Queensland Health

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

Queensland Health Discharge Letter

Date: .....

To whom it may concern,

RE: ..... *(patient name, DOB)*

..... *(patient name)* will be discharged to

..... *(RACF name)* on ..... *(date)*.

..... *(patient name)* has been screened at the time of discharge as per the recommendations in the Queensland Health Guideline: *"Transitions between hospital and residential aged care facilities during the COVID-19 pandemic"*.

On the day of discharge, an assessment has been performed by the treating Senior Medical Officer against the risk stratification domains in Table 1. As per table 1, this patient has been assessed to be:

1. ☐ LOW RISK
2. ☐ MODERATE RISK

For guidance surrounding the ongoing management of residents following an encounter with a Queensland Health Hospital Facility, please refer to the "key points" section of this letter. The information provided is from the Queensland Health Guidance Document *"Transitions of residents from hospital to residential aged care facilities during the COVID-19 pandemic*".

Resident COVID-19 vaccination status at discharge:

☐Unknown ☐Unvaccinated ☐Partially vaccinated (1st dose only)

☐Fully vaccinated (2 or more doses)

COVID-19 vaccine administered during this hospital encounter:

☐1st dose ☐2nd dose (please specify vaccine, e.g. AZ, Pfizer _____)

date administered_____

next dose due_____ **(note follow-up vaccine doses are the responsibility of the resident's usual primary care provider)**

☐COVID-19 vaccine not administered

Kind regards

.....

(signature)

.....

(name, contact details)

Key Points

Actions on discharge of residents

Prior to discharge, assessment by treating Senior Medical Officer against the risk stratification domains in 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 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**[1]:

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.

[1] 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.

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 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 - close contact at a Queensland Health declared exposure site - exposure in an interstate exposure venue or hotspot	No	N/A	Yes – Potential or confirmed close contact
	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

*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"*.

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.	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"*.