COVID-19

Primary Care Update #2

Kat Taylor
John Ferguson
Tony Isaac
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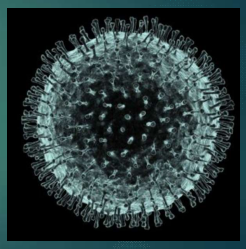
10 March 2020



Latest developments

Coronavirus

What's in a name? A lot apparently:

'COVID-19'

- 'CO' stands for corona
- 'VI' for virus
- 'D' for disease
- '19' for 2019 - the year it was first identified

Source: World Health Organization

The virus is called SARS-CoV-2

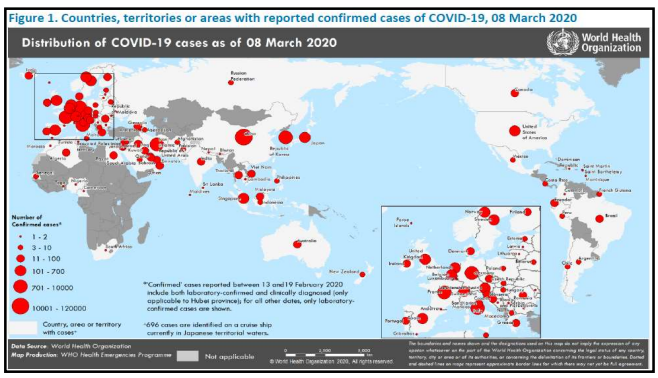
Coronavirus: A Timeline

- Dec 31 — China alerts WHO to several pneumonia cases
- Jan 7 — France confirms Europe's first case
- Jan 11 — China announces first death
- Jan 13 — WHO reports case in Thailand, the first outside China
- Jan 30 — WHO declares outbreak a global health emergency
- Feb 2 — First death outside China recorded in the Philippines
- Feb 7 — Chinese doctor & whistleblower Li Wenliang dies
- Feb 11 — WHO names virus COVID-19
- Feb 14 — Egypt confirms Africa's first case

12 Feb
First Primary Care Update

Late Feb
First community transmission in Sydney

9 March
First HNE case announced



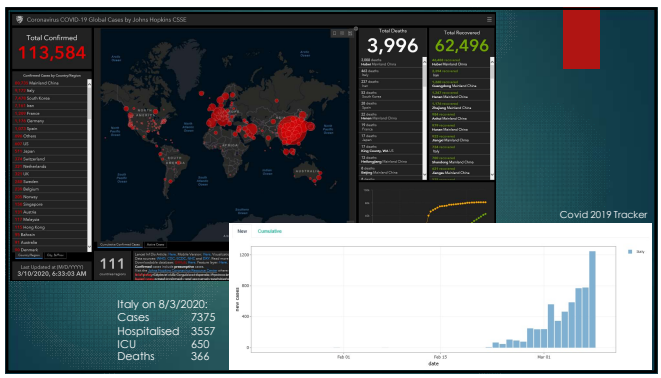


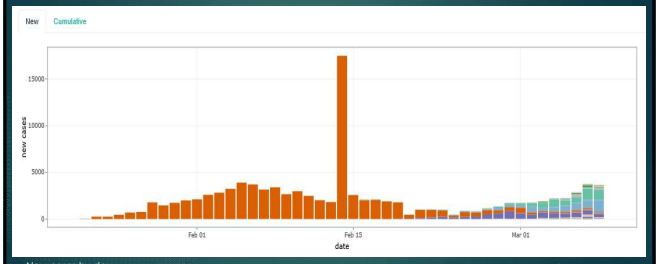
Table 1: Actions for travellers and healthcare workers returning from countries considered to pose a risk of transmission.

Risk	Country	General actions	Action for Hospital and/or Residential/Aged Care facilities*
Higher risk	Mainland China Iran South Korea	Self-quarantine for 14 days	No work for 14 days
Higher risk	Italy	Self-monitor for 14 days Practise social distancing Isolate if unwell	No work for 14 days
Moderate risk	Cambodia Hong Kong Indonesia Japan Singapore Thailand	Self-monitor for 14 days Practise social distancing Isolate if unwell	Can return to work if well

*People working in hospitals or aged/residential care facilities who have patient contact.

Cambodia and Indonesia based on risk not current cases

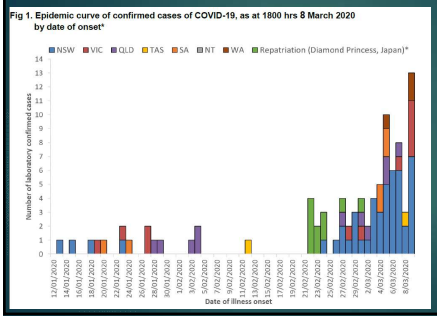
The world v China



New cases by day

Covid 2019 Tracker

Australia



Confirmed cases (10/03/2020 @15:00

Australia 100

NSW 57 (24 no travel)

HNE 1

Total negative tests in NSW: > 8300
HNE: > 530

WHO-China Joint Mission Report - new insights into COVID-19

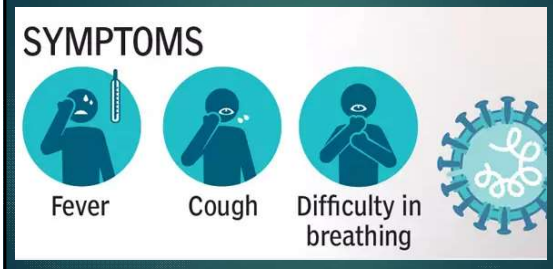
*"The COVID-19 virus is unique among human coronaviruses in its combination of **high transmissibility, substantial fatal outcomes in some high-risk groups, and ability to cause huge societal and economic disruption.***

…. The novel nature, and our continuously evolving understanding, of this coronavirus demands a tremendous agility in our capacity to rapidly adapt and change our readiness and response planning as has been done continually in China"

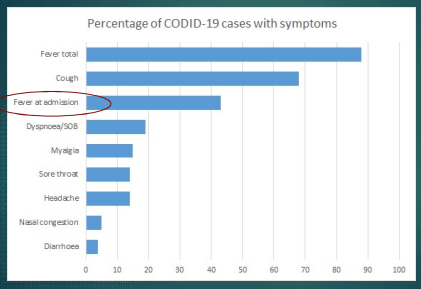
- Team leader Bruce Aylward

WHO-China Joint Mission Report

- Clinical severity
  - 80% Mild to moderate illness (incl some with pneumonia)
  - 14% severe (hospital)
  - 6% critical (ICU)
- Mortality 0.7% overall (outside Hubei, post 1 February)
- High level care (ECMO, ventilators), mortality may be higher outside China
- Most deaths in elderly and with underlying disease: heart, lung, BP, cancer, maybe smoking
- Pregnant women relatively spared
- Children rarely develop disease and not implicated in transmission dynamics
- Extensive community testing outside Hubei, likely not missing a lot of mild disease
- Asymptomatic infection uncommon and not implicated in transmission chains



Clinical features - China



Guan et al
Case series hospitalised patients in mainland China n=1099

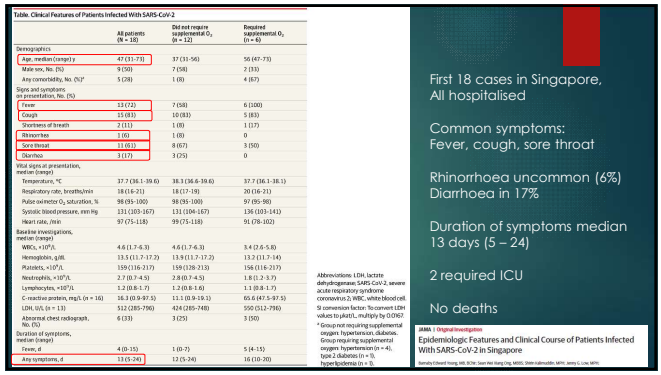


Table. Clinical Features of Patients Infected With SARS-CoV-2

	All patients (N = 18)	Did not require supplemental O_2 (n = 12)	Required supplemental O_2 (n = 6)
Demographics			
Age, median (range) y	47 (31-73)	37 (31-56)	56 (47-73)
Male sex, No. (%)	9 (50)	7 (58)	2 (33)
Any comorbidity, No. (%)*	5 (28)	1 (8)	4 (67)
Signs and symptoms on presentation, No. (%)			
Fever	13 (72)	7 (58)	6 (100)
Cough	15 (83)	10 (83)	5 (83)
Shortness of breath	2 (11)	1 (8)	1 (17)
Rhinorrhea	1 (6)	1 (8)	0
Sore throat	11 (61)	8 (67)	3 (50)
Diarrhea	3 (17)	3 (25)	0
Vital signs at presentation, median (range)			
Temperature, °C	37.7 (36.1-39.6)	38.3 (36.6-39.6)	37.7 (36.1-38.1)
Respiratory rate, breaths/min	18 (16-21)	18 (17-18)	20 (16-21)
Pulse oximetry O_2 saturation, %	98 (95-100)	98 (95-100)	97 (95-98)
Systolic blood pressure, mm Hg	131 (103-167)	131 (104-167)	136 (103-141)
Heart rate, /min	97 (75-118)	99 (75-118)	91 (78-102)
Baseline investigations, median (range)			
WBCs, $\times 10^9$/L	4.6 (1.7-6.3)	4.6 (1.7-6.3)	3.4 (2.6-5.8)
Hemoglobin, g/dL	13.5 (11.7-17.2)	13.9 (11.7-17.2)	13.2 (11.7-14)
Platelets, $\times 10^9$/L	159 (116-217)	159 (128-213)	156 (116-217)
Neutrophils, $\times 10^9$/L	2.7 (0.7-4.5)	2.8 (0.7-4.5)	1.8 (1.2-3.7)
Lymphocytes, $\times 10^9$/L	1.2 (0.8-1.7)	1.2 (0.8-1.6)	1.1 (0.8-1.7)
C-reactive protein, mg/L (n = 16)	16.3 (0.9-97.5)	11.1 (0.9-19.1)	65.6 (47.5-97.5)
LDH, U/L (n = 13)	512 (285-796)	424 (285-748)	550 (512-796)
Abnormal chest radiograph, No. (%)	6 (33)	3 (25)	3 (50)
Duration of symptoms, median (range)			
Fever, d	4 (0-15)	1 (0-7)	5 (4-15)
Any symptoms, d	13 (5-24)	13 (5-24)	16 (10-30)

Abbreviations: LDH, lactate dehydrogenase; SARS-CoV-2, severe acute respiratory syndrome coronavirus 2; WBC, white blood cell.
SI conversion factor: To convert LDH values to μkat/L, multiply by 0.0167.
* Group not requiring supplemental oxygen: hypertension, diabetes. Group requiring supplemental oxygen: hypertension (n = 4), type 2 diabetes (n = 1), hyperlipidemia (n = 1).

First 18 cases in Singapore, All hospitalised

Common symptoms: Fever, cough, sore throat

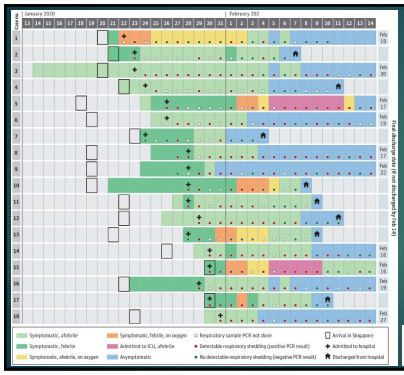
Rhinorrhoea uncommon (6%) Diarrhoea in 17%

Duration of symptoms median 13 days (5 – 24)

2 required ICU

No deaths

JAMA | Original Investigation
Epidemiologic Features and Clinical Course of Patients Infected With SARS-CoV-2 in Singapore



Many afebrile at presentation

Admitted 10 days to 30+ days

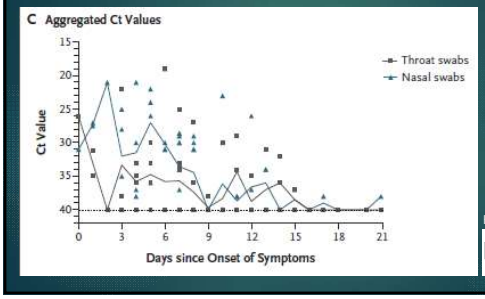
Viral detection (by PCR) persisted for a median 12 days (1 – 24d)

Viral load peaked within the first few days of onset – infectious early

No HCWs infected

JAMA | Original Investigation
Epidemiologic Features and Clinical Course of Patients Infected With SARS-CoV-2 in Singapore

Viral load



Chinese case series

High viral load early

Nose > throat early

Feb 2020

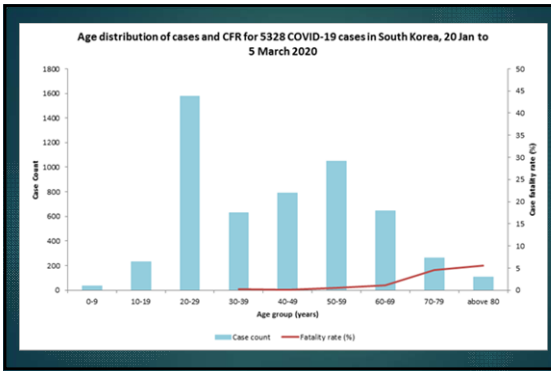
CORRESPONDENCE
SARS-CoV-2 Viral Load in Upper Respiratory Specimens of Infected Patients

Typical clinical course – 3 patterns

1. Mild URTI

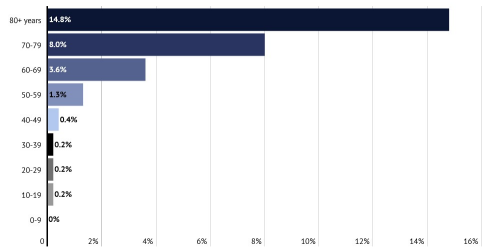
2. Viral Pneumonia. Potential for rapid progression to death in those with comorbidities

3. Mild progressing to severe pneumonia / ARDS after 7+ days. Deaths due to ARDS potentially delayed 2 – 4 weeks after onset



The risk of dying if infected with COVID-19 (by age group)

Based on more than 72,000 cases in China until February 11



*Source: Chinese Center for Disease Control paper released on February, based on **72,314 confirmed, suspected and asymptomatic cases** of COVID-19 in China, published in the Chinese Journal of Epidemiology.*

Transmission pathways – droplet and contact

*COVID-19 is transmitted via **droplets and fomites** during **close unprotected contact** between an infector and infectee.*

*(people who shared the same household as someone with COVID-19 (in the Province of Guangdong) had **3–10%** chance of being infected)*

***Airborne** spread has not been reported for COVID-19 and it is not believed to be a major driver of transmission based on available evidence;*

*The **faecal-oral** route does not appear to be a driver of COVID-19 transmission; its role and significance for COVID-19 remains to be determined*

WHO-China Joint Mission Report

"But lots of people die with flu" - How does COVID-19 compare?

"But lots of people die with flu" - How does COVID-19 compare?

- Completely different disease
- No prior immunity
- COVID-19 :
  - More severe outcomes than influenza
  - Different Transmissibility. Higher Ro (~2.5) but longer incubation period (serial interval ~7 days). Provides an opportunity for public health action
  - Children appear not to feature in transmission
  - Pregnant women appear not to be at higher risk

"But lots of people die with flu" - How does COVID-19 compare?

Pathogen	Population AR%	Case Fatality Ratio
Seasonal influenza	7 – 10%	Up to 0.1% *
Pandemic H1N1(2009)	10 - 20%	0.01 - 0.1% **
SARS (2003)	Very low	10%
COVID-19	20 - 50%+?	0.7% + ?

*Eg USA last winter – 16,000 deaths, > 100 in children
**Est 150,000 to 575,000 deaths

COVID-19 likely to be at least 10 times worse than a bad flu season

Patient care

- Supportive care
- No established antiviral treatment, RCTs underway
- Vaccine likely 18 months away
- Avoid aerosolisation where possible - no nebulisers

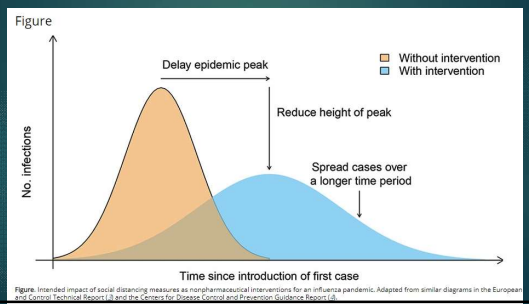
Home management of mild cases

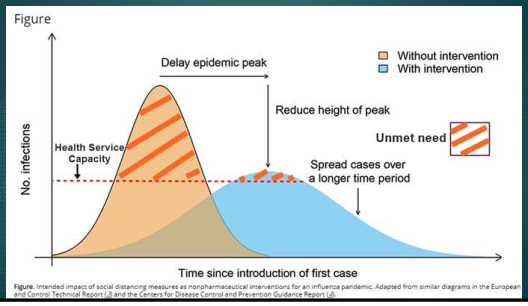
- Strictly remain at home, except for medical review, until cleared
- Daily review by phone (Clinicians / PHU)
- Separate bedroom and bathroom
- Surgical mask on case and carer when in same space
- Increased cleaning of surfaces – at least daily using a fresh clean cloth with detergent (wash hands after cleaning)
- Carer – also quarantined (14 days post clearance), self monitor for symptoms
- Clearance – two negative PCRs following resolution
- More details in the NSW Health Factsheets

Current recommendations

Public Health action plan - containment

1. Identify cases
2. Isolate case to stop transmission
3. Trace contacts
4. Repeat





Who to quarantine (no symptoms)

For 14 days after last potential exposure:

Returned travellers from high risk countries

- Currently mainland China, Iran, South Korea

Close contacts of confirmed COVID-19 cases

Healthcare workers

- Returning from any higher risk country (China, Iran, Sth Korea, Italy)

N.B. Asymptomatic people should not be tested

Who to test (symptomatic)

1. Suspected cases

Also consider testing:

1. Fever or respiratory symptoms in those with international travel in 14 days prior to illness onset
2. Inpatients with pneumonia regardless of travel
3. HCWs with influenza-like illness (fever AND respiratory symptoms)*

N.B. Those tested for COVID-19 must be isolated whilst awaiting results, and if in quarantine must continue to wait out 14 days irrespective of test result

Suspected Case definition

Epidemiological criteria

In 14 days prior to illness onset:

- Travel (incl. transit) to a country considered to pose a risk of transmission
- Close or casual contact with a confirmed case of COVID-19

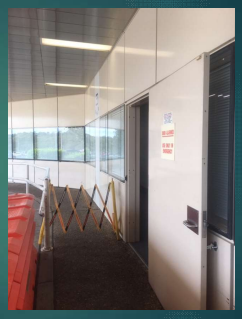
AND

Clinical criteria

- Fever OR
- Acute respiratory symptoms (cough, shortness of breath)

Testing options

- Collect onsite
- Refer to private pathology collection centre
- Fever clinics (JHH from today 0800-2200)
- Refer to ED



Testing

Samples:

- Two combined nose and throat viral swabs OR
- Two nasopharyngeal swabs OR
- Lower respiratory specimen (sputum) if obtainable*

Request:

- Routine respiratory pathogens
- COVID-19 testing

*Less appropriate for collection in primary care setting

Recommended infection control

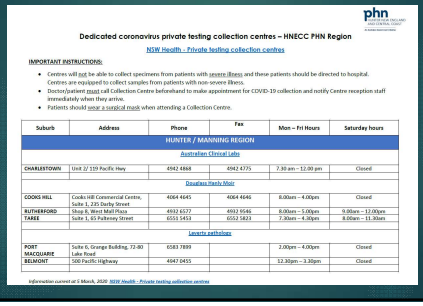
Mildly unwell patient

- Standard, Contact and Droplet precautions
  - Surgical mask, goggles, gloves, (gown?)
  - Wipe contact surfaces, no need to 'rest' the room

Moderate to severely unwell patient (coughing +)

- Standard, Contact and Airborne precautions
  - Referral to Emergency Department

Testing locations



Dedicated coronavirus private testing collection centres – HNECC PHN Region

NSW Health - Private testing collection centres

IMPORTANT INSTRUCTIONS:

- Centres will not be able to collect specimens from patients with severe illness and these patients should be directed to hospital. Centres are equipped to collect samples from patients with non-severe illness.
- Doctor/patient must call Collection Centre beforehand to make appointment for COVID-19 collection and notify Centre reception staff immediately when they arrive.
- Patients should wear a surgical mask when attending a Collection Centre.

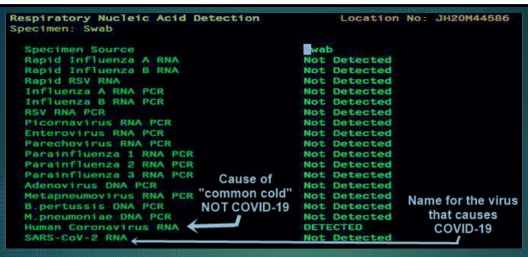
Suburb	Address	Phone	Fax	Mon – Fri Hours	Saturday hours
HUNTER / MANNING REGION					
Australian Clinical Labs					
CHARLESTOWN	Unit 2/ 159 Pacific Hwy	4942 4868	4942 4775	7.30 am – 12.00 pm	Closed
Douglass Hanly Moir					
COOKS HILL	Cooks Hill Commercial Centre, Suite 1, 235 Darby Street	4064 4645	4064 4646	8.00am – 4.00pm	Closed
RUTHERFORD	Shop 8, West Mall Plaza	4932 6577	4932 9646	8.00am – 5.00pm	9.00am – 12.00pm
TAREE	Suite 3, 65 Pulteney Street	6551 5453	6552 5823	7.30am – 4.30pm	8.00am – 11.30am
Laverty pathology					
PORT MACQUARIE	Suite 6, Grange Building, 72-80 Lake Road	6583 7899		2.00pm – 4.00pm	Closed
BELMONT	500 Pacific Highway	4947 0455		12.30pm – 3.30pm	Closed

Information current at 5 March, 2020 NSW Health - Private testing collection centres

Result interpretation

Respiratory Nucleic Acid Detection — Location No: JH20M44586
Specimen: Swab

Specimen Source	Swab
Rapid Influenza A RNA	Not Detected
Rapid Influenza B RNA	Not Detected
Rapid RSV RNA	Not Detected
Influenza A RNA PCR	Not Detected
Influenza B RNA PCR	Not Detected
RSV RNA PCR	Not Detected
Picornavirus RNA PCR	Not Detected
Enterovirus RNA PCR	Not Detected
Parechovirus RNA PCR	Not Detected
Parainfluenza 1 RNA PCR	Not Detected
Parainfluenza 2 RNA PCR	Not Detected
Parainfluenza 3 RNA PCR	Not Detected
Adenovirus DNA PCR	Not Detected
Metapneumovirus RNA PCR	Not Detected
B.pertussis DNA PCR	Not Detected
M.pneumoniae DNA PCR	Not Detected
Human Coronavirus RNA	DETECTED
SARS-CoV-2 RNA	Not Detected



Note that some people who are being tested for COVID-19 may need to remain in isolation even following a negative COVID-19 test
Eg close contacts of confirmed cases or returned travellers from selected high risk countries

PCR test performance

- When virus is present – PCR has high sensitivity and specificity
- NPS PCR likely negative during incubation
- Negative result in asymptomatic patients not helpful
- COVID19 has tropism for upper and lower reparatory tract
  - Lower respiratory tract samples (eg sputum) may have higher yield
  - Some pneumonia patients have had NPS samples negative, sputum positive
  - Clinical suspicion drives further testing

Practice implications when consulting COVID-19 patients

- When would Doctors or staff need to go into quarantine?
- How long off work?
- Resting clinic areas?
- Should I start consulting routinely in PPE?

Melbourne GP clinic closed after doctor tests positive for coronavirus

Updated Sun at 12:05am

A doctor who recently returned from the US and since treated dozens of patients has become Victoria's 11th confirmed coronavirus case, health authorities have said.

State Health Minister Jenny Mikakos said the GP was confirmed to have the virus last night, six days after returning from overseas, and was now recovering at home.

The doctor, from the Toorak Clinic in Malvern Road, consulted about 70 patients between March 2-6, Ms Mikakos said.

PHOTO: The Toorak Clinic has been temporarily closed in the wake of the GP testing positive. (Google Maps)

When to call PHU?

- Confirmed case
- Suspected case in high risk group or priority settings*
- Management challenges (i.e. non-compliance with recommended PH action isolation/ quarantine) for cases or close contacts

*e.g. HCW, institutional settings, Aboriginal or Torres Strait Islander communities, attended mass gathering

- **No need to call for testing enquiries**

COVID-19 – aspects of testing, infection control and treatment

John Ferguson
John Hunter Hospital
University of Newcastle
NSW, Australia
10th March 2020
Primary Care Update #2

Neil Diamond: Hands
CDC: Yes, wash them for at least 20 seconds
Neil Diamond: Touching hands
CDC: No, please don't touch hands
Neil Diamond: Reaching out
CDC: Avoid that too
Neil Diamond: Touching me
CDC: Oh hell
Neil Diamond: TOUCHING YOU
CDC: We're doomed

Testing – RT-PCR- various targets in use

False negatives

Quality and type of specimen affects this parameter.

No systematic evidence available

Some suggestion that lower respiratory samples are better

Re-testing: if high suspicion (international travel history and deteriorating respiratory condition and no other diagnosis), re-test with nasopharyngeal sample

False positives – none reported; however it is possible that the primers for PCR are not entirely specific

- ICPMR (Westmead) has several confirmatory assays including viral sequencing which can provide high specificity


THE LANCET
Infectious Diseases

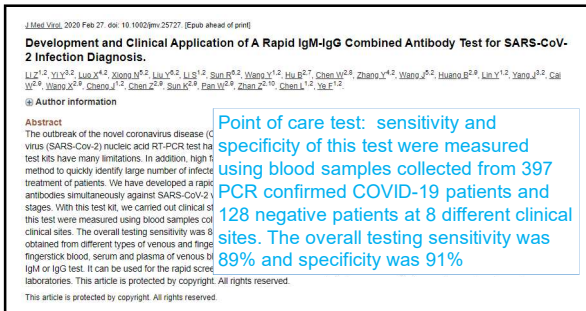
CORRESPONDENCE | ONLINE FIRST

Covert COVID-19 and false-positive dengue serology in Singapore

Gabriel Yan · Chun Kiat Lee · Lawrence T M Lam · Benedict Yan · Ying Kiat Chua · Anita Y N Lim · et al.

Show all authors

Published: March 04, 2020 · DOI: https://doi.org/10.1016/S1473-3099(20)30158-4


J Med Virol. 2020 Feb 27. doi: 10.1002/jmv.25727. [Epub ahead of print]

Development and Clinical Application of A Rapid IgM-IgG Combined Antibody Test for SARS-CoV-2 Infection Diagnosis.

Li Z[1,2], Yi Y[3,2], Luo X[4,2], Xiong N[5,2], Liu Y[6,2], Li S[1,2], Sun R[6,2], Wang Y[1,2], Hu B[2,7], Chen W[2,8], Zhang Y[4,2], Wang J[5,2], Huang B[2,9], Lin Y[1,2], Yang J[3,2], Cai W[2,9], Wang X[2,9], Cheng J[1,2], Chen Z[2,9], Sun K[2,9], Pan W[2,9], Zhan Z[2,10], Chen L[1,2], Ye F[1,2].

Author information

Abstract

The outbreak of the novel coronavirus disease (C virus (SARS-Cov-2) nucleic acid RT-PCR test ha test kits have many limitations. In addition, high f method to quickly identify large number of infecte treatment of patients. We have developed a rapic antibodies simultaneously against SARS-CoV-2 stages. With this test kit, we carried out clinical st this test were measured using blood samples col clinical sites. The overall testing sensitivity was 8 obtained from different types of venous and finge fingerstick blood, serum and plasma of venous b IgM or IgG test. It can be used for the rapid scree laboratories. This article is protected by copyright. All rights reserved.

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Point of care test: sensitivity and specificity of this test were measured using blood samples collected from 397 PCR confirmed COVID-19 patients and 128 negative patients at 8 different clinical sites. The overall testing sensitivity was 89% and specificity was 91%

General practice setting 1: routine consultation process

- Bare below elbows standard
- Routine eye protection (reuse ok – clean with alcohol wipe)
- Hand hygiene (alcohol) before & after interactions (even shaking hands). Apply sufficient and spread over all hand surfaces; allow to dry. 30 second rule.
- Equipment cleaning/disinfection (wipes easiest) before & after
- Sophisticated triage mechanisms to forewarn of respiratory illness

Standard infection control precautions reduce infection spread via the contact route

GP 2: respiratory illness or fever or testing

- CONTACT & DROPLET TRANSMISSION-BASED PRECAUTIONS
  - Additional PPE required - surgical mask, gloves (after hand hygiene), eyewear
  - Gown or plastic apron – technically required for contact precautions – dispense with this only if care taken to avoid contact between own clothing and patient skin or clothes
  - Clean / disinfect chair and touched surfaces post consultation
  - Room does not require spelling

Surgical masks

- Ensure it covers nose and mouth!
- Facial hair – avoid
- Do not reuse
- Don't touch the front of the mask
- Maximum 60 minutes with continuous wearing; discard earlier if becomes very moist
- Care++ with removal to avoid self-contamination
- Hand hygiene (alcohol) after disposal

Environmental cleaning: principles

In general, coronaviruses are unlikely to survive for long once droplets produced by coughing or sneezing dry out.

- Clean general surfaces and fittings when visibly soiled and immediately after any spillage.
- Disinfect after cleaning or follow a dual process with a Therapeutic Goods Administration (TGA) approved product.

Routine environmental cleaning and disinfection

FREQUENTLY TOUCHED SURFACES	MINIMALLY TOUCHED SURFACE
Doorknobs, bedrails, tabletops, light switches	Floors, Ceilings, Walls, Blinds
Should be cleaned more frequently than minimally touched surfaces. Detergent and disinfection solution/wipes (as per manufacturers IFU*) can be used, with the exact choice of product determined by the nature of surface and likely degree of contamination. Detergent and disinfectant - impregnated wipes may be used but should not be used as a replacement for the mechanical cleaning process	Detergent and disinfectant solution/wipes (as per manufacturers IFU* instructions) is adequate for cleaning general surfaces and non-patient care areas. Damp mopping is preferable to dry mopping. Walls and blinds should be cleaned when visibly dusty or soiled. Curtains should be regularly changed in addition to being replaced or cleaned when soiled. Sinks and basins should be cleaned on a regular basis

Adapted from Australian Guidelines for the Prevention and Control of Infection in Healthcare, Canberra: National Health and Medical Research Council (2019). *IFU- Instruction for use

Surgical versus airborne (p2/n95) masks for protection from droplet transmission

JAMA | Original Investigation

N95 Respirators vs Medical Masks for Preventing Influenza Among Health Care Personnel
A Randomized Clinical Trial

Key Points

Question Is the use of N95 respirators or medical masks more effective in preventing influenza infection among outpatient health care personnel in close contact with patients with suspected respiratory illness?

Findings In this pragmatic, cluster randomized clinical trial involving 2862 health care personnel, there was no significant difference in the incidence of laboratory-confirmed influenza among health care personnel with the use of N95 respirators (8.2%) vs medical masks (7.2%).

Meaning As worn by health care personnel in this trial, use of N95 respirators, compared with medical masks, in the outpatient setting resulted in no significant difference in the rates of laboratory-confirmed influenza.

- Staff were 'fit tested' for n95 fit
- Indicates that either mask was equivalent but not fully effective
- Compliance with hand hygiene and other IC precautions not documented
- Indicates that there was no significant airborne spread component detected as N95 not found to be superior (c.f. tuberculosis or measles)

Severe Illness & aerosol generating procedures – avoid !

- Aerosol generating procedures
  - Nebulisation
  - tracheal intubation,
  - non-invasive ventilation,
  - tracheotomy,
  - cardiopulmonary resuscitation,
  - manual ventilation before intubation,
  - bronchoscopy and BAL,
  - high flow nasal oxygen
- Referral to Emergency Department

Standard, Contact and Airborne precautions:

- Fluid resistant long sleeved gown
- Gloves
- Protective eyewear
- P2/N95 respirator or mask
- Place in negative pressure isolation room, door closed (where available)
- Room cleaning and disinfection

General advice to staff (10/3/20)

HNE Health staff are advised to consider:

- No handshaking
- Videoconferencing as default for meetings
- Options and alternatives to large meetings that bring external groups together. If you do have large meetings, then try to use larger rooms where there can be more space between participants
- The necessity of overseas travel
- Sanitisation of high touch surfaces regularly and between uses.
- Limiting food handling and sharing of food in the workplace.

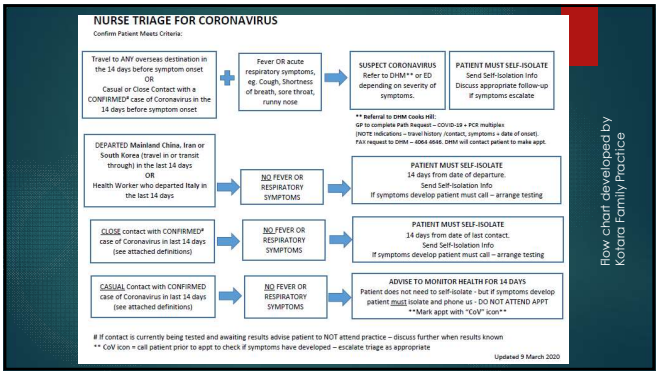
Treatment

- Supportive management
- No conclusive evidence:
  - Steroids
  - Ribavirin IV or PO
  - IVIg
  - Interferon alpha and beta
- Current clinical trials:
  - Remdesivir (GS-5734)
  - Chloroquine
  - Lopinavir-ritonavir (Kaletra)
  - Antibody therapy (passive immunisation)

Questions?

Testing service opens JHH 10/3/20

Clinical scenarios



Scenario 1 – Traveller from China in 14 day quarantine period

Allen returned from China 24/2/20

- Booked appointment for day after quarantine
- Appt marked with COVID icon to flag need for symptoms check
- Patient called prior to appointment to check for symptoms
- No symptoms - patient attended appt as normal

Scenario 2 – Traveller from Bali

Rhonda called to make an appt 3/3/20

- Returned from Bali on 1/3/20
- 2/3/20 developed sore throat but no other symptoms - went to work AM, PM developed fever with night sweats, dry cough, sore throat persisted
- Escalated triage - appropriate for testing
- Testing arranged and request faxed to pathology
- Patient given information re: isolation until results returned
- Medical certificate provided for work
- COVID PCR -ve

Scenario 3 – Traveller from Italy

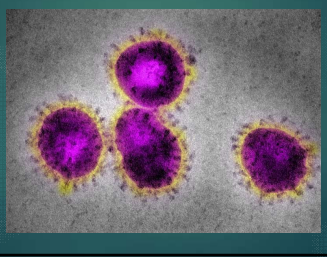
HNE case – GP management

- COVID19 suspected on basis of travel and mild resp symptoms (cough)
- Patient phoned ahead to request test, waited in car park until GP was ready, wore a mask into practice
- First patient of the day, single room, no other patients in waiting room
- GP wore PPE: eye protection, mask and gloves
- Patient had mask on throughout (except for sample time)
- Nasopharyngeal swab collected by GP
- Patient returned to home isolation
- Room surfaces cleaned by staff wearing PPE
- COVID19 positive, managed at home, mild illness doing well
- Practice staff will be alert for symptoms and immediately isolate themselves if become unwell following 14 days (very low risk)
- **No impact on practice operating hours or staff attendance**

Be prepared…

- Workplace stress – look after yourselves and your staff
- Strengthen workplace hygiene practices
- Business continuity and surge planning
- Modified or flexible service delivery
- Triaged waiting areas
- Other strategies?

Panel Q&A



Resources

Hunter New England
Community HealthPathways

- NSW Health Coronavirus resources

https://www.health.nsw.gov.au/Infectious/diseases/Pages/coronavirus.aspx

- CEC Infection Prevention and Control in Primary Care

http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0007/567988/Infection-Control-Primary-and-Community-Care-2019-nCoV.pdf

- Australian Government Coronavirus resources

https://www.health.gov.au/resources/collections/novel-coronavirus-2019-ncov-resources

- WHO COVID-19 research database https://www.who.int/emergencies/diseases/novel-coronavirus-2019/global-research-on-novel-coronavirus-2019-ncov
- ProMED
- HNE Public Health Unit: 1300 066 055 (24 hours, 7 days)

Other questions

- Clearance certificates
- Aged Care Facility preparedness
- Serology
- Immunity
- Travel advice