling technique
- Poor specimen quality

- The sampling site
- The specimen was collected late or very early in the illness (viral loads are usually highest early on in the disease course)
- The specimen was not handled and transported appropriately, e.g. the cold chain of specimens was not properly maintained through the process e.g. from the point of collection up until receipt and processing
- Technical reasons inherent in the test, e.g. virus mutation or PCR inhibition

A single positive PCR test is sufficient proof of COVID-19 infection. There is no indication for repeat “confirmatory” PCR testing on patients who test positive despite the absence of symptoms, as PCR-based tests have excellent specificity, and asymptomatic and presymptomatic COVID-19 patients are now well described.

Antibody-based (serological) tests are not currently recommended for the diagnosis of acute COVID-19. These tests are not sensitive enough early in the disease course (before sufficient antibodies have been produced) and are less specific than PCR-based tests.

When the proportion of the population who have active or resolved COVID-19 is low, antibody-based tests may consequently have a low positive-predictive value (meaning that a substantial proportion of “positive” results may be false positives).

Point of care antigen-based tests are not recommended due to concerns about poor sensitivity and specificity.

3.4 CASE NOTIFICATION

COVID-19 is classified as a **Category 1 notifiable medical condition** under “Respiratory Disease caused by a novel respiratory pathogen” and according to Regulation 1434, Regulations relating to the surveillance and the control of notifiable medical conditions of the National Health Act, 2003 (61 of 2003) and the Mediclinic Corporate Policy: **Notifiable medical condition**

Notification of probable and laboratory confirmed cases should be made immediately using the NMC web portal, mobile app or NMC paper based form.

There are 2 forms which form part of the notification process:

1) The Enhanced COVID-19 Notifiable Medical Conditions (NMC) Notification Form either by:

- Submission of **paper based forms** to be sent via e-mail to the NICD : NMCSurveillanceReport@nicd.ac.za
- **Completion directly on to the NMC app** from a mobile device or via the icon on Mediclinic computer desktops (preferred method)

2) Contact Line List

To be sent to the Provincial Department of Health team (district or provincial communicable disease coordinator) for contact tracing and follow-up.
Consult NICD site for more information: <https://www.nicd.ac.za/nmc-overview/> and documents are also available on the Mediclinic COVID-19 Intranet site.

NOTE: It is no longer a requirement to inform the Mediclinic Corporate Office IPC team of all positive cases.

If a confirmed positive result is obtained from testing which occurred at the NICD/NHLS laboratory, the result must be manually captured on ICNet after receipt of a copy of the result .

3.5 MANAGEMENT OF SUSPECTED AND CONFIRMED CASE

- Separate patients with respiratory symptoms or confirmation of a positive contact with a COVID patient from others, preferably an isolation room if available
- Give the patient a surgical mask (N95 respirators are NOT required or suitable for patients)
- Symptomatic suspected cases should be triaged promptly using standard emergency department triage systems. This facilitates:
 - Rapid initiation of supportive therapy (e.g. supplementary oxygen)

- Recognition of patients who can be allowed home to await results of the COVID-19 testing (see below)
- Protection of both patients and staff
- If admitted, **isolate the suspected case immediately and implement the necessary transmission based precautions in addition to standard precautions**
- Where an individual isolation room is not available, a 2 metre distance should be kept between suspected COVID-19 cases and other patients
- Limit their movement (e.g. use portable X-rays rather than sending the patient to the X-ray department). If they have to be moved, ensure that they wear a surgical mask at all times
- **Manage all suspected cases as if positive, until proven negative**
- A suspected case with severe illness, the treating physician should consider routine laboratory tests as clinically indicated to determine the presence of other potentially primary aetiologies of pneumonia (e.g. *Streptococcus pneumoniae*, *Haemophilus influenzae*, *Mycoplasma pneumoniae*, *Legionella pneumophila*, *Mycobacterium tuberculosis* and respiratory viruses, including influenza and respiratory syncytial virus (RSV)
- Contact the 24 hour NICD Hotline (**082 883 9920**) for clinical management if necessary
- Contact an Infectious Diseases Specialist for the management of severe cases if necessary

Consult the latest NICD guideline: **Clinical Management of suspected or confirmed COVID-19 disease** for the complete clinical management of the patient available on the Mediclinic COVID-19 Intranet site and the NICD website.

Suspected and confirmed cases have to be managed at the hospital where they present as far as possible. There are no dedicated Mediclinic hospitals for the management of confirmed cases and all hospitals should be ready to treat patients with COVID-19.

4. INFECTION PREVENTION AND CONTROL

The prevention of transmission of the virus is based on the **general principles of Infection Prevention and control**.

IPC strategies to prevent or limit transmission in health care settings include the following:

1. Ensure prompt triage, early recognition, and prevent transmission (isolating patients with suspected COVID-19)
2. Applying **standard precautions for all patients**
3. Implement additional transmission based precautions (droplet and contact and, whenever applicable, airborne precautions) for suspected and confirmed cases of COVID-19

NOTE: The Universal use of masks and visors (face shields/eye protection) has been implemented for all healthcare workers in clinical areas

This document will briefly discuss the principles of early recognition and source control, and standard precautions and transmission based precautions. *For more information go to: WHO Infection Prevention and control during health care when COVID-19 is suspected (19 March 2020) [https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-\(ncov\)-infection-is-suspected-20200125](https://www.who.int/publications-detail/infection-prevention-and-control-during-health-care-when-novel-coronavirus-(ncov)-infection-is-suspected-20200125) or DOH COVID-19 Disease: Infection Prevention and Control Guideline V2 (21st May 2020)*

4.1 EARLY RECOGNITION AND PREVENTION OF TRANSMISSION

- Clinicians should have a high level of suspicion and actively screen patients for COVID-19 infection. See the latest NICD guideline: **Clinical Management of suspected or confirmed COVID-19 disease for the complete clinical management of the patient**. The latest guidelines are available on the Mediclinic Intranet COVID-19 site as well as on the NICD website
- Ensure access control and early triage at the entrance to the facility available on the Mediclinic Intranet COVID-19 site. **Refer to MCSA Hospital access control policy**
- Ensure all coughing patients receive a surgical mask and separate patients who are suspected of having COVID-19
- Screening and testing of patients should occur according to the case definition

- Specimen collection should occur according to recommended guidelines and the appropriate documentation should be submitted with the specimen to the laboratory (**Refer to: Specimen collection procedure in Addendum 2, available on the the Mediclinic COVID-19 Intranet site**).

4.2 STANDARD PRECAUTIONS

SARS-CoV-2 is an enveloped virus which makes it fragile and vulnerable to heat, chemicals and ultraviolet sunlight. Therefore standard precautions are one of the main principles of preventing transmission in addition to the necessary transmission based precautions to protect the mucous membranes.

The following standard precautions have been highlighted due to its importance to prevent the transmission of SARS-CoV-2:

- **Hand hygiene**
 - Perform hand hygiene according to the 5 Moments of Hand Hygiene and **Mediclinic Corporate Policy: Hand Hygiene: MCSA.C.IPC.1.6** <http://intranet/sites/Policies/Records/Hand%20Hygiene.pdf>
 - Always perform hand hygiene before donning PPE and after removal thereof
 - Do not move between patients without changing gloves between patients
 - Do not wear gloves if not performing clinical tasks on patients
 - **Do not write in clinical notes with contaminated gloves**
 - Never spray gloves with alcohol handrub. It degrades the nitrile and increases the risk of contamination of the hands
 - **Contaminated gloves can transmit the virus and pose a bigger risk than not wearing gloves and performing hand hygiene when indicated**
- **Environmental cleaning**
 - Ensure that the environment is cleaned and disinfected meticulously according to the **Mediclinic Corporate policy: Cleaning and Disinfection: Bed and Patient Environment: MCSA.C.IPC.1.5** <http://intranet/sites/Policies/Records/Cleaning%20and%20Disinfection%20Bed%20and%20Patient%20Environment.pdf>
 - SARS-CoV-2 can remain on certain surfaces (such as plastic and stainless steel) for up to 9 days. Therefore, cleaning of the environment is paramount
 - **Increase the frequency of routine cleaning rounds to 3 times per day, with additional cleaning of frequently touched areas**, especially in dedicated COVID wards. Refer to the IPC Memo (22 May 2020) <http://intranet/communities/ClinicalServices/IPC/Guidelines/COVID-19%20IPC%20Update%2022%20May%202020.pdf>
 - Ensure that shared areas and equipment is cleaned frequently (keyboards, telephones, photostat machine keypads, tables and chairs in tearooms)
 - Ensure that terminal cleaning occurs upon discharge
 - When there is an increase of cases in a specific unit or area, ensure that the unit is “deep cleaned” and consider the additional use of **hydrogen peroxide** fogging to the cleaning process as an additional measure
 - Mediclinic only endorses fogging with hydrogen peroxide and no other chemical
 - Fogging has to be done in an empty room, without any staff or patients being present
 - Document cleaning processes and ensure that a certificate/proof of fogging process is obtained after the fogging
 - Ensure that cleaning verification audits are performed, documented and captured
- **Equipment**
 - **Do not share equipment as far as possible and ensure dedicated equipment for (isolated) patients wherever possible**
 - If equipment is shared, ensure that it is adequately cleaned and disinfected after use: **Mediclinic Corporate policy: Disinfectant Guidelines.: MCSA.C.IPC.1.5** <http://intranet/sites/Policies/Records/Disinfection%20Guidelines.pdf>
 - **Ensure that all equipment used in the room is cleaned and disinfected** as part of terminal cleaning upon discharge of the patient
 - **Ensure that the green “cleaned after use” sticker (CL0425) is used on all equipment that has been cleaned and disinfected.**

- Ensure that all electronic equipment is cleaned according to the manufacturer's guidelines and included in the routine cleaning schedule
- **Linen Management**
 - Linen should be handled as infectious linen according to the Mediclinic Corporate policy: Handling of used, dirty and contaminated linen: MCSA.C.IPC.1.5
<http://intranet/sites/Policies/Records/Handling%20of%20used%20dirty%20and%20contaminated%20linen.pdf>
- **Movement**
 - **Limit the number of healthcare workers, family and visitors in contact with the patient with suspected or confirmed infection**
 - Prevent healthcare workers (as far as possible) from working between different departments and wards, at least on one shift and restrict any movement that is not essential
 - Allied healthcare workers that attend to patients in multiple units should ideally move from green to orange to red zones and adhere to required IPC principles at all times, including stringent cleaning and disinfection of any equipment that has to be moved between units
 - **Limit movement of patients within the hospital unless essential** and then notify and plan with the receiving department
 - Whenever patients leave their rooms, masks have to be worn
 - If more than one patient is in a room, all patients have to wear masks continuously
- **Additional precautions to be taken during aerosol-generating procedures**
 - Perform procedures in an adequately ventilated room.
 - Ensure that a healthcare worker has received fit testing or **at least seal check training** prior to donning of N95 respirators
 - There are a wide variety of respirators available that staff can choose from. See "**Masks and Respirator Management**" 1 July 2020:
<http://intranet/communities/ClinicalServices/IPC/Guidelines/COVID-19%20Update%201%20July%202020%20Mask%20and%20respirator%20management.pdf>
 - Minimising respirator face-seal leakage to fully protect the healthcare worker from exposure to aerosolised infectious droplets when using N95 respirators
 - Eye protection (goggles/face shield) to protect the eyes from respiratory splash or spray
 - Contact precautions (non-sterile long-sleeved gown and gloves)
- **Social distancing**
 - Maintain a distance from other people of 1.5 - 2 meter. SARS-Cov-2 droplets are heavy and do not normally travel more than 1 meter.
 - Ensure that social distancing is maintained **in tearooms and during hand over**
 - **Create awareness of maintaining safe practices outside the hospital**
 - Avoid large crowds, social gatherings and any unnecessary travel or contact outside the hospital
 - Wear visors, especially in areas where social distancing is problematic. Refer to document: **Rationale for the universal use of face shields/visors, 1 July 2020:**
<http://intranet/communities/ClinicalServices/IPC/Guidelines/COVID-19%20Update%201%20July%202020%20Universal%20Face%20shields%20V2.pdf>

4.3 TRANSMISSION-BASED PRECAUTIONS

- Standard Precautions have to be applied at all times
- Implement specific transmission-based precautions in addition to Standard Precautions for all patient contact
- Contact precautions (disposable gown or apron and gloves)
- Droplet precautions (surgical mask and eye protection)
- Airborne precautions (well-fitting N95 respirator, eye protection) for collection of NP & OP swabs and when aerosol-generating and invasive procedures, such as tracheal intubation, non-invasive ventilation, tracheostomy, cardiopulmonary resuscitation, manual ventilation before intubation and bronchoscopy, are performed
- **Limit movement of patients** (e.g. use designated portable X-ray equipment)

As new evidence becomes available, the PPE guidelines will be adapted.

Corporate Policy: Isolation - Standard and Transmission based precautions: MCSA.C.IPC.2.1

<http://intranet/sites/Policies/Records/Isolation,%20standard%20and%20transmission%20based%20precautions.pdf>

4.4 PERSONAL PROTECTIVE EQUIPMENT (PPE)

The selection of PPE is determined by the route of transmission, interventions which may result in aerosols being produced and the risk of exposure to body fluids and aerosols.

All patients with any upper respiratory tract infection symptoms (coughing/sneezing/sore throat) must be advised to don a surgical mask while they wait and attempts made to limit waiting times in general areas.

Face shield should be worn by all staff to:

- Protect the mucous membranes of the eye
- Prevent people from touching their masks
- To add an additional layer or protection, especially in areas where social distancing is problematic due to space constraints.

Refer to: **Rationale for the universal use of face shields/visors**, 1 July 2020

<http://intranet/communities/ClinicalServices/IPC/Guidelines/COVID-19%20Update%201%20July%202020%20Universal%20Face%20shields%20V2.pdf>

All patients and staff have to wear masks continuously. See **“Masks and Respirator Management”** 1 July 2020 for the types of masks/respirators that should be worn by staff:

<http://intranet/communities/ClinicalServices/IPC/Guidelines/COVID-19%20Update%201%20July%202020%20Mask%20and%20respirator%20management.pdf>

Table 1 provides recommendations for PPE for certain categories of staff and the selection is based on the risk of possible exposure.

| STAFF CATEGORY | HAND HYGIENE | EYE PROTECTION | N95 *** RESPIRATOR | SURGICAL MASK | APRON | GOWNS (Disposable) | GLOVES (Disposable) |
|--|--------------|----------------|--------------------|--|---|--------------------|---|
| Reception staff | Yes | Yes | | Cloth mask | | | |
| Triage nurse | Yes | Yes | | Yes | | | |
| Healthcare worker* attending to non-COVID-19 patients | Yes | Yes | | Yes | Only if indicated as part of Standard Precautions | | Only if indicated as part of Standard Precautions |
| Healthcare worker* attending to the COVID-19 patient (routine examination) | Yes | Yes | | Yes | Yes | | Yes |
| Healthcare worker* Performing aerosol generating procedures ** and caring for a confirmed case or very ill patient | Yes | Yes | Yes | | Yes (if gown is not available) | Yes | Yes |
| Housekeeping staff | Yes | Yes | | Yes | Yes | | Yes |
| Porter | Yes | Yes | | Yes (only if the patient does not wear a mask) | | | |
| Security officer | Yes | Yes | | Cloth Mask | | | |
| Staff transporting specimens | Yes | | | | | | |
| Pharmacy | Yes | Yes | | Yes | | | |

*Healthcare worker: In this context refers to nurses and medical practitioners.

**Aerosol generating procedures: Refers to specimen collection, intubation, suctioning, etc. tracheal intubation, non-invasive ventilation, tracheostomy, cardiopulmonary resuscitation, manual ventilation before intubation and bronchoscopy

***N95 respirators can be used for one shift by the same healthcare worker if not contaminated or wet and if stored correctly. If there is however a risk of contamination, discard the N95 respirator after use.

WHO Rational use of personal protective equipment (PPE) for coronavirus disease 19 March 2020 (COVID-19) https://apps.who.int/iris/bitstream/handle/10665/331498/WHO-2019-nCoV-IPCPPE_use-2020.2-eng.pdf

5. MANAGEMENT OF EXPOSED HEALTHCARE WORKERS / CONTACTS

It is a requirement of the Department of Health that healthcare workers that have been in contact with confirmed COVID-19 cases must be followed up and monitored. The Department of Health (district or provincial) will follow up on the household and community contacts and Mediclinic Southern Africa will follow up affiliated employees and allied healthcare workers.

Any person who has had close contact with a confirmed case **2 days prior to a positive result or symptom onset until 14 days since onset of the symptoms of a case** should be carefully monitored for the appearance of respiratory symptoms (WHO Contact tracing).

A close contact in a healthcare setting is defined as:

- A person having had **face-to-face contact (≤ 1 meter)** or who was in a **closed space** with a confirmed COVID-19 case **for at least 15 minutes**. This includes, amongst others:
 - People working closely in the same environment as a confirmed case
 - All persons living in the same household as a confirmed case
 - A healthcare worker or other person providing **direct care for a confirmed COVID-19 case**, while **not wearing recommended PPE** (e.g. aprons, gowns, gloves, mask/N95 respirator, eye protection)
 - A healthcare worker or other person providing direct care for a confirmed COVID-19 case, while wearing recommended PPE. (Low risk contact)
- The names of all exposed healthcare workers have to be recorded on the “contact line list” accessible on the Mediclinic intranet:
<http://intranet/communities/ClinicalServices/IPC/Guidelines/Forms/CoronaView.aspx>
- High risk contacts have to be monitored for 14 days after **first** exposure as required by the NICD and added to the Mediclinic Healthcare worker (HCW) monitoring application. If high risk HCWs are not responding on the app, they should be followed up telephonically
- Low risk contacts are added on the HCW application, but monitor themselves and do not have to be followed up actively
- **All line managers should do a daily “check in” of staff that are on duty, to ensure that no symptomatic people are at work**
- **Access control should also be monitored on a daily basis and all staff who failed access control should be followed up immediately**
- For further management of exposed healthcare workers, please consult the **Human Resources Guidelines as well as the COVID-19 Contact Monitoring and Follow up documents**

6. QUARANTINE

Quarantine refers to the separation of asymptomatic individuals potentially exposed to COVID-19 from non-exposed individuals.

- Quarantine may be voluntary (e.g. asking contacts to stay at home for 8 days and then be tested to determine early return to work) or involuntary (e.g. using legal powers to enforce quarantine against a person’s will)
- Quarantine will depend on the levels of exposure and might be considered in the following scenarios:
 - If a person comes back from an affected area with ongoing community transmission
 - Exposed healthcare workers not wearing appropriate PPE
 - Asymptomatic contacts
 - Symptomatic persons who have been waiting for test results

7. ISOLATION AND DE-ISOLATION CRITERIA

Patients can be de-isolated 14 days after the onset of their symptoms (mild cases), or 14 days after achieving clinical stability (moderate-severe cases), providing the fever has resolved and their symptoms have improved.

Patients who remain asymptomatic after a positive COVID-19 result can also be de-isolated 14 days after their positive test.

Repeat PCR test is not recommended to de-isolate a patient. Patients can remain PCR positive even after they are no longer infectious. A positive PCR test does not equate to an infectious, viable virus.

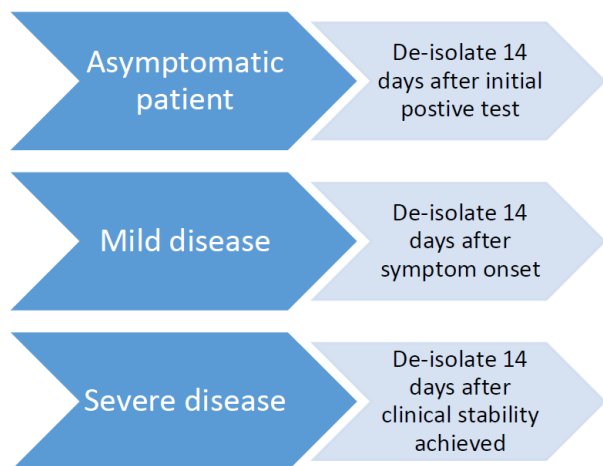


Figure 3: Graphical summary of de-isolation criteria ¹²

See the latest NICD clinical management guidelines for COVID-19: [https://www.nicd.ac.za/Department of Health. Guidelines for quarantine and isolation in relation to COVID-19 exposure and infection. 5 May 2020.](https://www.nicd.ac.za/Department%20of%20Health%20Guidelines%20for%20quarantine%20and%20isolation%20in%20relation%20to%20COVID-19%20exposure%20and%20infection.5%20May%202020)

8. MANAGEMENT OF HEALTHCARE RISK WASTE

The waste generated from a patient with COVID-19 should be managed as any other waste from a patient with an infectious disease or a patient in isolation.

The Mediclinic Corporate policy: Waste: Collection, disposal and removal: MCSA.C.IPC.2.1 refers. http://intranet/sites/Polices/Records/Waste_Collection%20disposal%20and%20removal.pdf as well as the Department of Health COVID-19 Environmental health guidelines. http://intranet/sites/Polices/Records/Waste_Collection%20disposal%20and%20removal.pdf

Some service providers have however currently other requirements.

- Safely disposed of in doubled bagged designated **single use box sets** (50L or 142L)
- At present, single use box sets must be used for waste generated by patients managed as suspected or confirmed “COVID-19” patients and marked as such indicating the date, unit and hospital name in a permanent marker on the external bag covering the box
- The box and outside bag must be secured with tape displaying the biohazard sign
- The sharps container must then be placed in an 80 micron red bag and sealed with a cable tie

9. MANAGEMENT OF THE DECEASED WITH COVID-19

All attempts should be made to confirm the diagnosis in persons who are close contacts who die. Post mortem nasopharyngeal swabs, and if possible, bronchial washings may be taken. Contact and airborne precautions should be implemented. **Refer to the Mediclinic Corporate Policy: Care of the deceased with a communicable disease: MCSA.IPC.C.1.6:**

<http://intranet/sites/Polices/Records/Care%20of%20the%20deceased%20with%20a%20communicable%20disease.pdf> and the **Department of Health COVID-19 Environmental health guidelines** <http://intranet/communities/ClinicalServices/IPC/Guidelines/COVID-19-ENVIRONMENTAL-HEALTH-GUIDELINE-1.pdf>

- Deaths exclusively as a result of suspected or confirmed COVID-19 are NOT unnatural deaths and therefore, do NOT require medicolegal autopsies and should not be referred to Forensic Pathology Service (FPS) mortuaries for medicolegal autopsies
- People that die of unnatural causes with suspected or confirmed COVID-19; however, are still required by law to be referred for medicolegal examination by FPS
- The precautions required for the patient at the time of their demise would remain in place:
- Lines can be removed (as long as no other criteria for unnatural death are relevant)
- The human remains have to be double bagged (requirement in certain provinces and undertakers) and sanitised to ensure safe transportation in line with that of a Biological safety Hazard level 3
- Wipe the outer surface of the body bag with a 1:1000 ppm hypochlorite solution and a cloth to reduce the risk of any possible contamination of the outer surface
- The relevant contracted undertaker should be contacted for the removal of the deceased from the healthcare facility

Note: Deaths resulting from COVID-19 in Namibia will be handled by the state authorities.

10. REPORTS

A COVID-19 dashboard has been developed on SAS for daily updates on the situation in MCSA.

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