COVID-19 Response
Community management of mild COVID-19 illness in rural Queensland v1.0
Acknowledgment of Aboriginal and Torres Strait Islander people of Queensland

We acknowledge the Traditional Owners and Custodians of the lands on which we work and pay our respect to Aboriginal and Torres Strait Islander Elders past, present and emerging.

Disclaimer

This document is intended as a guide and provided for information purposes only. The information has been prepared using a multidisciplinary approach with reference to the best information and evidence available at the time of preparation. No assurance is given that the information is entirely complete, current, or accurate in every respect and it recommended to refer to the Queensland Health COVID-19 website for the most recent advice.

This document is not a substitute for clinical judgement, knowledge and expertise, or medical advice. Variation from the document, taking into account individual circumstances, may be appropriate.

This document does not address all elements of standard practice and accepts that individual clinicians are responsible for:

- providing care within the context of locally available resources, expertise, and scope of practice
- supporting consumer rights and informed decision making, including the right to decline intervention or ongoing management
- advising consumers of their choices in an environment that is culturally appropriate and which enables comfortable and confidential discussion. This includes the use of interpreter services where necessary
- ensuring informed consent is obtained prior to delivering care
- meeting all legislative requirements and professional standards
- applying standard precautions, and additional precautions as necessary, when delivering care
- documenting all care in accordance with mandatory and local requirements

Queensland Health disclaims, to the maximum extent permitted by law, all responsibility and all liability (including without limitation, liability in negligence) for all expenses, losses, damages and costs incurred for any reason associated with the use of this document, including the materials within or referred to throughout this document being in any way inaccurate, out of context, incomplete or unavailable.
Contents

Introduction ................................................. 4

Preparation for community management ............. 7
  1.1 Providing clinical care to people with COVID-19  7
  1.2 COVID-19 Virtual Ward .......................... 8
  1.3 Clinician factors .................................. 9
  1.4 Facility factors .................................... 11
  1.5 Infection control .................................. 12

2. Patient identification of appropriate patients .... 13
  2.1 Diagnosis ......................................... 13
  2.2 Disease severity .................................. 13
  2.3 Assess suitability for community management ... 14

3. Admission into community management .......... 18
  3.1 Notification to Public Health Unit ................ 18
  3.2 Clinical governance ................................ 18
  3.3 Consultation with local clinical team and admission 18
  3.4 QH Telehealth support ............................ 19
  3.4 Patient counselling and consent ................... 19

4. Clinical management of mild COVID-19 in the community 21
  4.1 Clinical monitoring ................................ 21
  4.2 Symptom assessment and severity ................. 22
  4.3 Appropriate intervention .......................... 24

5. Transition of care into hospital wards ............. 24
  5.1 Indicators for admission ........................... 24
  5.2 Integration to hospital .............................. 25
  5.3 Transfer procedures ............................... 26

6. Discharge of patients from community management 26
  6.1 Illness resolution .................................. 26
  6.2 Subsequent care and precautions ................... 27
  6.3 Palliation and certification of death ............... 27
  Summary .................................................. 27
  Acknowledgements ..................................... 28
  Additional resources .................................. 29
  Definitions ............................................. 29

Appendices .................................................. 30
  Reference list .......................................... 42
Introduction

As Queensland moves into the “system rebalancing” phase of COVID-19 management, attention turns to the approximately 90% of COVID-19 patients who may potentially be safely managed within the community.

The purpose of this document is to provide HHSs with rural facilities, and the clinicians working in those communities, with a safe and consistent community management pathway within which patients who should not require inpatient care (i.e. mild COVID-19) can be kept in their communities. The patient-centred care approach involves:

- Integrating a community's primary care workforce within Queensland Hospital and Health Services, i.e. Rural Generalists (RGs) and Visiting Medical Officer General Practitioners (GP VMOS).
- Creating Hospital in the Home, Virtual Ward and community isolation by making use of houses and other accommodation in which patients can be safely quarantined using virtual modalities such as telephones, videoconferencing (either on a mobile telephone, tablet or computer) and internet 'data.'
- Establishing regular and appropriate clinical monitoring processes to review patients’ conditions and escalation points for additional intervention and transfer to the local hospital.
- Figure 1 below depicts the patient’s journey after being diagnosed, through to being treated via a community pathway in the case of a diagnosis of mild COVID-19. If the diagnosis is not a mild case, or the patient’s condition changes/deteriorates, clinical review/hospitalisation is recommended as per the flow chart.

Many of these patients may be asymptomatic, may be pending a negative swab result for clearance, or indeed unaware that they have the disease at all.

Other patients may have only mild symptoms but have predisposing factors requiring attention. These may be physical, psychological or social, and may or may not be directly related to their COVID-19 infection but place the patient at greater risk of either personal deterioration, or community transmission.

A final cohort for whom community care would be most appropriate is those who have previously nominated that they wish to remain in their home setting if demise is likely. These patients, their families and carers also require assistance throughout this process.

A rural community in which COVID-19 becomes epidemic has the potential to have its hospital over-run with cases, particularly if minimally symptomatic patients are admitted and recuperating patients are retained as inpatients.

For the purpose of this document virtual care includes telehealth, telephone calls and other ICT enabled communication.
Caring for clinically well patients with COVID-19 in their homes allows for the provision of appropriate care while minimising the impact on the community and health system. It also frees up hospital beds for more severe cases.

A range of models have been developed and deployed across metropolitan and regional areas of Queensland to provide support for patients who are suspected and/or confirmed COVID-19 but who are well and able to manage at home (i.e. mild cases). These models of care allow remote supervision of patients, with intervention and admission where indicated.
Figure 1 Patient diagnosed as COVID-19 patient journey

Patient diagnosed as COVID-19 positive
(see General Practitioner (GP) assessment and management of patients with suspected COVID-19 for clarification)

Patient confirmed COVID-19 positive - assess clinical status using appropriate PPE

If asymptomatic or mild, discuss with Admitting Medical Officer (e.g., Incident Controller, or delegate)

If moderate or severe, arrange for Hospital transfer and ensure infection control measures are implemented in transit

Assess suitability for community management
(Clinical status, comorbidities, health literacy, access to technology, living arrangements, capacity for isolation; Isolation considerations: health/welfare checks, food, pets, childcare)

Suitable self-isolation arrangements if suitable, arrange admission to Virtual Ward or HTH

If not suitable, arrange for hospital transfer with appropriate PPE OR admission to community isolation facility

Explain Community Management process to patient and determine most appropriate venue

If home selected, ensure no relatives or guests attending. Arrange shopping, food delivery etc.

If alternative premises selected, arrange transport and orientation

Commence admission with twice daily monitoring (based on clinical need) via telehealth. Assess for fever, cough, shortness of breath (or exertion or rest), syncope, nausea. Assess for other issues (chest pain, psychological distress, frailty, dehydration)

If symptoms stable or improving, reduce to once daily telehealth review - test/assessment to confirm COVID-19 negative

If symptoms developing or worsening, arrange Clinical review with full PPE (via QAS if urgent)

Preparation for community management

1.1 Providing clinical care to people with COVID-19

The National COVID-19 Clinical Evidence Taskforce (NCCET) is undertaking continuous evidence surveillance to identify and rapidly synthesise emerging research in order to provide national guidelines for the clinical care of people with COVID-19. The guidelines address questions that are specific to managing COVID-19 and cover the full disease course across mild, moderate, severe and critical illness.

On 4 June 2020 the NCCET published the fourth version of a guideline detailing the *Management of patients with suspected mild COVID-19*. The definition of mild COVID-19 is a person not presenting any clinical features suggesting a complicated course of illness, with a stable clinical picture and no symptoms or mild upper respiratory tract symptoms.

The guideline notes that patients with mild COVID-19 disease can be managed in the community with advice on symptomatic management and self-isolation. COVID-19 in children is less common than adults and generally milder, health care professionals are encouraged to contact the Children’s Health Queensland Infectious Diseases Service through Queensland Children’s Hospital switchboard (07 3068 1111) for questions related to paediatric testing or management.

Aspects of the guideline are incorporated within this community management pathway. A copy of the guideline (as at 5 June 2020) is provided at Appendix 1.

Rural aspects of COVID-19 infections

It is recognised that the high prevalence of co-morbidities particularly diabetes, cardiovascular and respiratory conditions combined with limited access to primary, secondary and tertiary health care means rural and remote communities should be considered vulnerable to COVID-19.

Isolation of suspected and confirmed cases and contacts may present challenges in rural and remote communities, including:

- the availability of resources to enable isolation of cases and contacts away from older individuals (over 50 for Aboriginal and Torres Strait Islander people and over 60 for the general population)
- the availability of resources to enable quarantining of individuals who may have had contact with a confirmed case including and not limited to telecommunication resources such as telephones, videoconferencing (either on a mobile telephone, tablet or computer) internet access and technology literacy.
- access to PPE for vulnerable individuals, health care workers and ancillary support.

Aboriginal and Torres Strait Islander people are also particularly susceptible when it comes to COVID-19. Compared to other Australians, Aboriginal and Torres Strait Islander people experience a higher burden of disease, greater social disadvantage, and more crowded housing conditions that increase the risk of disease transmission.
1.2 COVID-19 Virtual Ward

Figure 2 illustrates the three elements of community care. The most similar of these to hospital care are the Virtual Ward. Virtual Wards work just like a hospital ward, using the same staffing, systems and daily routines, except that the people being cared for stay in their own homes or other accommodation throughout.

The purpose of a COVID-19 Virtual Ward is to enable the monitoring and care of patients with suspected or confirmed COVID-19 in the community. This model is based on evidence suggesting that more than 80% of all cases will never require hospital admission. However, up to 20% may require hospitalisation during their illness. The situation is complicated further by delays in requiring hospital care, often more than five days from symptom onset, and the lack of prognostic markers that identify which patients will progress to severe disease.

As such, a Virtual Ward allows the monitoring of a patient, to identify any deterioration early, and to facilitate hospital review and admission. A Virtual Ward also supports public health units (PHUs) in their work to limit ongoing transmission, by providing advice and support regarding home isolation, as well as eventually classifying patients as recovered and providing confirmation to enable completion of isolation requirements.
Positive patients who are mildly symptomatic are being admitted to Virtual Wards in metropolitan and regional communities of Queensland. There are clinical as well as social criteria that needs to be met, for these cases to be eligible for this process. These patients, and potentially their close contacts are being checked on twice daily and monitored both symptomatically and socially.

Figure 3: illustrates an example of the care pathway provided on a Virtual Ward^9

1.3 Clinician factors

For communities and facilities where inpatient requirements are already anticipated to occupy or overwhelm staffing capacity, alternative workforce arrangements may be required. HHSs are encouraged to consider available additional support within their local community. Where other clinicians are available, such as general practitioners, community health nurses, or Aboriginal or Torres Strait Islander Health Practitioners or Workers, they may be appointed to supervise Virtual Ward patient care.

Medical workforce

Existing local arrangements for respiratory or infectious disease physician supervision of COVID-19 patients should be utilised to allow telehealth supervision where available. Other facilities may have rural generalist staffing, where one Senior Medical Officer is delegated by the Incident Controller of that HHS to provide local supervision.

Regardless of their individual settings, the responsibilities of rural generalists (RGs) and general practitioners (GPs) in rural Queensland do not necessarily end at diagnosis of COVID-19. By virtue of their key roles in rural communities, RGs and GPs are well positioned to determine whether a person requires inpatient hospital care. They also tend to have an enhanced understanding of community living arrangements and insight into whether isolation and quarantine in the community is possible and safe.

General practitioners may be appointed as Visiting Medical Officers where clinical requirements are likely to extend for the prolonged period of the COVID-19 pandemic. This
appointment would then allow patients to be admitted under usual VMO arrangements, allowing independent supervision of patients with mild COVID-19, and facilitating routine transfer of care if inpatient admission becomes necessary.

Nursing

Nurse navigators are well placed to coordinate care for those in community isolation and support the provision of care across service boundaries and multi-disciplinary teams (e.g. for patients with chronic disease comorbidities). The decision as to who is to perform this role should be made at a facility level (e.g. DON/NUM of rural facility as lead, with delegation to other senior nursing roles such as Nurse Navigator). Each facility will need to determine if they have capacity to provide this role. The service needs to be available 7 days a week and be able to be activated after hours and on public holidays.

Nurse navigators can provide care planning, patient education and support, and coordination of access to services. Specifically, Navigators can support this cohort of patients via:

- symptom assessment and triage to inform escalation of clinical interventions
- increasing health literacy of patients and helping the patient to manage their own care
- assistance to patients to maintain isolation to avoid the risk of infecting others
- management of virtual wards
- facilitation of end-of-life care conversations and formulation of advance care plans.

Rural and isolated practice nurses (RIPEN) and nurse practitioners, particularly those working in single nurse sites can also be linked in with integrated care teams from larger rural, regional and/or metropolitan areas.

Within the community management pathway for mild COVID-19, nurses may be trained and deployed to:

- manage the daily checks and initiate medical reviews of patients in virtual wards and community isolation
- train and supervise staff and visitors in the donning/doffing of PPE
- manage the re-supply, storage and inventory of equipment
- manage medication delivery and checking
- maintain bed management and patient flow information
- support essential pandemic research projects
1.4 Facility factors

Patient’s residence

A patient’s residence may be appropriate as a Hospital in the Home and Virtual Ward setting if following are available to enable proper isolation:

- access to a single bedroom, ideally with own bathroom/ensuite
- no persons at higher risk of serious illness live in the household (e.g. elderly, pregnant women, people who are immunocompromised or who have chronic cardiovascular, lung, or kidney conditions)
- a willing and able caregiver and/or relative(s) or neighbour(s) nearby who can assist with animals or childcare if required
- the patient (and anyone who lives in the same home) have access to the recommended personal protective equipment (at a minimum, gloves and mask)
- ability to easily access medical care if condition deteriorates (proximity to hospital)
- reliable telecommunications access exists, ideally including internet and virtual telecommunication resources (such as telephones, computer or tablet access) and internet access. At a minimum, telephone access is required.
- access to food, medicines and other necessities (e.g. delivered by family or friends, home doorstep delivery packages)
- access to psychological and social supports (e.g. telephone, internet contact with social supports).

Refer to the Appendix 6 for links and community resources to support patients/carers/families during COVID-19 pandemic.

Alternative accommodation

If one or more of the conditions listed in the previous section cannot be met, alternative accommodation in a community facility will need to be found for the patient. HHSs and integrated Local Disaster Management Group (LDMG) or District Disaster Management Groups (DDMG) (as appropriate) planning groups should identify and procure existing accommodation that can be used to house suspected and confirmed cases and contacts of confirmed cases if they are not able to isolate in their residence.

Suitable accommodation may include empty buildings, motels, hostels, transition housing, stadiums, halls, outstations, bush camps) or temporary buildings such as tents, containers,

---


caravans, recreational vehicles, etc). These can all be considered for cohort care while patients remain asymptomatic or with mild COVID-19 illness.

Ideally, community isolation facilities should also include space for recreational movement and exercise. For example, motels with an enclosed courtyard arrangement for parking and restricted public access are readily suited to an exercise yard.

HHSs will need to consider appropriate arrangements for catering and cleaning services for these patients. Community management may also require a police or security presence to ensure no unauthorised visits or breaches of isolation.

**Resources for accommodation providers/teams:**

- [Biosecurity Quarantine Accommodation Training v1.0](#)
- [Biosecurity Quarantine Operational Plan Template v1.0](#)
- [Discharge process checklist v1](#)
- [Guest Information Pack v1](#)
- [Medical clearance v1](#)
- [Return to community quarantine flow chart v1](#)
- [Hotel verification checklist v1](#)
- [Accommodation situation report v1](#)
- [Queensland Health Guideline for the development of a Health Management Plan: Accommodation and private or charter workforce transportation](#)

### 1.5 Infection control

Due to the very highly contagious nature of COVID-19, every precaution must be taken to minimise this risk.

Proper Personal Protection Equipment (PPE) needs to be available and used, not only by any visiting clinician, but also by others providing care or services to these patients. Patients must be explicitly aware of their need to remain indoors and avoid contact with others, while operational duties such as catering, and cleaning should be performed by staff familiar with proper PPE, infection control and waste management protocols.

---

2. Patient identification of appropriate patients

2.1 Diagnosis


2.2 Disease severity

The following (as at 5 June 2020) Definitions of COVID-19 disease severity have been endorsed by National COVID-19 Clinical Evidence Taskforce. Table 1: Definitions of disease severity for COVID-19

<table>
<thead>
<tr>
<th>Mild Illness</th>
<th>Adults not presenting any clinical features suggestive of moderate or severe disease or a complicated course of illness.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• no symptoms</td>
</tr>
<tr>
<td></td>
<td>• or mild upper respiratory tract symptoms</td>
</tr>
<tr>
<td></td>
<td>• or cough, new myalgia or asthenia without new shortness of breath or a reduction in oxygen saturation.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Moderate Illness</th>
<th>Stable adult presenting with respiratory and/or systemic symptoms or signs. Able to maintain oxygen saturation above 92% (or above 90% for patients with chronic lung disease) with up to 4L/min oxygen via nasal prongs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Characteristics:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• prostration, severe asthenia, fever &gt; 38°C or persistent cough</td>
</tr>
<tr>
<td></td>
<td>• clinical or radiological signs of lung involvement</td>
</tr>
<tr>
<td></td>
<td>• no clinical or laboratory indicators of clinical severity or respiratory impairment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe Illness</th>
<th>Adult patients meeting any of the following criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• respiratory rate ≥ 30 breaths/min</td>
</tr>
<tr>
<td></td>
<td>• oxygen saturation ≤ 92% at a rest state</td>
</tr>
<tr>
<td></td>
<td>• arterial partial pressure of oxygen (PaO2)/ inspired oxygen fraction (FiO2) ≤ 300</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Critical Illness</th>
<th>Adult patients meeting any of the following criteria:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Respiratory Failure</td>
</tr>
<tr>
<td></td>
<td>• Occurrence of severe respiratory failure (PaO2/FiO2 ratio &lt; 200), respiratory distress or acute respiratory distress syndrome (ARDS). This includes patients deteriorating despite advanced</td>
</tr>
</tbody>
</table>
forms of respiratory support (NIV, HFNO) OR patients requiring mechanical ventilation.

OR other signs of significant deterioration
• hypotension or shock
• impairment of consciousness
• other organ failure

HiTH or Virtual Ward care is **only** appropriate for the following groups of patients[^10], and following consultation with the local specialist teams, public health unit or Incident Controller as appropriate:

| 1. Majority of patients (approx. 80%) with mild or no symptoms of COVID-19 at diagnosis | These patients would be characterised by mild fevers (<38.0°C), no dyspnoea at rest, and maintaining SpO2 >92% on room air. |
| 2. Convalescent patients recovering from moderate to severe illness following inpatient care | These patients would be characterised by mild fevers (<38.0°C), no dyspnoea at rest, and maintaining SpO2 >92% on room air. |
| 3. Palliative care patients who have previously expressed and appropriately documented their wishes to not proceed with invasive intervention or hospital care | This may apply for elderly patients who have completed Advance Health Directives, or equivalent. These patients are likely to be requiring significant amounts of care and present a very serious threat of infection to others. It is appropriate to discuss care choices with the patient at the time of diagnosis, early in the course of disease, or if the condition is deteriorating (so long as the patient’s capacity is preserved). Consideration of HiTH or Virtual Ward palliation can only be in consultation with the patient’s usual treating specialist or care team in conjunction with family, local Incident Controller and the patient themselves. |

### 2.3 Assess suitability for community management

Any decision to isolate patients in their home rather than a hospital must be a two-way dialogue between patients and their health practitioners[^12]. Patient’s circumstances, health and wellbeing, and the capacity for the patient to be managed in the community setting must be considered when having the discussion. A well-informed patient can actively participate in the decision-making process about their care, and better understand the likely or potential outcomes of their treatment[^12].

Some patients with COVID-19 may not be considered appropriate for home isolation and should be isolated in a hospital or alternative accommodation. Successful community management in COVID-19 is highly dependent on multiple factors beyond disease severity. These must all be considered and include:
• **Absence of significant comorbidities**; such as chronic respiratory disease, cardiovascular disease, renal disease, diabetes or immunosuppression. All these conditions may mask disease severity, complicate COVID-19 presentation or progression, or create a risk of rapid deterioration.

• **Adequate health literacy**; including good communication and English language skills. Community management, especially via telehealth, requires patients to be very familiar with symptom descriptions and performing measurements.

• **Adequate communication literacy and resources**; There needs to be a discussion between the clinician and the patient/patient’s carer regarding what mode of telehealth will be implemented and to ensure the patient, their family or their carer have the adequate resources: including tablet, phone, internet access, and data. Patient needs to be very familiar with the operation of the communication resources. At a minimum, telephone access is required.

• **Social and cultural compliance**; especially where patients may themselves have carer or parental responsibilities. If proper isolation cannot be guaranteed, these factors need to be openly discussed and addressed before considering admission into community management.

• Older age, especially for those aged over 70 or Aboriginal and Torres Strait Islander individuals over 50, is associated with increased risk of serious COVID-19 illness. These patients may not be appropriate for community management, but merit further discussion with local specialist teams and the patient/family/carer.

• **The location of the** patient’s residence, particularly the distance from emergency medical care.

• **The composition of the patient's household**; particularly if the patient resides with multiple other persons, for example in high density housing, and/or other residents who are at high-risk.

• The patient or carer has poor understanding of, or resistance to, infection control measures, for example, compliance with isolation requirements.

• Availability of support, particularly delivery of food, medications and other essential supplies. Those patients living alone should identify someone to check in on them regularly (adhering to social distancing requirements).

• The patient has the capacity (ability) to make a decision about the specific issue at the specific time, and is not affected by therapeutic or other drugs, or alcohol.

• The consent is voluntarily given, and free from manipulation by, or undue influence from, family, medical staff or other social coercive influences.

• The discussion between the patient and the health practitioner is transparent, well balanced, and involves two-way communication which is sensitive to the situation.

• The patient is able to clearly understand the information because it is provided in a language or by other means the patient can understand.
Patients with mild COVID-19 should continue to receive their usual care for pre-existing conditions, including the prescription and dispensing of existing medications. Community pharmacies may be participating in medication home delivery services.
Table 2: Therapies for pre-existing conditions\(^\text{11}\)(as at 5 June 2020)

<table>
<thead>
<tr>
<th>General</th>
<th>• Ensure that people with suspected COVID-19 continue to receive their usual care for pre-existing conditions. People advised to take NSAIDs routinely may continue with treatment.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma and chronic obstructive pulmonary disease</td>
<td>• Use inhaled or oral steroids for the management of people with co-existing asthma or COPD and COVID-19 as you normally would for viral exacerbation of asthma or COPD. Do not use a nebuliser.</td>
</tr>
<tr>
<td>Diabetes and cardiovascular disease</td>
<td>• In patients with COVID-19 who are receiving ACE-I/ARB, these medications should be continued, unless contraindicated (e.g. hypotension). • Do not cease or change the dose of treatments such as insulin or other diabetes medications, statins.</td>
</tr>
<tr>
<td>Conditions managed with immunosuppressants</td>
<td>• Only cease or change the dose of long term immunosuppressants such as high-dose corticosteroids, chemotherapy, biologics, or disease-modifying anti-rheumatic drugs (DMARDs) on the advice of the treating specialist.</td>
</tr>
</tbody>
</table>

Caring for Aboriginal and Torres Strait Islander patients

The Aboriginal and Torres Strait Islander\(^\text{22}\) Patient care guideline provides general advice to support healthcare staff in delivering safe, clinically and culturally responsive care for Aboriginal and Torres Strait Islander patients.

Aboriginal and Torres Strait Islander Health Workers (ATSIHW), and Indigenous Hospital Liaison Officers (IHLOs) play a pivotal role in providing support and assistance to patients, including practical and emotional support, advocacy and discharge planning. The ATSIHW and IHLO’s provide cultural safety and connection and can help patients understand information relating to their hospitalisation and treatment. For further advice contact your local Hospital and Health Service Aboriginal and Torres Strait Islander lead.

The COVID-19 Protection and Containment Considerations for First Nations Communities – Information Resources\(^\text{21}\) has also been developed to provide community leaders, Mayors, community organisations and health services with key considerations in the protection and containment of COVID-19 for Aboriginal and Torres Strait Islander communities.
3. Admission into community management

3.1 Notification to Public Health Unit

Regardless of clinical severity or suspected infection origin, every patient with a positive diagnosis of COVID-19 must be notified to the local PHU which will then undertake the appropriate contact tracing measures in order to minimise risk of further spread. Responsibility for Public Health notification remains with the clinician making the diagnosis, not with the patient or the hospital to which an unwell patient may be sent.

3.2 Clinical governance

Clinical governance is an integrated component of corporate governance of any health service organisations. It ensures that everyone - from Clinical Incident Controller, or their delegate for each facility, is accountable to patients and the community for assuring the delivery of health services that are safe, effective, high quality and continuously improving. Each health service organisation needs to put in place strategies for clinical governance that consider its local circumstances26.

3.3 Consultation with local clinical team and admission

Where HHSs have local specialist care available with respiratory or infection diseases physician supervision, this team must be consulted prior to determining appropriateness for community management. If no such team is available, the Incident Controller for your HHSD must be consulted.

There are several important issues to focus on during the admission:

<table>
<thead>
<tr>
<th>Question</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>When did the symptoms start?</strong></td>
<td>This is important for assessing when the isolation period can end. If onset is unclear, document the dates at which various symptoms started. In the setting of essentially asymptomatic disease, consider day 1 of the illness to be the day of the swab.</td>
</tr>
<tr>
<td><strong>Is the patient well enough to stay at home?</strong></td>
<td>This is a clinical judgement. The primary pathophysiological change in COVID-19 is viral pneumonitis leading to acute respiratory distress syndrome. The critical symptom to screen for is dyspnoea and it is necessary to try and differentiate true exertional dyspnoea from chest tightness or awareness of breathing.</td>
</tr>
</tbody>
</table>
Is the patient able to effectively isolate in the community? If the patient is unable to isolate at home they may require admission to the hospital or another designated facility for isolation.

Each patient is who is admitted under the COVID-19 Virtual Ward model must should meet pre-determined physiological and social suitability criteria. A sample admission template for a COVID-19 Virtual Ward is provided at Appendix 3.

If supervision of the COVID-19 patient in community management is to be performed by a local general practitioner or rural generalist, including those acting in VMO positions, this medical officer must be notified immediately, with a full clinical handover taking place at the time of admission.

Once a decision to admit to a Virtual Ward for community management has been made, additional local support may need to be arranged. If community nursing or Indigenous health worker supervision is needed, these team members must also be consulted and an agreed schedule of visits, communication and community management requirements developed. These team members also need to be trained in infection control and adequate use of PPE.

3.4 QH Telehealth support

The Telehealth Service Desk is available Mon-Fri during business hours for technical support on 1800 066 888 or telehealthservicedesk@health.qld.gov.au.

Clinical Excellence Queensland’s Telehealth Support Unit team are available to assist clinicians with implementing telehealth enabled models of care. For further information contact telehealth@health.qld.gov.au.

3.4 Patient counselling and consent

The decision to allow asymptomatic or mildly unwell COVID-19 patients to remain in the community may indicate to the patient that their condition does not require any isolation, monitoring or treatment. The clinical team make it clear to the patient that this is not the case.

Each patient considered for community management must be completely aware of their responsibilities under this framework, most importantly:

- strict adherence to isolation, without exception
- proper usage of masks and other infection control measures to reduce potential spread to others
- agreement to provide full and honest clinical details for clinical review, whether in person or via telephone or videoconferencing
- notification to supervising clinicians of any new symptoms, or change in their clinical condition.
Patient and their family and/or carers need to be informed of the risk of spread to other contacts in the household and should also be consulted on whether the patient may be effectively managed in the home.

Written and signed consent to these conditions should be placed in the patient record, even if the patient is being admitted to community management rather than inpatient care.

Patients should also be provided with an information pack which includes:

- what community management is (e.g. a virtual ward) is and why it is being used for mild cases of COVID-19
- when the patient may need to be assessed in person by a clinician
- how the hospital will stay in contact
- a contact within the hospital if the patient thinks they may need to visit/be admitted
- information on disease transmission and infection control measures
- what additional supports may be available, including resources to maintain good mental health
- when the isolation may end and whether any further tests will be required
- information for other members of the patient’s household on:
  - symptoms of COVID-19 and when they should seek help for the patient and/or themselves
  - isolation and infection requirements (e.g. delivery of food and supplies to the patient’s room, guidelines on cleaning and hygiene
  - how to use relevant equipment (e.g. masks, cleaning agents, gloves, contaminated waste disposal).

A sample template for a COVID-19 Virtual Ward patient information sheet is provided at Appendix 3.

**Equipment and resources**

Patients who can isolate at home should be asked if they have equipment which can be used to monitor illness progression and inform daily reviews (e.g. thermometers, oximeters). If the patient does not have relevant equipment, support staff may be able to assist in the procurement and delivery of purchased or loaned equipment.

Observation kits may also be developed to support patients. These may include:

- symptom monitoring factsheets
- ‘how to guides’ for thermometers and oximeters (if available/provided)
- information on how to use telehealth or videoconferencing applications (e.g. Skype, FaceTime, Messenger).
4. Clinical management of mild COVID-19 in the community

4.1 Clinical monitoring

At admission, each patient should be assessed twice daily for symptom progression and the need for additional support, medical education or monitoring. Where possible, this assessment should be performed via a secure video-link platform to allow the supervising clinician to visually assess the patient for signs such as tachypnoea, cough or dyspnoea. If telephone contact alone is available, clinicians must be very confident that their patient remains at very low risk of disease progression.

A guide to conducting COVID-19 telehealth consultations in primary care settings is provided at Appendix 5.

It is well recognised that a COVID-19 patient’s condition can deteriorate, without apparent warning, during the second week of the illness. Initially uneventful progress should not lead to complacency in monitoring, especially over weekends. However, if a patient has been asymptomatic for the first 48 hours of their community management, the patient may be deemed appropriate for once daily review.

The treating clinical team in consultation with the patient must establish a plan for monitoring the patient. This includes:

- contact telephone numbers for the patient, their carer and/or emergency contact
- suitable video and microphone enabled applications (computer, telephone and tablet) for telehealth assessments (along with guides/fact sheets if available)
- confirming whether the patient has access to medical instruments which can be used to monitor symptoms.

Patients should be advised to seek medical advice if they develop new symptoms and/or the patient or their carer has concerns about their wellbeing. Indications for further review or admission may include:

- severe shortness of breath at rest or difficulty breathing
- blue lips or face
- cold, clammy or pale and mottled skin
- new confusion
- pain or pressure in chest
- becoming difficult to arouse
- little or no urine output
- coughing up blood
- patient concern.
Other conditions:
- neck stiffness
- Non-blanching rash.

Clinicians must have adequate PPE supply, and be fully proficient in their usage, to allow personal review where required. Especially in any case where disease progression may be suspected, arrangements must be made for prompt clinical review and proper examination, even if this requires urgent transfer to hospital. If this is to occur with the Queensland Ambulance Service, they need to be informed in advance to ensure staff are properly prepared and protected.

Figure 4. Monitoring Flow

- Daily for symptom progression
- Any patient or clinician concern – discuss with RG / GP VMO

- Private transport (ideally with surgical mask)
- Queensland Ambulance service if unwell (via 000)

- To occur in: COVID-19 inpatient ward or Emergency Department (if unstable)
- Receiving unit should be called ahead of time to notify of incoming review

- Admission to either COVID-19 inpatient ward OR retrieved to ICU
- OR Discharge home with twice daily phone calls for the next 48 hours

Daily welfare calls must continue throughout the isolation period. If the patient is uncontactable after three attempts, the Rural Generalist/GP VMO should be notified, and they should escalate to the PHU for assistance and further intervention. This may include a welfare check by the Queensland Police Service.

If during a call a breach of isolation is disclosed, this must be escalated to PHU and any contacts identified.

A sample monitoring template for a COVID-19 virtual ward is provided at Appendix 4.

4.2 Symptom assessment and severity

At diagnosis and admission, a full clinical assessment is required, as outlined previously. However, regular reviews need to include the key COVID-19 symptoms of fever, cough, sore throat, and/or shortness of breath (at rest and on exertion). Each should be explicitly explored, as being either absent, mild, moderate or severe, and progress monitored closely.

One of the most important symptoms to screen for is dyspnoea and it is important to try and differentiate true exertional dyspnoea from chest tightness or awareness of breathing.
A March 2020 review by the Centre for Evidence-Based Medicine, University of Oxford, found:

- no validated tests for assessing breathlessness in an acute primary care setting
- no evidence that attempts to measure a patient’s respiratory rate over the phone would give an accurate reading
- that the Roth score is not-evidenced based and should not be used. Though it is a test which was initially considered might have potential, recent anecdotal experience with COVID-19 patients suggests the tool is not sufficiently sensitive for identifying serious illness and may falsely reassure.

A rapid survey conducted as part of the review found consensus among respondents that patients should best be assessed over the telephone using the questions indicated in the table below.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. <strong>Ask the patient to describe the problem with their breathing in their own words and assess the ease and comfort of their speech. Ask open ended questions and listen to whether the patient can complete their sentences.</strong></td>
<td>“How is your breathing today?”</td>
</tr>
</tbody>
</table>
| 2. **Ask the patient three questions (developed through user testing but not evaluated in formal research).** | “Are you so breathless that you are unable to speak more than a few words?”  
“Are you breathing harder or faster than usual when doing nothing at all?”  
“Are you so ill that you’ve stopped doing all of your usual daily activities?” |
| 3. **Focus on change. A clear story of deterioration is more important than whether the patient currently feels short of breath. Ask questions such as:** | “Is your breathing faster, slower, or the same as normal?”  
“What could you do yesterday that you can’t do today?”  
“What makes you breathless now that didn’t make you breathless yesterday?” |
| 4. **Interpret the breathlessness in the context of the wider history and physical signs. For example, a new, audible wheeze and a verbal report of blueness of the lips in a breathless patient are concerning.** |   |
It may be possible, however, to measure the patient’s respiratory rate via a good video connection. This may also enable:

- assessment of the patient’s demeanour, whether the patient is lying in bed or up and about, skin features (such as flushing, pallor, cyanosis), and oropharynx
- taking readings from patient’s instruments at home—for example, temperature, pulse, blood pressure, blood glucose, peak expiratory flow rate, and oxygen saturation
- monitoring pre-existing conditions and confirming medications are being taken are well controlled and in adequate supply
- attending to the patient’s mental health.

Secondary symptoms such as nausea, syncope, and loss of taste and smell should all be regularly reviewed also, along with other assessments of mental wellbeing, appetite, frailty and hydration. Deterioration in any area, including for pre-existing conditions, should prompt medical review and consideration of inpatient admission.

4.3 Appropriate intervention

With no specific or proven therapeutic interventions in treating COVID-19 illness, little active management can be offered in the community setting.

In the case of community palliation, supplementary oxygen may be of benefit, and symptoms of respiratory distress may require treatment with opiates. However, this treatment plan must be discussed with appropriate specialist teams, as usual supportive measures such as suctioning or airways or nebulisers are contra-indicated in COVID-19 care due to risk of spread.

5. Transition of care into hospital wards

5.1 Indicators for admission

Careful and ongoing monitoring of COVID-19 progression should provide a robust clinical picture for the 14 days over which the illness typically lasts. While it would be unrealistic to expect that every patient's symptoms are going to remain mild throughout their illness course, sustained or worsening significant symptoms of high fever, (including rigors if no measurement is available) and cough, or new symptoms of shortness of breath at rest, should alert the supervising clinician that inpatient care may become necessary.

The National COVID-19 Clinical Evidence Taskforce recommends transfer to hospital if the patient develops symptoms or signs suggestive of Moderate (suspected) COVID-19 or Severe (suspected) COVID-19. Moderate (suspected) COVID-19 symptoms or signs can include:
• Epidemiology, symptoms and signs are consistent with COVID-19; plus any one of the following:
  o symptoms or signs of pneumonia
  o breathlessness
  o low (or reduced) oxygen saturation.
• SaO2 on room air ≤92% or ≤90% for patients with chronic lung disease.

Severe (suspected) symptoms or signs of COVID-19 can include:
• Epidemiology, symptoms and signs are consistent with COVID-19; plus any one of the following:
  o severe shortness of breath or difficulty breathing
  o blue lips or face
  o pain or pressure in the chest
  o cold, clammy or pale and mottled skin
  o new confusion or fainting
  o becoming difficult to rouse
  o little or no urine output
  o coughing up blood.

Equally important are the functional complications of dehydration, psychological distress, and exhaustion. If any of these are present, clinical review should be arranged and admission considered.

5.2 Integration to hospital

If patients have already been admitted to the HiTH model for community management, the patient should not require routine re-admission through the Emergency Department (ED). However, if clinical condition requires acute intervention, patients should most definitely be treated in the most appropriate area. In some instances it may be appropriate for the receiving SMO to review the patient in the ambulance or vehicle before entering the ED to again reduce the risk of transmission to others, if direct ward transfer may be safe and appropriate.

Hospital staff should be notified prior to arrival to allow not only for proper PPE to be arranged for the receiving team, but also for a single room to be prepared according to inpatient treatment protocols.

Where community management has been under the supervision of a GP or RG VMO, full clinical handover needs to occur to the SMO who will be continuing inpatient management. This should provide full documentation of prior clinical reviews to allow optimal continuity of care. Similarly, if the patient is able to be returned to community management following a brief period of inpatient care, the same processes should be followed.
5.3 Transfer procedures

Where urgent hospital transfer is required, emergency QAS assistance should be requested. However, advance notification (at the time of calling) that the paramedics will be attending a COVID-19 patient is essential. Especially if supplementary oxygen is indicated, ambulance transfer should be requested, even if non-urgent.

Additional transfer options may be required – there may only be 1-2 QAS vehicles in the rural community which can bring the patient to hospital for medical review. These vehicles will need to be cleaned following each transfer.

If transfer is to be by private vehicle, the patient should travel in the rear passenger seat across from the driver, and have a surgical mask properly fitted with windows down for the duration of travel. It is not advised that the patient drive themselves to hospital unless no other option is available. The person accompanying the patient to hospital should be informed of where they should park and enter the hospital, so that contact with other members of the public or other patients can be avoided, and staff be ready to receive the patient with full PPE already fitted.

6. Discharge of patients from community management

6.1 Illness resolution

With a usual illness duration of up to 14 days, patients should be showing signs of improvement by day 10 after onset of symptoms. The Communicable Diseases Network Australia (CDNA) National Guidelines for COVID-19 outline\(^9\) (revised version 4 June 2020) the circumstances under which a confirmed case can be released from necessary isolation restrictions, and if relevant, cleared to go into high risk settings. The criteria should apply to the discharge of a mild COVID-19 patient from a virtual ward or community isolation setting. The Communicable Diseases Network Australia (CDNA) National Guidelines for COVID-19 can be found at:


If a patient has an improving cough and/or dyspnoea on day\(^10\) and is otherwise symptom free for ≥72 hours, then their discharge should be discussed with the supervising SMO (i.e. rural generalist or GP VMO) at this time.

At discharge, the patient should be informed that:

- they have completed their isolation period and the relevant PHU will contact them to end their legal isolation notice
- household contacts will still need to complete 14 days quarantine from last contact
• if they develop any further symptoms they should seek medical attention for investigation
• they should contact their GP for review of existing medical conditions
• they should still observe established social distancing and personal cough etiquette and hand hygiene protocols.

6.2 Subsequent care and precautions

Discharged patients may have some delayed effects of their illness and will require ongoing monitoring for respiratory complications. The discharged patients should be encouraged to receive seasonal influenza immunisation and stop smoking if applicable. While there is early evidence that protective immunity may exist for those who have recovered from COVID-19 illness, this has not been confirmed, nor is the duration of immunity known.

6.3 Palliation and certification of death

Where death has occurred at home, whether as an admitted patient under community management or not, usual life extinct certification procedures are still required. Attending medical staff must ensure full PPE is used, as respiratory droplets can remain infectious on the skin even after death. Similarly, undertakers must be informed that the deceased was COVID-19 positive to allow their own precautions to be taken.

In Queensland, death from COVID-19 is not a cause for Coronal referral\(^0\). However, the relevant PHU must be notified of the death. Although patients receiving community management of COVID-19 may not be inpatients on the wards, they remain admitted patients, and usual procedures remain in place.

Summary

With proper preparation, open communication between all treating clinicians, and proper utilisation of modern communication technology, it is anticipated that the majority of rural Queensland patients who may contract COVID-19 should be able to receive the same care as their metropolitan counterparts.

Early diagnosis, thorough initial assessment, regular structured monitoring, and admission only when clinically indicated will allow these patients to be cared for outside the hospital setting, relieving critical pressures on the health system anticipated during the COVID-19 pandemic, while safely reducing the risk of transmission to other community members and health care workers.
Acknowledgements

The SRRCN and the ORRHE gratefully acknowledge the contribution of Queensland clinicians and other stakeholders who participated or provided information throughout the development of this resource, particularly:

- Aboriginal and Torres Strait Islander Health Division
- Statewide Respiratory Clinical Network
- Statewide Rural and Remote Clinical Network
- Cairns and Hinterland Hospital and Health Service
- Gold Coast Hospital and Health Service
- Metro North Hospital and Health Service
- Torres and Cape Hospital and Health Service
- Rural Doctors Association of Queensland
- Health Consumers Queensland
- Chief Medical Officer and Healthcare Regulation Branch
- Office of the Chief Nurse and Midwifery Officer
- Healthcare Improvement Unit
- Healthcare Purchasing and System Performance Division
- GP Liaison, HIU
Additional resources

Queensland Health and the Australian Government regularly review and publish COVID-19 guidelines and resources for clinicians and health service providers.

International organisations are also producing material which is relevant to the management of COVID-19 cases.

The reference list provides a list of these resources as well as other key contacts who are available to assist rural clinicians in responding to COVID-19.

Definitions

Hospital in the Home (HiTH)⁷ - The Queensland Health definition of Hospital in the Home is ‘provides care in a patient’s permanent or temporary residence for conditions requiring clinical governance, monitoring and/or input that would otherwise require treatment in the traditional inpatient hospital bed. The admission criterion is governed by the authorising officer and as such the HiTH program is focused exclusively on admitted care substitution’

Virtual care⁸ - has been defined as any interaction between patients and/or members of their circle of care, occurring remotely, using any forms of communication or information technologies with the aim of facilitating or maximizing the quality and effectiveness of patient care.
Appendices
Appendix 1: National COVID-19 Clinical Evidence Taskforce Management of Mild COVID-19
COVID-19 THERAPIES

ANTIBIOTICS

Do not prescribe antibiotics unless indicated for other reasons, such as expected CAP [PP].

ANTIVIRALS AND OTHER DISEASE MODIFYING TREATMENTS

Hydroxychloroquine

For people with COVID-19 only, a trial of hydroxychloroquine is acceptable and may be considered for symptomatic relief [PP].

Lopinavir/Ritonavir

For people with COVID-19 only, a trial of lopinavir/ritonavir is acceptable and may be considered for symptomatic relief [PP].

Remdesivir

For people with COVID-19, only administer remdesivir in the context of randomised trials with appropriate ethical approval. [TF5.2]

Lopinavir/Ritonavir

For people with COVID-19, only administer lopinavir/ritonavir in the context of randomised trials with appropriate ethical approval. [TF5.2]

Other disease modifying treatments

Consider using other disease modifying treatments in the context of randomised trials with appropriate ethical approval. CBR

ANTIVIRALS

Remdesivir

For people with COVID-19, only administer remdesivir in the context of randomised trials with appropriate ethical approval. TF5.2

Lopinavir/Ritonavir

For people with COVID-19, only administer lopinavir/ritonavir in the context of randomised trials with appropriate ethical approval. TF5.2

Remdesivir

For people with COVID-19, only administer remdesivir in the context of randomised trials with appropriate ethical approval. TF5.2

Remdesivir

For people with COVID-19, only administer remdesivir in the context of randomised trials with appropriate ethical approval. TF5.2

ANTIVIRALS

Remdesivir

For people with COVID-19, only administer remdesivir in the context of randomised trials with appropriate ethical approval. TF5.2

Lopinavir/Ritonavir

For people with COVID-19, only administer lopinavir/ritonavir in the context of randomised trials with appropriate ethical approval. TF5.2

Remdesivir

For people with COVID-19, only administer remdesivir in the context of randomised trials with appropriate ethical approval. TF5.2

Remdesivir

For people with COVID-19, only administer remdesivir in the context of randomised trials with appropriate ethical approval. TF5.2

OTHER DRUGS

An antipyretic is generally not required, but paracetamol can be considered for symptomatic relief. PP

ANTIBIOTICS

Do not prescribe antibiotics unless indicated for other reasons, such as expected CAP [PP].

GENERAL

Ensure that people with suspected COVID-19 continue to receive their regular care for pre-existing conditions. PP

ASTHMA AND COPD

- To prevent viral exacerbation of asthma or COPD. Do not use a nebuliser.

DIABETES AND CARDIOVASCULAR DISEASE

- In patients with COVID-19 who are receiving ACE-I/ARB, these medications should be continued, unless contraindicated.

CONDITIONS MANAGED WITH IMMUNOSUPPRESSANTS

- Only cease or change the dose of other treatments such as inhaled, oral steroids, biologics, or disease-modifying anti-rheumatic drugs (DMARDs) on the advice of the treating specialist [PP].

EVIDENCE-BASED RECOMMENDATIONS

•= Evidence-Based Recommendation

•= Committee-Based Recommendation

•= Practice Point

•= Consensus-Based Recommendation
Appendix 2: Admission template

**COVID-19 Virtual Ward Admission**

**Physiological factors:**

If vital signs are available, a patient must meet the following criteria at the time of initial assessment when the investigation for COVID-19 was performed:

- Oxygen SpO2 ≥ 95% on room air
- Respiratory rate ≤ 20 breaths/min
- Heart rate ≤ 100 bpm
- Nil oxygen requirement
- Nil confusion
- Adequate PO intake
- Nil clinician concern

Otherwise a clinical decision will be made during the initial medical assessment to deem suitability for admission to the virtual ward.

**Social factors:**

Patient must meet the following criteria at the time of initial assessment:

- the patient is well enough to receive care at home
- there is a separate bedroom where the patient can recover without sharing an immediate space with others
- the patient has access to food and other necessities
- the patient (and anyone who lives in the same home) has access to the recommended personal protective equipment (at a minimum, gloves and mask)
- the patient does not live with household members who may be at increased risk of complications from novel coronavirus infection (e.g. people over the age of 65 years, young children, pregnant women, people who are immunocompromised or who have chronic heart, lung, or kidney conditions).

If any of the above vulnerable groups are at home then discuss to determine if the risks can be adequately mitigated to the vulnerable household member.

**Epidemiological risk**

**Sx & onset date**
PMHx

Regular medications/Allergies

SHx
- Living arrangement
- Smoker
- Occupation (is patient classified as a health care worker)

Exam
Obs (at time of testing if available):

Ix
- positive swab collected at (location) on (date)

Contact details
Mob.
Email.

Impression
- Suitable for admission to COVID-19 virtual ward as:
  - Does not currently have a medical indication for admission
  - Able to comply with home isolation
  - Able to be contacted for ongoing telehealth review

Plan
- Admit COVID-19 virtual ward
- Notify HHS PHU re. admission
- Advice re.
  - Monitoring
  - Risk of deterioration and indications for review
  - Importance of home isolation
- Emailed patient information pack
Appendix 3: COVID-19 Virtual Ward Patient information template

COVID-19 Virtual Ward Patient Information

Contact Number: XXXX XXX XXX

What is the COVID-19 virtual ward?

The Virtual Ward operates in the same way as a normal hospital ward. The difference is you (the patient) stays comfortably and safely in your own home. The COVID-19 virtual ward is for patients (like you) who have tested positive to COVID-19 and are well enough to stay out of hospital. You will be reviewed daily and have a direct link to health support should your condition change.

Why is there a COVID-19 virtual ward?

Approximately 80% of patients with COVID-19 will have a mild illness and not require hospitalisation. During the COVID-19 pandemic we anticipate the hospital to be operating at maximum capacity, that means we need to reserve inpatient beds for those patients who need them most.

What will happen when I am “admitted” to the virtual ward?

You will be contacted daily by our nurses and doctors. They will monitor several important factors during your illness:

1. Are you well enough to remain in the community?
2. Are you able to continue to maintain self-isolation in your own home? It is critically important that people with confirmed infection minimise physical contact with others to prevent further cases. This is the most important factor in bringing the pandemic under control.

How do I know if I am well enough to remain at home?

There are several circumstances that would require you to come to hospital for assessment, including:

• symptoms or signs of pneumonia
• severe shortness of breathe
• blue lips or face
• pain or pressure in the chest
• cold, clammy or pale and mottled skins
• new confusion or fainting
• becoming difficult to arouse
• little or no urine output
• coughing up blood
• patient or family concern

**How will the hospital stay in touch? What if I can’t be contacted?**

We will either call on the telephone or arrange a videoconference, depending on your progress. If you cannot be contacted, despite multiple attempts by the clinical team, we may ask the Queensland Police Service to make a welfare check at your home and to ensure you are maintaining isolation.

**Who do I call if I think I might need to come to the hospital?**

Between 8am-5pm please call our COVID-19 virtual ward medical officers/ nurses (XXXX XXX XXX)

After hours call the above mobile (XXXX XXX XXXXX) and you will be transferred to the doctor in charge of the COVID-19 inpatient ward.

Transport to the hospital can either be via private transport or with the Queensland Ambulance Service as appropriate.

**NOTE:** At any time in the case of an emergency please call Queensland Ambulance Service via 000

**How important is self-isolation?**

Self-isolation, especially of confirmed cases, is the single most important factor that will determine if we are able to limit ongoing spread of COVID-19 in the community. The importance of self-isolation is underscored by new emergency public health legislation which includes both fines (up to $13345) and other measures to enforce isolation.

**When can I come out of self-isolation?**

Please see the form “AHPPC ceasing isolation” guideline. We will also notify you, and the public health service, when your period of isolation is completed.

**What additional support is available?**

People who have no other means of support can call the Community Recovery Hotline for assistance. The hotline has been activated by the Queensland Government to assist people who have been advised to quarantine at home by a medical professional, Queensland Health or through government direction and have no other mechanisms for support.

Community Recovery will work with partner organisations to arrange non-contact delivery of essential food and medication to people in isolation with no other means of support. The Community Recovery Hotline can be contacted on 1800 173 349.

Queenslanders who require health advice or information while in quarantine or self-isolation should continue to call 13 HEALTH (13 43 25 84) or visit the Queensland Health website. Staff at 13 HEALTH can connect people through to a local public health unit and other health support services.

**NOTE:** If you have any concerns please call XXXX XXX XXX 24 hours per day.
**In an emergency call Queensland ambulance service via 000**
Appendix 4: Monitoring template$^{29,30}$

<table>
<thead>
<tr>
<th>Overall status:</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐Deteriorating</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Red flag symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe shortness of breath at rest: ☐Yes ☐No</td>
</tr>
<tr>
<td>Difficulty breathing: ☐Yes ☐No</td>
</tr>
<tr>
<td>Pain of pressure in the chest: ☐Yes ☐No</td>
</tr>
<tr>
<td>Cold, clammy or pale and mottled skin: ☐Yes ☐No</td>
</tr>
<tr>
<td>New confusion: ☐Yes ☐No</td>
</tr>
<tr>
<td>Becoming difficult to arouse: ☐Yes ☐No</td>
</tr>
<tr>
<td>Blue lips or face: ☐Yes ☐No</td>
</tr>
<tr>
<td>Little or no urine output: ☐Yes ☐No</td>
</tr>
<tr>
<td>Coughing up blood: ☐Yes ☐No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other conditions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Neck stiffness: ☐Yes ☐No</td>
</tr>
<tr>
<td>Non-blanching rash: ☐Yes ☐No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Isolation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any breaches of isolation$^{6}$ ☐Yes ☐No</td>
</tr>
<tr>
<td>Anyone else in the household unwell? ☐Yes ☐No</td>
</tr>
<tr>
<td>Can you please send me your current location (screenshot vs. shared location)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional patient questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are you having any difficulty with any of the following:</td>
</tr>
<tr>
<td>Petcare: ☐Yes ☐No</td>
</tr>
<tr>
<td>Food delivery/access: ☐Yes ☐No</td>
</tr>
<tr>
<td>Medication delivery/access: ☐Yes ☐No</td>
</tr>
<tr>
<td>Childcare: ☐Yes ☐No</td>
</tr>
<tr>
<td>Living arrangements: ☐Yes ☐No</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Any patient questions:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>
### Assessment

- Safe to remain at home
- Requires PM call
- Requires medical assessment
Appendix 5: COVID-19 Telehealth and Consultation in GP Respiratory Clinics
### Telehealth and Consultations in GP Respiratory Clinics

**Clinical characteristics**

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cough</td>
<td>69%</td>
</tr>
<tr>
<td>Temperature</td>
<td>22%</td>
</tr>
<tr>
<td>Sputum</td>
<td>38%</td>
</tr>
<tr>
<td>Fatigue</td>
<td>34%</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td>19%</td>
</tr>
<tr>
<td>Sore throat</td>
<td>14%</td>
</tr>
<tr>
<td>Headache</td>
<td>14%</td>
</tr>
<tr>
<td>Chills</td>
<td>12%</td>
</tr>
<tr>
<td>Nose/ear congestion</td>
<td>5%</td>
</tr>
<tr>
<td>Nausea or vomiting</td>
<td>5%</td>
</tr>
<tr>
<td>Diarrhoea</td>
<td>4%</td>
</tr>
<tr>
<td>Any comorbidity</td>
<td>24%</td>
</tr>
</tbody>
</table>

**Red flags**

- **COVID-19:**
  - Severe shortness of breath at rest
  - Difficulty breathing
  - Pain or pressure in chest
  - Cold, clammy or pale and mottled skin
  - New confusion
  - Becoming difficult to arouse
  - Blue lips or face
  - Little or no urine output
  - Coughing up blood
  - Other conditions such as:
    - Neck stiffness
    - Non-blanching rash

### Telehealth Only

1. **Set up**
   - Prepare yourself to connect
   - Review patient Care at Home advice. Provide to patient if appropriate.

2. **Connect**
   - Make video link if possible, otherwise call on the phone
   - Check video and audio
   - Confirm the patient’s identity
   - Check where the patient is and who else is present

3. **Get started**
   - Rapid assessment
     - If they sound or look very sick such as too breathless to talk, consider calling an ambulance and inform them of COVID risk.
   - Establish what the patient wants out of the consultation, such as:
     - Clinical assessment
     - Referral
     - Certificate
     - Reassurance
     - Advice on self isolation

### Telehealth and GP Respiratory Clinics

4. **History**
   - Adapt questions to patient’s own medical history
   - Exposure risk
     - Close contact with a known COVID-19 case
     - Health care worker
     - Travel overseas or on a cruise ship
     - Area of local transmission
     - Living in a ‘closed community’
       - Residential care
       - Boarding school
       - Correction facilities
       - Detention centres
       - Rural and remote communities
       - Military barracks
   - History of current illness
     - Day of first symptoms
   - Most common presentation
     - Fatigue
     - Short of breath
     - Cough
     - Fever
   - Cough is dry but sputum is not uncommon
   - Up to 50% of patients do not have fever presentation

5. **Examination**
   - Assess physical and mental function as best as you can
   - During the consultation ask patient or carer to describe:
     - State of breathing
     - What does your breathlessness prevent you doing?
     - Colour of face and lips (text a photo if possible)
   - During the consultation look for:
     - General demeanour
     - Skin colour
     - Work of breathing

6. **Consider comorbidities that place patient at risk of more severe disease and need closer monitoring**
   - Unlikely COVID-19
     - Self management, paracetamol for symptomatic relief
   - Likely COVID-19, but well
     - Test and follow up results
     - Self management, paracetamol, encourage fluids
   - Likely COVID-19, unwell
     - Test and arrange follow up depending on clinical picture
     - Self management, paracetamol, encourage fluids
   - Consider sending to hospital if:
     - Respiratory Rate >20 breaths per minute
     - Heart rate >100 with new confusion
     - Oxygen saturation by oximeter >= 94%
     - Any Red Flag symptom or sign

7. **Decision and action**
   - Self isolate. Enable self care at home and if living alone get someone to check on them, e.g. family. Consider medical review at days 5 and 8.

Adapted and distributed by the Australian Department of Health. For more information and the latest Australian health advice visit www.health.gov.au
Appendix 6: COVID-19 community support resources

For a comprehensive list of COVID-19 community support resources go to:

Community resources

COVIDSAFE app
Testing and fever clinics
Care Army – 1800 173 349
Community Recovery Hotline – 1800 173 349 – for support with essential food and medication
13 Health – 13 43 25 84 - 24 hour assessment, referral and advice
Australian Red Cross – 1800 733 276
Financial Assistance
Beyondblue – 1300 22 46 36
Lifeline Australia – 13 11 44

Self-quarantine

Queensland Health – self-quarantine information
Self-isolation requirements
Community recovery essential checklist
13 Health – 13 43 25 84 - 24 hour assessment, referral and advice
Community Recovery Hotline – 1800 173 349 – for support with essential food and medication

Family and carers support services

Queensland Health family and carers support services
Commonwealth Government My Aged Care service provider or phone 1800 200 422
Respite Care
National Disability Insurance Agency (NDIA) – 1800 800 110
Community Recovery Hotline – 1800 173 349 – for support with essential food and medication
Disability Information Hotline – 1800 643 787
Care Army – 1800 173 349
13 Health – 13 43 25 84 - 24 hour assessment, referral and advice
Australian Red Cross – 1800 733 276
National Relay Service – 133 677
Mensline – 1300 78 99 78
Headspace – 1800 650 890
Youthbeyondblue – 1300 22 46 36
Lifeline Australia – 13 11 44
KidsHelpLine – 1800 55 1800
Queenslanders with Disability Network (QDN) – 1300 363 783
Multicultural information

Queensland Health – COVID-19 translated information
Australian Government Translating and Interpreting Services
SBS COVID-19 video in various languages
Community Recovery Hotline – 1800 173 349 – for support with essential food and medication
13 Health – 13 43 25 84 - 24 hour assessment, referral and advice

NDIS and aged care resources

The National Coronavirus Health Information Line on 1800 020 080
The NDIS Contact Centre on 1800 800 110
The My Aged Care contact centre on 1800 200 422
The National Relay Service Helpdesk on 1800 555 660
13 Health – 13 43 25 84 - 24 hour assessment, referral and advice

Aboriginal and Torres Strait Islander people

13 Health – 13 43 25 84 - 24 hour assessment, referral and advice
Aboriginal and Torres Strait Islander Family Wellbeing Services – list of services
Mensline – 1300 78 99 78
Kids Helpline - 1800 55 1800
Strong Spirit, Safe Mob
iBobby app – social and emotional wellbeing self-help app for young Aboriginal and Torres Strait Islander Australians aged 15 years and over.
Community Recovery Hotline – 1800 173 349 – for support with essential food and medication
1800Respect – 1800 737 732
Reference list


16. Adapted from material produced by Cairns and Hinterland Hospital and Health Services


