
Public Health Advice for the management of COVID-19 cases and contacts

V1.1.

Publication Date: 10/03/2022

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

This guidance has been developed based on recent advice from the National Public Health Emergency Team (NPHE) and government. This guidance is under constant review based upon emerging evidence at national and international levels and national policy decisions.

Please note this guidance does not apply to patients and residents in congregated healthcare settings including acute hospitals and residential care facilities. This guidance can be found at [acute hospitals](#) and [residential care facilities](#).

For occupational health guidance, please see [here](#).

Please note this guidance replaces National Interim Guidelines for Public Health management of COVID-19 cases and contacts. V11.6. 14/02/2022. This document is uncontrolled when printed.

Version History

Version	Date	Update	Completed by
1.1	10/03/2022	<ul style="list-style-type: none">Update to Section 6.0 regarding symptoms in children	Research and Guidance Unit
1.0	25/02/2022	<ul style="list-style-type: none">Updated version of Contact Tracing guidance	Research and Guidance Unit

Contents

1.0	Introduction	4
2.0	Purpose	4
3.0	Information on COVID-19	5
4.0	Public Health Protective Measures.....	7
5.0	Confirmed cases (either by Rapid Antigen Detection Tests or by RT-PCR).....	8
6.0	Symptomatic individuals.....	9
7.0	Asymptomatic close contacts	10
8.0	References	11
9.0	Appendix 1	12

1.0 Introduction

Following a meeting on 20th January 2022, the National Public Health Emergency Team (NPHET) advised that the prevailing profile of the disease in Ireland and the available evidence and experience of Omicron internationally allowed for a fundamental change in the management of COVID-19. The NPHET advised that this should entail a transition, in broad terms, from a focus on regulation and population wide restrictions to a focus on **public health advice, personal judgement and personal protective behaviours**. Specifically, following that meeting, the NPHET advised that there was no longer a continuing public health rationale for the majority of the public health measures that were in place at that time. It therefore advised that a range measures could be removed, with a small number of mandatory requirements remaining in place. This was agreed by Government and implemented on 22nd January 2022, please see [here](#) for more information.

The NPHET on **17th February 2022** considered these remaining requirements and concluded that there is no longer a continuing public health rationale for retaining them and advised that the measures as outlined in this document could be removed with effect from the **28th February**. There is, however, a continuing requirement for clear public health advice and for targeted public health action to manage COVID-19 related risks.

2.0 Purpose

The purpose of this document is to meet the need referred to above for public health advice for the management of COVID-19 cases and contacts.

3.0 Information on COVID-19

COVID-19 is an illness, identified in late 2019, caused by a virus called SARS-CoV-2. Internationally and in Ireland we continue to learn about how easily the virus spreads from person to person and how to control it.

Effective vaccines against COVID-19 are available and a robust vaccination programme has been implemented in Ireland. Viruses constantly change and mutate due to evolution and adaptation processes. As a consequence, the emergence of new variants is to be expected.

The available evidence at this time regarding real world vaccine effectiveness and duration of protection shows that all vaccines authorised in the EU/EEA are currently highly protective against hospitalisation, severe disease and death for a variety of strains of COVID-19 (1). This does **not** mean that individuals are immune from SARS-CoV-2 infection once vaccinated. People who are vaccinated may still be able to transmit SARS-CoV-2 infection to susceptible contacts (2). Definitions of the primary vaccination schedule, booster vaccines and additional vaccination doses are displayed in [Appendix 1](#).

A [letter](#) from the Chief Medical Officer (CMO) on 17th February 2022 stated:

“that the COVID-19 pandemic is not over, levels of infection remain high, a cohort of the population still remain vulnerable to more severe infection and the emergence of new variants with increased levels of transmissibility, immune escape and/or virulence remains a risk both nationally and globally. For these reasons, it is outlined that the following must remain critical components of our collective response and ongoing communication in relation to COVID-19 and all will need to be retained and reviewed on a periodic basis.

- *Clear guidance and communication with the public on the evolving disease profile and a cultural shift towards embedding individual and collective personal behaviours to mitigate against COVID19 and other respiratory infections;*
- *A renewed and sustained focus on the importance of rapid self-isolation if symptomatic (even if fully vaccinated/boosted) or if diagnosed with COVID-19;*
- *Continued promotion of vaccination against COVID-19 in line with evolving national strategy and seasonal influenza vaccination;*
- *Continued wearing of masks, practicing of physical distancing and avoidance of crowded environments based on individual risk assessment and with a continuing focus on protecting others, and adherence to basic hand and respiratory hygiene;*

- *Sector specific measures, based on risk assessments by individual sectors, to ensure a safe environment including in relation to the promotion of rapid self-isolation when symptomatic, hand and respiratory hygiene, ventilation, signage, and use of face masks and physical distancing if appropriate;*
- *Continuing engagement with and support for global vaccination and surveillance initiatives;*
- *The impact of the pandemic on the health system has been significant. It is important that a continued focus on health service resilience is maintained, including in particular:*
 - *ongoing strengthening of health system capacity across the spectrum of public health and community and hospital services, to ensure the system is adequately prepared for future challenges. This includes critical care and isolation capacities, and the continuation of appropriate support for non-COVID care in a COVID environment.*
 - *a continued focus on infection prevention and control measures in healthcare settings, including appropriate mask wearing and physical distancing requirements based on national guidance and local risk assessment and advice from IPC teams, given the ongoing requirement to provide care for both COVID and non-COVID patients and the need to protect both patients and staff'.*

4.0 Public Health Protective Measures

Following Government decision, from 28th February 2022, the following public health measures will **NO LONGER APPLY**

1. **Mandatory** mask wearing in settings where it is currently regulated for, including: public transport, taxis, retail and other indoor public settings, and staff in hospitality settings.
2. **Public health measures** in early learning settings, school-aged childcare, primary and secondary schools. These measures include physical distancing measures such as pods, and mask wearing. It is recognised that there will be some children who will wish to continue wearing masks. It is important that any child who wishes to wear a mask should not be discouraged.

However, the following is **STILL ADVISED**:

- continued wearing of masks, adherence to basic hand and respiratory hygiene, practicing of physical distancing and avoidance of crowded poorly ventilated environments based on individual risk assessment with a continuing focus on protecting others.
- the continuation of **mask wearing on public transport**. This is a setting where physical distancing can be difficult and where those who are more vulnerable to the severe impacts of COVID-19 do not always have a discretion to avoid.
- the continued adherence to infection, prevention and controls measures including **mask wearing in healthcare settings** in line with evolving national guidance.
- the continuation of **public health measures including hand and respiratory hygiene, ventilation, advice to stay home if symptomatic, and maintenance of good basic cleaning schedules to reduce the risk of spread of all infections, in all settings including** in early learning settings, school-aged childcare, primary and secondary schools. These measures are important for mitigating the spread of COVID-19 but also for mitigating the spread of other viral infections.
- everyone is encouraged and supported to complete their **primary and booster programmes of vaccination**.
- Government also indicated on 22/02/22 that, *“during this transition phase, the current arrangements in place in respect of the schools’, early learning and school-aged care facilities antigen testing programmes will also continue”*.

5.0 Confirmed cases (either by Rapid Antigen Detection Tests or by RT-PCR)

- **All confirmed cases should [self-isolate](#) for 7 full days** from date of onset of symptoms or if asymptomatic, from the date of a positive test result (either a Rapid Antigen Detection Test (RADTs) or RT-PCR test). **On receipt of a positive test result, no further testing is required.**
- **Any individual with a positive RADT should regard it as confirmed COVID-19 and [register it with the HSE](#). A confirmatory PCR test is not required.** This individual should now be managed as a case and continue to [self-isolate](#) from the date of onset of symptoms or if asymptomatic, from the time of the positive test result.
- Confirmed cases can exit self-isolation after 7 full days, once symptoms have substantially or fully resolved for the final 2 days (48 hours) of the self-isolation period.
- On exiting self-isolation after **7 full days**, cases* should continue to adhere to the following public health protective measures until day 10
 - wear an FFP2 mask or medical grade face mask (surgical mask) in crowded, enclosed or poorly ventilated spaces and where they are in close contact with other people
 - limit close contact with other people outside their household, especially in crowded, enclosed or poorly ventilated spaces (**excluding childcare and educational settings**)
 - avoid contact with anyone who is at higher risk of severe illness if infected with COVID-19
 - work from home unless it is essential to attend in person
 - follow all public health protective measures

**Please note children can exit self-isolation after 7 full days and return to childcare and educational settings, once symptoms have substantially or fully resolved for the final 2 days (48 hours) of the self-isolation period.*

- Cases should advise all of their household contacts to be vigilant for symptoms and that if symptoms develop they should self-isolate.
- **Cases should advise specific groups of household contacts as follows:**
 - household contacts that have an underlying condition associated with very high risk or high risk of severe COVID-19 disease, should be extra vigilant in relation to symptom development and if they develop **any** symptoms, they should get PCR tested as soon as possible, as anti-viral treatment may be indicated. Please see NIAC Immunisation Guidelines on COVID-19 vaccine Chapter 5a. Table 5a.2: [Underlying conditions associated with very high risk or high risk of severe COVID-19 disease](#).

- Asymptomatic household contacts that are **Healthcare Workers** do not need to restrict their movements, but must undertake **3 RADTs** over a 7-day period, (the first RADT should be performed as soon as possible, the second 3 days later and the final test on the 7th day). **The requirement for testing does not apply if the healthcare worker has recovered from COVID-19 in the previous three months.**
- All individuals aged over 12 years old with a positive COVID-19 test result should use a well-fitted medical grade (surgical) or FFP2 face mask for 10 full days except when they are alone in a room or alone outdoors. Children aged 9-12 years old should wear a well fitted mask¹ as much as is reasonably practical during the 10-day period.
- For confirmed cases in healthcare workers, please see [here](#) for further information.

6.0 Symptomatic individuals

- Anyone with symptoms of COVID-19 or other viral respiratory tract infection, regardless of vaccination status, should immediately self-isolate until 48 hours after symptoms have substantially or fully resolved. *Please note children can have persistent minor symptoms e.g. a cough. However, if all new or acute symptoms have substantially or fully resolved, children can return to school or crèche. If their condition significantly deteriorates, please contact your GP for further advice.*
- Public health indications for testing will differ between those at high risk of severe disease who may benefit from early detection or treatment, and other groups/people. However, based on a clinical risk assessment, and clinical judgement, testing may be appropriately requested in certain situations.
- **Testing will no longer be needed for clinical or public health purposes for otherwise healthy people with symptoms, with the exclusion of the following, for whom PCR testing is recommended** (through the [HSE portal](#))
 - Those who have not had booster vaccination and are aged 55 years and older
 - Those with a high-risk medical condition²
 - Those who are immunocompromised
 - Those who live in the same household as a person who is immunocompromised

¹ A medical grade mask (surgical mask) is preferable, if it fits the child well; otherwise a well-fitting cloth mask can be worn. For further information please see [here](#)

² For a list of high risk medical conditions and those who are immunocompromised, please see NIAC Immunisation Guidelines on COVID-19 vaccine Chapter 5a. Table 5a.2: [Underlying conditions associated with very high risk or high risk of severe COVID-19 disease.](#)

- Those who provide care or support for person they know to be immunocompromised
- Those who are pregnant
- Healthcare Workers
- All **symptomatic individuals** should use a well-fitted medical grade (surgical) or FFP2 face mask. Children aged 9-12 years old should wear a well fitted mask³ as frequently as is reasonably practical.
- If a child aged less than 3 months is symptomatic, contact your GP for advice.
- For advice for symptomatic healthcare workers, please see [here](#) for further information.

7.0 Asymptomatic close contacts

- Asymptomatic close contacts **do not need to restrict movements, regardless of vaccination status.**
- If they develop symptoms, they should **self-isolate until 48hrs after the symptoms have fully or substantially resolved.**
- Asymptomatic individuals, including close contacts, other than healthcare workers who are household close contacts, **do not need PCR or Rapid Antigen Detection Testing (RADTs).**
- Healthcare workers, identified as **household close contacts**, do not need to restrict movements but must undertake 3 RADTs over a 7-day period, (the first RADT should be performed as soon as possible, the second 3 days later and the final test on the 7th day). **The requirement for testing does not apply if they have recovered from COVID-19 in the previous three months.**
- Any asymptomatic individual who has a positive RADT result should consider this result definitive and self-isolate.

³ A medical grade mask (surgical mask) is preferable, if it fits the child well; otherwise a well-fitting cloth mask can be worn.

8.0 References

- (1) ECDC '*Interim public health considerations for the provision of additional COVID-19 vaccine doses*' [Internet]. European Centre for Disease Prevention and Control. 2021 [cited 2021 Nov 11]. Available from: <https://www.ecdc.europa.eu/en/publications-data/covid-19-public-health-considerations-additional-vaccine-doses>
- (2) ECDC Technical Report '*Risk of SARS-CoV-2 transmission from newly infected individuals with documented previous infection or vaccination*' [Internet]. European Centre for Disease Prevention and Control. 2021 [cited 2022 Jan 12]. Available at: <https://www.ecdc.europa.eu/en/publications-data/sars-cov-2-transmission-newly-infected-individuals-previous-infection>
- (3) National Advisory Immunisation Committee (NIAC) '*Chapter 5a – COVID-19*' [Internet]. National Advisory Immunisation Committee. 2022 [cited 2022 Feb 28]. Available at: <https://www.hse.ie/eng/health/immunisation/hcpinfo/guidelines/covid19.pdf>
- (4) World Health Organisation. '*Interim statement on booster doses for COVID-19 vaccination*' [Internet] World Health Organisation 2021 [cited 2021 Nov 11]. Available from: <https://www.who.int/news/item/04-10-2021-interim-statement-on-booster-doses-for-covid-19-vaccination>

9.0 Appendix 1

An additional vaccination dose may be needed as part of an extended primary series for targeted populations where the immune response rate following the standard primary series is deemed insufficient. The objective of an additional dose in the primary series is to optimise and enhance the immune response to establish a sufficient level of effectiveness against disease. (4).

Booster doses are administered to a vaccinated population that has completed a primary vaccination series (currently one or two doses of COVID-19 vaccine, depending on the product), when with time the immunity and protection has fallen below a rate deemed sufficient in that population (4) The objective of a booster dose is to restore vaccine effectiveness from that deemed no longer sufficient.

Primary vaccination schedule definition

A list of authorised and recommended vaccines can be found [here](#).

Ideally the same vaccine should preferably be used for both doses of a primary vaccination course, however, in some instances a heterologous vaccination schedule can be delivered. Heterologous COVID-19 vaccination means getting two different COVID-19 vaccines e.g., getting the Vaxzevria[®] vaccine for the first dose followed by an mRNA vaccine Comirnaty[®] (Pfizer BioNTech) or Spikevax[®] (COVID-19 Vaccine Moderna) for the second dose. In these circumstances, these individuals are also considered to have completed their primary vaccination schedule after their second dose (7 days after Comirnaty[®] and 14 days after Spikevax[®]).

The National Immunisation Advisory Committee (NIAC) advises that individuals may be offered an additional vaccine dose in addition to their primary vaccination course because evidence suggests that those who are severely immunocompromised⁴ do not have adequate protection following a primary COVID-19 vaccine course. This additional vaccine dose enhances their protection; however, if the person's immune system response to vaccination could be compromised due to either of the following conditions:

- i. a transplant (solid organ, bone marrow, haematopoietic stem cell) in the past 12 months
- ii. systemic cytotoxic chemotherapy or other systemic cancer chemotherapy in the past 12 months.

A booster dose may also be offered to a vaccinated population that has completed a primary vaccination series, when with time, the immunity and clinical protection has fallen below a rate deemed sufficient for that population (3)

⁴ An additional mRNA vaccine dose should be given to those aged 12 and older who are immunocompromised, associated with a suboptimal response to vaccines who have completed their primary course, regardless of whether the primary course was an mRNA or an adenoviral vector vaccine. This is an extended primary vaccination course. The additional vaccine should be given after a minimum interval of two months following the last dose of an authorised COVID-19 vaccine