Queensland Health

Transitions between hospital and residential aged care facilities during the COVID-19 pandemic

Guidance Document [version 1.2]

"Transitions between hospital and residential aged care facilities during the COVID-19 pandemic" guidance document has been developed to provide a consistent approach to the safe provision of care for residents of Residential Aged Care Facilities (RACFs) who have healthcare needs that necessitate physical attendance at an acute hospital facility during the COVID-19 pandemic.

A Residential Aged Care Facility (RACF) is defined as: a residential aged care facility at which accommodation and personal care, or nursing care, are provided and funding is received from the Commonwealth under the *Aged Care Act 1997*, or under the *National Aboriginal and Torres Strait Islander Flexible Aged Care Program*."

The Guidance Document covers considerations around the transfer to and from the acute hospital system. This approach has been designed to ensure safe provision of acute care for residents and healthcare workers. It further provides confidence that those transitioning from acute to RACF settings have been appropriately clinically screened and reviewed by a Senior Medical Officer to assess risk of COVID-19 prior to discharge.

This guidance document aims to:

1. Minimise the risk of transmission of COVID-19 in a RACF, hospital or ambulance setting following an interaction with a Queensland Health (QH) facility / hospital including but not limited to attendance at an emergency department (ED) or outpatients department, an inpatient admission, or attendance for a hospital based diagnostic test or procedure (note: where clinically appropriate, outpatient department visits should occur via virtual means such as Telehealth at times of significant community transmission during the pandemic).
2. Minimise the risk of healthcare worker COVID-19 exposure.
3. Ensure safe access to appropriate acute care when clinically necessary.
4. Maintain resident quality of life by ensuring that quarantine or isolation is only undertaken when public health risk justifies this approach.
5. Build confidence and transparency between the RACF and QH facilities around relative risk of COVID-19.
6. Support RACFs to make informed choices when considering the need for quarantine or isolation or enhanced infection control following a QH interaction to ensure that the highest standards of infection control and communicable disease containment are upheld.
7. Avoid preventable delays in transfer of residents with low risk of COVID-19 infection to and from RACFs.
8. Ensure clear and timely communication between Queensland Health, Residential Aged Care Facilities, General Practitioners, Residents and their Families.
9. Encourage opportunistic vaccination against COVID-19 in unvaccinated or partially vaccinated residents of Residential Aged Care Facilities during admission to QH facilities.

1. Scope

Compliance with this guidance document is recommended and sound reasoning should exist for departing from the recommendations. This guidance document is intended to provide Queensland Health clinicians with a framework on which to base decisions and to inform advice given to residential aged care providers, patients/residents, families and peak bodies during the pandemic.

This guidance may not apply in the event of a hospital or RACF outbreak of COVID, in which the Outbreak Control Team and or Public Health Unit will make appropriate decisions regarding the safe management of patients and residents

2. Related documents

2.1. Standards, procedures and guidelines

- Novel Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units: https://www1.health.gov.au/internet/main/publishing.nsf/Content/cdna-song-novel-coronavirus.htm
- Department of Health Infection Control in RACF: https://www.health.gov.au/resources/publications/coronavirus-covid-19-guidelines-for-infection-prevention-and-control-in-residential-care-facilities
- Queensland Health pandemic response guidance: escalation of personal protective equipment usage in residential aged care and disability accommodation services

3. Guidance for transitions between hospital and residential aged care facilities during the COVID-19 pandemic

3.1. Guiding Principles

The principles that form the foundation for the requirement of this document are as follows:

- To ensure the highest quality of care for all residents.
- To maintain a consistent and collaborative approach to resident care.
- To reduce risk of infection to RACF residents, staff and acute healthcare providers in the hospital and ambulance setting.
- To ensure clinical engagement across all levels of the care continuum.
- To ensure clear and timely communication.

NOTE: this document is not a mandate and does not act to replace individual clinical decision making.

RACF residents should be assessed on an individual basis with consideration of:

- Clinical judgement.

- Signs and symptoms the resident is currently or has recently been experiencing.
- Potential exposure during all phases of care within their own residential facility, elsewhere in the community, or during hospital presentation, particularly within the previous 14 days.
- End of life decision-making and palliative care management where appropriate.
- RACF environment and staffing.
- Current public health advice and alerts.
- Relevant Public Health Directions and any Commonwealth Directions.

All resident risk assessments and discharge needs are to be communicated in writing to the RACF clinical manager (or their nominated delegate), treating General Practitioner and resident and their family.

3.2. Current State

An up-to-date list of COVID-19 hotspots can be viewed at the following link:
https://www.qld.gov.au/health/conditions/health-alerts/coronavirus-covid-19/current-status/hotspots-covid-19

Aged Care Direction at the following link:
https://www.health.qld.gov.au/system-governance/legislation/cho-public-health-directions-under-expanded-public-health-act-powers/aged-care

Queensland COVID-19 Restricted Areas Direction at the following link:
https://www.health.qld.gov.au/system-governance/legislation/cho-public-health-directions-under-expanded-public-health-act-powers/queensland-covid-19-restricted-areas-direction

This guideline incorporates the consideration of local community transmission in decision making as defined by published COVID-19 hotspots and public health advice. If in doubt, please contact your local public health unit.

3.3. Target Population

The target populations for the below approved process are current or new residents of RACFs that have an interaction within a Queensland Health facility / hospital including but not limited to the following:

- Emergency Department
- Inpatient admission - acute and subacute (E.g. rehabilitation, GEM) wards
- Outpatient occasion of service*
- Hospital based diagnostic test or procedure*.

* In times of community transmission of COVID-19 outpatient occasions of service should be undertaken by telehealth where-ever clinically appropriate. Hospital based diagnostic tests or procedures should only be undertaken where clinical risks warrant this.

3.4. Risk Stratification Process

The risk stratification of residents is an essential component of risk minimisation. Risk stratification includes assessment of environmental risk and individual clinical risk.

A high proportion (>50%) of COVID positive residents will be missed by traditional screening criteria; furthermore, 43% to 73% of COVID positive residents are asymptomatic / presymptomatic on testing. Therefore, risk assessment in the context of local RACF suspected / confirmed outbreaks and community levels of transmission is critical.

When identifying if a RACF resident is at risk of having, or having been exposed to, COVID-19, it is essential that the responsible medical officer assesses the resident against the following:

- New onset of signs and symptoms of respiratory illness (including cough - dry or productive, shortness of breath, sore throat, nasal congestion, haemoptysis).
- Presence of a fever, or symptoms that suggest fever (e.g. chills, sweats).
- New onset of atypical COVID-19 symptoms (e.g. acute confusion or behavioural change/delirium, loss of appetite, fatigue, loss of taste or smell, diarrhoea, nausea, vomiting, headache, myalgia, arthralgia, or conjunctival congestion).
- Potential source of infection (close contact or significant casual contact with a confirmed or suspected COVID-19 case, or presence at a Queensland Health declared exposure site or interstate exposure venue/hotspot, within the preceding 14 days).
- Geographic location and risk profile of the area of treatment or residence (active COVID-19 ward/area versus "clean" area, suspected or confirmed outbreak at the resident's RACF of origin, level of community transmission in the local government area in which the RACF is located).

Risk stratification and actions are outlined in table 1.

Clinicians should make all efforts to ensure that they accurately assess against these domains in order to limit the potential for avoidable transmission of COVID-19, and so that residents are not unnecessarily subjected to isolation. Such assessment requires senior medical input. Where residents are at end of life, specialist palliative care input is suggested.

3.5. Vaccination Considerations

Clinicians should attempt to ascertain the COVID-19 vaccination status of residents presenting to a QH facility, and, if the resident is admitted as an inpatient, opportunistically provide vaccination (where it is feasible to do so, where vaccination is not contraindicated and where valid informed consent can be obtained) to all unvaccinated and partially vaccinated individuals. Note the omission by a Queensland Health facility to provide opportunistic vaccination will not be taken as a valid reason to delay discharge.

Table 1: Risk stratification of resident influencing assigned risk

Risk assessment domain	**Risk assessment criteria**	**Low risk if ALL "No"**	**Moderate risk if ANY "Yes"**	**High risk if ANY "Yes"**
Clinical risk assessment	Does the resident have typical symptoms of COVID?	No	N/A	Yes
	Does the resident have atypical symptoms of COVID? (E.g. acute confusion or behavioural change/delirium, acute loss of appetite, fatigue, loss of taste or smell, diarrhoea, nausea, vomiting, headache, myalgia, arthralgia, or conjunctival congestion)	No	Yes – symptoms completely explained by definitive* non-COVID illness	Yes – symptoms not completely explained by definitive* non-COVID illness
	Does the resident have a fever?	No	Yes - fever with definitive* non-COVID cause	Yes - fever without definitive* non-COVID cause
	Cognitive impairment that precludes the ability to reliably assess for the presence or absence of symptoms AND the resident is from a RACF within a restricted local government area? (as defined by current Chief Health Officer Direction)	No	Yes – definitive* non-COVID diagnosis established as cause for presentation	Yes – no definitive* non-COVID diagnosis established as cause for presentation
Epidemiological risk assessment	Does the resident's RACF have a current suspected or confirmed COVID-19 outbreak? (consult with the local RaSS[1] or directly with the RACF management if unsure)	No	N/A	Yes
	Is the RACF or the hospital in a restricted local government area (as defined by current Chief Health Officer Direction)?	No	Yes	N/A
	In the last 14 days was there a known: - close contact with a confirmed COVID +ve case	No	N/A	Yes – Potential or confirmed close contact

[1] Residential Aged Care Facility Acute Support Service

	- close contact at a Queensland Health declared exposure site - exposure in an interstate exposure venue or hotspot			
	In the last 14 days was there a known 'casual contact' at a Queensland Health declared exposure site	No	Yes – with a negative COVID test subsequent to exposure	Yes – COVID test not yet done or result pending

Table 2: Recommendations: for the management of the resident, according to resident's assigned risk level

Recommendations		**Low risk**	**Moderate risk**	**High risk**
COVID testing in hospital	COVID PCR	Not indicated	Not indicated	Indicated.
Discharge considerations	Personal Protective Equipment during 14 days after discharge	Refer to current Personal Protective Equipment information for RACF staff	Refer to current Personal Protective Equipment information for RACF staff	Refer to current Personal Protective Equipment information for RACF staff
	Additional precautions, review and monitoring for 14 days to assess for new symptoms	Daily screening for symptoms and signs of COVID-19	Minimum twice daily screening for symptoms and signs of COVID-19 and institute any infection control procedures indicated by the persons diagnosis	As directed by medical team on discharge Residents with confirmed COVID 19 will remain in hospital and will not be discharged until no longer infectious. Discharge planning should occur in consultation with the public health unit +/- the hospital COVID-19 team. If close contact with a confirmed case has been confirmed by public health, the resident will need to be quarantined for 14 days from last date of exposure and the location of quarantine would be determined in consultation with the public health unit +/- the hospital COVID-19 team.
*Assessment of fever must follow best practice recommendations specific to evaluation of this cohort, particularly for suspected UTI – see Therapeutic Guidelines – antibiotics: UTI in residents of aged care facilities				

3.6. Actions on discharge of residents

Prior to discharge, assessment by treating Senior Medical Officer against the risk stratification domains (see Table 1) **must** be performed. All residents must have:

1. Communication with the accepting RACF and General Practitioner to confirm transfer and clinical care requirements.
2. A letter (see attachment 1) confirming the resident's risk status completed by the responsible Senior Medical Officer or Medical Officer delegate. Letter should be faxed / electronically communicated to RACF and treating General Practitioner.
3. Discharging clinician is to communicate with the resident and the resident's next of kin regarding the plan for transfer.
4. Transfer is to be arranged as per local process.

If the resident is unvaccinated or partially vaccinated against COVID-19, vaccination is not contraindicated, and the patient or (where relevant) their valid substitute decision maker for healthcare consents to vaccination, if possible vaccination should be offered.

Where a resident is assessed as **low risk** and is ready for discharge, in addition to above requirements for all residents:

1. On return of the resident to the RACF, implement usual daily screening for symptoms or signs of COVID-19 that should be applied to all residents and staff during COVID-19 pandemic; no indication for isolation of resident unless develops new symptoms or signs of COVID-19.

Where a resident is assessed as **Moderate risk**, in addition to above requirements for all residents:

1. Discharge appropriateness should be considered on a case by case basis in consultation with RACF infection prevention and control personnel and the resident's usual General Practitioner, along with the local Public Health Unit and/or hospital COVID-19 team where required.
2. Screening for signs and symptoms of COVID-19 after discharge, should occur at a minimum of twice daily for 14 days to assess for new symptoms; isolation of the resident is not routinely required unless develops new symptoms or signs of COVID-19, or unless the resident has a non-COVID-19 illness that would otherwise warrant transmission based precautions.

Where a patient is deemed to be **High risk**[2]:

1. A resident who has been tested for COVID-19 **will not** be discharged while the results of testing are pending.
2. A resident with confirmed COVID-19 will be managed in hospital and **will not** be discharged until no longer infectious, and only in consultation with public health unit +/- the hospital COVID-19 team.
3. Where a resident has tested negative for COVID-19, but is a close contact with a confirmed case the resident will need to be quarantined for 14 days from last date of exposure and the location of quarantine would be determined in consultation with the public health unit +/- the hospital COVID-19 team.

[2] This recommendation may be modified if capacity of the hospital sector to accommodate Emergency Department presentations and inpatients (when all level 4 public hospital and private hospital responses have been activated) is exceeded, as per the current Queensland Health Pandemic Response Framework.

1. Definitions

Term	Definition / Explanation / Details	Source
Quarantine	The separation of a person or group of people reasonably believed to have been **exposed** to communicable disease but not yet symptomatic, from others who have not been so exposed, to prevent the possible spread of the communicable disease.	https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/COVID-19-SoNG-v4.8.pdf I
Isolation	The separation of a person or group of people known or reasonably believed to be **infected** with a communicable disease and potentially infectious from those who are not infected to prevent spread of the communicable disease. Isolation for public health purposes may be voluntary or compelled by federal, state, or local public health order.	https://www1.health.gov.au/internet/main/publishing.nsf/Content/7A8654A8CB144F5FCA2584F8001F91E2/$File/COVID-19-SoNG-v4.8.pdf
RACF	RACF is a residential aged care facility at which accommodation and personal care, or nursing care, are provided and funding is received from the Commonwealth under the *Aged Care Act 1997,* or under the *National Aboriginal and Torres Strait Islander Flexible Aged Care Program"*.	

2. Document approval details

Document custodian

Residential Aged Care and Disability Services Clinical Advisory Committee

Consultation

This document has been created in collaboration with a wide range of stakeholders. Input has been sought from the following groups:

- Statewide Older Persons Health Clinical Network
- Residential Aged Care facility (RACF) Support Service (RaSS)
- Queensland Emergency Department Strategic Advisory Panel (QEDSAP)
- Strategic Policy and Legislation Branch
- Statewide Infection Clinical Network
- Communicable diseases/COVID-19 Incident Management Team
- Leading Age Services Australia
- Consumer groups
- Private Residential Aged Care Providers
- Unions

This document will be subject to regular ongoing review and updated to align with current health directives and guidelines.

DOCUMENT REVISION HISTORY

Version	Date	Authorised	Review Date
1.0	3 September 2020	Deputy Director-General Clinical Excellence Queensland	March 2021
1.3	16 September 2021	Residential Aged Care and Disability Services Clinical Advisory Committee	March 2022
1.3	11 October 2021	COVID Response Group	

Version Control

Version	Date	Comments
0.2	10/06/2020	First version of document reviewed by members of the COVID-19 Incident Management team. Suggested changes in wording accepted and DOH infection control for RACF document attached.
0.3	16/07/2020	Second version of the document reviewed by several aged care providers. Input sought from the COVID-19 Incident Management team in relation to feedback and document updated accordingly.
0.4	28/07/2020	Document updated as per feedback received from key stakeholder. Risk stratification process updated to include atypical symptoms of COVID-19.
0.5	3/08/2020	Document substantially changed as per stakeholder input. Title changed. Content revised.
0.6	4/08/2020	Document updated as per input from members of the RACF Clinical Advisory Group. Document now includes prompt for communication with RACF and treating General Practitioner.
0.7	24/08/2020	Document updated following input from consumer groups and other stakeholders. Name changed to align with document purpose.
0.8	25/08/2020	Table updated as per feedback

Version	Date	Comments
0.9	28/08/2020	Table reviewed by representatives from Statewide Infection Clinical network, Public Health and RaSS services. Updated accordingly.
1.0	31/08/2020	Document updated following input from Statewide Infection Control Network, Public Health and clinician feedback.
1.1	1/09/2020	Table updated as per public health advice.
1.2	16/09/2021	Document updated to reflect the emergence of the Delta variant. The template discharge letter that accompanies the resident back to their RACF has also been updated.