



Coronavirus Disease 2019 (COVID-19)

CDNA National Guidelines for Public Health Units

Version 6.4

14 January 2022

Summary of revision history

For full revision history, refer to Appendix E

Version	Date	Revised by	Changes
6.4	14 January 2022	Communicable Diseases Network Australia	Revisions to reflect National Cabinet decisions and AHPPC recommendations to revise test, trace, isolate and quarantine (TTIQ) in the context of high levels of COVID-19 transmission. Updated: Surveillance, Case definition, Testing, Case management, Release from isolation criteria, Close contact definition, Management of contacts
6.3	24 December 2021	Communicable Diseases Network Australia	Updated: Vaccination, Surveillance, Case investigation, Release from isolation criteria, Management of contacts, Aircraft passengers and crew, Appendix B
6.2	09 December 2021	Communicable Diseases Network Australia	Revisions to reflect emergence of the Omicron variant Updated: The Disease, Case definition, Genomic sequencing, Release from isolation criteria, Close contact definition, Management of contacts, Use of vaccination in outbreak situations, Appendix D (Table 4)
6.1	15 November 2021	Communicable Diseases Network Australia	Updated: Release from isolation criteria
6.0	08 November 2021	Communicable Diseases Network Australia	Revisions reflect ongoing community transmission in some Australian jurisdictions and progress through the phases of the National Plan to transition Australia's National COVID-19 Response.

These guidelines outline Australia's national minimum standard for surveillance, laboratory testing, case management and contact management for coronavirus disease 2019 (COVID-19). Jurisdictions may implement policies that exceed the national minimum standard based on local epidemiological context. CDNA will review and update these recommendations as new information becomes available on COVID-19 and the situation in Australia.

Readers should not rely solely on the information contained within these guidelines. Guideline information is not intended to be a substitute for advice from other relevant sources including, but not limited to, the advice from a public health specialist or other health professional. Clinical judgement and discretion may be required in the interpretation and application of these guidelines.

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Abbreviations

- COVID-19: Coronavirus disease 2019. The name of the disease caused by the virus SARS-CoV-2, as agreed by the World Health Organization, the World Organisation for Animal Health and the Food and Agriculture Organization of the United Nations. For more information, refer to the [WHO Director-General's remarks at the media briefing on 2019-nCoV on 11 February 2020](#).
- SARS-CoV-2: Severe acute respiratory syndrome coronavirus 2. The formal name of the coronavirus that causes COVID-19, as determined by the International Committee on Taxonomy of Viruses. Previously, this coronavirus was commonly known as 'novel coronavirus 2019 (2019-nCoV)'. For more information, refer to the [Consensus Statement of the Coronaviridae Study Group of the International Committee on Taxonomy of Viruses](#).

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1. Summary

These guidelines outline Australia's national minimum standard for surveillance, laboratory testing, case management and contact management for COVID-19. Jurisdictions may adapt this guidance based on local epidemiological context.

Guidance within this document reflects Australia's progress through the [National Plan to transition Australia's National COVID-19 Response](#) and the evolving COVID-19 situation in Australia.

Updates have been made in response to the National Cabinet's decision to [reset TTIQ measures in the context of high case numbers and the Omicron variant](#), including the [usage of rapid antigen tests \(RATs\)](#), as well as the [AHPPC statement on TTIQ in high levels of COVID-19 community transmission in the context of high levels of COVID-19 transmission](#).

Additionally, this document contains revised case and contact management guidance as detailed in the [National Cabinet agreed COVID-19 Test & Isolate National Protocols](#).

CDNA has revised the guidance in this document for pragmatic reasons in response to a context of high case prevalence, altered policy settings and increased risk tolerance, and the significant impacts previous requirements have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

For detailed guidance on infection prevention and control, refer to [Infection Control Expert Group \(ICEG\) endorsed infection prevention and control guidance](#).

Public health priority

Urgent – initiate public health responses as soon as possible. Public health responses may be automated and prioritised to assist with maintaining public health workforce capacity.

Case management

[Confirmed cases](#) must isolate according to [isolation and restriction guidance](#) until they meet the appropriate [release from isolation criteria](#), regardless of vaccination status.

Hospitalised confirmed cases should be isolated in a negative pressure room with anteroom, where available. For guidance on infection prevention and control for routine care of confirmed COVID-19 patients, including personal protective equipment (PPE), see [ICEG-endorsed infection control guidance](#).

[Historical cases](#) do not need to isolate and public health units (PHUs) do not need to follow up their contacts.

Contact management

PHUs should manage [close contacts](#) according to [management of contacts](#) guidance.

2. Key definitions

Low or no community transmission

Low or no community transmission, in this guidance refers to infrequent or no COVID-19 cases acquired within a PHU's geographic area of responsibility.

Community transmission

Community transmission, in this guidance refers to when there are multiple COVID-19 cases in the community, where the source is unknown and presumed to have been acquired from another case within that jurisdiction.

Fully vaccinated person

Fully vaccinated refers to a person who is ≥ 14 days following receipt of the final dose of a primary course of COVID-19 vaccine [approved or recognised by the Therapeutic Goods Administration \(TGA\)](#)¹.

Partially vaccinated person

Partially vaccinated refers to a person who has received at least one dose of a COVID-19 vaccine registered by the TGA but does not meet the definition of a fully vaccinated person.

Reinfection

A subsequent confirmed SARS-CoV-2 infection in a person with a past known history of confirmed COVID-19 that is determined to be a separate episode to the first based on epidemiological and/or laboratory findings. SARS-CoV-2 RNA detection must be greater than **4 weeks** after the first laboratory confirmed infection to be considered reinfection. Wherever feasible, whole genome sequencing should be undertaken for suspected reinfections.

Breakthrough infection

A confirmed episode of SARS-CoV-2 infection in a fully vaccinated person > 14 days following their final dose of a primary course of COVID-19 vaccine.

COVID-19 death

A COVID-19 death is defined for surveillance purposes as a death in a confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death. Where a Coroner's report is available, these findings are to be observed.

¹ There may be differing operational definitions of fully vaccinated in jurisdictions and for purposes of international travel.

3. The disease

Infectious agent

SARS-CoV-2 is the infective agent that causes COVID-19. SARS-CoV-2 is a novel coronavirus that was first identified in humans in Wuhan, China, in December 2019. In 2021, the SARS-CoV-2 Delta variant became the predominant variant of the virus in Australia.

Coronaviruses are a large family of viruses, some causing illness in people and others that circulate among animals, including camels, cats and bats. Human coronaviruses cause mild illness in humans, such as the coronaviruses that cause the common cold. Rarely, animal coronaviruses can evolve and infect people and then spread between people. Mutations allowing human-to-human transmission have led to outbreaks of severe acute respiratory disease due to MERS-CoV and SARS-CoV.

Reservoir

The [*WHO-convened Global Study of Origins of SARS-CoV-2: China Part*](#) suggests bats and pangolins may be the reservoir for SARS-CoV-2. While the coronaviruses most highly related to SARS-CoV-2 are found in bats and pangolins, they are not sufficiently similar to be definitively confirmed as the reservoir. Further investigation is required to confirm the origin of SARS-CoV-2 (1).

Mode of transmission

SARS-CoV-2 can be transmitted through respiratory droplets, smaller particles (aerosols), direct physical contact with an infected individual, and indirectly through contaminated objects and surfaces (2). While the exact relative contributions of these routes remains unclear, those who have been in close contact with a COVID-19 case are at highest risk (2).

Aerosol transmission

There is a gradient from large droplets to smaller aerosols, which may contribute to transmission of SARS-CoV-2 in certain situations. These include during aerosol generating procedures in clinical settings, in the context of certain behaviours, such as singing and shouting (3) and in certain environmental conditions. These behaviours and conditions can increase the force and range of spread of both large and small particles. Where an indoor environment has a low air exchange rate (i.e. less movement of outside air replacing the air indoors), small particles that are normally rapidly dispersed may remain suspended or be recirculated for longer periods. The particles may be moved around by natural airflow, fans or air conditioners. In these situations, airflow may play a role in transmission.

Indirect transmission

Respiratory droplets and secretions expelled by an infectious person can contaminate surfaces and objects (2). Indirect transmission via contact with contaminated surfaces and objects may be possible but does not present the same degree of risk as direct close contact with an infected person. Live SARS-CoV-2 virus can survive on surfaces for several hours to a few days, depending on the surface type and environmental conditions (4, 5). However, SARS-CoV-2 can be rapidly inactivated by alcohol, household bleach, and other chemicals (6).

Reproduction number and transmission dynamics

Estimates for the basic reproductive number (R_0) of early SARS-CoV-2 variants ranged from 2–4 (7). R_0 for confined settings were potentially at the higher end of this range. The Delta variant of SARS-CoV-2 is more transmissible than previously identified variants with infectiousness nearly twice that of the historical variant (8).

Estimates of the effective reproductive number (R_{eff}) vary between settings and at different time points. R_{eff} is dependent on a range of factors. These include public health interventions such as isolation, quarantine, physical distancing, and mask wearing to limit exposure between people (9, 10).

SARS-CoV-2 variants of concern or interest

As the pandemic progresses SARS-CoV-2 variants continue to emerge. Some variants are classified as ‘variants of concern’ (VOC), as there is evidence for epidemiological, biological, or immunological features of concern. Some SARS-CoV-2 VOC may be associated with increased transmissibility or higher mortality compared with other lineages (11, 12).

As VOC are identified, studies are required to understand the impact of mutations on viral characteristics such as transmissibility, disease severity, vaccine efficacy, immunity after previous infection, incubation period, and infectious period. These factors have implications for public health measures necessary to protect the community and the health system. There may be a delay between the identification of cases in Australia who are infected with a new VOC, and the availability of data and evidence to guide appropriate public health interventions. Where there are emerging VOC with uncertain viral characteristics, it is prudent for jurisdictions to consider a more conservative approach to case and contact management, such as increased testing, isolation and quarantine requirements until more is known about the VOC and its epidemiological and clinical implications. More conservative public health and social measures may also be considered during this time. Depending on the characteristics of the virus, these measures may remain in place, even once the epidemiological and clinical implications are known.

Lineages for which there is no clear evidence that the mutations confer epidemiological, pathological or immunological features of concern may be denoted ‘variants under investigation’ or ‘variants of interest’. For more information see: [PHLN statement on reporting of SARS-COV-2 variants of concern and interest](#).

The [Communicable Diseases Genomics Network \(CDGN\)](#) actively monitors variants and their reported mutations to understand how they influence the behaviour of the virus.

Jurisdictions should review, reinforce and continue to monitor the full range of existing infection prevention and control measures in response to SARS-COV-2 variants. For more information see [ICEG-endorsed infection control guidance](#).

Incubation period

Prior to the emergence of the Delta variant, the median incubation period for people who became symptomatic was 5 to 6 days after coming into contact with another infected person, with a range of 1 to 14 days (13-15). Around 1% of COVID-19 cases developed symptoms more than 14 days after exposure (16). Evidence for the Delta variant incubation period is still emerging, however some studies suggest it may be shorter than other lineages (17, 18).

There is currently limited evidence to determine how the incubation period for breakthrough infection in vaccinated individuals may differ from infection in unvaccinated individuals.

Infectious period

Several studies have confirmed the occurrence of pre-symptomatic and asymptomatic transmission (19, 20). Pre-symptomatic transmission can occur 1-3 days before symptom onset (21, 22). Peak viral load in upper respiratory tract samples occurs most often around the time of symptom onset and declines after the first week following symptom onset (23).

High viral loads have been detected in asymptomatic, pre-symptomatic and symptomatic individuals, suggesting the potential for transmission irrespective of the presence of symptoms (20). However, faster viral clearance and subsequent shorter infectious periods have been observed for asymptomatic individuals (23). Symptomatic and pre-symptomatic individuals have a greater role in the spread of SARS-CoV-2 with a higher secondary attack rate than those who remain asymptomatic throughout their illness (24).

It has been demonstrated that the Delta variant is associated with higher viral burden and longer duration of viral shedding compared to previous variants of SARS-CoV-2 (25, 26). Currently available evidence suggests that initial viral load is similar between vaccinated and unvaccinated individuals, however some studies have found that vaccinated people have a more rapid decline in viral load than unvaccinated people (27-29).

For the purposes of routine contact tracing, cases are considered infectious from 48 hours prior to symptom onset. More conservative periods (e.g. 72 hours prior to illness onset) may be considered in high risk settings. This should be at the discretion of the PHU. Confirmed cases pose a risk of onward transmission and require isolation until criteria listed in the [Release from isolation section](#) have been met.

Clinical presentation and outcome

COVID-19 presents as a mild illness in approximately 80% of cases. Evidence suggests the most common symptoms are fever, cough, dyspnoea, malaise, fatigue, loss of taste and/or smell, and sputum/respiratory secretions (30-32). Other symptoms include headache, sore throat, shortness of breath, myalgia, rhinorrhoea, chills, and vomiting. Atypical symptoms may include chest pain, diarrhoea, and conjunctivitis (30-33). Loss of smell and/or taste are more common presenting symptoms than initially thought, seen in approximately 50% and 40% of cases, respectively (34).

The majority of cases recover from infection without clinical intervention, however, approximately 20% of identified cases globally to date have resulted in moderate to severe disease requiring hospitalisation. International cohort studies have suggested unvaccinated or partially vaccinated people infected with the Delta variant are more likely to be hospitalised than patients infected with the Alpha variant (35, 36)

Some individuals remain asymptomatic throughout infection. Estimates of the proportion of cases which remain asymptomatic throughout their infection range from 15 to 48% (19, 20, 37-40). It is unclear at this stage whether the higher viral burden associated with the Delta variant has changed the proportion of asymptomatic infections.

Fully vaccinated people can still become infected though infection is less likely than in someone who is unvaccinated. Disease associated with breakthrough infection is less severe, however, the risk of onward transmission appears to be similar to that for

unvaccinated individuals (41); however the period of infectiousness appears to be shorter in vaccinated cases. Severe disease can still occur in a small proportion of vaccinated people particularly the elderly and those with certain co-morbidities (42, 43).

COVID-19 in children

Acute infection with SARS-CoV-2 is generally associated with mild disease in children, and compared to adults, children have almost 25 times lower risk of severe disease (44, 45). However, however the period of infectiousness appears to be shorter in vaccinated cases. children may be hospitalised for social, rather than clinical, reasons, for example if both parents are too unwell to care for them. A rare but severe complication of COVID-19 seen in children and adolescents is Paediatric Inflammatory Multisystem Syndrome Temporally associated with SARS-CoV-2 (PIMS-TS). PIMS-TS has features resembling Kawasaki disease (KD) and toxic shock syndrome and typically occurs approximately 2 to 4 weeks after the onset of COVID-19 (46).

Longer term outcomes of COVID-19

Emerging evidence suggests up to 80% of patients with COVID-19 experience ongoing symptoms beyond two weeks following onset of acute infection (47). A large systematic review of the body of evidence collected on the post-acute sequelae of COVID found the median proportion of COVID-19 survivors experiencing at least one sequelae was 54% at 1 month (short-term), 55% at 2 to 5 months (intermediate-term), and 54% at 6 or more months (long-term.) (48, 49). In the UK, prevalence of self-reported post-acute sequelae of COVID-19 has been highest in people aged 35 to 69 years, females, people living in more disadvantaged areas, people working in health or social care, and people with disabilities (50).

Case fatality rate

As at **13 January 2022**, the crude case fatality rate (CFR) for confirmed cases reported globally is approximately **1.8%** (51). The true case fatality rate for COVID-19 is difficult to estimate due to variable case ascertainment, especially for mild cases, and the impact of health systems and patient outcomes. Mortality is influenced by individual risk factors and health care quality and access. Australia's CFR is less than 1% (based on surveillance data notified in Australia as of **13 January 2022**). As of **13 January 2022, 39% (977/2522)** of COVID-19 deaths in Australia have occurred in residential aged care facility residents who may be at higher risk of severe disease and death (based on aged care public dashboard data and surveillance data).

Immune response

Evidence is still emerging about the immune response to SARS-CoV-2 infection, including duration of immunity and duration of antibody response (51).

The immune response to SARS-CoV-2 involves both humoral and cell-mediated immunity.

IgM antibodies are detectable before IgG antibodies. Levels of IgM antibodies appear to peak at weeks two to five from the onset of symptoms, and then decline (51). IgG antibody levels peak later, approximately three to seven weeks following symptom onset, and then plateau. IgG antibodies have been shown to persist for at least eight weeks and up to several months (51, 52).

Host cellular immunity also plays an important role in the immune response to SARS-CoV-2. (52). Evidence suggests enduring T cell immunity, with a greater magnitude of T cell response, in patients who recovered from severe, compared to mild, disease (52). The longevity of this T cell immunity and the degree of protection it provides remain unclear.

Further studies are required to understand the implications of SARS-CoV-2 variants of concern and the risk of re-infection (see [SARS-CoV-2 variants of concern or interest](#)).

Durability of immunity after SARS-CoV-2 infection likely differs significantly from person to person depending upon a range of factors (age, co-morbidities and pre-existing immunosuppression and previous vaccination). Studies suggest a strong immune response after previous infection, with effective natural immunity to future infectious in most individuals (53). However, vaccination continues to provide the best protection against reinfection (54-58).

Persons at increased risk of exposure

People who have frequent, close, or extended contact with others have the potential for greater exposure to SARS-CoV-2.

People at increased risk of exposure include those who:

- Have travelled to areas with higher prevalence of COVID-19 through international or domestic travel;
- Are caring for COVID-19 cases; or
- Come in contact with people with a higher likelihood of having active infection.

These groups of people often work in certain occupational groups and include, but are not limited to:

- international border staff
- workers supporting quarantine and isolation services
- air and maritime crew
- health care and aged care workers with direct patient contact

Depending on the epidemiological context, there are other groups of workers at higher risk of infection, such as casual and mobile employees working across multiple settings. Some of these workers include cleaners, rideshare service and taxi drivers, and security personnel. There are several factors that may put them at higher risk, including:

- multiple exposure points;
- staff who may have a perceived need to continue work despite being unwell; and
- language barriers for people from culturally and linguistically diverse backgrounds.

Other people at increased risk of exposure might include those in public facing occupations or crowded settings (e.g. hospitality, public transport, retail).

Persons who live or work in a [high-risk setting](#), where there is evidence of a risk for rapid spread and ongoing chains of transmission, may also be at increased risk of exposure if an infectious case is introduced. Settings where disease is likely to readily transmit and be amplified are those with a high population density, settings where people are living or working in close proximity to others, or specific environmental conditions. These settings may include, but are not limited to:

- health care facilities;
- residential aged care facilities;

- residential care facilities;
- crowded or high-density housing;
- Aboriginal and Torres Strait Islander communities (particularly in rural and remote areas)
- correctional and detention facilities;
- homeless shelters and residential/crisis hostels;
- mining sites; and
- food processing, distribution and cold storage facilities, including abattoirs.

People at increased risk of severe disease

Older individuals are at the highest risk of severe COVID-19. Others with certain comorbidities are also at increased risk of severe COVID-19. Information on those at high and moderate risk of severe illness, and other factors that might increase the risk of severe disease, is available on the Department of Health's [Advice for people at risk of coronavirus \(COVID-19\)](#).

4. Routine prevention activities

Vaccination

The COVID-19 vaccination program commenced in Australia on 22 February 2021. The overarching goal of the program is to protect all people in Australia from the harm caused by SARS-CoV-2, through preventing serious illness and death, and, as much as possible, disease transmission. It is anticipated that high levels of COVID-19 vaccination coverage will facilitate the progressive winding back of public health and social measures such as travel restrictions and physical distancing.

As of December 2021, the Australian Technical Advisory Group on Immunisation (ATAGI) recommends vaccination for all individuals aged 5 years and over in a two-dose vaccine schedule (3 doses for severely immunocompromised individuals). ATAGI recommends the use of a single booster dose for anyone aged 18 and older who completed their primary COVID-19 vaccine course ≥ 4 months ago. This will initially include, but not be limited to, groups who were prioritised in the rollout of the vaccine program from early 2021. For more information, see [ATAGI statement on the Omicron variant and the timing of COVID-19 booster vaccination](#) and [ATAGI recommendations on Pfizer COVID-19 vaccine use in children aged 5 to 11 years](#).

The COVID-19 vaccines registered for use in Australia have all been shown to be highly effective against severe disease, including due to the Delta variant (59). Vaccine effectiveness against hospitalisation due to Delta infection has been shown to be 95.2% and 98.4% for Vaxzevria (AstraZeneca) and Comirnaty (Pfizer), respectively, 2 to 9 weeks following the second dose (59). The effectiveness of these two vaccines against death has been shown to be 94.1% and 98.2%, respectively (59). Existing vaccine safety monitoring systems have been strengthened, with weekly COVID-19 vaccine safety reports [provided by the Therapeutic Goods Administration](#) and [AusVaxSafety active surveillance system](#).

Other prevention activities

When combined, prevention and control activities, can help limit the spread of certain respiratory diseases, including COVID-19. These measures may include:

1. Physical distancing and gathering
 - Physical distancing can reduce the potential for transmission. Physical distancing measures may include:
 - maintaining a distance of 1.5m from people
 - density restrictions; and
 - limits on the number of people allowed to participate in an event.
2. Environmental controls, such as optimised ventilation
3. Personal hygiene
 - PHUs should encourage good hygiene practices to prevent SARS-CoV-2 infection including:
 - wearing a face mask where physical distancing cannot be maintained, particularly indoors;
 - staying home if unwell;
 - effective hand and respiratory hygiene; and
 - cleaning surfaces
4. Travel restrictions
 - Some jurisdictions will require quarantine or testing of domestic and international travellers. See [COVID-19 FAQs- international travellers to Australia](#).

5. Surveillance

There are five main objectives of surveillance for COVID-19, which are to rapidly:

1. Identify, isolate and manage cases.
2. Identify, quarantine and provide relevant information to contacts.
3. Detect and manage clusters and outbreaks.
4. Characterise the epidemiology of COVID-19 in Australia to inform the public health response including:
 - analysing the progression of the epidemic in time, person and place;
 - describing the transmission dynamics;
 - identifying groups at special risk of infection or more severe disease; and
 - monitoring for SARS-CoV-2 variants.
5. Monitor the effectiveness of the following routine prevention and control activities, in managing the COVID-19 outbreak over time:
 - vaccination;
 - test, trace, isolate and quarantine processes; and
 - public health and social measures.

Reporting

PHUs should immediately notify the central state/territory communicable diseases unit upon receipt of a notification or report of a confirmed case of COVID-19 or death in an infected person. Jurisdictions can determine reporting requirements for probable cases (e.g. requiring probable cases to self-report positive RAT results).

As much information regarding the case's age, sex, comorbidities, vaccination status, place of residence, occupation, Indigenous status, any culturally/linguistically diverse background, date of onset, travel history, laboratory results, clinical status, likely place of acquisition, identification of close contacts and follow-up action taken should be collected, with additional information being followed up based on risk assessment.

Central state/territory communicable diseases units will notify confirmed COVID-19 cases and deaths as soon as practicable to the Australian Government Department of Health via both transmission of data to the National Notifiable Diseases Surveillance System (NNDSS) and via email or telephone notification to the National Incident Room.

Data management

PHUs should enter initial information on confirmed cases of COVID-19 onto the jurisdictional notifiable diseases database, for transmission to the NNDSS, within one working day of the notification/report. Enter enhanced surveillance data shortly after case follow-up. Jurisdictions are encouraged to prioritise and automate as many of these processes as possible, including linking COVID-19 cases to clinical services.

Surveillance of variants of concern

Early identification of cases, where there is a high probability of infection with a VOC such as the Omicron variant, can inform appropriate public health responses. Ideally, these VOC are identified through whole genome sequencing. Omicron primary test results with spike gene target failure may indicate probable infection with this variant. Where possible, public health reference laboratories should confirm the infecting strain using whole genome sequencing, although this may not be possible where large numbers of cases are occurring.

Jurisdictions can refer to the [CDGN Laboratory Case Definitions for SARS-CoV-2 Variants of Concern](#) for more information.

6. Cases

Definitions

Reporting

Notify confirmed cases in the jurisdiction of public health management. Jurisdictions can determine reporting requirements for probable cases.

People meeting the confirmed or probable case criteria who were previously diagnosed and managed overseas or in another Australian jurisdiction in the past 4 weeks² do not need to be re-notified. In this situation, the person should provide documented evidence of diagnosis overseas or interstate to the PHU.

Confirmed case

The confirmed case definition intends to capture newly diagnosed cases with laboratory definitive evidence to support a diagnosis.

A confirmed case requires [laboratory definitive evidence](#).

Laboratory definitive evidence:

1. Detection of SARS-CoV-2 by nucleic amplification acid testing (NAAT);
OR
2. Isolation of SARS-CoV-2 in cell culture, with confirmation using a NAAT;
OR
3. SARS-CoV-2 IgG seroconversion or a four-fold or greater increase in SARS-CoV-2 antibodies of any immunoglobulin subclass including 'total' assays in acute and convalescent sera, in the absence of vaccination³.

Probable case

A probable case includes individuals who have [laboratory suggestive evidence](#)

Laboratory suggestive evidence:

Detection of SARS-CoV-2 by rapid antigen testing (RAT)

² This time period has been recommended for pragmatic reasons. CDNA will review this recommendation as more evidence becomes available.

³ Antibody detection must be by a validated assay and included in an external quality assurance program. For all serological responses to be counted as laboratory evidence, a person should not have had a previous COVID-19 vaccination.

Testing

Specimen collection and testing for SARS-CoV-2

Nucleic acid amplification testing using reverse transcription polymerase chain reaction (RT-PCR) or transcription-mediated amplification (TMA) is the gold standard for diagnosing acute symptomatic SARS-CoV-2 infection. For advice on selecting a suitable sample for diagnostic RT-PCR testing for SARS-CoV-2; specimen handling in the laboratory; and different types of SARS-CoV-2 specific testing, see [Public Health Laboratory Network \(PHLN\) guidance on laboratory testing for SARS-CoV-2](#).

Alternative testing methods, including rapid antigen testing for SARS-CoV-2, may be used in specific contexts and settings where pre-test probability is high. See [PHLN and CDNA joint statement on SARS-CoV-2 rapid antigen tests](#). PHUs should follow jurisdictional guidance on the use of RATs.

See [CDNA and PHLN Testing Framework for COVID-19 in Australia](#) for guidance on local approaches to testing, including key priority groups based on the likelihood of infection and the epidemiological situation.

Guidance on Personal Protective Equipment (PPE) for specimen collection is available from [ICEG-endorsed infection control guidance](#).

Who to test for SARS-CoV-2

People who have at least one of the following COVID-19 like symptoms should test for SARS-CoV-2:

- Fever (≥ 37.5 °C) or history of fever (e.g. night sweats, chills); or
- Acute respiratory symptoms (e.g. cough, shortness of breath, sore throat); or
- Loss of smell or loss of taste.

Other non-specific symptoms of COVID-19 include: fatigue, headache, runny nose, acute blocked nose (congestion), muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite.

Testing following a possible vaccine-related adverse event

If a vaccine recipient has not had [known contact with a confirmed COVID-19 case](#) and develops fever, headache, fatigue or other mild systemic symptoms within and lasting for less than 48 hours after receipt of a COVID-19 vaccine in the absence of respiratory symptoms (including loss of smell), it is more likely that they have an expected vaccine response and testing may not be required.

If symptoms persist past 48 hours post vaccination, these individuals should get tested. For more information, see [Australian Technical Advisory Group on Immunisation \(ATAGI\) Clinical guidance on use of COVID-19 vaccine in Australia in 2021](#).

Stay at home requirements after COVID-19 testing

Health care workers providing testing services should clearly communicate the following stay at home requirements after COVID-19 testing:

1. Symptomatic people who have tested for SARS-CoV-2 should stay at home until they receive a negative test, regardless of vaccination status.

2. Asymptomatic people who are not close contacts do not need to stay at home whilst awaiting a negative test result, unless instructed to stay at home by a public health authority.

See [Management of Contacts](#) for guidance on quarantine and testing of close contacts.

Assessing indeterminate and suspected false positive NAA results

PHUs should have processes in place with laboratories to manage equivocal results, which may include repeat testing.

Indeterminate or inconclusive NAA results

Indeterminate results may occur due to low viral loads; persistent shedding; or non-SARS-CoV-2 reactivity in the NAAT. In these circumstances, PHUs should contact the laboratory microbiologist to discuss the results and decide whether further testing is required. Consider results in the context of the clinical and epidemiological circumstances to inform whether further public health action is required.

Suspected false positive NAA results

PHUs might suspect a false positive SARS-CoV-2 NAA result when there are no epidemiological risk factors for COVID-19. This is particularly relevant for jurisdictions with low or no community transmission with high levels of enhanced testing.

If a false positive NAAT result is suspected, PHUs should contact the laboratory microbiologist to obtain more details of the test results before designating the result a false positive. The laboratory microbiologist will investigate whether there is evidence of laboratory error or non-specific reactivity in the NAAT, and ascertain whether further testing of the sample is required. If further laboratory investigations provide convincing evidence the case is negative, the test may be considered a false positive and the laboratory will issue an amended report.

For more information on the possible sources of false positive NAAT results, see [PHLN Guidance on Nucleic Acid Test Result Interpretation for SARS-CoV-2](#).

Case management

Response times

Confirmed cases:

For timely follow up of cases, PHUs should use automated case management systems that utilise self-managed contact tracing. Where feasible, jurisdictions may complete case interviews, exposure site identification and contact tracing by phone. Phone-based public health follow up would typically be used in situations where case numbers are very low, where new cases have been identified in settings previously without cases (such as remote communities), in some settings with vulnerable cases and contacts, and where SMS or other automated follow up is not practical.

In exceptional circumstances, some PHU staff may be required to contribute to the expert assessment of patients under investigation on hospital clinician or general practitioner request.

Probable cases:

Where feasible, conduct follow up of [probable cases](#) as per confirmed cases (see above).

Response procedure

Genomic sequencing

Genomic sequencing is an important part of SARS-COV-2 surveillance and can be used to monitor transmission dynamics, identify lineages of concern, and inform outbreak investigation and public health response.

Where community transmission is established, it may not be justifiable to attempt to sequence every COVID-19 case. In these situations, PHUs should employ prioritisation strategies based on their jurisdiction's epidemiological context, capacity and priorities. This approach balances the costs and benefits of real-time SARS-CoV-2 genomic surveillance, where there is rapid spread of a dominant variant.

The [CDGN, PHLN and CDNA Sampling strategy for SARS-CoV-2 genomic surveillance](#) provides guiding principles and outlines an approach to selective and targeted sequencing. This includes guidance on priority groups for targeted sampling (e.g. international travellers).

For further information, see:

- [PHLN guidance on laboratory testing for SARS-CoV-2](#)
- [Testing Framework for COVID-19 in Australia](#)
- [Australian National Disease Surveillance Plan for COVID-19](#)

Case investigation

Where feasible, PHUs should respond to COVID-19 case notifications as soon as possible via a case interview. However, where public health capacity is exceeded, PHUs can automate and prioritise case investigation processes (e.g. SMS based questionnaires). This may include automated surveys to collect only essential information that will assist with risk stratification, prioritisation of cases for public health follow up and surveillance. Priority cases include people in high-risk settings or situations.

PHUs can use [Appendix A - COVID-19 PHU checklist](#) and their state or territory COVID-19 case report as a guide for case investigation.

If automated case management systems are utilised, PHUs should direct cases to self-isolate and provide them with information on how to isolate from others in their residence and what supports are available. PHUs should also provide information detailing how to conduct case-initiated contact management and how to access medical care.

Clinical management

In the absence of pathogen-specific interventions, patient management largely depends on supportive treatment, and vigilance for and treatment of complications. For further advice on *clinical management*, see:

- [WHO](#)
- [National COVID-19 Clinical Evidence Taskforce](#)
- [Cochrane Library: Coronavirus \(COVID-19\)](#)

Prophylaxis against severe disease:

Proactive use of monoclonal antibody therapy in people at high risk of developing severe disease may help prevent hospitalisation if it is administered within the first five days of developing symptoms. PHUs, in conjunction with the local clinical team, can help identify cases for clinical treatment early. For further information on emerging clinical treatments, see [National COVID-19 Clinical Evidence Taskforce](#).

Education

PHUs should **provide access to educational resources** about the nature of the illness, importance of isolation and infection control measures that prevent the transmission of COVID-19. PHU staff should make accessible a COVID-19 factsheet to cases and their household contacts.

Hospitalised COVID-19 patients

To minimise the risk of transmission from hospitalised COVID-19 patients, PHUs should encourage hospitals to undertake a system based risk assessment. Hospitals can manage risk by applying layered mitigations using the [hierarchy of controls](#). This includes using a combination of:

- Elimination controls to reduce opportunities for staff exposure and transmission of the virus (e.g. reducing entry to patient rooms, excluding staff who are unwell and vaccinating staff).
- Engineering controls (e.g. optimising ventilation and using negative pressure rooms, where available).
- Administrative controls (e.g. through implementation of effective infection prevention and control policies and protocols).
- Appropriate use of PPE.

Hospitalised confirmed **or probable** cases should isolate in a negative pressure room with anteroom, where available. If a negative pressure room is not available, the hospitalised case can isolate in a standard isolation room or single room with negative airflow as an alternative. Avoid rooms with positive pressure airflow.

If there is concern about a potential exposure related to a hospitalised case, PHUs should **assist with providing resources to support** risk assessment of hospital staff, visitors or other patients to determine whether further public health response is required (See [Health and residential care workers](#)).

For further guidance on infection prevention and control, including PPE, see [ICEG-endorsed infection control guidance](#).

Release from isolation

Release from isolation criteria for all confirmed or probable cases

Updates to the release from isolation criteria have been made in response to the National Cabinet's decision to [reset TTIQ measures in the context of high case numbers and the Omicron variant](#) and the [AHPCC statement on TTIQ in high levels of COVID-19 community transmission in the context of high levels of COVID-19 transmission](#).

Revisions have been made for pragmatic reasons in response to a context of high case prevalence and the significant impacts previous requirements have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

The following table details release from isolation criteria for all [confirmed](#) or [probable](#) cases as outlined in the [National Cabinet agreed COVID-19 Test & Isolate National Protocols](#).

To calculate the isolation period, day 0 is the day the case took their first positive test. Day 1 is the first full day after the first positive test was taken.

Summary of release from isolation criteria agreed by National Cabinet ⁴	
Asymptomatic case	If they remain asymptomatic after 7 days have passed since their first positive test, the case can be released from isolation.
Symptomatic case	If acute respiratory symptoms ⁵ resolve after 7 days since their first positive test, the case can be released from isolation.
	If acute respiratory symptoms ⁴ remain after 7 days since their first positive test, the case should remain in isolation until their acute symptoms have resolved.

In addition to the above criteria, in some high-risk clinical settings, confirmed cases who are significantly immunocompromised⁶ may be requested to meet the below additional criteria:

- Negative NAAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 7 days have passed since the first positive test; OR

⁴ Some jurisdictions have not adopted the National Cabinet agreed COVID-19 Test and Isolate National Protocols. PHUs in these jurisdictions should refer to their state or territory health department guidance.

⁵ Some people may have pre-existing illnesses with chronic respiratory signs or symptoms, such as chronic cough. Others may have on-going sequelae that result in symptoms such as continuing shortness of breath or post viral cough. For these people, the treating medical practitioner can make an assessment as to whether the respiratory signs and symptoms of acute COVID-19 have resolved.

⁶ Persons who are clinically assessed as being significantly immunocompromised may have a reduced ability to effectively clear SARS-CoV-2 and a prolonged infectious period. Significantly immunocompromised persons may include, but are not limited to, those who: have had an organ transplant and are on immune suppressive therapy; have had a haematopoietic stem cell transplant in the past 2 years; are on immune suppressive therapy for graft versus host disease; have had an active haematological malignancy; human immunodeficiency virus infection with CD4 T-lymphocyte count below 200 cells/per mm³; are receiving dialysis; or other conditions specifically noted by the treating medical practitioner.

- Negative RAT on at least two consecutive respiratory specimens collected at least 24 hours apart, after 14 days have passed since the since the first positive test.

Testing after release from isolation

Recovered cases should be tested for SARS-CoV-2 if they develop new symptoms of COVID-19 at least 4 weeks⁷ after release from isolation.

If at least 4 weeks have passed after release from isolation, and a recovered case has a re-exposure that is outside their immediate household, or there is a new case in their household (and the recovered case had previously isolated away from their household), the recovered case should be managed as a contact.

In the absence of a re-exposure, recovered cases that are asymptomatic do not need to be retested within 4 weeks after release from isolation².

Release from isolation and high-risk settings

Cases returning to a high-risk setting can be released from isolation based on the above criteria and do not need to meet a higher standard/ additional assessment before going into any high-risk settings. This includes persons returning to work in a health care setting, living in a residential aged care facility, or who regularly attend health care settings for any other reason. Specifically, if a person has met RFI criteria, it is not necessary for them to:

- undergo isolation or quarantine in another ward, the facility they are returning to, or any other location, or
- have evidence of any negative test results for SARS-CoV-2 prior to returning to residential aged care or any other setting.

However, there is some laboratory based evidence that a small proportion of people with a previous SARS-CoV-2 variant infection may still be infectious despite fulfilling RFI criteria.

Hospitalised patients who are being transferred to another ward or hospital should remain in isolation with transmission-based precautions and appropriate PPE until release from isolation criteria are met. People who have recovered from COVID-19 and have been released from isolation based on the criteria above do not require COVID-19 testing if they are hospitalised for a non COVID-19 related condition.

As a precaution, all recovered cases should continue following community recommendations (e.g. physical distancing, hand hygiene, masks where indicated, etc.) and health care workers should continue to use appropriate PPE as recommended when caring for COVID-19 patients, or in settings of potential exposure. Infectious cases living in the same household as recovered cases should remain isolated from recovered cases to the extent practicable.

⁷ This time period has been recommended for pragmatic reasons. CDNA will review this recommendation as more evidence becomes available.

7. Contacts

Close contact definition

The aim of contact tracing is to interrupt transmission of SARS-CoV-2 through identification and quarantining of people in contact with infectious cases. PHUs can use the below close contact criteria to identify and prioritise people who have been exposed and potentially incubating the disease.

Updates to the close contact definition have been made in response to the National Cabinet's decision to [reset TTIQ measures in the context of high case numbers and the Omicron variant](#) and the [AHPPC statement on TTIQ in high levels of COVID-19 community transmission in the context of high levels of COVID-19 transmission](#).

Revisions have been made for pragmatic reasons in response to a context of high case prevalence and the significant impacts previous definitions have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

The following definitions have been adapted from the definition outlined in the [National Cabinet agreed COVID-19 Test & Isolate National Protocols](#).

Contact classification ⁸	Type of contact made during the case's infectious period
Close contact	A person who resides with or stays overnight in the same premises or has had more than 4 hours of cumulative contact with a COVID-19 case in a residential setting ⁹ . In exceptional circumstances or where a significant transmission event has occurred, PHUs may consider classifying additional persons as close contacts.
Other contact	A person who has been exposed to a COVID-19 case but does not meet the definition of a close contact.

Some jurisdictions have developed risk matrices for classification of close contacts in certain settings (e.g. for schools, workplaces). The rationale for risk assessment guidance is to balance COVID-19 transmission risk with the risk of furloughing staff to the extent that the business becomes non-operational. Such guidance will take account of specific risk mitigations within the operation of the business.

⁸ Some jurisdictions have not adopted the National Cabinet agreed COVID-19 Test and Isolate National Protocols. PHUs in these jurisdictions should refer to their state or territory health department guidance.

⁹ A residential setting is a building or a part of a building where individuals: spend the night for sleeping; including a house, apartment, or other private dwelling, and share facilities for acts of daily living which have the potential to create exposure between co-residents.

Residential settings may include: aged care facilities, military residential settings, boarding schools, boarding houses, homeless shelters, and maritime vessels

Note that:

- For contact tracing, the infectious period is considered to be the period extending from 48 hours before onset of symptoms in the case until the case is classified as no longer infectious (refer to [Release from isolation](#)).
- If the case is asymptomatic, the infectious period is the period extending from 48 hours before the initial positive test until the case is classified as no longer infectious (refer to [Release from isolation](#)).
- For guidance on individual risk assessment of workers in health care settings, including recommended work permissions and restrictions as determined by risk, see [Health and residential care workers](#).

Management of contacts

Jurisdictions with community transmission may devolve contact management practices to other methods such as automated identification and management of contacts. Jurisdictions may also provide public information to support self-managed contact tracing, testing and quarantine. PHUs may direct cases to follow up their own contacts and tell them to follow relevant public health advice.

Quarantine and testing of close contacts

Close contacts who have recovered from COVID-19 do not need to quarantine if:

- they remain asymptomatic;
- they are not immunocompromised; and
- re-exposure is less than 4 weeks since release from isolation (see [Testing after release from isolation](#)).

The following table has adapted the quarantine and testing requirements outlined in the [National Cabinet agreed COVID-19 Test & Isolate National Protocols](#).

Revisions have been made to quarantine and testing requirements for pragmatic reasons in response to a context of high case prevalence and the significant impacts previous requirements have had on Australian communities, laboratory testing capacity and the public health workforce. CDNA notes the viral characteristics of SARS-CoV-2 have not changed.

To calculate the quarantine period, day 0 is considered the last day the close contact had contact with the COVID-19 case. Day 1 is the first full day after the close contact no longer has contact with the COVID-19 case.

Contact classification	Testing recommendations and quarantine requirements ¹⁰ (regardless of vaccination status)
Close contact	Testing recommendations <ul style="list-style-type: none">• Where feasible, get a RAT/NAAT if symptoms develop.• Where feasible, get a RAT on day 6 or 7 of quarantine.

¹⁰ Some jurisdictions have not adopted the National Cabinet agreed COVID-19 Test and Isolate National Protocols. PHUs in these jurisdictions should refer to their state or territory health department guidance.

	<p>Quarantine requirements</p> <ul style="list-style-type: none"> • Quarantine for 7 days after the day they last had contact with a COVID-19 case in their household and monitor for COVID-19 symptoms. • If getting a RAT is not feasible, continue quarantine for 10 days from the date of exposure. • If the day 6 or 7 RAT is negative, the close contact has no symptoms, and there are no new cases in the household, the close contact may exit quarantine at day 7. • If new cases are identified in the household, PHUs may request the close contact and their household to continue quarantine for an additional 7 days after identification of the last household case. • If a positive RAT is returned at any time during quarantine, the close contact is now a probable case and should isolate until they meet the release from isolation criteria. <p>Other recommendations</p> <ul style="list-style-type: none"> • In the 7 days after exiting quarantine: <ul style="list-style-type: none"> ○ Wear a mask when outside home. ○ Monitor for COVID-19 symptoms. If the close contact becomes symptomatic, the close contact should isolate and be tested (RAT or NAAT). ○ Where applicable, follow the requirements and guidance of high-risk settings.
Other contact	<p>Quarantine requirements</p> <ul style="list-style-type: none"> • No quarantine is required. <p>Other recommendations</p> <ul style="list-style-type: none"> • Monitor for symptoms for 14 days following exposure to a COVID-19 case. Where feasible, get a RAT/NAAT if symptoms develop. • If a positive RAT is returned at any time within the 14 days following exposure to a COVID-19 case, the contact is now a probable case and should isolate until they meet the release from isolation criteria.

Health and residential care workers

For guidance on individual risk assessment of workers in health care settings, including recommended work permissions and restrictions as determined by exposure risk, see [Work Permissions and Restrictions Framework for Workers in Health Care Settings](#).

In the context of an outbreak and community transmission, this framework supports safe decision making when determining whether to place work permissions/restrictions, independent of quarantine, on a worker after a COVID-19 exposure in a health care setting.

Aircraft passengers

PHUs may classify aircraft passengers seated in the same row or two rows in front or behind a confirmed COVID-19 case during the case's infectious period as close contacts. PHUs can use similar criteria for people who have had close contact on bus or train trips.

Other factors PHUs may consider when determining close contacts among passengers include possible interactions within airport terminals, such as sitting in gate lounges and moving between gates, and transport to, from and within the airport.

For domestic flights, jurisdictions may consider alternative ways of managing passengers who may be contacts of COVID-19 cases, such as posting flight details on a website and issuing public health alerts.

Quarantine and essential workers

Close contacts who are essential workers in a [critical infrastructure industry](#) should work from their quarantine location (e.g. home, hotel) and/or implement alternate staffing arrangements wherever possible. Where this is not feasible, PHUs should conduct an individual risk assessment to identify if some essential workers can be permitted to maintain normal work patterns while in quarantine.

This should only occur in circumstances where there is risk of grave damage to Australian national interests and security if the worker is unable to work. If permitted to maintain normal work patterns, the essential worker must practise vigilant physical distancing and hand and respiratory hygiene, and wear a mask whilst at work. They should adhere to normal quarantine restrictions when outside of essential work activities.

Medical care for quarantined individuals

PHUs should advise close contacts that if they require medical attention for any reason (e.g. fever and respiratory symptoms or other illness/injury), they should telephone their GP or hospital Emergency Department and advise them of their close contact status before presenting. Close contacts with severe symptoms should call 000 and clearly communicate to the emergency services operator that they are a close contact. Close contacts should wear a mask before presenting to any health care setting.

Education

Close contacts should be counselled about their risk and the symptoms of COVID-19 and provided with a COVID-19 factsheet. They should be given advice about the need to immediately self-isolate and get tested should they develop symptoms and given information about where and how to access COVID-19 testing.

8. High-risk settings

Residential care facilities

Outbreaks of COVID-19 in residential care facilities should be managed with close reference to the [CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia](#). These guidelines provide specific advice on the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia.

Outbreaks of COVID-19 in congregate disability accommodation settings should also be managed with reference to the [CDNA national guidelines for the prevention and management of COVID-19 outbreaks in disability residential services – The Disability Supplement](#). These guidelines add tailored advice to support disability residential service providers and public health authorities to respond to the risk and occurrences of COVID-10 outbreaks in these settings.

Aboriginal and Torres Strait Islander Communities

CDNA will continue to monitor the emerging evidence around COVID-19 transmission risks in Aboriginal and Torres Strait Islander communities and revise these recommendations as needed. For further information, refer to the [CDNA National Guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19](#) and [CDNA National Guidance for Urban and Regional Aboriginal and Torres Strait Islander Communities for COVID-19](#).

Correctional and detention facilities

Correctional and detention facilities may have existing frameworks and protocols in place for testing and isolation in the event of a communicable disease outbreak. Correctional and detention facilities should prepare for and manage outbreaks of COVID-19 with close reference to the [CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in correctional and detention facilities in Australia](#).

Meat processing facilities

Meat (including poultry) processing facilities may present a higher risk of COVID-19 transmission to workers. These workplaces are vulnerable for a number of reasons including: production line work in close proximity to others; limited hygiene measures due to tally driven work; temperature and humidity; and employer sponsored communal housing and transport.

PHUs may assist work health and safety representatives to implement measures aimed at mitigating risk of COVID-19 exposure. Further information on COVID-19 in these facilities is available in Work Safe Victoria's recommendations for [Managing the risk of COVID-19 exposure: meat and poultry processing](#). PHUs may also refer to the US Centers for Disease Control's [Facility Assessment Tool for Meat and Poultry Processing Facilities](#) to conduct an assessment of infection prevention and control measures within the facility.

9. Special situations

Use of COVID-19 vaccination in outbreak situations

Targeted vaccination of defined populations who may be at risk of exposure is an important activity complementing existing public health interventions. Targeted vaccination may increase the proportion of people who have received one dose, are fully vaccinated, or have received a booster dose of a COVID-19 vaccination (where eligible).

In an outbreak, PHUs can use COVID-19 vaccination to:

1. Reduce the number and severity of COVID-19 cases in an outbreak, where there is likely to be an ongoing risk of exposure.
2. Opportunistically increase vaccination uptake in the population through timely messaging around the benefits of vaccination.

Key considerations about using COVID-19 vaccines during outbreaks include: the location, target population, context of the outbreak, local epidemiology of COVID-19, and timing of potential exposure.

Vaccination as an outbreak response tool is of greatest use in geographic areas or populations with low vaccination coverage. However, public communications should emphasise the importance of people getting vaccinated even in areas of high coverage.

PHUs can also use COVID-19 vaccination in closed settings where there is an ongoing risk of exposure due to multiple chains of transmission. Example settings include residential aged care facilities, correctional facilities, remote industrial sites (e.g. mining camps) or educational institutions.

In these contexts, vaccination may provide both direct protection against severe illness and death, and indirect protection by limiting outbreak size and duration.

Where possible, PHUs should evaluate the effectiveness of vaccination campaigns in limiting the impacts of COVID-19 at the conclusion of the outbreak.

International travellers

Quarantine requirements for international travellers entering Australia are different for fully vaccinated versus partially or unvaccinated arrivals. It is important to note that the definition of fully vaccinated for international travel purposes differs to the definition included in this guidance. For more information about vaccination and international travel, pre-flight testing and travel requirements, see [International travel and COVID-19](#) and [Coronavirus \(COVID-19\) FAQs – international travellers to Australia](#).

Schools

The best way to prevent transmission of COVID-19 in schools is through the promotion of correct hand hygiene habits and cough/sneeze etiquette. Children or staff with respiratory symptoms should not attend school while symptomatic. If a child or staff member becomes ill with respiratory symptoms, they should be isolated from other students and sent home as soon as possible.

Contact tracing or management of school outbreaks may require temporary full or partial school closures; however, closures are not generally recommended as a reactive measure on public health grounds.

Workplaces

If a confirmed case has attended the workplace while infectious, PHUs can assist workplaces to conduct a risk assessment of potential workplace transmission. This includes assisting workplaces in the identification of workers who have had close contact with the infected worker. PHUs should provide workplaces with a general framework to help with internal risk assessment. In settings with high vaccine coverages, PHUs may take a more considered approach to risk assessment to ensure that economic and social costs are minimised. For more information, see [Safe Work Australia's COVID-19 information for workplaces](#) or jurisdictional COVID-19 work health and safety guidance.

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11. Appendices

- [Appendix A:](#) Public health unit checklist
- [Appendix B:](#) Outbreak investigation and management
- [Appendix C:](#) Risk assessment and identification of close contacts in aircrew
- [Appendix D:](#) Guidance on the management of aircrew
- [Appendix E:](#) Full revision history of the COVID-19 SoNG

Appendix A: Public health unit checklist

Using the appropriate jurisdictional investigation form or program, contact the patient or their doctor to:

- Confirm the onset date and symptoms of the illness.
- Confirm results of relevant pathology tests, or recommend that tests be done, including repeat tests where relevant.
- Confirm vaccination status including vaccine type, date and country of administration.
- Where applicable and feasible, seek the doctor's permission to contact the case or relevant care-giver.
- Review case management including:
 - infection control measures being used in caring for the case; and
 - home isolation procedures are being followed.
- Ensure appropriate infection control measures are followed in caring for the case.

Interview the case or care-giver to complete exposure and contact history and other details

- Complete the exposure history and other sections of the relevant jurisdictional investigation form.
- Identify close contacts according to the contact definition.
- Identify the likely source of infection.
- Determine if the case has attended settings that are at higher risk for infection.

Follow-up case's contacts to:

- Assess risk of COVID-19 transmission and identify any close contacts.
- Determine current symptoms, if any, and manage as a suspect case if present.
- Explain symptoms, advise on active daily monitoring of symptoms by the PHU (close contacts) where feasible and need to immediately report any new symptoms.
- Explain to all close contacts the need for quarantine.
- Provide state based factsheets as appropriate.
- Arrange NAA and serological testing if available and contact is symptomatic, and follow local policy for testing in an outbreak setting. Seek protocol on this from the reference laboratory or central communicable disease agency where necessary.
- For cases in schools, aged care facilities, correctional and detention facilities, and Aboriginal and Torres Strait Islander communities, relevant guidelines should be followed. Refer to [High-risk settings](#) and [Special situations](#) for links to guidelines.

Notify central jurisdictional communicable disease control agency, if they do not already know.

Central communicable disease control agency to notify Commonwealth Department of Health Office of Health Protection and follow the cross-border protocol for notifying cases to other jurisdictions as appropriate.

Consider need for media release and designate a media spokesperson.

Appendix B: Outbreak investigation and management

Definitions

Outbreak:	For the purposes of investigation, an outbreak is defined as a single confirmed case of COVID-19 in the community.
Index case:	An index case is defined as the first confirmed COVID-19 case reported to a health agency that is part of an outbreak.
Primary case:	A primary case is the first confirmed COVID-19 case that occurred in the outbreak.

Outbreak investigation for specific settings

The following guidance relates to the general epidemiological investigation and response to an outbreak. Outbreak investigation and management differs depending on the specific context.

Some identified high-risk settings have specific guidance for the prevention, control and public health management of COVID-19 outbreaks. These include:

- Residential care facilities:
See [CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia](#).
- Disability residential services:
See [CDNA national guidelines for the prevention and management of COVID-19 outbreaks in disability residential services – the disability supplement](#).
- Correctional and detention facilities:
See [CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in correctional and detention facilities in Australia](#).
- Aboriginal and Torres Strait Islander communities:
See [CDNA national guidance for remote Aboriginal and Torres Strait Islander communities for COVID-19](#) and [CDNA national guidance for urban and regional Aboriginal and Torres Strait Islander communities for COVID-19](#).

Steps in outbreak investigation

1. Define the scope of the outbreak

COVID-19 outbreaks can occur in a range of settings where people congregate. This may include group residential settings, Aboriginal and Torres Strait Islander communities, schools, gyms, workplaces, places of worship, or other public places.

A single case of COVID-19 in the community should trigger an extensive review of potential exposure sites or settings for an outbreak. A case may have visited several settings while infectious leading to multiple related investigations.

Identifying potential exposure sites where cases may have visited while infectious is critically important. To achieve high levels of control, PHUs should use a conservative approach to identifying exposure sites or settings. Affected exposure sites can be scaled back once additional investigation and/or testing is completed.

2. Confirm and declare a COVID-19 outbreak

For the purposes of investigation, a single COVID-19 case in the community is considered an outbreak to initiate active case finding and supplement routine case and contact follow-up.

3. Establish governance structures and lines of responsibility

PHUs are the lead agency in COVID-19 outbreaks, however, management and governance arrangements may vary depending on the context. In some contexts (such as outbreaks in group residential settings) PHUs should collaborate with managers of the setting to form a dedicated outbreak management team (OMT). Guidance on who should be included in an OMT can be found in the [CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in residential care facilities in Australia](#) and [CDNA national guidelines for the prevention, control and public health management of COVID-19 outbreaks in correctional and detention facilities in Australia](#).

4. Identify and inform relevant internal and external stakeholders

It is important to ensure transparent and clear messaging about the outbreak to stakeholders, particularly when investigation and management follows an extended testing strategy. PHUs should also identify other agencies involved in the oversight and management of the facility or setting.

5. Case interview

The case interview will help determine the number of contacts requiring follow up and classification of close contacts.

6. Contact tracing

A proactive approach to contact tracing is required in order to minimise potential transmission in the community. The PHU should contact all persons who have attended the setting or facility, and are deemed to be close contacts. These include, staff, residents (if relevant) and visitors.

PHUs may need to use multiple communication methods to alert people of exposure where infectious cases have visited multiple venues and exposure sites.

7. Contact management

PHUs should ensure all close contacts are quarantined and undergo testing as outlined in [Management of Contacts](#) guidance. Some PHUs may also require secondary close contacts or casual contacts to quarantine.

- I. Identify those most at risk of severe disease

Identify and document those at highest risk of severe disease as described in [Advice for people at risk of COVID-19](#). Monitor those at risk of severe disease for symptoms.

- I. Assess and record vaccination status

During outbreak investigations, it is important for PHUs to assess all exposed individuals' vaccination status and capture it to estimate vaccine effectiveness. Vaccine type and timing of doses should be recorded routinely on case investigation forms.

8. Arrange COVID-19 testing for all people who attended the setting or exposure site

When an index case is likely to have acquired their infection within the setting or facility, it is likely there are already other transmission chains. Widespread testing of those exposed should help identify people who may be shedding virus or were part of the transmission chain.

Consider if serological tests are available to identify persons previously infected. See [PHLN guidance for serological testing in COVID-19](#) for more information.

If others who attended or live in the specific setting or facility are symptomatic and receive a negative SARS-CoV-2 test result, consider testing for other respiratory pathogens such as influenza.

9. Assist with notifying all people who attended the setting or exposure site

Ensure managers of an affected setting or facility notify all staff, visitors and residents (if relevant) that cases of COVID-19 have occurred within the specific setting or facility. Advice about who should be tested and quarantined must be clear. Management of the affected setting or facility should take a strong leadership role in responding to the outbreak with support from PHU staff.

10. Isolate and treat individuals who test positive

All confirmed cases must isolate according to [isolation and restriction](#) guidance until they meet the appropriate [release from isolation criteria](#).

11. Advise staff about implementation of enhanced infection prevention and control (IPC) measures and develop a process for ongoing IPC observation

In certain settings, such as health and residential care facilities, there may be a need to enhance IPC in response to an outbreak of COVID-19. Enhanced IPC measures are detailed in the Infection Control Expert Group's [COVID-19 Infection Prevention and Control for Residential Care Facilities](#). While the advice in these guidelines is tailored specifically to residential care facilities, these principles and actions can be applied to any setting where there is potential for rapid transmission.

Residential care facilities and other high-risk settings should ensure all staff have completed the IPC training relevant for their workplace, in person or online as required (e.g. COVID-19training.gov.au). Facility managers may consider appointing a specific staff member to observe day-to-day practices, provide advice as needed and report daily to the OMT.

12. Descriptive epidemiology

Throughout the course of the investigation, epidemiologists should describe the epidemiology of cases associated with the outbreak. This may be as simple as collating information into a line list describing people infected in terms of time, place, and person. A map of the setting (such as those used to identify evacuation points) may be useful to identify case locations. Seek staff rosters for employees who have been in close proximity to the index case. Consider diagrams for chains of infection.

Consider information that may assist with investigation of the source of introduction of disease, such as exposure type and ventilation patterns. This seeks to identify other chains of transmission in the community that may be unrecognised. For further information, see [identification of potential source \('upstream'\) contacts](#).

At each stage of investigation, consideration should be given to the collection of data which may be valuable for future epidemiological investigation.

13. Ensure enhanced environmental cleaning of the setting

Regular, scheduled cleaning is essential during an outbreak. Frequently touched surfaces should be cleaned more often. These surfaces include:

- equipment
- door handles
- trays
- tables
- handrails
- chair arms
- light switches

During a suspected or confirmed COVID-19 outbreak, an increase in the frequency of cleaning and disinfection is recommended.

Detailed information on environmental cleaning and disinfection in health and residential care settings is in the [COVID-19 Environmental cleaning and disinfection principles for health and residential care facilities factsheet](#). Disinfectants registered with the TGA as effective against the virus (SARS-CoV-2) are listed on the [TGA website](#).

Additional instructions for group residential settings

14. Quarantine exposed individuals who test negative and monitor for illness

Individuals who have attended the affected setting during a COVID-19 cases' infectious period but test negative still require protection from any possible further exposure. Monitor these individuals for symptoms and consider a program of repeat testing.

15. Consider a program of repeat testing for those in quarantine who initially test negative

Repeat testing of people in quarantine can assist in identification of those who are pre-symptomatic or asymptomatic.

In group residential settings, frequent facility-wide repeat testing of both staff and residents is recommended until it is clear there is no ongoing spread of infection. Those already identified as positive do not require further diagnostic testing.

As described in *Table 1: Repeat testing and ongoing actions for outbreaks in residential settings* (see below):

- a) With each round of testing, those who are NAA positive can be removed to positive cohort isolation wherever possible.
- b) In subsequent rounds, only those who are NAA negative (i.e. those who may be susceptible) should be tested.
- c) Symptom screening should be conducted daily for the negative (quarantined) cohort.

Table 1: Repeat testing and ongoing actions for outbreaks in residential settings

	Testing overview		Date for quarantine	
	Day 1	Repeat Testing Days (where feasible)	Quarantine Cohort Day 1	Quarantine Cohort on Retest Day/s
Recommended testing and actions	<p>Who to test</p> <ul style="list-style-type: none"> <input type="checkbox"/> Test all members of the setting via NAA. <p>Actions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Isolate positive persons (may designate an area to cohort positive cases). <input type="checkbox"/> Quarantine cohort of negative residents (an off-site quarantine site may suit depending on the setting). Where possible, people who initially test negative should be quarantined separately. 	<p>Who to test</p> <ul style="list-style-type: none"> <input type="checkbox"/> Re-test NAA negative cohort where feasible (e.g. 72 hourly) <p>A subset of the quarantined cohort may be re-tested if appropriate.</p> <p>Actions</p> <ul style="list-style-type: none"> <input type="checkbox"/> Isolate positive persons <input type="checkbox"/> Quarantine cohort of NAA negative residents and screen for symptoms. <input type="checkbox"/> Where possible, people who initially test negative should be quarantined separately. 	<p>Recommended quarantine period (see quarantine and restriction of close contacts) starts from date that the quarantine cohort are NAA negative</p>	<p>If any of the quarantined cohort are positive:</p> <ol style="list-style-type: none"> 1. Recommence recommended quarantine period (see quarantine and restriction of close contacts) 2. Consider retesting every 72 hours until no new NAA positive tests.

16. For group residential settings, identify suitable sites where individuals may be cohorted or zoned into either isolation (symptomatic or SARS-CoV-2 positive) OR quarantine (exposed)

People who require isolation should be cared for separately to protect those in quarantine. Residents who have not been exposed should avoid exposure to both isolated and quarantined individuals.

Residents and staff from affected areas, wings or buildings should not work in unaffected areas.

Staff working at a facility with an outbreak should only work within one cohort and not move between those in isolation and those in quarantine. They should not work at a different facility for the duration of the outbreak. Staff should be regularly screened for symptoms, in addition to participating in whole of setting testing.

In some group residential settings (such as residential care facilities) consideration should be given to transferring NAA positive individuals to a suitable hospital or hospital-equivalent setting. If confirmed cases remain within the group residential setting, specific staff should be allocated to support and care for NAA positive isolated individuals.

The facility should ensure that staff members:

- Do not move between their allocated room/section and other areas of the facility or care for other residents.
- Follow guidelines for IPC and correct use of PPE.

Staff in outbreak settings

Staff working in a facility or setting where an outbreak is occurring should not enter a high-risk setting until the outbreak is declared over (from 14 days following the date of isolation of the last case). All staff should self-monitor for symptoms of acute respiratory illness and self-exclude from work if unwell, even if appropriate PPE has been used or there was no obvious contact with a known case.

The setting should maintain a register for all staff and volunteers to check for symptoms of COVID-19 at the beginning of every shift. Contact details of attendees, contractors and other people visiting the setting should also be recorded. There may be a need to undertake frequent or daily screening of staff in an outbreak or high risk setting.

Declaring an outbreak over

In most circumstances, a COVID-19 outbreak can be declared over if no new cases occur within 14 days (maximum incubation period) following the date of isolation of the last case.

Once the outbreak is over, PHUs should ensure cluster reports are provided to relevant stakeholders, and data are summarised appropriately.

Repeat testing allows for close observation of the outbreak and clarity regarding when it can be declared over.

Appendix C: Risk assessment and identification of close contacts in aircrew

These recommendations are intended to assist PHUs to undertake risk assessments, in collaboration with airlines, to identify which aircrew are close contacts of a confirmed COVID-19 case. These recommendations relate to the specific circumstance where an ill passenger or crew member has travelled on a flight and potentially exposed aircrew. It is important to note that an infected person may be infectious up to 48 hours prior to onset of symptoms and while asymptomatic. Any risk assessment needs to consider that a person may appear well, but still be infectious.

This risk assessment is directed at identifying aircrew close contacts. For more information on contact tracing of aircraft passengers see [Close Contacts- Aircraft passengers and crew](#).

General principles

- Case-by-case risk assessments should be conducted by the relevant PHU, in collaboration with airlines, to identify close contacts among aircrew where one or more confirmed cases of COVID-19 were present on a flight.
- As part of risk assessments, PHUs should consider whether aircrew have adhered to adequate infection control precautions (including the use of appropriate PPE, physical distancing and separate donning/doffing areas).
- Risk assessments for aircrew should be consistent with [criteria for being a close contact](#).

Considerations for conducting risk assessments

For aircraft crew exposed to a confirmed case, a case-by-case risk assessment should be conducted by the PHU, in collaboration with the airline, to identify which crew members should be managed as close contacts.

Appropriate use of PPE and adhering to documented infection control procedures is an important consideration for assessing the risk for aircrew. This should include considerations about use of separate resting areas for crew and adherence to PPE and physical distancing while on layovers and airports. The PHUs should determine this for all crew on affected flights. Where a PHU considers that both PPE and infection control are adequate throughout the potential exposure period, crew may be excluded as close contacts.

Additional considerations for conducting a risk assessment should include:

1. Variants of concern

If the passenger is infected (or suspected to be infected) with a SARS-CoV-2 variant of concern, PHUs may consider classifying all aircrew and passengers on board the flight as close contacts.

2. Proximity of crew to confirmed cases

Crew who have had face-to-face contact with an infected passenger of any duration during the course of the flight may be considered close contacts. Face to face contact may include provision of in-flight service, checking in a passenger and their baggage, or answering page calls.

3. Duration of exposure to confirmed cases

Crew who provided prolonged periods (e.g. one hour) of in-flight service in the section of the aircraft where the infected passenger was seated should be considered close contacts.

4. Size of the compartment in which the crew and confirmed case interacted

Subject to considerations about aircraft design and airflow patterns, crew who provided in-flight service of any duration in confined sections (e.g. first or business class) or within two rows of where the infected passenger was seated should be considered close contacts.

5. The number of confirmed cases of COVID-19 on board

More than one case on board a flight may represent a higher risk to aircrew and should be factored into the risk assessment.

6. Potential breaches of PPE

Crew who experienced potential breaches of PPE whilst providing assistance to an infected passenger (e.g. emergency medical assistance) should be considered close contacts.

Considerations for when the confirmed COVID-19 case is an aircrew member:

Where the confirmed COVID-19 case is an aircrew member, all crew should be considered close contacts unless there is evidence that they did not have face-to-face contact with the case. In this circumstance, PHUs will concentrate contact tracing efforts on passengers seated in the area where the crew member worked during the flight along with other members of the crew. Additionally, PHUs may consider factors such as common use of facilities, transport to and from work, and communal resting/dining areas. The same general principles and considerations detailed above can also be adapted to identify close contacts in these circumstances.

If an aircrew member is infected (or suspected to be infected) with a SARS-CoV-2 variant of concern, PHUs may consider classifying all aircrew and passengers on board the flight as close contacts.

Aircrew and passengers who are close contacts

If an airline becomes aware of a crew member or passenger who was a close contact of a confirmed case whilst on board a flight, they should notify the local PHU to facilitate management of the close contacts. For more information, see [Appendix D: Guidance on the management of aircrew](#).

Appendix D: Guidance on the management of aircrew

1. Aircrew who test positive for SARS-CoV-2 in Australia

Aircrew who test positive in Australia and who are still in quarantine in Australia when the positive test result is notified should remain in isolation in Australia until they meet the release from isolation criteria. Note that those who meet the release from isolation criteria for a historical infection should be allowed to leave Australia, including as working crew.

Under exceptional circumstances aircrew who have tested positive for COVID-19 may be permitted to return overseas where the following conditions are met:

- the affected crew member is asymptomatic;
- the return flight does not carry any passengers;
- all other aircrew on board the flight wear PPE and practice physical distancing;
- where possible, the infectious crew member is isolated in a separate segment of the plane;
- the airline is aware and accepts the risk to crew and endorses the travel; and the receiving country is aware.

2. Aircrew who are a close contact of a person with confirmed COVID-19

Aircrew who are a close contact of a person with confirmed COVID-19 can be permitted to leave Australia if they are asymptomatic and the returning aircraft does not carry any passengers, PPE is worn by all on board and physical distancing is practiced.

Under certain circumstances a close contact can return on a passenger flight and where appropriate risk mitigation is in place. This might be that the close contact remains asymptomatic, is in an area completely separate to passengers, for example in a separate first-class section of the plane with a dedicated toilet.

3. Return to Australia of infected crew and crew who are close contacts

Aircrew who have tested positive for COVID-19 should not return to Australia within 14 days of their onset of symptoms and until there has been resolution of symptoms of the acute illness for at least 72 hours (note the 14 day period covers the situation where the infection is due to a variant of concern).

Aircrew who are a close contact should not return to Australia within 14 days of their last known exposure to a case.

Note that the above applies to instances where the case/close contact departed Australia prior to the result for the positive person being available, as well as instances where the close contact was in Australia at the time that the positive result was notified.

Jurisdictions can advise airlines that should individual crew return in the above time frames they will then be placed in isolation/quarantine in a managed hotel on arrival. Information on individuals and their relevant exclusion period may be shared between jurisdictions via the NIR.

4. Crew with historical infections

Aircrew with a recent history of COVID-19 infection who swab positive on a SARS-COV-2 NAA test can be considered a historical infection and do not require follow-up as a confirmed case if they meet the following criteria:

- the NAAT has high Ct values (as defined by the testing laboratory);
- the person is asymptomatic;
- the person has evidence of a previous positive NAAT for SARS-COV-2 between 10 days and 8 weeks ago; and
- the person is not known to have been in contact with a confirmed case in the previous 14 days.

5. Onward domestic travel of aircrew who are Australian residents

Aircrew who have been tested on arrival into Australia and are not known to be a close contact of a person with infectious COVID-19 are permitted to travel onto their jurisdiction of residence if they travel on a flight with only aircrew on board (no passengers), PPE and physical distancing are undertaken, and there is COVID-safe travel transit/travel to the domestic airport (including an overnight stay in managed hotel quarantine if required).

If the above measures cannot be implemented, then they are required to quarantine for 14 days at point of entry prior to onward travel.

Jurisdictions should inform the receiving jurisdiction of any incoming aircrew who are completing onward domestic travel following an international flight.

Appendix E: Full revision history of the COVID-19 SoNG

Revision history

Version	Date	Revised by	Changes
6.4	14 January 2022	Communicable Diseases Network Australia	Revisions to reflect National Cabinet decisions and AHPPC recommendations to revise test, trace, isolate and quarantine (TTIQ) in the context of high levels of COVID-19 transmission. Updated: Surveillance, Case definition, Testing, Case management, Release from isolation criteria, Close contact definition, Management of contacts
6.3	24 December 2021	Communicable Diseases Network Australia	Updated: Vaccination, Surveillance, Case investigation, Release from isolation criteria, Management of contacts, Aircraft passengers and crew, Appendix B
6.2	09 December 2021	Communicable Diseases Network Australia	Revisions to reflect emergence of the Omicron variant Updated: The Disease, Case definition, Genomic sequencing, Release from isolation criteria, Close contact definition, Management of contacts, Use of vaccination in outbreak situations, Appendix D (Table 4)
6.1	15 November 2021	Communicable Diseases Network Australia	Updated: Release from isolation criteria
6.0	08 November 2021	Communicable Diseases Network Australia	Revisions to reflect ongoing community transmission in some Australian jurisdictions and progress through the phases of the National Plan to transition Australia's National COVID-19 Response.
5.1	08 October 2021	Communicable Diseases Network Australia	Revised: Contact management- Casual contacts
5.0	06 October 2021	Communicable Diseases Network Australia	Inclusion of new guidance: Appendix C- Work Permissions and Restrictions Framework for workers in health care settings. Revised: Case definition, Enhanced testing, Contact management- Casual contacts

Version	Date	Revised by	Changes
4.8	07 September 2021	Communicable Diseases Network Australia	Revised: Testing, Case management, Close contact definition, Contact management
4.7	24 June 2021	Communicable Diseases Network Australia	Revised: Case definition, Release from isolation criteria, Contact management
4.6	16 June 2021	Communicable Diseases Network Australia	Revised: The Disease, Testing, Case Management
4.5	26 May 2021	Communicable Diseases Network Australia	Inclusion of new guidance: Use of COVID-19 vaccination in outbreak situations Revised: Special situations
4.4	11 May 2021	Communicable Diseases Network Australia	Inclusion of new appendix: Appendix B: Outbreak investigation and management Revised: Summary, The Disease, Case definition, Testing, Case Management, Release from Isolation, Management of contacts, High-risk settings
4.3	03 March 2021	Communicable Diseases Network Australia	Revised: The Disease, Case Definition, Testing, Case Management, Release from Isolation, Close contacts, Outbreak investigation and management in high-risk settings, Special situations, Appendix B Inclusion of new section: Appendix C
4.2	29 January 2021	Communicable Diseases Network Australia	Revised: Case definition
4.1	12 January 2021	Communicable Diseases Network Australia	Inclusion of new subsection: Prioritisation of whole genome sequencing for all cases Revised: Case management with inclusion of subsection detailing management of cases infected with a SARS-CoV-2 variant
4.0	23 December 2020	Communicable Diseases Network Australia	Modifications to meet a setting of low prevalence of disease in Australia. Inclusion of new sections: Close contact definitions, Appendix D. Revised: The disease, Routine prevention activities, Case definition, Laboratory testing, Case management, Contact management, Outbreak investigation and management in high-risk settings, Appendix C

Version	Date	Revised by	Changes
3.11	10 December 2020	Communicable Diseases Network Australia	Revised: Summary, The disease, Case definition, Case management, Special risk settings, Appendix A
3.10	28 October 2020	Communicable Diseases Network Australia	Revised: The disease, Laboratory testing, Release from isolation, Contact management, Appendices
3.9	09 October 2020	Communicable Diseases Network Australia	Revised: The disease, Release from isolation, Outbreak investigation and management in high-risk settings, Special risk settings, Special situations.
3.8	23 August 2020	Communicable Diseases Network Australia	Revised: Modes of transmission, Release from isolation, Close contact definition – notes.
3.7	12 August 2020	Communicable Diseases Network Australia	Revised: Enhanced testing. Inclusion of new Special situations sub-section: Workplaces. Inclusion of new Special risk settings sub-section: Meat processing facilities.
3.6	30 July 2020	Communicable Diseases Network Australia	Revised: Case definition – Enhanced testing, Contact management.
3.5	24 July 2020	Communicable Diseases Network Australia	Inclusion of new section: Routine prevention activities. Inclusion of new Laboratory testing sub-section: Procedure for assessing indeterminate and suspected false positive SARS-CoV-2 PCR results.
3.4	01 July 2020	Communicable Diseases Network Australia	Revised: Case definition – suspect case, The disease, Communications, Laboratory testing, Case management, Appendix A, Appendix B, Appendix D. Minor wording changes in other sections.
3.3	22 June 2020	Communicable Diseases Network Australia	Revised: Case definition – enhanced testing, Case management – definition of COVID-19 death
3.2	12 June 2020	Communicable Diseases Network Australia	Revised: Case definition – suspect case clinical criteria.
3.1	04 June 2020	Communicable Diseases Network Australia	Revised: Laboratory testing, Case management – Release from isolation, Contact management.

Version	Date	Revised by	Changes
3.0	28 May 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management, Appendix B. Inclusion of new section: 11. Outbreak investigation and management in high-risk settings.
2.11	22 May 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management, Contact management.
2.10	13 May 2020	Communicable Diseases Network Australia	Inclusion of new sections: Appendix C, Appendix D, Appendix E. Revised sections: The disease, Communications, Case definition – inclusion of serology, Laboratory testing, Case management, Contact management, Special risk settings, Special situations, Appendix A.
2.9	05 May 2020	Communicable Diseases Network Australia	Revised: Case definition – clinical criteria.
2.8	01 May 2020	Communicable Diseases Network Australia	Inclusion of new sections: Summary, The disease, Surveillance, Communications, and Data management. Revised: Case definition, Laboratory testing Case management, Contact management, Special risk settings, Special situations, Appendix A, and Appendix B.
2.7	24 April 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management.
2.6	17 April 2020	Communicable Diseases Network Australia	Revised: Case management, Contact management – Close contact definition.
2.5	06 April 2020	Communicable Diseases Network Australia	Revised: Case definition.
2.4	26 March 2020	Communicable Diseases Network Australia	Inclusion of advice for probable cases throughout.
2.3	24 March 2020	Communicable Diseases Network Australia	Revised: Case definition.
2.2	21 March 2020	Communicable Diseases Network Australia	Revised: Case management – Release from isolation.

Version	Date	Revised by	Changes
2.1	20 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Contact management, Special situations.
2.0	13 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Contact management, Laboratory testing, Appendix A.
1.18	10 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Case management, Contact management. Inclusion of Aircrew and Schools advice in Special situations section.
1.17	05 March 2020	Communicable Diseases Network Australia	Inclusion of self-quarantine advice for returned travellers from South Korea, revised Case management, inclusion of table of contents.
1.16	04 March 2020	Communicable Diseases Network Australia	Inclusion of Aboriginal and Torres Strait Islander community advice in Special situations section.
1.15	03 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Contact management.
1.14	02 March 2020	Communicable Diseases Network Australia	Revised: Case definition, Risk stratification of countries, Contact management.
1.13	28 February 2020	Communicable Diseases Network Australia	Revised: Laboratory testing, isolation and restriction and Appendix A: laboratory testing information.
1.12	27 February 2020	Communicable Diseases Network Australia	Inclusion of Cambodia in the list of countries in the Person under investigation section.
1.11	26 February 2020	Communicable Diseases Network Australia	Inclusion of Italy in the list of countries in the Person Under Investigation section.
1.10	23 February 2020	Communicable Diseases Network Australia	Inclusion of South Korea and Iran in the list of countries in the Person Under Investigation section.
1.9	21 February 2020	Communicable Diseases Network Australia	Revised: case definition, infectious period, contact management, special situation (cruise ship). Specific changes are highlighted.
1.8	17 February 2020	Communicable Diseases Network Australia	Inclusion of statement reflecting that passengers of the Diamond Princess cruise meet the criteria for close contact.
1.7	15 February 2020	Communicable Diseases Network Australia	Revised case definition.

Version	Date	Revised by	Changes
1.6	14 February 2020	Communicable Diseases Network Australia	Addition of Appendix B: Interim recommendations for the use of personal protective equipment (PPE) during hospital care of people with Coronavirus Disease 2019 (COVID-19). Updated nomenclature.
1.5	07 February 2020	Communicable Diseases Network Australia	Inclusion of advice on release from isolation.
1.4	06 February 2020	Communicable Diseases Network Australia	Revised case definition and added rationale. Updated infection control advice throughout.
1.3	04 February 2020	Communicable Diseases Network Australia	Revised the case definition and use of the terms 'quarantine' and 'isolation'.
1.2	02 February 2020	Communicable Diseases Network Australia	Revised the case definition, close and casual contact definitions and added self-isolation guidance.
1.1	27 January 2020	Communicable Diseases Network Australia	Removed references to Wuhan and revised the case definition.
1.0	23 January 2020	Communicable Diseases Network Australia	Developed by the 2019-nCoV Working Group.