COVID-19 - SARS CoV-2

Special Precautions/Considerations

Precautions: Contact/Droplet

Reporting

Notifiable: Yes
Reporting: Immediate (as soon as suspected)

Please note that evidence and best practice for the COVID-19 response continues to evolve as new information emerges. This guidance has been updated based on the situation and epidemiology for Nunavut; therefore, it may differ from guidance in other parts of Canada and internationally. **This is version 7.1 of the protocol. Information in this protocol was developed as of March 2021**. Please update your health centre's communication binder with this version of this protocol and ensure to share new versions with anyone recently starting in a role.

Note that this version is specifically 7.1 (to distinguish it from other previous drafts of this version). It is approximately 15 pages long with 10-15 pages of appendices. Updated versions of the protocol will be circulated in the future.

Although the COVID-19 response is requiring considerable resources at this time, we will also need to continue to be mindful of reporting and control of other communicable diseases (including TB and syphilis) as well as other public health work.

Infectious Agent	Coronavirus is a large family of viruses, of which 7 strains infect humans. COVID-19 is an infection from a novel coronavirus (SARS CoV-2) first detected in Wuhan, China in late 2019.[1]
Clinical	
Clinical Presentation	The following is a list of symptoms that may be present in COVID-19 infection. Consider COVID-19 infection in all individuals with the following symptoms, especially when unrelated to other known causes or conditions. Common symptoms include:[2] • Fever • Cough • Shortness of breath (SOB) • Fatigue • Loss of appetite • Loss of smell and/or taste Less frequent: [2] • Sputum production • Muscle aches • Chest pain • Nausea, vomiting, diarrhea • Headache • Dizziness • Sore throat • Runny nose Atypical signs and symptoms (consider in infants, children, elders, and people living with a developmental disability): • Fatigue, lethargy, malaise • Chills • Decreased or lack of appetite • Hypoxia • Difficulty feeding in infants • In elders, presentation may include: delirium, increased number of falls, acute functional decline

	If an individual has respiratory symptoms, consider also testing for pertussis and/or TB as indicated. An **asymptomatic** person is someone with a positive SARS-CoV-2 test on validated testing who never develops symptoms, whereas a **pre-symptomatic** person is someone who has contracted COVID-19 but is not yet showing symptoms. Both of them can transmit the virus to others but it is not clear how frequently this occurs.[1] Vulnerable populations at risk of more severe disease or negative outcomes include older adults (especially over 60 years), those with chronic medical conditions (e.g. heart disease, lung disease, diabetes, hypertension, kidney disease, liver disease, stroke or dementia), those with a compromised immune system (e.g. from a medical condition or treatment), and people living with obesity (BMI of 40 or higher).[2] Individuals potentially more likely to be exposed to COVID-19 virus include those living or working in congregate settings such as rotational worker camps as well as occupations where workers are in close contact with large numbers of people, and those who face barriers that limit their ability to implement or access effective public health measures.[2] A syndrome called Multisystem Inflammatory Syndrome in Children may be linked to COVID-19 in children. It is rare and not well understood; symptoms include persistent fever, stomach pain, vomiting/diarrhea, rash or redness in fingers or toes, SOB/or breathing problems, conjunctivitis (pink eyes) or swollen lips, hands or feet.[2] Please note that this information continues to evolve as we learn more about the virus and will be updated in future versions of the protocol.
Diagnostics	**Follow guidance from the COVID-19 Healthcare Provider Flowchart (Appendix D) to determine eligibility for testing.** Physicians, Nurse Practitioners, and Community Health Nurses (CHNs) may enter the test under current professional standards. All other nurses must refer to the *COVID-19 Laboratory Testing Authority Medical Directive* (policy #07-034-00 in the CHN Manual). For nurses in communities who are uncertain as to whether or not to test please contact the Regional Communicable Disease Coordinator (RCDC). The decision to test can also be communicated by the RCDC, Territorial Communicable Disease Specialist (TCDS), or Public Health Officer (PHO) directly. This guidance may be updated as the situation evolves. **Nasopharyngeal swabs** (e.g. flocked swabs, or FLOQSwab™) should be collected while maintaining DROPLET and CONTACT precautions (see Occupational Health section) and sent in Universal Transport Media (UTM) or Viral Transport Media. (Appendix A *Nasopharyngeal Swab Procedure*). Other swab types may be used with specific collection guidance as communicated by PHO and/or laboratory guidance. The preferred site for specimen collection is the nasopharynx/deep nares; evidence on the use of other sites for testing is being followed closely and any changes will be communicated as required. Please contact your RCDC if questions. Follow regional lab guidance related to storage, handling, and shipment of lab specimens, as guidance may vary between region, testing facilities, and product(s) used. As of Oct 2020, nearly all COVID-19 specimens are tested in-territory, including for confirmatory testing, in Rankin Inlet (Kitikmeot and Kivalliq) or Iqaluit (Qikiqtaaluk). Surge and other testing is still happening in collaboration with partner labs in Alberta, Manitoba, and Ontario (more detailed testing guidance is circulated separately to this protocol). **Lower respiratory samples** (e.g. bronchoalveolar lavage, endotracheal suction, etc.) should only be collected under the guidance of the PHO on-call. Samples are collected

	in sterile containers while adhering to AIRBORNE PRECAUTIONS. Changes to this guidance will continue to be communicated by Memo as guidelines evolve. In general, where feasible and an individual does not require care at a health care setting, the following options for COVID-19 sample collection are listed in order of preference: - Collecting sample at individual's home or isolated unit (preferred). Refer to Appendix B *Home Testing Guidance* - Collecting sample at a health centre or hospital with minimal exposure to the public or vulnerable populations - Collecting sample in a rapid access clinic (RAC) or emergency department setting **Rapid testing:** Two types of COVID-19 rapid testing kits are being used in specific circumstances by the territory as of March 2021 (Abbott IDNow and Abbott Panbio). Specific guidance as required for these will be circulated by the health care / operations laboratory team. Please contact your RCDC if you have questions. **Note: if someone has symptoms of COVID-19 and declines testing, consult with RCDC who will discuss with the TCDS and PHO.**
Treatment	In most cases, treatment of patients with COVID-19 is supportive and focuses on symptom management.[2] For more information on clinical management of patients with COVID-19 see: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/clinical-management-covid-19.html It is possible that some patients will require medevac, which is arranged through the usual regional MD on-call protocols.
Vaccination	The Moderna COVID-19 Vaccine was approved by Health Canada on Dec 23, 2020 for adults and a Vaccination Program was initiated across Nunavut in early January 2021.[1] As of March 2021, over 50% of the adult population in Nunavut has received at least one dose of the COVID-19 vaccine. Approximately 30% of the overall population has received at least one dose of vaccine. Vaccination with Moderna is a 2-dose schedule [1] (Please see *COVID-19 Vaccine Protocol* in the Immunization Manual available here: https://www.gov.nu.ca/health/information/manuals-guidelines for more information.)
Pathogen	
Occurrence	On March 11, 2020 the World Health Organization declared COVID-19 a pandemic.[1] As of March 2021, there have been several outbreaks of COVID-19 identified in Nunavut; for information on COVID-19 case and vaccine counts in the territory see: https://www.gov.nu.ca/health/information/covid-19-novel-coronavirus For rates of COVID-19 cases in Canada see: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html For rates of COVID-19 vaccination in Canada see: https://health-infobase.canada.ca/covid-19/vaccination-coverage/
Reservoir	Human. Possible animal sources of COVID-19 have not been confirmed (see more information below in zoonotic transmission).[2]
Variants	Viruses are always changing and new variants are expected to emerge over time. Sometimes they occur and then disappear, sometimes they stay. There are many variants, sometimes called variants of interest. They become variants of concern (VOC) when the changes have a health care or

	public health significance such as: - Increased transmissibility (ability to spread) - Greater virulence (severity of disease) - Reduced vaccine effectiveness (e.g. the vaccine no longer works as well) - Impacts on diagnostic testing (e.g. tests no longer pick it up as well) This information will change but as of February 2021, VOCs identified globally and in Canada include: - B.1.1.7 variant first identified the UK - B.1.351 variant first identified in South Africa - P.1 variant first identified in Brazil[3] While these variants have not been identified in Nunavut at this time, it is expected they may be over time. There are national processes to assess variants and Nunavut will continue to participate in these process as required.
Transmission (human-to-human)	The virus spreads from a person who is infected to others through droplets created when a person who is infected: • breathes • talks • sings • shouts • coughs • sneezes[2] The droplets vary in size from large droplets that fall to the ground rapidly near the person who is infected, to smaller droplets, sometimes called aerosols, which may linger in the air under some circumstances. Aerosols laden with infectious virus increase the risk of spreading COVID-19, particularly if a person stays within an enclosed indoor space with poor air circulation for a long time.[2] A person may be infectious for 2-3 days before showing symptoms. Most cases of transmission occur in crowded places, close contact settings and/or poorly ventilated spaces. Avoiding, where feasible, what is referred to as the "Three Cs" (closed spaces, crowded places, and close-contact settings) is often discussed. Some have discussed encouraging the "Three Ws" (wear a mask, watch your distance, and wash your hands). While rare and not a main mechanism for spread, it is potentially possible that droplets may also be deposited on objects and spread infection to those touching the surfaces and bringing the virus to their mucous membranes. The amount of time the virus can survive on a surface (fomite) is unknown. Possible fecal-oral transmission has also been suggested. To reduce transmission in health care settings, review infection prevention and control guidance for droplet and contact precautions.[2] For aerosol generating procedures (e.g. intubation, bag-mask ventilation, nebulizer treatment), healthcare providers should follow airborne precautions as per the current guidance – see Policy # 07-037-00 *Community Health Centre Protected Code Blue During the COVID-19 Pandemic* in the CHN Manual.
Transmission (zoonotic)	Transmission from mink to humans has been reported in parts of Europe. The human cases were mink farm workers. Outbreaks in mink have been detected in several countries.[2] At this time, there is no evidence that domestic animals (livestock or pets) are a transmission source. There is evidence that bats, cats, dogs, ferrets, mink, non-human primates, and rabbits may be susceptible to SARS-CoV-2 infection.[2]
Incubation Period	**For public health purposes, an incubation period of 14 days is used.** The incubation period is estimated to range from 1 to 14 days with a median of 5-6 days from exposure to symptom onset. Most individuals (97.5%) are thought to

(exposure to symptom onset)	develop symptoms within 11.5 days of exposure.[1] The incubation period for asymptomatic cases is also considered to be 1 to 14 days from exposure. Please note that the incubation period is different from the communicable (infectious) period defined below. It's important to understand these concepts and consider implications for various exposures in large groups of people and with multiple contacts.
Communicable (Infectious) Period (time period during which an infected person can spread infection to others)	**As of February 2021, the estimated period of communicability is up to 3 days before symptom onset through at least 10 days after symptom onset.[2]** This means that contact tracing starts three days before symptom onset. If someone is asymptomatic, the date of sample collection for the positive test result can be used (instead of symptom onset date) to estimate the period of communicability. PHO or RCDC may suggest extending contact tracing timelines for asymptomatic cases on a case-by-case basis. Those with COVID-19 infection **must** remain on isolation until deemed non-infectious by the PHO (Appendix D *COVID-19 Healthcare Provider Flowchart*). **All confirmed cases require PHO approval to be removed from isolation.**
Transmission characteristics	**Figure 1** Image accessed from: https://www.nature.com/articles/s41598-019-39029-0 **Figure 2.2** The relationships of some important time periods. The patient at the bottom is infected first, and transmits the infection to a second patient. Adapted from Giesecke, J. Modern Infectious Disease Epidemiology. 2002.

Susceptibility and Resistance	Unknown at this time. Given that it is a novel virus, the majority of the population is considered susceptible to COVID-19 infection prior to vaccination.[1] Duration of protection following complete vaccination series is not known. As of February 2021, individuals who have been confirmed to have COVID-19 are typically thought to be immune for at least 2-3 months. They should not be re-tested in the first 3 months after their positive test collection date.[2]
Public Health Management	
Testing and Reporting	Testing criteria are very broad. **Individuals should be tested, even with presentation of one or very mild symptoms, to identify the presence of COVID-19 as soon as possible.** The testing also works best if someone is tested right around the start of their symptoms. Refer to *COVID-19 Healthcare Provider Flowchart* (Appendix D) for further details; symptoms are described above. Any one of the exposure criteria listed below increases the level of concern **in someone with symptoms** and should be called to the PHO on-call in addition to the usual processes informing the RCDC. • **Travel** outside the territory within 14 days of symptom onset. • **High risk contact** to a confirmed or probable **case** of COVID-19 infection within 14 days prior to onset of illness in a community with no known COVID-19 cases. High risk contact is defined later in this protocol. Routine testing of asymptomatic individuals in the community setting is not recommended. Testing asymptomatic individuals can result in a false negative lab result, which can lead to a sense of reassurance that may change compliance with the recommended public health measures such as self-isolation. Testing of asymptomatic individuals (e.g. contacts, cluster investigations) will only be done under the direction of a PHO in specific investigations for surveillance purposes, or as part of a screening program. All unexplained deaths in territory should be tested for COVID-19 infection in consultation with the coroner and PHO on-call. Health care providers (HCP) who have cared for probable or confirmed cases, including providing resuscitation, will be identified by contact tracing and contacted by the public health team. If testing is indicated, the timing of the test is important to ensure it minimizes the risk of false negatives; the RCDC/TCDS/PHO will provide direction on this. Due to the incubation period and test characteristics, testing immediately after exposure would be anticipated to be negative, even if the individual has been infected. It is therefore not appropriate to do this and it is important to follow RCDC/TCDS/PHO guidance on test timing. **Assessment and Reporting:** • If patient presents to the health care setting and meets the COVID-19 screening criteria, have the patient don a surgical/procedure mask immediately if they're not already wearing one. Place the patient in a separate room with contact and droplet precautions to collect the swab if testing indicated. • **Complete the Person Under Investigation (PUI) Assessment Form (Appendix C) on Meditech or by paper/pdf as soon as possible that day, or the next day if comes in after 10PM. If done by paper/pdf, scan and email to RCDC (copying CDsurveillance@gov.nu.ca).** • The individual covering CDsurveillance@gov.nu.ca will immediately email any highly concerning (e.g. OOT travel) forms to TCDS as they receive them as required; the TCDS may also receive them from the RCDC.

	• If an individual calls in and meets the COVID-19 screening criteria, but does not require immediate medical care, have them self-isolate at home and complete the PUI Assessment Form over the telephone where possible. RCDC can advise on the collection of the swab and daily check-ins. This may include a public health nurse or other nurse going to the patient's home to collect a swab (Appendix B *Home Testing Guidance*). If you are unsure if client meets testing criteria (see Appendix D *COVID-19 Healthcare Provider Flowchart*), please contact RCDC during business hours or the PHO on call for guidance after hours (3rd number available at 867-975-5772).

Management of Symptomatic Persons Under Investigation (PUIs)	**Refer to Appendix D (*COVID-19 Healthcare Provider Flowchart 1*) for detailed guidance on testing, precautions, and monitoring for symptomatic PUIs.** Brief summary included here.
	
	Consider testing for pertussis and TB for anyone with respiratory symptoms.
	
	Known exposure risk:
	
	• **High risk contacts** with a probable or confirmed case OR community transmission of COVID-19 in community **and** one or more of sore throat, nasal congestion, new/worsening cough or SOB, headache, loss of appetite, muscle aches, loss of sense of taste/smell, fatigue, GI symptoms, OR fever.
	  o Testing indicated and inform PHO on call if no previous COVID-19 in community.
	  o Isolate for at least 14 days from date of last exposure until cleared by RCDC. Note that this time period resets if additional individuals in the same household become symptomatic and/or are diagnosed with COVID-19 and also if there is a new exposure to COVID-19
	  o Regular monitoring to support isolation and, if needed, flag need for health care services. Note that the vast majority of individuals can isolate and recover safely at home.
	  o PUI form required immediately (typically also contact tracing form as directed by RCDC (in case positive))
	
	• **Returned from recent travel:** Returned from OOT travel within 14 days of symptom onset or returned from travel from community with COVID-19 (or contact with someone returned) **and** one or more of: sore throat, nasal congestion, new/worsening cough or SOB, headaches, loss of appetite, muscle aches, loss of sense of taste/smell, fatigue, GI symptoms or fever.
	  o Testing indicated
	  o Isolate until cleared by RCDC (typically upon resolution of symptoms and negative result of an appropriately-collected COVID-19 test)
	  o Regular monitoring
	  o PUI form required immediately. Contact tracing form may be completed as directed by RCDC (in case positive).
	
	No known exposure risk:
	
	• New/worsening cough/SOB AND fever
	  o Testing indicated
	  o Isolate until symptoms resolved or return to baseline and COVID test negative (can be cleared by HCP).
	  o Intermittent monitoring as per existing processes - discuss with RCDC if any questions.
	  o PUI Form
	
	• One or more of: sore throat, nasal congestion, new/worsening cough/SOB, headaches, loss of appetite, muscle aches, loss of sense of smell, fatigue, GI symptoms or fever unrelated to other causes or conditions.
	  o Testing indicated
	  o Isolate until symptoms resolved or return to baseline (can be cleared by HCP).

	○ Self-monitor and call to inform of test result ○ PUI Form Multiple factors impact consideration of lifting isolation including those listed below. A test result alone is not enough. Other applicable factors may include (but are not limited to): - Swab properly collected; - Swab collected while symptomatic; - No indication of freezing or sample issues; - No international or OOT travel in certain time frame; and - No known contact to a confirmed case in certain time frame. Individuals who have isolated in a Government of Nunavut – run self-isolation hub and been cleared through that process (or returned from the “travel bubble") do not need to repeat self-isolation in territory, but should practice physical/social distancing and limit contact with others as per current recommendations. If there is uncertainty about lifting isolation, please ask the RCDC. The RCDC may also discuss with the TCDS and PHO. Unless otherwise advised, all high-risk contacts of confirmed cases must remain on self-isolation for the full 14 days from last exposure**, even if test result is negative.** Review indications for self-isolation (quarantine), and self-monitoring in the *COVID-19 Healthcare Provider Flowchart* (Appendix D) and ensure the patient is aware of the recommended precautions. Scripts are provided in Appendix G to advise the patient of required isolation procedures. **Please provide anyone under isolation with an isolation fact sheet (see link in Resources).** Patients are recommended to isolate at home unless otherwise advised by the RCDC, TCDS, or PHO. The use of isolation hubs in communities is not routinely recommended. Active regular monitoring involves phone contact with the individual to provide support, assess symptoms, and assess isolation status/contact with others. If health status worsens, additional care may be required. PUIs should be monitored using the *Daily Monitoring Form* (Appendix E), until they have been cleared from isolation as above. Please note that the primary purpose of this monitoring is from a public health perspective rather than the provision of health care services. • If PUI does not have a phone, and a loaner phone is not available, consider a brief (10-15 min) porch visit for monitoring. • If unable to get hold of a case or PUI by phone after trying for 2 to 3 days, consider a porch visit for monitoring. Any PUI who tests positive for COVID-19 infection is managed as a case and should remain in isolation until cleared by the PHO.
Management of Cases	Refer to Appendix D (*COVID-19 Healthcare Provider Flowchart 2)* for detailed guidance on testing, precautions, and monitoring required. **The best and safest place for most people to recover from COVID-19 infection (both for them and their community) is at home.** If a change in location is being considered for either (i) an individual with infection or (ii) a vulnerable member of the household being relocated for infection control and communicable disease purposes, this will be decided on a case-by-case basis with the PHO on-call. *Public Health Monitoring of Cases:* **Confirmed and probable cases typically require active daily monitoring by public health.**

	Monitoring: This may be done in conjunction with the Virtual Public Health Nurse (VPHN) teams. Workflows for impacted communities will be determined within the outbreak team, with close involvement of the Health Centre COVID-19 Lead, Rapid Response Team Lead, and PHO, among others. Active daily monitoring includes having regular (e.g. daily) phone contact with the individual to provide support, assess symptoms, and assess isolation status/contact with others. If health status worsens additional care may be required but the vast majority of people can safely recover at home. Cases should be monitored using the *Daily Monitoring Form* (Appendix E), until they have been cleared from isolation by the PHO. Please note that the primary purpose of this monitoring is from a public health perspective rather than the provision of health care services. If symptoms worsen case should be advised to call the Health Centre. • If case does not have a phone, and a loaner phone is not available, consider a brief (10-15 min) porch visit for monitoring. • If unable to get hold of a case by phone after trying for 2 to 3 days, consider a porch visit for monitoring. *Clearance from isolation:* **All cases require clearance from PHO (e.g. by email) to lift isolation.** The criteria for discontinuing from isolation include: at least 10 days have passed since onset of first symptom or test collection date of an asymptomatic case, the case did not require hospitalization, the case is afebrile for more than 24 hours (without medication), and has improved clinically. Absence of cough is not required for those known to have chronic cough or for those who are experiencing reactive airways post infection.[2] *Symptomatic cases:* Those who are **not** severely immunocompromised and have mild to moderate symptoms that can be managed at home can typically return to their routine activities once the following criteria are met: a. At least 10 days have passed since onset of symptoms; AND b. Fever has resolved without use of fever-reducing medication; AND c. Symptoms (respiratory, gastrointestinal, and systemic) have improved[2] Those with more severe illness (e.g. admitted to hospital directly due to COVID-19) or who are severely immunocompromised can typically return to their routine activities once the following criteria are met: a. Twenty days have passed since onset of symptoms; AND b. Fever has resolved without use of fever-reducing medication; AND c. Symptoms (respiratory, gastrointestinal, and systemic) have improved.[4] Coughing may persist for several weeks and does not mean the individual is infectious and must self-isolate.[2] Asymptomatic cases: typically isolate for at least 10 days from the test collection date of the positive test. Adapted from the recommendations in *Public health management of cases and contacts associated with COVID-19* https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-cases-contacts.html
Exposure Assessment for Cases	Exposure assessment is done to determine the possible **source** of infection for someone with COVID-19. This is different to contact tracing which looks at who the case might have **transmitted** COVID-19 to. Contact tracing is intended to help prevent

	onward transmission; exposure assessment can help in conjunction to contain the overall outbreak by identifying patterns of spread. Potential exposures will be in the 14 days prior to symptom onset or 14 days prior to positive specimen collection date if asymptomatic. If there is concern about COVID-19 exposures in the community, you can ask about exposures in the past 30 days (i.e. 1-2 incubation periods). It assists in identifying where transmission may be occurring, and may identify others who have been exposed. Assess: • Participation at social events or other gatherings where close, prolonged contact with others may have occurred and particularly, larger gatherings involving multiple households (can ask about birthdays, parties, indoor games, holiday gatherings, etc); • Recent travel/residence history inside and outside Canada, or contact with a recent traveler outside Canada, including dates of travel, itineraries and mode of transportation (e.g., airplane, train, etc.); • Type of contact within health care settings with known COVID-19 cases (e.g., work, visiting patient, etc.), if applicable; • Recent contact with a known COVID-19 case or a person with COVID-19-like illness; • If other members in the household have similar symptoms or if there has been any contact with a known COVID-19 case/person with COVID-19 symptoms; and • If living or working in a congregate setting (Elders facility, correctional centre, shelter).
Level of Risk of Contacts	**Please use the *COVID-19 Contact Tracing Form* (Appendix F) for listing all contacts.** Contacts of a probable or confirmed COVID-19 case are assessed based on high and low level of risk exposure.[2] HIGH risk exposure has had close contact with a case:[2] • **Provided direct care** for the case (including health care workers, family members or other caregivers), **without** consistent and appropriate use of recommended personal protective equipment and infection prevention and control practices. • Anyone who lives with a case, has **direct** physical contact with a case, or is exposed to their infectious body fluids, including the case's caregiver, intimate partner, child receiving care from the case, etc. • Anyone who has shared an indoor space (e.g., same room) with a case for a prolonged period of time* including closed spaces, crowded places, or setting where close interactions may occur (e.g., social gatherings, workplaces, etc.), **without adhering to appropriate individual-level and setting-specific risk mitigation measures.** • Anyone who has had a close-range conversation with a case or has been in settings where a case engaged in singing, shouting, or heavy breathing (e.g., exercise), **without adhering to appropriate individual-level and setting-specific risk mitigation measures.** *Prolonged contact is often defined as greater than 15 minutes. LOW risk exposure to a case:[2] • Anyone who provided care for the case, **with** consistent and appropriate use of recommended PPE and infection prevention and control practices.

	• Anyone who has shared an indoor space (e.g., same room) with a case, including closed spaces, crowded places, or settings where close interactions occur (e.g., social gatherings, workplaces, etc.), **with adherence to physical distancing (2 metres between people) and mask wearing.**

Recommendations for Asymptomatic Contacts	Testing of asymptomatic individuals (e.g. contacts, cluster investigations) will only be done under the direction of a PHO in specific investigations for outbreak response, surveillance purposes, or as part of a screening program.
	
	If high-risk contacts develop symptoms of COVID-19 they should be tested immediately and RCDC informed. Please see section on management of symptomatic PUIs.
	
	High risk contacts:[2]
	
	• Quarantine (self-isolation) at home for 14 days from date of last exposure.
	• Follow recommended personal preventive practices. If living with the case, avoid further exposure to the case and wear a well-constructed and well-fitting, non-medical mask when in a shared space (e.g., same room) with the case.
	• Regular monitoring by phone for the appearance of symptoms consistent with COVID-19 for 14 days following their last exposure to the case. (This resets following additional exposures to other cases.)
	• Take and record temperature daily if have access to a thermometer and avoid the use of fever-reducing medications (e.g., acetaminophen, ibuprofen) when possible. These medications could mask an early symptom of COVID-19; if these medications must be taken, advise the RCDC,
	• If symptoms occur, inform HCP, isolate away from others within the home or co-living setting as quickly as possible; put on a medical mask if available (preferred), or well-constructed and well-fitting non-medical mask – see Appendix D (*COVID-19 Healthcare Provider Flowchart*) for testing.
	• Avoid close contact with those who are at risk for developing more severe disease or outcomes from COVID-19.
	
	Low risk contacts:[2]
	
	• Self-monitor for symptoms for 14 days following their last exposure.
	• If symptoms occur, inform health care provider, isolate away from others as quickly as possible, put on a medical mask if available (preferred), or well-constructed and well-fitting non-medical mask.
	• Where possible avoid interactions with individuals at higher risk for severe illness.
	• Follow recommended personal preventive practices as for all Nunavummiut including:
	  o Avoid closed spaces (with poor ventilation), crowded places, close contact settings and close-range conversation.
	  o Wear a non-medical mask when you're in a shared space.
	  o Stay home and away from others if you feel sick.
	  o Stick to a small and consistent social circle and avoid gathering in large groups.
	  o Talk to your employer about working at home if possible.
	  o Maintain a physical distance of 2 metres from people outside of your household.
	
	Individuals who have isolated in a Government of Nunavut run self-isolation hub and been cleared through that process do not need to repeat self-isolation in territory, but

	should practice physical/social distancing and limit contact with others as per current recommendations for all residents of the territory. Further guidance from the Public Health Agency of Canada (PHAC) regarding the management of high and low risk contacts of probable and confirmed cases is available online at: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-cases-contacts.html
Management of Post Vaccination Symptoms	Some of the systematic side effects of COVID-19 vaccination are similar to those of COVID-19 itself particularly chills or fever, tiredness, headache, muscle pain, joint pain, nausea, and vomiting. At the same time, it is possible for people who are **already infected with COVID-19,** but pre-symptomatic when they are vaccinated, to display symptoms a day or two later. To manage these symptoms post vaccination: • Mild non-respiratory symptoms developing within 48 hours of vaccination (headache, fatigue, myalgia, joint pain, GI symptoms) – no need to swab, stay home if they can. If symptoms do not resolve within 72 hours investigate other cause for symptoms and do COVID-19 swab as indicated under Testing. • Respiratory symptoms at any time after vaccination (cough, SOB, rhinorrhea, sore throat, or loss of taste or smell are **not** consistent with post-vaccination symptoms) – COVID-19 testing and self-isolation is indicated. • Consult RCDC if any questions
Health Education	The spread of COVID-19 can be reduced through, limiting contacts with others outside household, respiratory etiquette, hand hygiene, environmental cleaning and physical distancing >2 metres. The use of non-medical masks is also recommended, particularly in public settings where it is difficult to maintain physical distance. Frequent cleaning of high touch areas in the home (e.g. kitchen and bathroom) will help to reduce the spread of infection. Avoiding the three C's is recommended to reduce the spread of infection. They are: • Crowded places • Close contact settings • Confined and enclosed spaces Please see the *Resources* section for more information. Additional, guidance for someone isolating at home includes: ▪ Stay home until advised no longer required by RCDC or PHO ▪ Avoid contact with other people, particularly medically-vulnerable people or elders ▪ Separate room and sleeping arrangements where possible. ▪ Manage symptoms independently where possible. If caregiver required, designate one individual for that role. ▪ Stay 2m away from other individuals and no visitors. ▪ Avoid sharing unwashed dishes ▪ Clean high touch surfaces regularly ▪ Hand hygiene and respiratory etiquette For more detailed information refer to the *Isolating a Case in the Home or Co-living Setting* guidance document. On direction from the PHO, public health interventions to communicate potential exposures may include: • Public health notices or advisories • Individual letters of notification • Group notification or mail outs

Cultural Safety	Cultural safety is an integral part of the COVID-19 public health response. All staff need to remain mindful of the historical and intergenerational trauma caused by communicable diseases to Inuit communities. The heightened sense of anxiety that individuals may be feeling regarding the current global pandemic can be compounded by this history and care needs to be taken to provide an outbreak response that is sensitive to both past and current trauma, and that is aligned with the longer process of reconciliation. Public health management during an outbreak may elicit feelings that are similar to past experiences for clients. Even during this difficult time, all members of the outbreak team can have the ability to deliver culturally safe care that improves experiences and outcomes for Nunavummiut. Principles of cultural safety during an outbreak response and at other times: • Learn more about the health-related history of Indigenous peoples • Become more aware of your own worldview and assumptions and how they affect the care you provide or the work that you do • Respect the knowledge, experience, autonomy and the right to confidentiality of each client • Set the stage for calm, positive interactions with clients and colleagues by being kind, calm and patient • Give people physical and emotional space if needed • Do not take the reactions of others personally and be compassionate • Accept that you are playing a larger part in the longer process of reconciliation • Maintain safe and healthy personal boundaries by taking care of your own safety and wellness
Health Settings Management	
Infection Control Measures in Health Care Settings	Use droplet/contact precautions (consistent with national and territorial guidance).[2] Important to be informed and follow point-of-care risk assessments and routine practices. When triaging, suspect COVID-19 cases should be asked to wear a medical mask and be placed in a separate room away from other patients as soon as possible; or separated by at least two meters from others if it is not possible to use another room. Practice, diligent hand hygiene using either liquid soap and water or 60-90% alcohol-based sanitizer, before and after patient contact/ assessment and after contact with contaminated equipment. When handling soiled linen and garbage, create a barrier by wearing gloves and gowns that cover exposed contact skin areas. Increased frequency of cleaning high-touch surfaces is significant in controlling the spread of microorganisms during a respiratory outbreak. Environmental cleaning products registered in Canada with a Drug Identification Number (DIN) and labelled as a broad-spectrum virucide are sufficient. All surfaces, especially those that are horizontal and frequently touched, should be cleaned at least twice daily and when soiled. See the *Nunavut Housekeeping Procedures Manual* for more detailed information on terminal cleaning recommendations. https://www.gov.nu.ca/health/information/housekeeping-procedures-manual
Occupational Health	Staff should wear a surgical/procedural mask, eye protection (face mask or goggles), gown and gloves when providing care to clients with suspected or confirmed COVID-19 infection.[2] See Appendix for detailed information on donning and doffing Personal Protective Equipment (PPE).

	See the Infection Prevention and Control Manual for more detailed guidelines. https://www.gov.nu.ca/health/information/infection-prevention-and-control
Surveillance	
Case Counts and Definition	For information on COVID-19 case and vaccine counts in the territory see: https://www.gov.nu.ca/health/information/covid-19-novel-coronavirus For rates of COVID-19 cases in Canada see: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection.html For rates of COVID-19 vaccination in Canada see: https://health-infobase.canada.ca/covid-19/vaccination-coverage/ Epidemiological support and public health data information systems are crucial to containing outbreaks. Throughout the course of this outbreak in Canada, there have been Nunavut and/or national case definitions for the following: -Persons Under Investigation (PUI) -Suspect cases -Probable cases -Confirmed cases For more information on case definitions, please contact your RCDC who can obtain a copy from the epidemiology team. In the event of an outbreak of COVID-19 in territory, the up-to-date case definitions will be circulated to the outbreak team along with the linelist. Nunavut typically uses the national case definitions. More information is available here: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/national-case-definition.html As of March 2021, the definitions for confirmed and probable cases are: **Confirmed case** A person with confirmation of infection with SARS-CoV-2 documented by: • The detection of at least 1 specific gene target by a validated laboratory-based nucleic acid amplification test (NAAT) assay (e.g. real-time PCR or nucleic acid sequencing) performed at a community, hospital, or reference laboratory (the National Microbiology Laboratory or a provincial public health laboratory) **or** • The detection of at least 1 specific gene target by a validated point-of-care (POC) NAAT that has been deemed acceptable to provide a final result (i.e. does not require confirmatory testing) **or** • Seroconversion (see note below and national case definitions for more detail) **Probable case** A person who: • Has symptoms compatible with COVID-19 **and** ○ Had a high-risk exposure with a confirmed COVID-19 case (i.e. close contact) **or** was exposed to a known cluster or outbreak of COVID-19 **and** ▪ Has not had a laboratory-based NAAT assay for SARS-CoV-2 completed **or** the result is inconclusive **or** ▪ Had SARS-CoV-2 antibodies detected in a single serum, plasma, or whole blood sample using a validated laboratory-based serological assay for SARS-CoV-2 collected within 4 weeks of symptom onset

	or • Had a POC NAAT **or** POC antigen test for SARS-CoV-2 completed and the result is preliminary (presumptive) positive **or** • Had a validated POC antigen test for SARS-CoV-2 completed and the result is positive Notes on laboratory testing for COVID-19 and meeting case definitions: • Laboratory tests are evolving, and laboratory testing recommendations will change accordingly as new assays are developed and validated. • NAAT must be validated for detection of the virus that causes COVID-19. An **indeterminate** result on a real-time PCR assay is defined as a late amplification signal in a real-time PCR reaction at a predetermined high cycle threshold value. This may be due to low viral target quantity in the clinical specimen approaching the limit of detection (LOD) of the assay, or may represent nonspecific reactivity (false signal) in the specimen. When clinically relevant, indeterminate samples should be investigated further in the laboratory (e.g. by testing for an alternate gene target using a validated real-time PCR or nucleic acid sequencing that is equally or more sensitive than the initial assay or method used) or by collection and testing of another sample from the patient. • An **inconclusive** result on a real-time PCR assay is defined as an indeterminate result on a single or multiple real-time PCR target(s) without sequencing confirmation, or a positive result from an assay for which limited performance data are available. • **Rapid testing and point-of-care tests:** Local validation and provincial (and/or federal) evaluation is required for all POC tests (molecular and/or antigen-based), with the reference testing done in a licenced/accredited laboratory. If validation is not completed prior to clinical use at an individual location, a simultaneous sample should be obtained from the individual and tested following the guidance of the laboratory teams • **Serology testing:** At this time, serology testing should not be used for classification of cases who have been previously diagnosed with COVID-19 or who have received a SARS-CoV-2 vaccination. SARS-CoV-2 serology tests should not be used for screening or the routine diagnosis of acute infection.
Reporting Requirements and Forms	**COVID-19 infection is a notifiable disease in Nunavut. Please report as outlined in Appendix C *Person Under Investigation Assessment Form*.** Please note the following consideration, particularly when reporting occurs after hours: In addition, to providing any immediate follow-up required, the PHO on call is expected to notify other PHOs involved as appropriate as well as the TCDS immediately by email; the TCDS will ensure the epidemiologists and RCDCs are notified. Roles and responsibilities include: **Health care provider**: Notification to public health as outlined above and in Appendices C & D, care for individual, and providing education to the patient regarding self-monitoring, self-isolation and plan of care. **RCDC**: Following up all PUI and cases, ensuring initial information is gathered, ensuring case report form is filled out and send to TCDS, and other functions **TCDS**: Coordinating and advising RCDCs, liaising with PHOs, ensuring PUI and case information sent to epidemiologists **Epidemiologist**: Maintaining accurate linelist, circulating linelist to outbreak team, flagging any missed follow-up noted, monitoring for national surveillance updates

	MHO/PHO, DCPHO, and CPHO: Leading the investigation of an outbreak and overseeing public health control measures and interventions. Communicating with other agencies and with Department of Health as required. Please note that the PHO on call will often be the DCPHO or CPHO. Medical Health Officers (MHO) are sometimes also called PHO (Public Health Officer). Confirmed cases of COVID-19 require completion of the Public Health Agency of Canada COVID-19 case report form and submission to the national surveillance systems, typically daily. The epidemiology team will work with the RCDC/TCDS and HCP to ensure this information is gathered and submitted.
Tools	
Guidelines	Refer to the following online Government of Nunavut manuals available online at: **https://www.gov.nu.ca/health/information/manuals-guidelines** • Infection Prevention and Control Manual • Housekeeping Procedures Manual • Community Health Nursing Manual • Communicable Disease Manual • Immunization Manual **In the event of a COVID-19 outbreak in a community, a Standard Operating Procedure guidance document will be distributed to staff on the outbreak team with additional information regarding outbreak response.**
Appendices	Appendix A - Nasopharyngeal Swab Procedure Appendix B – Home Testing Guidance Appendix C – Person Under Investigation (PUI) Assessment Form Appendix D - COVID-19 Healthcare Provider Flowchart Appendix E – Daily Monitoring Form Appendix F – COVID-19 Contact Tracing Form Appendix G - Script for Explaining Self-Isolation or Isolation Appendix H – Personal Protective Equipment for Health Care Professionals
Resources	***For patients:*** - Instructions for isolating a case in the home or co-living setting - About coronavirus disease COVID-19 - Cleaning to Reduce the Risk of COVID-19 - COVID-19 Isolation - Managing Anxiety and Stress During Covid-19 - Social Distancing Additional translated resources for the public can be found online at https://gov.nu.ca/health/information/covid-19-novel-coronavirus More resources are available here: - NTI: https://covid19.tunngavik.com/ - ITK: https://www.itk.ca/what-we-do/covid19/ - Pauktuutit: https://www.pauktuutit.ca/health/covid-19-resources/

	- ISC: https://www.sac-isc.gc.ca/eng/1603132339009/1603132369373 - NCCIH: https://www.nccih.ca/485/NCCIH_in_the_News.nccih?id=450 ***For health care providers:*** COVID-19 Laboratory Testing Authority Medical Directive (policy #07-034-00 in the CHN Manual) Information on COVID-19 from the Department of Health: https://www.gov.nu.ca/health/information/covid-19-novel-coronavirus Public Health Orders in effect in Nunavut: https://www.gov.nu.ca/health/information/chief-public-health-officer-orders PHAC has developed COVID-19-specific IPC guidance for acute health care settings available at: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/infection-prevention-control-covid-19-second-interim-guidance.html BC has developed COVID-19-specific PICNet IPC guidance for acute health care settings available at: https://www.picnet.ca/ ***For information on COVID-19 immunization, please see the COVID-19 Immunization Protocol in the Immunization Manual.***

References

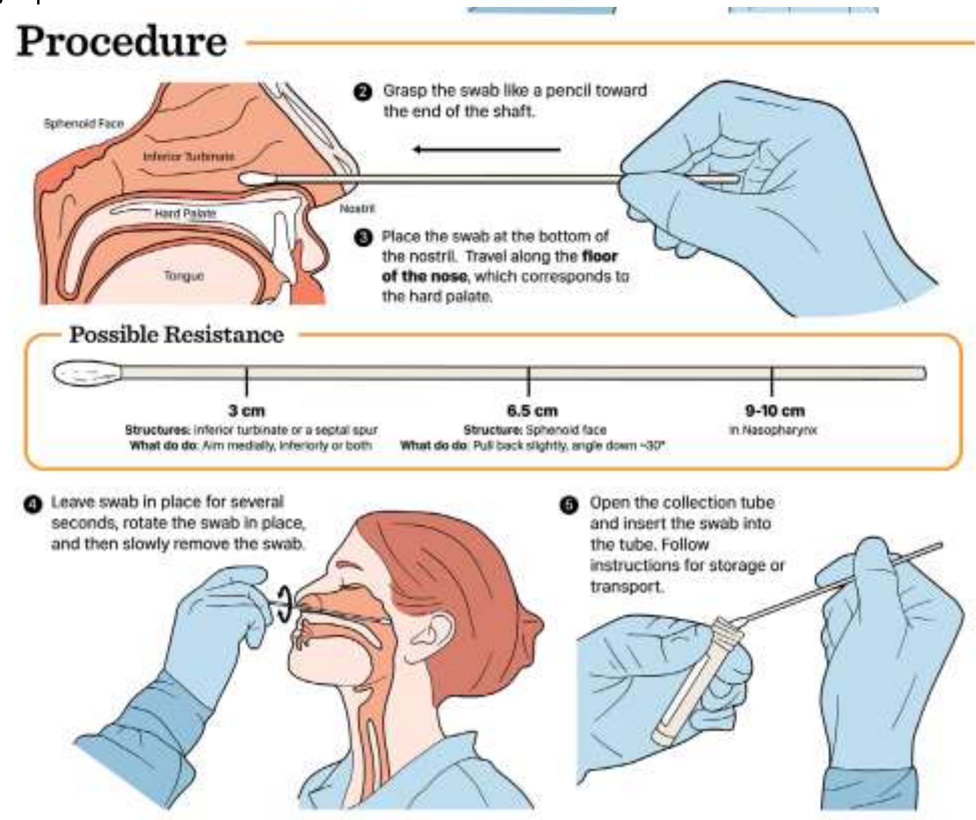
1. __________, *An Advisory Committee Statement (ACS) National Advisory Committee on Immunization (NACI): Recommendations on the use of COVID-19 Vaccines Mar 1 2021*. Public Health Agency of Canada: 2021. Available: https://www.canada.ca/en/public-health/services/immunization/national-advisory-committee-on-immunization-naci/recommendations-use-covid-19-vaccines.html (accessed 2021 Mar 1).
2. __________, *COVID-19 For health care professionals.* Public Health Agency of Canada: 2021. Available: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals.html#cg (accessed 2021 Mar 9).
3. __________, *SARS-CoV-2 (COVID-19 Virus) Variant of Concern (VoC) Surveillance.* Public Health Ontario: 2021. Available: https://www.publichealthontario.ca/en/laboratory-services/test-information-index/covid-19-voc (accessed 2021 Mar 19).
4. __________, *Interim Guidance: Public Health Management of cases and contacts associated with novel coronavirus (COVID-19) in the community.* BC Centre for Disease Control. 2020. Available: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%201%20-%20CDC/2019-nCoV-Interim_Guidelines.pdf (accessed 2021 Mar 19).

Version 7.1 approved by Dr. Jasmine Pawa on March 31, 2021.

Abbreviations: TCDS = Territorial Communicable Disease Specialist, RCDC = Regional Communicable Disease Coordinator, OOT=out-of-territory, HCP=health care provider

COVID-19 Public Health Protocol V 7.1
Appendix A - Nasopharyngeal Swab Procedure

1. Use the swab supplied with the viral transport media – carefully open collection container.
2. Explain the procedure to the patient.
3. When you collect specimens, wear gloves, a mask and eye protection (a face shield or googles).
4. If the patient has a lot of mucous in the nose, this can interfere with the collection of cells; ask the patient to use a tissue to blow nose.
5. The average distance from the nasal aperture to the nasopharynx in an adult is approximately 9-10cm (see procedure below).
6. Seat the patient comfortably with head support. Tilt the patient's head back slightly (not more than 30 degrees) to straighten the passage from the front of the nose to the nasopharynx.
7. Insert the swab gently as close to the floor of the nose as possible. It should be aimed parallel to the floor of the nose and to the septum.
8. If there are no obstructions from the nasal anatomy and the swab follows this trajectory, it will meet resistance once it has reached the nasopharynx.
9. Once in the nasopharynx, leave swab in place for several seconds to absorb the secretions. Then rotate it gently, completing 2 full 360-degree rotations and slowly withdraw.
10. Place swab in collection container; break off shaft at the break point or cut with scissors if required, and recap. It is important to tighten the lid carefully as the lab cannot process leaked specimens.
11. Place in a specimen bag with the requisition to be sent to the laboratory. 1 sample per specimen bag is preferred.



COVID-19 Communicable Disease Protocol V 7.1

Appendix B. Home Testing Guidance.

Stable clients may be tested at home for COVID-19. This document provides guidance on conducting home testing.

Nursing Practice, Section 7 of *Nursing Policy, Procedure and Protocols* (Policy 20-024-00 and 20-25-00) has additional information on planned and unplanned home visits.

Before going to the home

- Connect with RCDC to ensure have up-to-date information and direction on testing.
- Personal safety – **Do not** proceed to test in the home if you feel unsafe.
- Arrange a time with the client. Please see steps below for more detail.
- Complete the PUI tool in advance over the phone if possible.
- Enter the order in Meditech, or according to usual practice in your centre.
- Ensure you have swabs and personal protective equipment as per the checklist below.

Personal protective equipment (PPE)

- Minimize the time spent in the home (e.g. collect the swab within 15-20min).
- If doing a home visit for support, education, or as unable to reach, consider introducing self at door and then doing a distanced porch visit or subsequently calling in follow-up from a vehicle to continue the conversation.
- HCP should use droplet and contact precautions when visiting the home of a client with suspected COVID-19. This includes gown, gloves, and a surgical/procedure mask with face shield or goggles.
- Detailed steps are provided below.
- Additional resources are available in the Infection Prevention and Control Manual and Housekeeping Manual including posters on donning and doffing PPE. See also Appendix - Personal Protective Equipment for Health Care Professionals in the COVID-19 Communicable Disease Protocol.

Interview the client and collect swab

> **NOTE:** If client is unstable (severe shortness of breath, altered level of consciousness), seek health care assistance immediately. Please call ahead to health center or emergency department to advise of client arriving and recommend contact & droplet precautions. Do not complete home testing. Inform RCDC immediately who will inform TCDS and PHO.

- Must assess two client identifiers. Collect a nasopharyngeal swab as per steps below – see also Appendix A Nasopharyngeal Swab Procedure in COVID-19 Communicable Disease Protocol for more detail.
- Provide information on home isolation, COVID-19, and what to do if symptoms worsen to the client (provide 2 fact sheets and leave in home).
- Let client know results should be available within 3-4 days and who to call if questions.
- Let client know that nursing staff will be following up with them regularly (e.g. daily) while on isolation. Advise client will be asked to stay on isolation until otherwise informed.
- Provide client with one mask in case they need to go to health centre or hospital.

Specimen transport

- Ensure requisition is filled out and flag that specimen is for COVID-19 as per lab guidance.
- Ensure specimen is labelled with 2 patient identifiers, date, site, and flagged for COVID-19 testing.
- Ensure the lid is tightly closed and ideally have one specimen per specimen bag.
- Follow usual regional lab procedures for specimen transport.

Communication

- Inform RCDC that test completed and any other details for client.
- Decide which provider will be following up with client daily (Public Health Nurse, Community Health Nurse, or Regional Communicable Disease Coordinator).
- Convey any concerns or comments to RCDC who will inform TCDS

Supplies Checklist for COVID-19 Home Testing

- Hand sanitizer
- Surgical/procedure masks (one for provider and one to leave with client)
- Disposable face shield (note: eye glasses are not considered eye protection)
- Gown
- Gloves
- Booties
- Blue pad
- NP swab
- Transport media
- Biohazard Bag
- Designated cooler to transport specimen
- Safe donning/doffing instructions
- COVID-19 fact sheet
- COVID-19 home isolation fact sheet

Steps for Ensuring Safe Donning and Doffing

1. Call ahead to inform client of arrival, explain planned procedure and provide opportunity for questions. Collect as much information as possible before visit to minimize time in the home, including completing PUI tool where required. Explain to client that you will be using disposable PPE in line with health care worker practices. Ask that your disposable PPE can be left in the home for the client to discard. Explain to client that they should remain at least 2 metres away from you when you will be doffing PPE. Arrange a time and ask the patient to leave the door unlocked.
2. Arrive at the home at the specified time. Remove outerwear immediately upon entering the home and leave just inside the door or on sheltered porch. If warmer weather, can leave outerwear in vehicle.
3. Don disposable PPE immediately upon entry to home at least 2 metres away from the client.
4. At this time, should only be carrying disposable PPE, NP swab, media, biohazard bag, and cooler. Avoid using your cell phone or access anything that may be in your pockets.
5. Leave cooler with the lid open on a blue pad and hand sanitizer at the door just inside or on sheltered porch.
6. Complete NP swab procedure with client as outlined in Appendix A and place in biohazard bag.
7. Place specimen in cooler.
8. Doff PPE following safe doffing instructions at least 2 metres away from the client.
9. Perform hand hygiene with hand sanitizer.
10. Close cooler lid and exit home.
11. Perform hand hygiene with hand sanitizer.
12. Transport specimen to lab.

Reference

Ontario Ministry of Health. (2020). Novel Coronavirus (COVID-19) Guidance for Home and Community Care Providers Retrieved from: http://www.health.gov.on.ca/en/pro/programs/publichealth/coronavirus/docs/2019_home_community_care_guidance.pdf

Note: Please see COVID-19 protocol for any abbreviations as required

Appendix C: COVID-19 Person Under Investigation (PUI) Assessment Form

Date & Time of Assessment		Medical emergency? Y N
Assessment completed by (check):	Phone In person	Client sought healthcare? Y N
For calls made by caller on behalf of pt: Name & relationship to pt		
Patient name Last, First		
DOB (dd-mmm-yyyy)		Male Female Other
NU HCN# **Chart #**		
Patient phone number(s) (or # where HCP can leave message)		
Patient home address including community and house number		
TRAVEL HISTORY		
Has the patient returned from within Canada or International in the last 14 days?	Yes No	**Visited known high-risk locations? Specify if yes.** eg. gathering with known case. Yes No
Travel History Include travel dates and city/country. Details (flights, hotels, etc) for cases go on page 2.		
COVID-19 Vaccination Status **Vaccine name:**	Received one dose Eligible and not vaccinated Received two doses Not eligible	
CONTACT OF A CONFIRMED CASE		
Contact of a probable/confirmed case? Check. Specify if Yes.	Yes No Not asked Specify:	
Date of most recent contact		
SYMPTOMS		
Symptomatic?	Yes No Unknown	
Date of Onset (dd-mmm-yyyy)		
Symptoms Ckeck from list, add others if not listed. Please put details of cough or other symptoms as relevant in additional notes below	Fever New Cough Worsening Cough Shortness of Breath Sore Throat Congestion Others (list):	
Vulnerable patient. Check	Age (> 60 years) Immunocompromised Co-morbidities	
Specify co-morbidities. Check or write in notes	Heart Disease Lung Disease Cancer Diabetes Pregnancy	
Number of people in household		
Vulnerable household members	Yes No	
Healthcare provider Specify occupation and place of work	Yes No	
Place of employment		

Appendix C: COVID-19 Person Under Investigation (PUI) Assessment Form

Patient name:	**Patient DOB:**
RECOMMENDATIONS: **Follow flowchart and COVID-19 Protocol to determine precautions and testing guidance**	
Testing Indicated	☐Yes ☐No ☐Consult RCDC (who will work with TCDS and PHO) RCDC recommendation:
If testing indicated:	☐ NP swab done (for in person visits) **Date:** ________________ ☐ NP swab by home visit - arranged by CHN (in communities) ☐ NP swab to be arranged by RCDC for phone consults ☐ If indicated as per protocol – phone notification to PHO on-call (3rd # listed at 867-975-5772)
Precautions Indicated	☐ **Self-Monitor** - Dates: ________to________ or until symptomatic (then immediately contact HCP) ☐ **Self-Isolate** with Health Care Provider monitoring 3,7,14 days Dates: ________,________,________ AND until cleared by RCDC ☐ **Isolate** with Health Care Provider monitoring daily Dates: ________to________ AND until cleared by RCDC ☐ No precautions indicated – provide education (including reminder on self-monitoring and physical distancing)

Additional Notes (e.g. symptom, travel or contact information): ______________________________

____

____

____

____

____

Follow-up Checklist of initial health education advice to give to client (see protocol for more details):

- Inform client that public health team will contact them with more information and guidance.
- Inform client not to leave home or have others visit and answer any questions (see script).
- Provide advice regarding hand hygiene and respiratory etiquette.
- Ask if they have enough food and supplies on hand. Consider family services referral as needed.
- Advise to seek medical attention if symptoms worsen or in medical distress.
- Provide COVID19 isolation fact sheet and other documents* (Click here to access fact sheet)

Completed by (print name, signature and designation)	
Reporting HCP phone number	

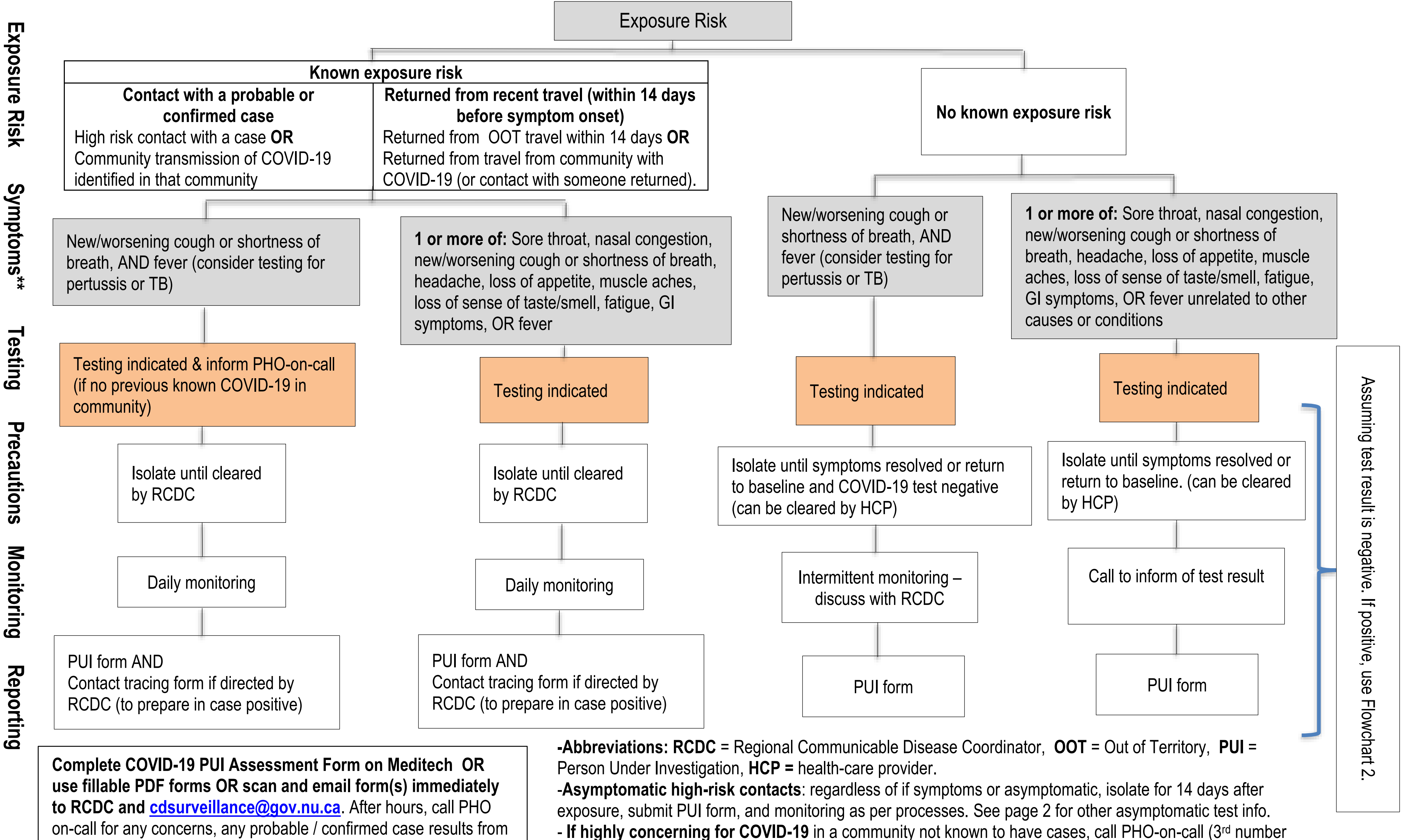
Scan and email form immediately to RCDC and cdsurveillance@gov.nu.ca. Can upload to meditech if feasible. After hours, call PHO on-call for any concerns, any probable / confirmed case results, as well as any PUI with hospitalization or international travel.

Note: this form is intended to be used for persons under investigation including symptomatic individuals and high-risk contacts of COVID-19 cases. There is a version of the form in Meditech that can be filled out instead if preferable. Abbreviations: PUI=person under investigation, PHO = Public Health Officer, HCP= health care provider, RCDC = Regional Communicable Disease Coordinator, DOB=date of birth, TCDS=Territorial Communicable Disease Specialist, OOT=out-of-territory, Epi=epidemiologist.

* Including COVID-19 fact sheet, Self-isolation fact sheet, and daily monitoring guidance.

Appendix D: CD Manual COVID-19 Protocol V7.1 Healthcare Provider Flowchart

Appendix D – Flowchart 1 – All communities testing and isolation guidance for Symptomatic PUIs



Complete COVID-19 PUI Assessment Form on Meditech OR use fillable PDF forms OR scan and email form(s) immediately to RCDC and cdsurveillance@gov.nu.ca. After hours, call PHO on-call for any concerns, any probable / confirmed case results from out-of-territory testing, as well as any PUI with hospitalization or international travel.

-**Abbreviations: RCDC** = Regional Communicable Disease Coordinator, **OOT** = Out of Territory, **PUI** = Person Under Investigation, **HCP =** health-care provider.

-**Asymptomatic high-risk contacts**: regardless of if symptoms or asymptomatic, isolate for 14 days after exposure, submit PUI form, and monitoring as per processes. See page 2 for other asymptomatic test info.

- **If highly concerning for COVID-19** in a community not known to have cases, call PHO-on-call (3rd number listed at 867-975-5772).

-Increased level of concern if healthcare provider or vulnerable population or lives/works in group setting:

- **Group settings =** shelter, group home, elders' home, household ≥ 10 members, jail, boarding home
- **Vulnerable populations** = age ≥ 60; individuals with: lung disease, heart disease, diabetes, cancer; immunocompromised, obesity

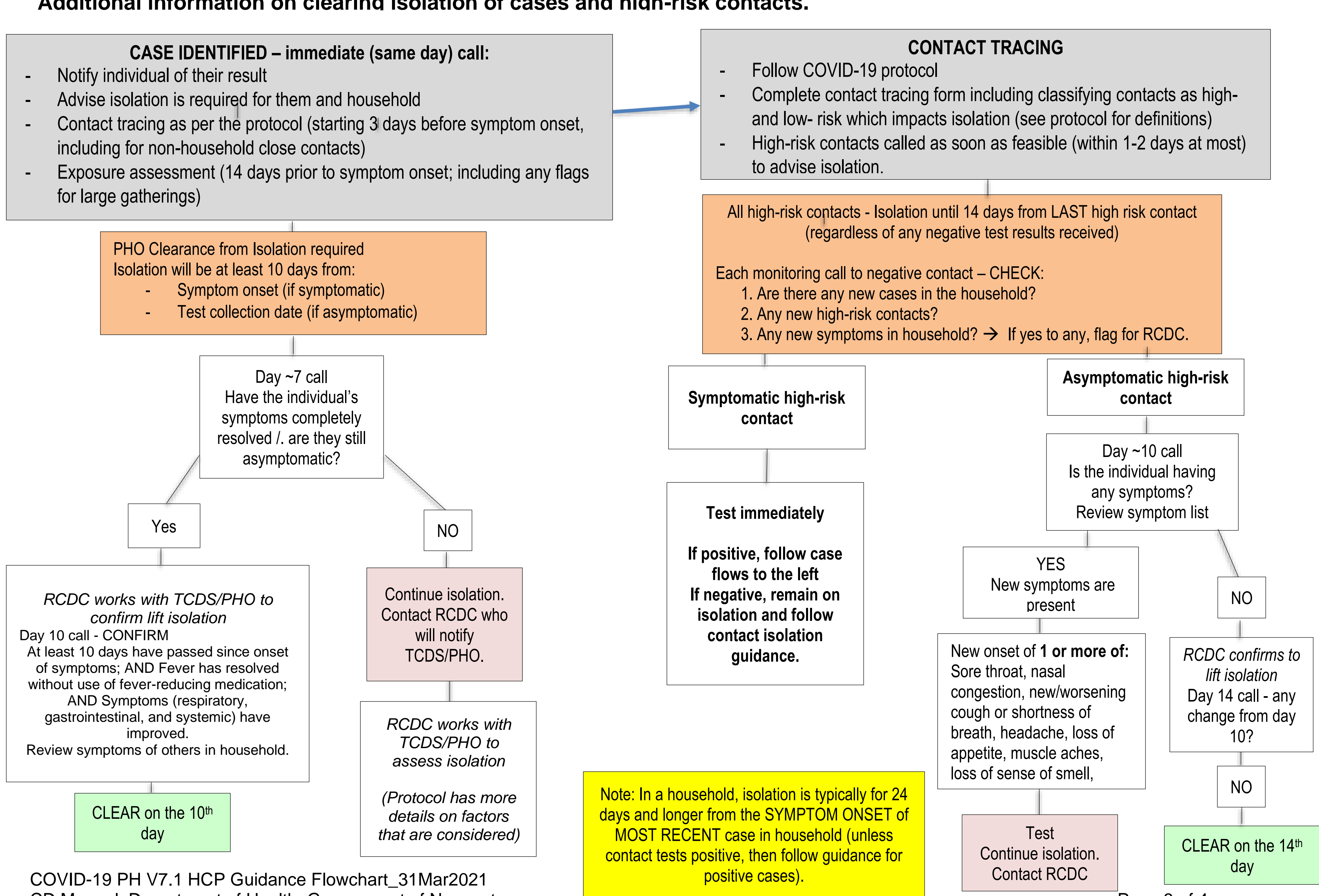
Appendix D: CD Manual COVID-19 Protocol V7.1 Healthcare Provider Flowchart

Table. Summary of Required Precautions and Monitoring.

	Criteria for applying	Description of precautions required	Monitoring required
Isolate	▪ Probable or confirmed case ▪ Individuals who are symptomatic (see page 1)	▪ Stay home and monitor symptoms until advised no longer required by RCDC, TCDS, or PHO ▪ Contact hotline or HCP if symptoms appear, worsen or are concerning. ▪ Avoid contact with other people, particularly medically-vulnerable people or elders ▪ Separate room and sleeping arrangements where possible ▪ If caregiver required, designate one individual ▪ Stay 2m away from other individuals and no visitors ▪ Use non-medical masks/face coverings for individual and household contacts as required ▪ Avoid sharing unwashed dishes ▪ Clean high touch surfaces regularly ▪ Hand hygiene and respiratory etiquette	▪ Day 0 or as soon as feasible – provide advice/script on isolation ▪ Symptom monitoring/inquiry as per flowchart above by telephone with monitoring form completion ▪ Consider utilizing a proxy if no phone available ▪ Ending isolation requires HCP or RCDC approval (see Flowchart 1) ▪ Provide reminder on social distancing.
Self-isolate (Quarantine)	▪ Asymptomatic high risk contact ▪ Case-by-case exceptions for exempt travellers returning to territory	▪ Stay at home and monitor symptoms for 14 days; contact HCP if symptoms develop. ▪ If possible, take temperature daily and avoid use of fever-reducing medications ▪ Avoid contact with other people at home (e.g. stay 2m apart where possible, no visitors) ▪ Avoid sharing unwashed dishes ▪ Clean high touch surfaces regularly ▪ Hand hygiene and respiratory etiquette ▪ Use non-medical masks/face coverings for individual and household contacts as required	For high-risk contacts only: ▪ Day 0 or as soon as feasible – provide advice/script on self-isolation ▪ Monitoring/inquiry by telephone as directed by RCDC/TCDS with monitoring form completion ▪ Consider utilizing a proxy if no phone available ▪ Ending isolation requires RCDC approval. Provide reminder on social distancing. ▪ If symptoms develop follow symptomatic guidance on Flowchart 1.
Self-monitor	▪ Asymptomatic medium or low risk contacts ▪ General public ▪ Returned from Hub or “travel bubble”	▪ Monitor yourself for 14 days for one or more symptoms of COVID-19 and inform HCP if they develop ▪ Go about your day but avoid crowded spaces ▪ Stay 2m apart from others wherever possible ▪ Do not attend any large gatherings ▪ Hand hygiene and respiratory etiquette ▪ Vulnerable populations encouraged to “reverse-isolate” where possible (e.g. shop at time allocated to elderly population) ▪ Follow masking recommendations for general public.	▪ No monitoring is required. ▪ Advise to call HCP if symptoms develop. ▪ Reminder regarding social distancing ▪ If symptoms develop follow symptomatic guidance on Flowchart 1.

Additional Notes:
Incubation period (from exposure to symptom onset) ranges from 1-14 days. **Communicable period** is typically up to 3 days before symptom onset to 10 days after symptom onset. An **asymptomatic case** is someone with a positive SARS-CoV-2 test on validated testing who never develops any symptoms. **Asymptomatic testing** not generally indicated except as directed by Public Health Officer (e.g. outbreak or cluster investigation, surveillance purposes, or as part of an organized screening program). Note that asymptomatic individuals may be asked to self-isolate (quarantine) as outlined above.

Appendix D – Flowchart 2. For use in communities with confirmed COVID-19 cases and/or COVID-19 outbreak - Additional information on clearing isolation of cases and high-risk contacts.



Appendix D: CD Manual COVID-19 Protocol V7.1 Healthcare Provider Flowchart

Additional notes on Flowchart 2:

- Printed Isolation handouts should be provided to individuals. Resources are available:
    - In the other appendices to this COVID-19 protocol: https://www.gov.nu.ca/health/information/manuals-guidelines
    - From the communications team posted here: https://www.gov.nu.ca/health/information/covid-19-novel-coronavirus
- Clearance on the 10th day, 14th day, or 24th day is acceptable (i.e. do not need to wait until day 11 or day 15 or day 25)
- For contacts in the same household, last day infectious (i.e. 10 days after symptom onset date or positive test collection date for case) is the last exposure or break in contact and individuals remain on isolation for 14 days from that time (e.g. 24 days from the case in household symptom onset date). This resets as additional individuals in the household become cases (i.e. 24 days from the symptom onset of the most recent household case).
- Isolation supports and kits are often available from NTI, the hamlet, or other sources – ask the Health Centre COVID-19 Lead for more information, they can ask the RCDC if needed.
- PHO clearance required for cases and epidemiology team (cdsurveillance@gov.nu.ca) needs to be copied on all clearance decisions for cases
- Asymptomatic testing as part of cluster and outbreak management follows the direction of the public health physician (i.e. PHO Lead).
- In a community with outbreak, those who decline testing, HCP to inform RCDC/TCDS who discuss with PHO Lead appropriate next steps.

- Purpose of the monitoring calls:
    - Case – daily check-in until day 10 after symptom onset (or test collection date if asymptomatic)
        - Purpose: support isolation, clarify contacts & gatherings, reminder to call health centre if need additional health care
        - Should not include detailed symptom inquiry
        - Recommended daily (PHO Lead may recommend different frequency in outbreak setting)
    - High-risk contact calls – daily if capacity (otherwise PHO Lead may advise an alternate schedule such as d 0,3,7,10,14) from last exposure date
        - Isolate for 14 days after last exposure (**regardless** of any negative test results received)
        - Purpose: identify if new onset symptoms and immediate test, support isolation, communicate test results, answer questions
        - For high-risk contacts with a case in the same household, calls should continue until 14 days after the last infectious date of the most recent case in the household (i.e. 10 days after symptom onset or test collection date for most recent household case).
        - asymptomatic testing only as directed by PHO Lead
    - Low risk contacts identified
        - No calls or monitoring required
        - If identified, can be listed and classified as low-risk contacts on contact tracing list.
    - Symptomatic individuals (non-case, non-contact; e.g. called hotline or presented to health center)
        - No calls or monitoring required
        - If high level of concern (e.g. recent return from OOT or community of concern such as Arviat), can treat as probable case and immediately do contact tracing and isolate high risk contacts until test result; this would typically be flagged for and discussed with PHO Lead and/or at outbreak team meeting.
        - If test result comes back positive, then follow case and contact flows above
    - When test results received
        - Positive result → follow case flows above
        - Negative result → at least one call to inform result, remember to re-enforce isolation 14 days after last exposure if high-risk contact
        - While awaiting results asymptomatic individuals self-isolate, high-risk contacts definitely self-isolate, asymptomatic individuals with no high-risk contacts (for example those who had asymptomatic surveillance testing done and are not a high-risk contact) do not need to self-isolate

Appendix E – Daily Monitoring Form

Last name: First name: Community:

Client Information:

DOB: ____(dd/mm/yyyy)____ **Language spoken:** ________________

Phone: ______________ **House #** ________________

Healthcare Provider Monitoring: daily or days 3 , 7 , 14

Start date: ____(dd/mm/yyyy)____ **Planned end date:** ____(dd/mm/yyyy)____

Revised end date (if applicable): ____(dd/mm/yyyy)____

Day		1	2	3	4	5	6	7	8	9	10	11	12	13	14
Month:________ Year: ________	M/DD A02 for April 2														
Symptoms	**Legend#1:** ✓ = present ×= not present (as required: ↑ = Increased (worse) ↓ = decreased (better))														
Shortness of breath/ difficulty breathing															
Cough															
Fever **Specify °C if possible**		°C	°C	°C	°C	°C	°C	°C	°C	°C	°C	°C	°C	°C	°C
Sore throat															
Nasal congestion															
Other (enter in notes below)															
	Legend#2: NH = not home M = message left NA = no answer RR= referral to RCDC AC = acute care referral														
Additional remarks: Use legend #2															
Initials of caller															

Caller's Name: ________________________ Caller's Initials: __________
Caller's Name: ________________________ Caller's Initials: __________
Caller's Name: ________________________ Caller's Initials: __________
Caller's Name: ________________________ Caller's Initials: __________

Caller's Name: ________________________ Caller's Initials: __________
Caller's Name: ________________________ Caller's Initials: __________
Caller's Name: ________________________ Caller's Initials: __________
Caller's Name: ________________________ Caller's Initials: __________

- Use in conjunction with COVID-19 Protocol.
- If questions asked of proxy, please document in notes.
- Refer to health care as required.

Completed form scanned and emailed to RCDC on: ____(dd/mm/yyyy)____
Scan and send to RCDC within 24 hours of end of monitoring period, sooner if concerns. Unless otherwise advised, place monitoring form into patient chart (or scan into meditech) once completed.

Appendix E – Daily Monitoring Form

Last name: First name: Community:

Last Name: ____________________

First Name: ____________________

DOB: ____________ (dd/mm/yyyy)

COVID-19 Contact Tracing Form

For RCDC/TCDS/EPI Use only: Case # _____

Community: Home ________________

Current ________________

Contact of: ________________

Date [-Á&æ^Á^{]d{ Á}•^c(or test collection date if asymptomatic): (dd/mm/yyyy) @ 24-hour clock

Person Under Investigation
Probable Case
Confirmed Case (if applicable)

Identify and list ALL contacts:

From: ____________________ **(72 hrs prior or as directed)**
(dd/mm/yyyy) @ 24-hour clock

To: ____________________
(dd/mm/yyyy) @ 24-hour clock

HIGH risk exposure (close contact of a case) includes the below, if during their infectious period:

•Anyone who lives with a case, has direct physical contact with a case, or is exposed to their infectious body fluids, including the case's caregiver, intimate partner, child receiving care from the case, etc.

•Anyone who has shared an indoor space (e.g., same room) with a case for a prolonged period of time (more than 15 minutes) including closed spaces, crowded places, or setting where close interactions may occur (e.g., social gatherings, workplaces, etc.), without adhering to appropriate individual-level and setting-specific risk mitigation measures.

LOW risk exposure:

• Anyone who provided care for the case, with consistent and appropriate use of recommended PPE and infection prevention and control practices.

• Anyone who has shared an indoor space (e.g., same room) with a case, including closed spaces, crowded places, or settings where close interactions occur (e.g., social gatherings, workplaces, etc.), with adherence to physical distancing (2 metres between people) and mask wearing.

Details about contact with the case (e.g: same household, baby sitting, house-visiting, work place)

Symptom inquiry for the **contact** under investigaton (**not** the source case)

Complete PUI assessment form for all high risk and symptomatic contacts

Follow COVID-19 Healthcare Provider Flowchart for guidance on lab testing and precautions.

Precaution types:

- Isolation
- Self-Monitoring
- N/A

Name of Contact (Last Name, First name)	**DOB** (dd/mm/yyy) Age	**Sex** M/F/ other	**Phone Number(s)**	**Community/ House #**	**Date and type of last contact** (dd/mm/yyyy)	**Relationship, setting or type of contact with case**	**Symptomatic** (Y/N) **and** onset date dd/mm/yyyy	**PUI form Completed** (dd/mm/yyyy)	**Testing indicated Y/N If yes: date done** (dd/mm/yyyy)	**Precautions Indicated (type) Date started:** (dd/mm/yyyy
#1			H:		☐ High ________					
			C:		☐ Low________					
#2			H:		☐ High ________					
			C:		☐ Low________					

Reporting Clinician Name ________________ Date Completed________________ Contact Information________________

COVID-19 Contact Tracing Form_v7_Final_31March2021
Government of Nunavut, Department of Health

Note: This PDF fillable must be opened in Adobe Acrobat or it will not work correctly. It can also be printed and scanned.

Last Name: ____________________

First Name: ____________________

DOB: ___________ *(dd/mm/yyyy)*

COVID-19 Contact Tracing Form

Continued…

Name of Contact (Last Name, First Name)	DOB (dd/mm/yyyy) / Age	Sex (M/F/ other)	Phone Number(s)	Community/ House #	Date and type of last Contact (dd/mm/yyyy)	**Relationship,** Setting or type of contact with case	Symptomatic (Y/N) **and** onset date dd/mm/yyyy	PUI form Completed (dd/mm/yyyy	Testing Indicated (Y/N) If yes, collected on (dd/mm/yyyy)	Precautions Indicated (type) Date started: (dd/mm/yyyy)
#3			H: C:		☐ High ___________ ☐ Low___________					
#4			H: C:		☐ High ___________ ☐ Low___________					
#5			H: C:		☐ High ___________ ☐ Low___________					
#6			H: C:		☐ High ___________ ☐ Low___________					
#7			H: C:		☐ High ___________ ☐ Low___________					
#8			H: C:		☐ High ___________ ☐ Low___________					

Additional information on contacts (e.g. gatherings while infectious, possible links between contacts not clearly indicated above or more information):

Exposure assessment ("backward contact tracing") for case (e.g. possible exposures for cases and others around them in past 14-30 days, large gatherings attended, crowded spaces, etc) [see protocol for more guidance]:

Reporting Clinician Name ____________________ Date Completed __________________ Contact Information______________________

APPENDIX G - Script for Explaining Self-Isolation or Isolation
Please note – may not be said verbatim but main points need to be addressed by health care provider or public health team member providing guidance

1. We are asking you to go into isolation at home because you ___________________.

2. The reason why it is so important to stay on isolation is because we are all working together to stop the spread of the virus to protect our whole community. Even if you don't feel sick you need to stay on isolation until you are told that you don't need to be anymore.

3. What does self-isolation mean to you? (listen to response & clarify with bullets below)
   - Staying home or in designated isolation area of your home (could be a room)
   - Not going out to grocery store, work, or anyone else's house
   - Household members to stay in separate area (at least 2 metres away where feasible)
   - Nobody should visit in your house who doesn't live there

4. Someone will be in touch with you regularly (usually by phone) to see how you are feeling, and to help you if you need anything.

5. Isolation can be hard for people, what do you think will help you to be able to follow this rule? (provide resources etc.)

6. In order to make sure our communities are protected, isolation is mandatory. People who are found to not follow these rules may get: a verbal warning, a written warning, or a large fine. We don't want this to happen to you but want you to understand how important it is to follow the isolation rules.

7. Once you are no longer on isolation, we ask that you still follow the general rules about physical distancing, wearing a mask, not visiting or spending time indoors with people you do not live with and avoiding crowds.

There are translated posters on the GN website and other resources that may help with isolation support.

More detailed guidance on isolation, initially gathered in Spring 2020, is also included on the subsequent pages below for optional reference.

Instructions for isolation of an individual with COVID-19 in the home or co-living setting

“Isolation” and “self-isolation” means:

- Not going out unless directed to do so (i.e. to seek medical care)
- Not going to school, work, or other public areas
- Not using public transportation (e.g. taxis)

The following steps should be followed by every household where a Person Under Investigation, or a positive case is isolating or self-isolating:

1. Limit Contact with Other People in the Household – Physical Distancing in the Home

Any person who is sick with COVID-19 should avoid being close to anyone else, including people who live in the same house. If possible, the person who is sick should have a room to themselves, and eat alone, and spend all day alone until they no longer have symptoms and the nurse or doctor says they are clear to come off isolation or self-isolation.

At all times – the person who is sick should be at least 2 meters apart from everyone else in the household. If the person requires a caregiver, then gloves, face protection and hand hygiene should be used.

If a separate room is not possible, ensure that shared spaces are well ventilated (e.g. windows open, as weather permits). If it is difficult to separate the person physically in their own room, hanging a sheet from the ceiling to separate the ill person from others may be considered. If the sick person is sleeping in the same room as other persons, it is important to maintain at least 2 metres distance from others (e.g. separate beds and have people sleep head-to-toe, if possible).

Visitors should not be allowed at any time, unless they are providing care or delivering supplies or food. Every effort should be made so that visitors can drop off supplies outside and have no contact with household members or enter the building of the sick person.

2. Avoid Sharing Personal Household Items

The individual should not share personal items with others, such as toothbrushes, towels, cloths, bed sheets and blankets, cigarettes, unwashed eating utensils, drinks, phones, computers, or other electronic devices. A garbage bin with garbage bags should be placed in the room where the sick person is.

3. Clean all high-touch surfaces

Disinfectants can kill the virus making it no longer possible to infect people. High-touch areas such as toilets, bedside tables and door handles should be disinfected daily. Rooms and shared spaces (such as bathrooms and kitchens) where sick people are

recovering should be disinfected at least every day. High-touch electronics such as phones, computers and other devices may be disinfected with 70% alcohol (e.g. alcohol prep wipes) if they can withstand the use of liquids for disinfection. If objects in the house can not be disinfected, they should not be shared between the person who is sick and other people in the household.

If possible, an approved *hard surface disinfectant* with a **Drug Identification Number (DIN)** should be used. A DIN is an 8-digit number given by Health Canada that confirms the disinfectant product is approved and safe for use in Canada. When approved *hard surface disinfectants* are not available for household disinfection, a diluted bleach solution can used by following the instructions on the bottle or the instructions provided by the Government of Nunavut available on their website. Follow instructions for proper handling of household (chlorine) bleach.

4. Be Safe When Doing Laundry and Throwing Out Garbage.

Clothing, towels and bed sheets and non-medical masks belonging to the sick person can be washed together with other laundry, using regular laundry soap and hot water (60-90°C). Laundry should be completely dried. If someone other than the sick person is washing the clothes, then gloves, face protection and hand hygiene should be used.

Garbage bags from the room of the sick person should be tied up by either the sick person themselves or a caregiver who is using proper gloves, face protection and hand hygiene.

5. All People in the Household Should Practice “hand hygiene”

Hand hygiene means the practice of hand washing, or hand sanitizing and actions taken to maintain healthy hands and fingernails. It should be done regularly with soap and water for at least 20 seconds:

- Before and after preparing food;
- Before and after eating;
- After using the toilet;
- Before and after using a mask;
- Before and after using disposable or reusable gloves;
- Whenever hands look dirty.

Handwashing with plain soap and water is the preferred method of hand hygiene, because it can remove infection causing bacteria and viruses and it can clean visibly dirty hands.

If soap and water are not available, hands can be cleaned with an alcohol-based hand sanitizer (ABHS) that contains at least 60% alcohol, ensuring that all surfaces of the hands are covered (e.g. front and back of hands as well as between fingers) and rub

them together until they feel dry. For visibly dirty hands, remove soiling with a wipe first, followed by use of ABHS.

When drying hands, disposable paper towels are preferred, but a dedicated reusable towel may be used and replaced when it becomes wet.

Avoid touching their eyes, nose, and mouth with unwashed hands because this is a main way to become infected with a virus or a bacteria.

6. Gloves

Disposable single use gloves should be worn when a household member is in direct contact with the sick person, cleaning surfaces or spaces where the sick person is, and handling things with body fluids, including dishes, cutlery, clothing, laundry, and garbage.

Reusable gloves are OK (the yellow and pink ones available at the stores); but they must be cleaned with soap and water then disinfected every time they are used.

You must also wash your hands before and after using gloves:

- Perform hand hygiene before putting on gloves;
- If your gloves become dirty or rips while giving care/cleaning the area of the sick person, remove them, wash your hands and put on new gloves. This will prevent you from spreading dirt around the room;
- Perform hand hygiene after removing gloves;
- Double-gloving is not necessary and does not provide extra safety.

When removing gloves be sure not to touch the outside of the glove (the dirty side). Make sure that you throw them into a garbage bin with a garbage bag that is dedicated to the sick person.

7. All people in the house should practice “Respiratory Etiquette”

“Respiratory etiquette” means paying attention to how you talk, breathe, cough and sneeze. By paying attention to these things you can help reduce the spread of the virus.

- Try to cough or sneeze into a tissue or Kleenex and throw it away into a garbage bin with a garbage bag OR
- Cough/sneeze into the bend of your arm
- Never cough or sneeze into your hand because your hand touches a lot of surfaces and may spread the virus quickly. If you accidentally cough/sneeze into your hand – be sure you wash your hands before touching anything else.

8. Masks and Homemade Masks/Barriers and Eye Protection

Medical masks (sometimes called surgical masks or procedure masks) provide some protection when trying to stop the virus from spreading from a sick person to someone who does not have the infection. When a sick person coughs, sneezes or breathes – they can release droplets of tiny liquid that have the virus in them. Physical barriers such as medical masks, homemade masks, or other barriers such as bandanas can stop the virus from spreading by someone who is infected with it.

Masks alone cannot stop the virus from spreading. “Respiratory etiquette” and hand hygiene are very important parts preventing the spread of the virus. Standing at least 2 meters apart (physical distancing) as much as possible will also stop the virus from spreading to people.

- When it is not possible to always stay 2 meters away from people, the sick individual should use either a mask or another barrier.
- If a healthy person must provide care to a sick person then the care giver should use a mask/barrier. Eye protection should be used with a mask or barrier, because the virus can enter through a person’s eyes.

Follow these steps to make sure you are using masks or other physical barriers properly:

1. Wash your hands before putting on a mask.
2. Hold the outside of the mask or barrier and put over the nose and the mouth. Make sure that the barrier is snug in place and will not fall off or need to be adjusted.
3. Once the mask is on – do not adjust it, lift it to speak or remove it and replace it. Part of stopping the virus from spreading is getting used to never touching your face. If you accidentally touch your face be sure to wash your hands immediately or as soon as possible.
4. To remove the mask/barrier: remove the loops of the mask or untie the barrier from behind. Make every effort to make sure the front of the mask does not touch your face or anywhere else.
5. Wash your hands after removing a mask/barrier.
6. If the mask becomes wet, dirty with mucus, or damaged it should be replaced. Follow steps 1-5.

9. Self-care while recovering

a) Treatment

There is no specific medicine/treatment for COVID-19. The individual with COVID-19 should rest, eat nutritious food, stay hydrated with fluids like water, and manage their symptoms. Over the counter medication can be used to reduce fever and aches. Vitamins and complementary and alternative medicines are not recommended unless they are being used in consultation with a licensed healthcare provider.

b) Monitor symptoms and temperature regularly
The individual should monitor their symptoms and immediately report worsening of symptoms to a health care provider. Daily monitoring is recommended as outlined in Appendix D – COVID-19 Healthcare Provider Flowchart.

The individual should monitor their temperature daily, or more frequently if they have a fever (e.g., sweating, chills), or if their symptoms are changing. Temperatures should be recorded and reported to healthcare providers doing the daily monitoring. If the sick person is taking acetaminophen (e.g. Tylenol) or ibuprofen (e.g. Advil), the temperature should be recorded at least 4 hours after the last dose of these fever-reducing medicines.

c) Maintain a suitable environment for recovery
The environment should have good air exchange (by vents not fans) and free of tobacco or other smoke where possible. Airflow can be improved by opening windows and doors, as weather permits. Where possible, the sick person should have access to electronics to remain "socially connected" by social media, or other communication.

10. Supplies for the Household If Possible

- Enough food for two weeks if possible;
- Medical mask or homemade mask/barrier;
- Disposable Gloves or reusable gloves;
- Eye protection; Thermometer;
- Fever-reducing medications;
- Hand soap;
- Alcohol based hand sanitizer containing at least 60% alcohol;
- Tissues; Garbage bin with garbage bags;
- Regular household cleaning products;
- Approved hard-surface disinfectants that have a Drug Identification Number (DIN) or if an approved hard surface disinfectant is not available, bleach;
- Alcohol (70%) prep wipes or cleaners suitable for cleaning high- touch electronics (e.g., phones);
- Regular laundry soap;
- Dish soap;
- Disposable paper towels or hand towels for drying hands.

Adapted from the Public Health Agency of Canada guidance retrieved from: https://www.canada.ca/en/public-health/services/diseases/2019-novel-coronavirus-infection/health-professionals/interim-guidance-cases-contacts.html#app

COVID-19 Public Health Protocol V 7.1
Appendix H
Personal Protective Equipment Education for Health Care Professionals

This learning package is intended for all Government of Nunavut Health Care Professionals. This training is self directed and is mandatory for all HCP's.

All government of Nunavut Employees working within the community health centre shall apply routine practices in the administration of their work. Please review document, and watch videos provided below.

Then complete a brief survey on Microsoft Teams. You will not officially be graded on this test. It will help keep track of how many people have completed the testing across the territory and will help to identify gaps needed for education.

1. Review the attached pdf on Personal Protective Equipment and Health Care Professionals:

PPE and HCP.pdf

2. Follow each link below to watch PPE Donning and Doffing video from Nunavut, and from Alberta Health services:

https://drive.google.com/file/d/1DPjmxIJO1yCCXrfWVEN81sBAV8SJ_jWl/view?ts=5e67a002

https://www.albertahealthservices.ca/info/page6422.aspx

3. Watch video from Health Canada on Hand Hygiene:

https://www.canada.ca/en/public-health/services/video/covid-19-hand-washing.html

4. Follow this link to complete test on PPE and HCP. It should only take 5-10 minutes.

https://forms.office.com/Pages/ResponsePage.aspx?id=d77rcoB6vUmHZ6GdCKt0bBX2-EZWOVxJp0hd8Gwney9UNzdFRkI2UTBFWFRITDRCM005R01BOVJTTC4u

Contact your regional educator for questions or concerns.