Guiding principles for safe and efficient admissions into Residential Aged Care Facilities and transfers to hospital during the COVID-19 pandemic

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Table of Contents
Guiding principles for safe and efficient admissions into Residential Aged Care Facilities and transfers to hospital during the COVID-19 pandemic ................................................................. 1

1. Introduction ........................................................................................................ 3

2. Purpose and audience ......................................................................................... 3

3. Background ........................................................................................................ 4

4. Principles for safe and efficient admissions into RACFs ................................. 4

4.1 Principle 1: Ensuring the right care at the right time in the right place - residents are transferred to hospital when clinically indicated and consistent with their wishes and avoidable hospital admissions are minimised ............................................................ 4

4.1.1 Maximise links to, and capacity of, outreach care and specialised clinical care staff ................... 5

4.1.2 Provide virtual care/telehealth ..................................................................... 5

4.1.3 Secondary triage ......................................................................................... 6

4.1.4 Promote Advance Care Planning ................................................................ 6

4.1.5 Maximise community palliative care for RACFs ........................................ 7

4.2 Principle 2. Protect vulnerable people - support efficient and safe admissions of new and returning residents to RACFs .................................................... 8

4.2.1 Admission to RACF from the community including respite: COVID-19 not suspected and RACF does not have a current outbreak ............................................ 9

4.2.2 Admission to RACF from the community: COVID-19 suspected or confirmed .............. 9

4.2.3 New/returning resident to RACF from hospital or Emergency Department and RACF does not have a current outbreak ................................................................. 10

4.2.4 Residents hospitalised with an illness unrelated to COVID-19 ....................... 10

4.2.5 Residents hospitalised for an illness suspected to be COVID-19 ...................... 10

4.2.6 Residents confirmed to have COVID-19 ..................................................... 11

4.2.7 Admissions/re-admissions to facilities where there is an outbreak: .................. 11

4.2.8 Safe discharge process from hospital .......................................................... 12

4.2.9 Managing COVID-19 cases in RACFs ....................................................... 12

4.2.10 Principles for determining the clinical care setting for a resident with COVID-19 13

4.2.11 Transfers to hospital from RACF: non-COVID-19 related .............................. 14

4.3 Principle 3. Communication to support COVID-19 strategies ....................... 14

4.3.1 Communication with stakeholders, residents, their carers and families .......... 14

5. Appendices ........................................................................................................ 16

Appendix 1: Secondary triage model ................................................................... 16

Appendix 2: Discharge to RACF: information and letter template ....................... 18

Appendix 3: PPE use in Aged Care: COVID-19 ..................................................... 20
1. Introduction

Residential aged care is an essential service that provides ongoing care to frail and vulnerable older people and some younger people with disability or complex health conditions. During the COVID-19 pandemic, a coordinated approach between the aged care, public health and primary care systems will support residential aged care accepting new residents from the community and from hospitals, as well as residents returning from a hospital stay following an acute admission for health issues (non COVID-19 related).

This will help to ensure:
- vulnerable residents of RACFs receive appropriate clinical care and are protected
- residents are admitted to hospital when medically necessary and can be safely and efficiently discharged into appropriate care, and
- frail and vulnerable older people and younger people with disability or complex health conditions and their carers/families are supported throughout the process.

2. Purpose and audience

This document provides guidance and recommends strategies to ensure safe and efficient care of older people and younger people with disability or complex health conditions with COVID-19 and other conditions, during the COVID-19 pandemic.

This guidance aims to assist NSW Health Local Health District/Specialty Health Network (LHD/SHN) staff in geriatric services, inpatient wards, emergency departments, and patient flow managers, as well as staff in RACFs, by providing principles to inform best practice strategies for the care of patients and residents. Practice according to the three interlinked principles below will assist in providing safe, efficient care in an appropriate setting.

This document captures the knowledge of experienced professionals and provides guidance based on the available evidence at the time of completion. Local judgement and discretion may be required in the application of this guidance. Each LHD/SHN will use strategies according to need, capacity and feasibility.

Guidance may change as testing, transmission in the community and healthcare associated infection rates in hospital change.

This document should be read in partnership with the policy documents addressing infection control and outbreak management for COVID-19:

- Communicable Disease Network of Australia (CDNA) National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia
- Communicable Disease Network of Australia (CDNA) Coronavirus Disease 2019 (COVID-19) National Guidelines for Public Health Units
- Australian Health Protection Principal Committee (AHPPC) advice on residential aged care facilities
- NSW Public Health (COVID-19 Residential Aged Care Facilities) Order 2020
- Clinical Excellence Commission Infection Prevention and Control COVID-19 – Residential and Aged Care Facilities
3. Background

There are approximately 81,000 residential aged care beds in NSW (GEN Data website, March 2020). Residential aged care in NSW is provided by:

- 881 non-government RACFs in NSW (March 2020), regulated by the Aged Care Quality and Safety Commission (ACQSC)
- 9 RACFs operated by NSW Health (regulated by ACQSC)
- 63 Multi-purpose Services with residential aged care operated by NSW Health (regulated by Australian Commission on Safety and Quality in Health Care).

The range of geriatric and specialised clinical care services offered to RACF residents varies between LHD/SHNs. Services may include outreach/in-reach teams, rapid response teams, hospital in the home (HITH), and acute/post-acute services. Many of these services have been scaled up to increase home and community-based care during the COVID-19 pandemic.

4. Principles for safe and efficient admissions into RACFs

1. **Ensuring the right care at the right time in the right place**: residents are transferred to hospital when clinically indicated and consistent with their wishes and avoidable hospital admissions are minimised.

2. **Protecting vulnerable people**: supporting efficient and safe admissions of new and returning residents to RACFs.

3. **Communication to support COVID-19 strategies**.

4.1 **Principle 1: Ensuring the right care at the right time in the right place** - residents are transferred to hospital when clinically indicated and consistent with their wishes and avoidable hospital admissions are minimised

**Key points**

- Maximise and support safe and appropriate care in place to minimise avoidable hospital admissions
- Adapt and innovate models of care to safely support clinical needs and resource capacity.
- Residents are transferred to hospital when clinically indicated and consistent with their wishes.
Applying Principle 1: Ensuring the right care at the right time in the right place

4.1.1 Maximise links to, and capacity of, outreach care and specialised clinical care staff

In partnership with primary care, specialised LHD/SHN aged care outreach models:

- provide proactive and timely access to aged healthcare that may reduce unnecessary hospital presentations and admissions
- improve consumer experiences of care, and
- are an effective strategy for keeping older people and younger people with disability or complex health conditions well in their homes (RACF).

LHD/SHN outreach services have existing clinical partnerships with local RACFs and General Practitioners (GPs), and provide a variety of general, acute and palliative care outreach services that support care of residents in place and minimise avoidable hospitalisations. It is recommended that aged care outreach teams provide multidisciplinary care including medical, nursing and allied health services as indicated and where possible.

GPs/GP VMOs remain the primary medical point of contact for residents.

Actions for local health districts

- Augment existing outreach services to maximise care in situ and minimise hospital admissions during the COVID-19 pandemic, both for residents with COVID-19 and those with other health conditions.
- Promote the available LHD/SHN supports and establish pathways for geriatric care with local RACFs during the COVID-19 pandemic.
- Where available, work in consultation with other specialist outreach services including palliative care, heart failure outreach programs, renal supportive care, respiratory care etc.
- Work with local RACFs to educate and support infection prevention and control practices where needed, including site visits.
- Early engagement of aged care outreach teams to assist with discharge planning for residents admitted for COVID-19 and other conditions.

Actions for RACFs

- Engage with LHD/SHNs to understand available clinical supports and pathways during the COVID-19 pandemic.
- Develop processes to support screening for new/returning residents in line with the CDNA Guidelines.

4.1.2 Provide virtual care/telehealth

Virtual care models and technologies minimise the exposure of residents and healthcare professionals to COVID-19, support resource allocation and disruption for residents by enabling remote assessment, monitoring and care. LHD/SHNs use telehealth (including videoconferencing) within some existing services.
Actions for local health districts

- Establish and/or augment clinical models that utilise telehealth and virtual care for the provision of clinical care to RACF residents (as part of the eHealthNSW Virtual Care strategy and related projects).

Actions for RACFs

- Work with LHD services to implement virtual care models.

4.1.3 Secondary triage

Secondary triage is a ‘safety net’ model to minimise unnecessary transfers to hospital from RACFs. It is activated when a RACF requests a lower acuity transfer to hospital via Ambulance, outside of a GP or LHD/SHN outreach initiated request. The secondary triage is performed by an accredited Emergency physician via a telehealth consultation with RACF staff. A plan for the most appropriate clinical care is determined and may include consultation with or referral by the Emergency physician to LHD/SHN services, GP follow up, or transfer to hospital.

The secondary triage process applies automatically when certain criteria are met during a call to Ambulance/Patient Transport Services (PTS) from an RACF and operates 24/7. See Appendix 1 for information on the secondary triage process.

Actions for local health districts

- Establish communication pathways and protocols with local RACFs to ensure escalation of less acute conditions is via GPs (primary contact) or LHD/SHN services.
- Contribute to statewide evaluation of secondary triage model.

Actions for RACFs

- Build awareness amongst care staff of secondary triage via information supplied by LHD/SHNs.
- Maintain GP as primary point of medical care for residents.
- Understand and utilise the clinical services offered by LHD/SHNs to support the care needs of residents in situ and avoid unnecessary hospitalisations.

4.1.4 Promote Advance Care Planning

Every RACF resident should have an Advance Care Plan or Advance Care Directive with regular updating at least annually, and if the person’s medical condition changes. Advance Care Planning is part of routine practice and with the increasing impact of COVID-19, it is critical for clinical and RACF staff to proactively engage in these discussions with all residents/patients and carers/families.
Actions for local health districts

- Support local RACFs to discuss Advance Care Planning and ensure Advance Care Planning information is current for all residents admitted to hospital, and for residents in a RACF where there is an outbreak. Use NSW Health’s guidance for health professionals.
- Advance Care Plans, including decisions about whether hospitalisation is appropriate should be discussed and updated with all residents/persons responsible when admitted to hospital. Social Work may assist where available.
- The development of, or changes to, an Advance Care Plan or Advance Care Directive during a hospital admission should be communicated to RACFs on discharge within discharge summaries.

Actions for RACFs

- Advance care plans, including decisions about whether hospitalisation is appropriate, should be discussed and updated with all residents/persons responsible. End of Life Directions in Aged Care and Advance Care Planning Australia provide resources to support ACP in aged care settings.
- Where the resident has capacity to make an Advance Care Directive, the NSW Government Advance Care Directive booklet and form should be used.
- RACF staff should share ACP information with other services when a medical decision is required and/or when transferring care.
- Endorsed NSW Ambulance Authorised Care Plans may be created by a resident’s medical or nurse practitioner to provide directions for treatment and to authorise NSW Ambulance paramedics to administer medications for specific and/or palliative conditions (authorised NSW Ambulance Palliative Care Plan).

4.1.5 Maximise community palliative care for RACFs

RACFs may need additional support to provide end of life and palliative care for residents confirmed as having COVID-19, particularly if there is an outbreak in the facility. People with COVID-19 can experience complex symptoms at end of life, including breathlessness and delirium.

If all palliative and supportive care needs can be met, care should be provided in the RACF if this meets the resident’s wishes. NSW Health palliative care, respiratory and geriatric services are available to provide specialist consulting and care as needed, particularly for complex cases. Specialist services will continue to work alongside GPs, who should continue to have a lead role in palliative care for many RACF residents.

The care plan and place of care should be kept under review. RACFs should provide access to oxygen if required as recommended in the clinical care plan and on specialist advice from palliative care. If a resident’s symptom management and distress/agitation escalate despite best management and cannot be managed in the facility, palliative care and primary care services should be consulted to consider the need for hospitalisation. The need for more sedation is an example when transfer to hospital may be recommended.
Actions for local health districts

- Provide in-reach models of care to RACFs where possible, including telehealth as needed.
- Support RACF staff to recognise and escalate when residents have increasing needs or are deteriorating.
- Provide specialist palliative care, advice and education on care planning for complex needs of residents. Provide advice on medication, symptom management, use of oxygen and need for hospital admission including admission to Hospital in the Home (HITH) if appropriate.
- Ensure reliable access to medicines and clinical equipment, such as supply of oxygen and syringe drivers, is available to meet clinical needs at end of life.

Actions for RACFs

- RACF staff should provide a palliative care approach to caring for residents who are at end of life
- Establish clear escalation protocols to seek specialist clinical advice and criteria for transfer to hospital for deteriorating patients. Protocols should consider RACF workforce capability, skill mix and availability.
- Ensure reliable access to medicines and clinical equipment, such as supply of oxygen and syringe drivers, is available to meet clinical needs at end of life.

4.2 Principle 2. Protect vulnerable people - support efficient and safe admissions of new and returning residents to RACFs

Key points

- When a resident has been admitted to hospital and is ready for discharge, the treating team will medically screen and risk assess the resident for COVID-19 prior to discharge. The receiving RACF should undertake their own screening process when the resident is admitted.
- RACFs should screen and risk assess all new and returning residents who are asymptomatic and not suspected of COVID-19. This includes medical screening and assessment of epidemiological risk factors. Depending on the risk assessment, the RACF may implement additional infection prevention and control measures on admission.
- Processes for admissions/re-admissions to facilities where there is a current outbreak will be in line with relevant national guidelines on infection control and prevention and based on the advice of the local Outbreak Management Team.
Applying Principle 2: Protect vulnerable people - support efficient and safe admissions of new and returning residents to RACFs

4.2.1 Admission to RACF from the community including respite: COVID-19 not suspected and RACF does not have a current outbreak

New admissions from the community can be accepted if the person:
- has no epidemiological risk factors including no overseas travel or contact with anyone who has travelled overseas in the last 14 days
- has had no contact with anyone with confirmed, suspected or probable COVID-19
- is not awaiting a COVID-19 test result, and
- does not have any acute respiratory symptoms (cough, fever, sore throat, anosmia).

The COVID-19 case definition can be found on the NSW Health website.

An Aged Care Assessment Team (ACAT) assessment should be completed in the lead up to admission, however direct entry can be arranged in emergency situations.

Prior to admission, all residents must be medically screened by a medical practitioner (GP or hospital physician) for symptoms of COVID-19.

As current swab PCR testing for COVID-19 can produce negative results until symptoms appear, a negative swab result does not necessarily mean a person is not infected (Australian Government). Therefore, RACFs should individually assess the COVID-19 risk of each new and returning resident and implement the infection prevention and control measures deemed necessary.

The CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia provide guidance for infection prevention and control measures.

It is important that respite continues to be available, particularly emergency respite places. The same precaution should be exercised by RACFs in admitting a person for respite, as with permanent placement. An exit plan for return to the community should be discussed between the RACF, their carer/family and the assessment service (if involved).

4.2.2 Admission to RACF from the community: COVID-19 suspected or confirmed

If a person requiring admission to RACF is suspected of having COVID-19, the assessment service will liaise with home care package providers and/or LHD/SHN aged care teams to continue to support the person at home while awaiting test results. New residents should not be admitted to a RACF while awaiting test results.

People with a negative test result can be admitted to an RACF. However, RACFs should undertake their own screening and risk assessment of all new and returning residents for COVID-19. This includes screening for symptoms and epidemiological risk factors. Depending on the risk assessment, the RACF may institute additional measures on admission. The CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia and the Infection Control Expert Group COVID-19 Infection Prevention and Control for Residential Care Facilities provide guidance for infection prevention and control measures.
4.2.3 New/returning resident to RACF from hospital or Emergency Department and RACF does not have a current outbreak

There may be increasing numbers of acutely unwell COVID-19 patients as the pandemic progresses. To ensure that hospitals can be as responsive as possible, it is critical that patients who no longer require hospital care are efficiently discharged. Older people who are medically fit and ready for discharge but whose discharge is delayed are at risk of further deterioration and deconditioning associated with lengthy hospital stays.

NSW Health has a risk management approach to discharging people to RACFs (see safe discharge process below), which involves medical and epidemiological screening for COVID-19. This process aims to provide confidence that new and returning residents have been risk assessed for COVID-19 at the time of discharge. Screening and testing for COVID-19 follows current NSW Health advice. This approach is consistent with advice in the Australian Health Protection Principal Committee (AHPPC) statement and the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia.

RACFs are also required to screen new and returning residents and may elect to implement additional infection prevention and control measures on entry.

LHD/SHN aged care outreach teams will assist with discharge planning and follow up, where available in the person’s geographic area. Otherwise discharge planning should follow usual processes.

Note: Hospital acquired functional decline (HAFD) in older patients can be significant: efforts should be made to prevent decline and to preserve function throughout the resident’s hospital admission through multidisciplinary input including allied health consultations (physiotherapists, occupational therapists, nutrition and dietetics, speech pathologists), as required. On discharge to the RACF, residents may require multidisciplinary rehabilitation to prevent further deconditioning and decline in independence and function.

4.2.4 Residents hospitalised with an illness unrelated to COVID-19

Residents hospitalised with an illness unrelated to COVID-19 will be returned to their usual RACF when medically appropriate, as per usual practice, if discharge screening shows no signs or symptoms compatible with COVID-19 and there has been no contact with confirmed or suspected cases of COVID-19. LHD/SHN aged care outreach teams/specialised staff should be engaged as soon as possible in the hospital admission to assist with discharge planning if required (where available in patient’s geographic area).

4.2.5 Residents hospitalised for an illness suspected to be COVID-19

Residents hospitalised for an illness suspected to be COVID-19 will have a medical assessment in hospital including SARS-CoV-2 PCR testing. If PCR testing is negative, repeat PCR testing is conducted in 24 hours. If both PCR tests are negative, no other respiratory infectious disease is suspected/has been ruled out, the resident can be de-isolated and discharged to RACF once the treating team has assessed them as medically
stable for discharge. Residents who are cleared from COVID-19 but remain symptomatic with an ARI (Acute Respiratory Infection) and returning to the RACF, should be assessed for the appropriate infection prevention and control measures.

The resident should not return to their RACF unless they have tested negative to COVID-19. The exception to this is where a resident has met the COVID-19 case definition and their return is part of an outbreak management plan, with appropriate infection prevention and control practices and support from the local health district in place – this should include support from the LHD Infection Control Practitioner (ICP) (CDNA Guidelines for outbreaks in residential care facilities: LHD/SHN aged care outreach teams/specialised staff should be engaged as soon as possible in the admission to assist with discharge planning (where available).

### 4.2.6 Residents confirmed to have COVID-19

Return of residents following hospital admission is permitted, providing the appropriate accommodation & infection prevention and control requirements can be met at the RACF (as per the CDNA Guidelines and the Infection Control Expert Group COVID-19 Infection Prevention and Control for Residential Care Facilities). The hospital treating team will discuss with the RACF prior to discharge whether the required isolation, infection control and monitoring requirements are feasible in the RACF. Where appropriate isolation of a resident with confirmed COVID-19 is not possible, e.g. due to wandering or lack of isolation rooms, alternative arrangements will be discussed with the resident, their carer/family and the RACF, and may include extension of hospital admission, or transfer to private hospital or another high-level care facility until the end of the isolation period. LHD/SHN aged care outreach teams/specialised staff should be engaged as soon as possible in the admission to assist with discharge planning (where available).

### 4.2.7 Admissions/re-admissions to facilities where there is an outbreak:

In circumstances when the facility has a current outbreak, decisions regarding admission/re-admissions should be in line with the relevant and up-to-date national guidelines on infection prevention and control. These include the CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia and the Infection Control Expert Group COVID-19 Infection Prevention and Control for Residential Care Facilities. Decisions should also be informed by the advice of the local Outbreak Management Team.

Carers/Families may wish to seek alternative arrangements until the outbreak is over. The LHD/SHN will assist in identifying alternate accommodation as needed. LHD/SHN aged care outreach teams/specialised staff may be engaged as soon as possible to assist with discharge planning (where available) in the person’s geographic area, and Social Work should be engaged to provide support as needed.
4.2.8 Safe discharge process from hospital

Medical screening
The treating team will medically screen all returning and new residents to RACF for COVID-19 prior to discharge, regardless of the clinical reason for admission/presentation. This includes screening for signs and symptoms compatible with COVID-19.

Epidemiological risk assessment
Individual risk is assessed by the treating team to determine potential exposure to COVID-19.

Testing
If a resident meets the criteria, they will be tested for COVID-19 prior to discharge. Note: SARS-CoV-2 PCR testing in asymptomatic people cannot be wholly relied on to indicate the person is COVID-19 negative. As testing is likely to produce negative results until the symptoms appear, a negative swab result does not necessarily mean a resident is not infected (Australian Government).

Discharge information
The treating team will communicate a resident’s COVID-19 screening result to the RACF, with an information sheet that explains the risk assessment. This is in addition to the usual discharge records. An RACF discharge letter template and information sheet is available on the NSW Health website and in Appendix 2. LHD/SHN aged care outreach teams/specialised staff will assist with discharge planning and follow up (where available in patient’s geographic area).

Discharge medication
Ensure the required medications are available at RACF or are provided by the hospital pharmacy at discharge, as scripts from GPs and supply by community pharmacy may be delayed.

The safe discharge process will be reviewed when there are changes to COVID-19 testing, community transmission, or nosocomial infection rates in hospital.

4.2.9 Managing COVID-19 cases in RACFs
If COVID-19 is suspected, residents should be immediately isolated and infection control measures used as per the Communicable Diseases Network Australia Guidelines for outbreaks in residential care facilities, Infection Control Expert Group COVID-19 Infection Prevention and Control for Residential Care Facilities, and the NSW Health Incident Action Plan for COVID-19 outbreaks in NSW Residential n Aged Care Facility. Medical assessment and testing should be sought via the resident’s GP or LHD/SHN outreach service. If a resident tests positive to COVID-19, the Australian Government Department of Health (DOH) and the LHD/SHN Public Health Unit (PHU, phone 1300 066 055) must be notified. The PHU also notifies the Aged Care Quality and Safety Commission (ACQSC).

The RACF is supported in outbreak management by a public health response team led by the LHD/SHN PHU and RACF Incident Controller with key stakeholders.
During an outbreak of COVID-19, the Australian Government Department of Health facilitates access to Commonwealth support in sourcing a surge workforce, assisting with relocation of cohorts, and providing financial assistance.

Residents confirmed to be COVID-19 positive should remain in situ as long as they can be appropriately isolated and receive the required level of clinical care. PPE requirements can be supported by accessing the national stockpile via the Australian Government Department of Health PPE process. State Government RACFs must access PPE through LHD processes. See Appendix 3 for the PPE required when caring for residents who are COVID-19 positive.

Clinical care in situ may be supported by LHD/SHN outreach services and/or virtual care. If the resident’s condition changes, a clinical and risk assessment is required to determine the best location to continue clinical care. The Commonwealth COVID-19 guidelines for outbreaks in residential care facilities (Section 5.1) recommends that for RACF residents with suspected or confirmed COVID-19, the RACF should “transfer residents to hospital only if their condition warrants. If transfer is required, advise the transport service provider and hospital in advance.”

Where appropriate, alternatives to hospital transfer such as local outreach services should be considered first.

If transfer to hospital is required, the Ambulance service and receiving hospital must be notified of the outbreak/suspected outbreak verbally and through using a resident transfer advice form (available from CDNA Guidelines for outbreaks in residential care facilities).

During an outbreak of COVID-19, the Australian Government Department of Health facilitates access to Commonwealth support in sourcing a surge workforce, assistance with relocation of cohorts, and providing financial assistance.

### 4.2.10 Principles for determining the clinical care setting for a resident with COVID-19

The CDNA Guidelines for outbreaks in residential care facilities recommend that RACF residents with suspected or confirmed COVID-19 are transferred to hospital only if their condition warrants. Where appropriate, alternatives to hospital transfer should be considered first.

Considerations:

- Decisions to transfer to hospital will be made on a case-by-case basis and will be based on the clinical assessment and the resident’s wishes
- Advance Care Plans and Advance Care Directives are in place and help guide the decisions regarding location of care
- Most cases can be managed within the RACF: efforts should be made to facilitate this wherever possible utilising primary care (GP), LHD/SHN outreach teams and virtual care where available
- Communication with the resident’s carer/family or person responsible is integral in deciding to transfer the resident, and they should be kept updated of the outcome
If transfer to hospital is required, the receiving facility and transport staff (Ambulance or Patient Transport Service) should be informed that the resident is a suspected or confirmed case of COVID-19 via discussion and use of transfer advice form (available from CDNA Guidelines for outbreaks in residential care facilities).

4.2.11 Transfers to hospital from RACF: non-COVID-19 related

RACFs should continue to seek medical advice through their associated GPs.

Except in the case of an acute emergency, the GP or RACF should access specialist telehealth advice (Geriatrician/GP VMO) prior to any transfer to hospital, where available. The objective is to provide clinical care in place where possible. Transfers to hospital should be pre-planned with the LHD/SHN team, considering the resident’s Advance Care Plan/Advance Care Directive. LHD/SHN outreach teams may liaise directly with the receiving Emergency Department and Ambulance/Patient Transport Service to arrange patient transfer if required.

If a major medical event or injury has occurred, Ambulance should be called as usual.

The transfer of residents to hospital (with prior Geriatrician/Specialist/GP VMO approval) will be managed as usual with Ambulance or Patient Transport Service. Lower acuity calls by RACF to Ambulance are subject to a secondary triage process to minimise avoidable transfers and redirect to LHD/SHN services or GPs for clinical care (see Appendix 1: Secondary Triage).

4.3  Principle 3. Communication to support COVID-19 strategies

Key point

- Support admission strategies with accurate, timely and coordinated engagement and communication

Applying Principle 3: Communication to support COVID-19 strategies

4.3.1 Communication with stakeholders, residents, their carers and families

Actions for local health districts

- Advise local RACFs and GPs/primary care team of LHD/SHN services pertaining to the COVID-19 pandemic:
  - Confirm the clinical services available for geriatric and specialised aged care, including pathways and access to outreach services
  - Public Health Unit advice and support for outbreak management and infection prevention and control
  - How to contact LHD/SHN services.
Actions for RACFs

- Understand the LHD/SHN services available, when and how to access
- Lead and drive early and ongoing two-way communication with residents, families, staff, primary care team and LHD/SHN services throughout pandemic.
- Provide technology to enable connection and communication between RACF residents and their carers/families during COVID-19 related visitor restrictions.
5. Appendices

Appendix 1: Secondary triage model

Since implementation on 25th March, monitoring of activity and staff feedback indicated a need to extend the criteria for secondary triage.

The extended criteria was trialed over 3 days and went live on Wednesday 8th April and will remain ongoing.

What does the new criteria cover?

The call from RACF must be identified by NSW Ambulance as non-urgent (priority 2A, 2B or R3). The Resident must be at their baseline level of consciousness and mobility, and undistressed; or is palliative.

If the Resident meets the above criteria and present with one of the following issues, they may be provided with a secondary triage:

- Influenza-like illness
- COVID-19
- Catheter Management
- Falls with no acute pain
- Wound management including skin tears
- Seizure Management
- Cellulitis
- PR Bleeding
- Behavioural management
- Back pain
- Abdominal pain
- Care reviews for abnormal observations (e.g. Fever, Hypertension)
- Care reviews for abnormal imaging and pathology results (e.g. blood tests, urine microscopy)

How are RACFs being supported to contact their LHD community based services directly?

LHDs should ensure all RACFs within their catchment are up to date with services available and referral processes. Communications have also been provided to RACFs to encourage GPs and LHD services to be the first point of call for all non-emergency concerns.

When a care plan is developed with the RACF onsite staff and referral to the LHD community based service is required, the RCAF staff are encouraged to make the referral. This is aimed to build on existing relationships and workflow that have been developed between the LHD and RACF.
If the LHD community based service has reviewed the Resident and determines further hospital care is necessary, will this still go through the secondary triage process?

No. If the Resident is reviewed by the LHD service and admission to hospital is warranted, direct admission to hospital avoiding the Emergency Department should be arranged where appropriate. Transport to hospital for direct admissions can be organised through Patient Transport Service where available and clinically appropriate.

For patient requiring transport to a hospital Emergency Department for further assessment and/or treatment, transport can be arranged through NSW Ambulance. Please ensure the NSW Ambulance Call Taker is made aware that the patient has been already been reviewed by the LHD team.

Calls meeting the criteria from RACF to NSW Ambulance that have been reviewed by a GP will still be provided with a secondary triage if meeting the criteria.

How does the Secondary Triage Team know what services are available for the patient?

A stocktake of services across NSW Health was conducted in March 2020. All services have been included in an operational tool used by the Secondary Triage Team, which identifies services options and referral pathways, by RACF.

Working together, the RACF onsite staff and Secondary Triage Team will plan the appropriate clinical management based on available community based services at the facility. A consultation summary document will be provided to the RACF to facilitate referrals.

What if our models of care or service capacity change?

Service capacity and models of care are continually evolving, especially in the current environment. As services and models of care change, LHDs should notify the RCAF’s directly. Service and models of care changes can also be provided in writing to the project lead (contact details below) who will coordinate information to the Secondary Triage Team.

The remote emergency physician and RACF staff will together advise on the most appropriate hospital site for transfer, which will be then provided to the Patient transport service or NSW Ambulance.

For further information or to provide feedback on Secondary Triage, please feel free to contact the Project Lead, Tracy Millen.

Tracy_Millen@health.nsw.gov.au
(m) 0411 305 762
Appendix 2: Discharge to RACF: information and letter template

Discharging new and returning residents: advice for residential aged care providers, NSW Health clinicians and peak bodies during COVID-19 pandemic

PURPOSE
To provide a consistent approach for discharging older people to residential aged care facilities (RACFs) during the COVID-19 pandemic. A consistent approach will provide confidence that all new and returning residents at the time of discharge from hospital to RACFs have been screened by an appropriate medical officer and:

- were not experiencing acute respiratory symptoms or fevers compatible with COVID-19 and
- had not had any close contact with a confirmed COVID-19 patient in hospital.

Facilities are still required to follow the Communicable Diseases Network Australia guidelines (section 3.2.1) for active screening of new/returning residents.

KEY INFORMATION
- RACF providers have a duty of care to their residents and are seeking sufficient information from NSW Health to ensure the discharged patient has been screened for COVID-19 symptoms at time of discharge. Screening and testing for COVID-19 follows the current advice from NSW Health:
- As the COVID-19 pandemic progresses, hospitals will be faced with increasing numbers of acutely unwell COVID-19 patients. To ensure that hospitals can be as responsive as possible, it is critical that hospitals efficiently discharge patients who no longer require hospital care.
- Older people who are medically fit and ready for discharge but whose discharge is delayed are at risk of further deterioration associated with lengthy hospital stays. It is essential to ensure that people who do not need to be in hospital do not remain there unnecessarily.
- NSW Health will now include a letter in the discharge paper work signed by the treating team confirming the person has been screened for COVID-19 symptoms.
- This approach is consistent with advice in the Australian Health Protection Principal Committee (AHPPC) statement and the Communicable Diseases Network Australia (CDNA) guidelines. Further information on COVID-19 including recommendations to RACFs can be found via the following links:

ATTACHMENT

Letter to RACFs
Date / / 

To whom it may concern

RE: PATIENT NAME, DOB:

PATIENT NAME will be discharged to RACF NAME on DATE. They were admitted for XXX and have been screened at the time of discharge to ensure they:

- are not experiencing acute respiratory symptoms or fevers compatible with COVID-19;
- have not had any close contact with a confirmed COVID-19 patient in hospital.

As per the advice in the Communicable Diseases Network Australia guidelines (section 3.2.1), facilities should continue their usual process for active screening of resident admissions/returning residents. This includes assessing residents for symptoms of COVID-19 upon admission to the facility and implementing appropriate infection prevention practices.

Kind regards

Sign here
Insert contact details
Appendix 3: PPE use in Aged Care: COVID-19

**WHEN TO USE PERSONAL PROTECTIVE EQUIPMENT (PPE) IN AGED CARE**

- **PPE should be worn whenever you are caring for someone with a confirmed or suspected case of COVID-19, or in quarantine.**

- **Before putting on any PPE, you must wash your hands using soap and water or alcohol-based hand sanitiser.**

- **Put on the PPE before you enter the room/person’s home.**

- **When you’re providing clinical or personal care to them you will need to wear a:**
  - Gown
  - Mask
  - Protective eyewear
  - Gloves

- **Where a care recipient is in quarantine and they are not showing symptoms, eye protection is not essential.**

- **Quarantine is a precautionary period of self-isolation for someone who is well, but is at risk of infection through their recent movements or exposure.**

- **Isolation is when a person is confirmed or suspected to have COVID-19.**

- **After treating a patient, all PPE should be removed - gloves and gown, then mask (without touching the front of it) before exiting the room/person’s home.**

- **You must then wash your hands using soap and water or an alcohol-based hand sanitiser immediately after removing all PPE.**

- **To prevent the spread of disease it is important to remember to always practice good hygiene. Everybody should:**
  - Wash your hands for at least 20 seconds
  - Cough or sneeze into a tissue or your elbow and wash your hands
  - Stay 1.5 metres from others when not providing direct care

- **PPE is a limited resource so please only use it when it’s needed.**