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HEALTH UPDATE

COVID-19: HOSPITAL PRE-ADMISSION GUIDANCE FOR HOME CARE PROVIDERS

This guidance will support home care providers in developing local hospital preadmission procedures for care recipients who are suspected/confirmed as having COVID-19 and require transfer to hospital as part of an integrated clinical care management approach.

The National COVID-19 Clinical Evidence Taskforce has issued 'living' clinical guidelines for primary and acute health care settings to inform clinical care management of suspected/confirmed COVID-19 cases. The guidelines distinguish between mild, moderate, severe and critical illness.

Mild illness describes a care recipient who presents without any clinical features suggestive of a complicated course of illness. Characteristics include no symptoms or mild upper respiratory tract symptoms and a stable clinical picture. Managing mild COVID-19 disease in care recipients will typically occur in the care recipient's place of residence with their GP and/or treating medical specialist overseeing clinical care management.

Increasing illness and the escalation of symptom load suggestive of moderate or severe illness may be concerned with increasing respiratory difficulties and/or the interaction of COVID-19 symptoms with the care recipient's pre-existing symptoms ascribed to frailty, comorbidities and/or disability. Transfer to hospital may occur if a care recipient experiences escalating symptoms or signs suggestive of moderate or severe illness. The transfer will typically be undertaken in discussion with the care recipient's GP, treating medical specialist, and/or attending paramedics.

Integrated care arrangements

Integrated care describes the provision of seamless, effective and efficient care that responds to all of a person's health and social care needs. In the context of the COVID-19 pandemic, home care providers need to contribute to clinical care arrangements and work collaboratively with a care recipient's GP and/or treating medical specialist, as well as the local hospital.

Home care providers need to:

- Maintain contact with the care recipient's GP, who will oversee clinical care assessment, management and review in the event of COVID-19 symptom presentation and escalation. Home care providers should have GP contact details documented and readily available in the event that a care recipient presents with COVID-19 symptoms. Clear communication processes should be agreed to with a care recipient's GP in advance of symptom escalation about how the home care provider should respond to changing clinical care needs.
- Contact the local hospital well in advance of any hospital admission to confirm admission arrangements for care recipients with a suspected/confirmed case of COVID-19. Where symptom escalation to moderate or severe illness is indicated, rapid hospital admission may be necessary. Home care providers need to identify and note any State-based guidance for COVID-19 hospital admissions.
- Document integrated care arrangements, including access to primary care services and hospital transfer/admissions as part of your organisations clinical care procedures for responding to home care recipients with COVID-19 symptom presentation and escalation. Communicate these procedures to all relevant care staff.
- Establish ongoing open communication with treating GPs, medical specialists and local hospitals overseeing the clinical care management of care recipients to account for any changes in confirmed arrangements, updating clinical care procedures as required.
- Monitor COVID-19 clinical guidelines in ensuring integrated care arrangements are consistent with the best available evidence, noting 'living' guidance may be updated as new understandings concerning COVID-19 emerge.

Assessment of Symptoms

The GP overseeing the assessment and management of a care recipient's clinical care needs has primary responsibility for the assessment and management of symptoms consistent with a suspected/confirmed COVID-19 case.

Initial telephone referral should be made to the care recipient's GP where the care recipient presents with initial COVID-19/respiratory symptoms such as fever, cough, sore throat, runny nose, tiredness and/or shortness of breath.

Official guidance has been issued to GPs with regard to operating both telehealth and face-to-face respiratory clinics for the assessment and management of care recipients with regard to:

- getting the patient's history
- conducting the examination/COVID-19 testing
- considering comorbidities
- making a decision and taking action

Where a care recipient's test results indicate they are a confirmed case of COVID-19 and the care recipient is **assessed as being well**, the care recipient will be encouraged to self-isolate at home.

Where a care recipient's test results indicate they are a confirmed case of COVID-19 and the care recipient is **assessed as being unwell**, the care recipient may be encouraged to self-isolate at home until such time that the GP determines the care recipient needs to be transferred to hospital for ongoing monitoring and symptom management. Alternatively, the GP may seek an immediate hospital transfer.

General Management

Advice on clinical care management for mild COVID-19 disease typically attended to in the care recipient's home will be issued by their GP and/or treating medical specialist.

Care plan reviews should give regard to clinical care management advice provided by the care recipient's GP and/or treating medical specialist in the continued delivery of essential services.

Attending care workers who are to deliver essential care services are to use transmission-based precautions as per infection control procedures.

Ensure that care recipients who live alone in their own home have someone to check on them regularly, even if they are currently well.

Advance Care Planning

Consult with the care recipient's GP and/or treating medical specialist in coordinating advance care planning, and the review of any existing advance care plan, as a matter of urgency. This should include discussions about how COVID-19 may contribute to care recipients becoming critically unwell, and a clear decision about whether hospital admission would be considered in this circumstance.

Be aware that escalation decisions for transfer to hospital will be undertaken in discussion with the care recipients GP, treating medical specialist, and/or attending paramedics.

All care professionals should be aware that transfer to hospital may not be offered if it is not likely to benefit the care recipient if they are on a palliative care trajectory and if palliative or conservative care within the care recipient's home is deemed more appropriate. Home care providers should work with the care recipients GP and/or treating medical specialist to support families and care recipients through these clinical care management decisions.

Advance care plans must be recorded in a way that is useful for health care professionals called to attend the care recipient in an emergency. A copy should be filed in the care recipient's official record and an electronic version used which can be shared with relevant health care services/hospitals.

Emergency Planning

Care recipients who display symptoms consistent with a suspected/confirmed case of COVID-19 should be encouraged to develop an emergency plan while they are well, in the event their condition deteriorates and they need to be transferred to hospital.

The emergency plan should contain:

- Details of the name, address and other contact details of the care recipient
- Emergency contacts, such as their friends, family, legal representative, or others
- Details of any medications they take, including dose and frequency
- Details of allergies
- Details of the care recipient's GP and any other relevant treating medical specialists
- Details of any ongoing treatment
- Details of the advanced care plan (if the care recipient has one)

Encourage the care recipient to ask their GP for a shared health summary on their MyHealthRecord (if the care recipient has not opted out), and update the shared health summary as applicable.

Preparing an Emergency Bag

Care recipients who have symptoms consistent with a suspected/confirmed case of COVID-19 can be supported to prepare a hospital bag in the event they become unwell and may require hospital transfer. This should include the details of their emergency plan and advanced care plan

(if generated), as well as any planned care appointments and things they might need for an overnight stay (snacks, pyjamas, toothbrush, medication etc.). Care recipients should also pack a phone and charger if available.

After Hours Arrangements

Confirm arrangements with the care recipient's GP about who is to be contacted outside business hours in response to any change in the care recipient's health condition or circumstances, including where there are new or worsening symptoms.

Where a 24-hour personal monitoring service is in place for care recipients who reside in their own home, ensure details of documented integrated care arrangements are made available to this service for access to inform any emergency response they need to initiate.

Up-to-date Documentation and Care Plans

Ensure all care plans and documentation for the care recipient are up-to-date and include:

- Confirmed arrangements for GP communications in the event of COVID-19 symptom presentation and escalation
- Confirmed arrangements for hospital transfer where a suspected/confirmed case of COVID-19 is assessed by a GP as being required
- A copy of the care recipient's emergency plan
- A copy of the care recipient's advance care plan (where this has been documented) or documentation of conversations in which a care recipient has expressed preferences associated with their end-of-life care

Supportive Care

Management of a care recipient with mild COVID-19 is similar to management of seasonal flu: patients should rest, take fluids, and use paracetamol for symptomatic relief.

Transmission-based precautions, including the use of appropriate personal protective equipment (PPE) by attending care staff, should be used in the provision of supportive care where a care recipient has suspected/confirmed COVID-19. Care should be taken to correctly don and doff PPE (video guide).

Encourage people who are current smokers to quit, as smoking may increase the risk of severe illness.

The care recipient's GP and/or treating medical specialist will advise on any considerations to support clinical care management with regard to pre-existing conditions.

Monitoring

Advise the care recipient, their family/carer and attending care staff to look out for the development of any change in the care recipient's health condition or circumstances, including new or worsening symptoms; especially breathing difficulties that may indicate the development of pneumonia or hypoxaemia.

Provide the care recipient and their family/carer with phone numbers to call if they become aware of any change to the care recipient's health condition or circumstances. This may include contacting your own service, as well as the care recipient's GP and/or treating medical specialist.

Where possible, attending care staff should be trained to measure vital signs including blood pressure, heart rate, pulse oximetry and respiratory rate. This will support the care recipient's GP and/or treating medical specialist to triage and prioritise clinical assessment, review and support of care recipients according to need. More frequent visitation by nursing staff may be required to facilitate these arrangements.

Escalation of Care

Transfer to hospital is recommended if the care recipient develops symptoms or signs suggestive of moderate or severe illness associated with COVID-19, such as:

- Symptoms or signs of pneumonia
- Severe shortness of breath or difficulty breathing
- Blue lips or face
- Pain or pressure in the chest
- Cold, clammy or pale and mottled skin
- New confusion or fainting
- Becoming difficult to rouse
- Little or no urine output, and/or
- Coughing up blood

Where home care providers become alert to changes in the care recipient's health condition or circumstances, they should contact the care recipient's GP and/or treating medical specialist to advise them of the change and follow any directions that are provided.

Pre-existing Conditions

Seek advice from the care recipient's GP and/or treating medical specialist on the management of pre-existing conditions when the care recipient has mild COVID-19 disease. Generally, care recipients with suspected COVID-19 will continue to receive their usual care/essential services for pre-existing conditions.

Care recipients with comorbidities, such as chronic obstructive pulmonary disease (COPD), asthma, hypertension, cardiovascular disease and diabetes may have a higher risk of deterioration. They may need ongoing monitoring and more intensive management that requires transfer to hospital.

Asthma and Chronic Obstructive Pulmonary Disease (COPD). Care recipients with asthma or COPD do not cease or change the dose of preventers or inhaled coriticosteroids. Use of nebulisers is not recommended and use of metered dose inhalers are preferred where possible. Note the use of nebulisers carries a high risk of transmitting viral infections because they generate aerosols that can spread infectious droplets for several metres.

Diabetes and Cardiovascular Disease. Care recipients with diabetes or cardiovascular disease do not cease or change the dose of treatments such as insulin or other diabetes medications, statins, ACE inhibitors, or angiotensin receptor blockers.

Conditions managed with immunosupressants. Care recipients with conditions managed with immunosupressants do not cease or change their dose of long-term immunosuppressants such as high-dose corticosteroids, chemotherapy, biologics, or disease modifying anti-rheumatic drugs.

Transfer to hospital

Check the care recipient's wishes regarding transfer to hospital.

Note transfer to hospital may be required where clinical care measures in the home are assessed by the care recipient's GP or treating medical specialist as not being feasible to maintain the health, wellbeing, comfort and dignity of the care recipient.

If the care recipient wishes to stay at home, consult with their GP and/or treating medical specialist (and palliative care service if appropriate). Based on medical advice regarding the feasibility for provision of continuing care at home, discuss care arrangements with the care recipient, their carer and family as appropriate.

If the care recipient wishes to be admitted to hospital, consult with their GP and/or treating medical specialist. Based on medical advice, discuss hospital transfer arrangements with the carer or family member. This may include arrangements for contacting hospital patient transport or ambulance service as per confirmed advice provided by the local hospital in facilitating a hospital transfer.

If other organisations or volunteers are involved with the care recipient, advise them of the hospital transfer as per any care recipient instructions. Consider how volunteer groups can stay in touch with care recipients to provide psychosocial support, especially care recipients who have become socially isolated.

The circumstances and outcome of any hospital transfer should be documented. Arrangements should be put in place to monitor the care recipient's hospital admission with response and communication among relevant stakeholders as required.

Consideration should be given to the likelihood of the care recipient's being discharged from hospital and continuation of essential services in the care recipient's home with transmission based precautions as appropriate.

LASA has also made available additional advice and resources which home care providers are encouraged to access.

Don't forget that as part of your LASA Membership you can contact us for all your specific needs. Please reach out to us during normal business hours by calling **1300 111 636**.

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