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Home-care guidelines for adult patients with mild COVID-19

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We acknowledge the Traditional Custodians of the lands and seas on which we work and live, and pay our respects to Elders, past, present and future.

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Contents

1. Background

People who test positive for COVID-19 are most likely to only experience mild symptoms and recover without requiring special treatment or hospitalisation.[1]

This guide contains information for general practitioners (GPs) who are providing home-based care in a private residential home (including public or community housing) for **adult patients** who have tested positive for COVID-19 and who are **asymptomatic** or have **mild** symptoms.

Caring for patients with COVID-19 in their homes allows the provision of appropriate care, minimises the impact on the healthcare system and frees up hospital beds for patients with moderate or severe illness.

Discharge processes that facilitate timely and adequate communication and clinical handover to GPs and their teams should be in place when a COVID-19-positive patient is discharged from hospital into home care.

Most states/territories will have models of care that allow remote supervision of patients, which cover escalation pathways for intervention and admission to hospital if required. These models of care ensure patients receive the required services and supports based on their healthcare requirements, preferences and other needs.

This document is generic, interim guidance for GPs and should be used to support any local or other more contemporaneous advice, acknowledging that in this rapidly changing pandemic environment, uncertainties remain in our understanding of the spread of COVID-19 and its management.

2. Patient results and notification

GPs may become aware of a COVID-19-positive patient in their care through the receipt of:

- a positive result following GP-initiated testing
- notification from the local public health unit after testing initiated by another agency
- discharge notification regarding a patient hospitalised with COVID-19.

COVID-19 is a notifiable disease in all states and territories. The doctor requesting the SARS-CoV-2 nasopharyngeal testing is responsible for notifying the patient and local public health unit of a positive result. If another agency has requested the test, they are also responsible for notifying the patient's nominated GP of the result.

3. Patient triage and clinical care overview

If a patient tests positive for COVID-19, the severity of their illness (refer to Box 1) will need to be determined to ensure appropriate care is provided in the appropriate location. Local factors such as remoteness, resources, escalation pathways and access to health services will influence this decision. Many regions will have local processes documented on their HealthPathways website.

Options for the location of care for patients with mild COVID-19 can include:

- care in a private home, residential facility or temporary accommodation – using telehealth and remote monitoring, and face-to-face clinical contact as required
- admission into a hospital diversion program such as Hospital in the Home
- admission to hospital (for those at higher risk, including the elderly and those with chronic disease or compromised immunity).

A decision regarding home care will be based on the processes of the local public health unit, local hospital service or other jurisdictional agency, as well as the patient's symptom severity, risk factors and home situation.

GPs who are not involved in COVID-19 management processes should still manage the patient's usual healthcare and be kept up to date on the patient's care plans. However, if a patient is admitted to hospital (including Hospital in the Home), the GP is not able to provide any Medicare Benefits Schedule-funded services during that admission. Some regions have resolved this issue by managing these patients as outpatients.

4. Home-care suitability assessment

Currently in the majority of Australian regions home-care suitability is determined by public health units and the local hospital-supported community care processes. With increasing disease prevalence, the role of the GP in patient home-care assessment may be of increasing importance. The following factors are currently used to determine location of care.

Disease severity

Refer to Box 1 for the current disease severity definitions.

Currently only patients with mild illness are cared for in the community.

Box 1. Definition of disease severity for adults

Mild illness	Adults not presenting any clinical features suggestive of moderate or severe disease or a complicated course of illness. Characteristics: • no symptoms; or • mild upper-respiratory tract symptoms; or • cough, new myalgia or asthenia without new shortness of breath or a reduction in oxygen saturation
Moderate illness	Stable adult patients presenting with respiratory and/or systemic symptoms or signs. Able to maintain oxygen saturation (SpO2) above 92% (or above 90% for patients with chronic lung disease) with up to 4 L/min oxygen via nasal prongs. Characteristics: • prostration, severe asthenia, fever >38 ºC or persistent cough • clinical or radiological signs of lung involvement • no clinical or laboratory indicators of clinical severity or respiratory impairment
Severe illness	Adult patients meeting any of the following criteria: • respiratory rate ≥30 breaths/min • oxygen saturation ≤92% at a rest state • arterial partial pressure of oxygen (PaO2)/inspired oxygen fraction (FiO2) ≤300
Critical illness	Adult patient meeting any of the following criteria: Respiratory failure • occurrence of severe respiratory failure (PaO2/FiO2 <200), respiratory distress or acute respiratory distress syndrome (ARDS), including patients deteriorating despite advanced forms of respiratory support (non-invasive ventilation [NIV], high-flow nasal oxygen [HFNO]) or patients requiring mechanical ventilation OR other signs of significant deterioration • hypotension or shock • impairment of consciousness • other organ failure

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Patient health factors

- Does the patient have any risk factors for adverse outcomes or severe COVID-19? (refer to Box 2)
- What other health conditions need to be monitored and managed?
- Are there any cultural and social factors that may affect compliance with self-isolation and infection control measures?
- Does the patient or their carer have an adequate understanding of their illness and medical guidance (health literacy)?
- How easily can the patient be moved if their condition deteriorates?

Box 2. Established and potential risk factors for severe COVID-19[2]

The following are determined to be risk factors for severe COVID-19:

- Older age (>65 years)
- Chronic lung disease
- Cardiovascular disease
- Diabetes mellitus
- Obesity
- Immunocompromised status
- End-stage renal disease
- Liver disease
- Cancer
- Smoking history

Accommodation/household factors

- Does the patient have suitable accommodation and access to food, medicines and essential supplies?
- If needed, is there a caregiver who can provide support and help cover the patient's basic needs?
- Does the patient feel safe in their home?
  - Is there a history of family violence?
- Who else lives in the house with the patient?
  - Is it safe for other household members to be in the household?
  - Do other household members understand the precautions they will need to take while the patient is isolating?
- Does the patient understand their COVID-19 diagnosis, and are they clear about the isolation requirements while they are at home?
- Are any of the other household members unwell with COVID-19 or at higher risk of severe COVID-19 (for example, have risk factors outlined in Box 2)?
- Does the patient have care responsibilities that may be affected by their diagnosis?

Monitoring/communication factors

- Will the patient be able to undertake telehealth consultations? Do they have access to a telephone?
- Will the patient be able to self-monitor and communicate deterioration of symptoms?
- Is tertiary care support available for increased home surveillance requirements?

Geographic/transport factors

- Where is the closest emergency medical care, if needed?
- Where is the nearest COVID-19-equipped care environment?

5. Developing a management plan

The decision on where to manage the patient will differ across local jurisdictions. GPs should seek to collaborate with their local hospital networks/districts and public health units. If a patient has been assessed as suitable for home care, a management plan will need to be put in place to ensure the safety of the patient and other household members. This may include a formal collaboration between the GP and hospital service and should include the following:

- Establishing the date of onset of symptoms as day 1 (or the date of testing, if asymptomatic)
- Detailing current symptoms (refer to Box 3)
- Establishing high-risk comorbidities or risk factors (refer to Box 2)
- Educating the patient about indicators for disease progression; in particular, discussing the risk of deterioration in the second week after symptom onset
- Considering the use of pulse-oximetry to self-monitor oxygen saturation for patients at higher risk of complications
- Educating the patient and other household members about infection prevention and control procedures to stop the spread of COVID-19
- Determining the frequency of contact and follow-up required via telehealth or in person as appropriate – this could be daily or every 2–3 days and will depend on the severity of the illness, the stage of the illness, and individual patient characteristics and concerns
- Providing information on where, when and how to seek emergency medical assistance (refer to section 8, Escalating care) to the patient, their caregivers and/or other household members
- Establishing who will manage the patient if the treating GP is not available
- Creating an action plan for the patient and their carers to monitor their symptoms and know when and how to escalate support

6. Managing symptoms and medicines

Box 3. COVID-19 symptoms[1]

The most commonly reported symptoms of COVID-19 include:

- fever
- respiratory symptoms
- coughing
- sore throat
- shortness of breath

Other symptoms can include:

- runny nose
- headache
- muscle or joint pains
- nausea
- diarrhea
- vomiting
- loss of sense of smell
- altered sense of taste
- loss of appetite
- fatigue

Refer to Box 3 for common symptoms of COVID-19.

The current recommendation from the National COVID-19 Clinical Evidence Taskforce is to manage mild COVID-19 in a similar way to seasonal influenza, ie plenty of rest, drinking fluids and eating well.[3]

- Make sure the patient has access to their regular medicines.
- Encourage paracetamol, if required, for management of fever. However, patients already using ibuprofen or other nonsteroidal anti-inflammatory drugs (NSAIDs) may continue to do so.[4]
- Patients requiring inhaled medication for asthma or chronic obstructive pulmonary disease (COPD) should continue these medications using metered-dose inhalers and spacers as appropriate. However, they should avoid using nebulisers due to risk of aerosol spread.[5]
- Do not prescribe chloroquine, hydroxychloroquine, antivirals or antiretrovirals for the treatment of COVID-19.[6]
- Do not discontinue angiotensin converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) in patients already receiving these medications as there is no evidence to support an association between these agents and severe COVID-19.[7]
- Do not prescribe corticosteroids for patients with suspected COVID-19 unless they are indicated for another reason (eg patient is already on them; COPD/asthma exacerbation).
- If the patient is on prednisone, biologics or other immunosuppressive drugs, seek advice from the treating specialist before considering any changes to these drugs.

7. Monitoring symptoms

The National COVID-19 Clinical Evidence Taskforce advises patients with COVID-19 and their caregivers or family members to look out for the development of **new** or **worsening** symptoms.[3]

GPs can provide reassurance that four out of five people with COVID-19 will have a mild illness and will usually recover 2–3 weeks after the initial onset of symptoms.[3]

If symptoms do worsen, this is most likely to occur in the second or third week of illness.

A checklist to monitor symptoms during follow-up consultations could include:

- General observation
  - What is their appearance?
  - What is their colour?
  - What is their level of comfort or distress?
- Shortness of breath
  - What is the observed respiratory rate?
  - Does the patient have any shortness of breath?
  - Is the patient able to speak in full sentences, or are they pausing to catch their breath?
  - Has the patient's breathing changed since yesterday?
  - Can they walk the same distance as yesterday?
  - Can they lie flat at night and sleep without any breathlessness?
  - Does the patient have any cough? Haemoptysis?
- Fever, myalgia and lethargy
  - Does the patient have a fever?
  - Does the patient have myalgia?
  - Does the patient have any tiredness or lethargy?
  - Is the patient light-headed?
  - Is the patient well hydrated (drinking with clear urine output)?
- Chest pain
  - Does the patient have any chest pain?
  - Can the patient breathe without chest pain?
- New symptoms
  - Is the patient displaying/reporting new symptoms? (refer to Box 3)
  - Is there any calf pain or swelling suggestive of deep vein thrombosis?
- Confusion
  - Does the patient appear confused or have their caregivers observed any confusion?

- Daily living
  - Is the patient eating, drinking and sleeping well?
  - Is the patient having increased difficulty with their activities of daily living?
- Mental health
  - Is there evidence of
    - anxiety?
    - changes in mood or affect (eg depression)?
    - lethargy?
    - suicidal ideation?
- Deterioration
  - Has the patient deteriorated in any way since last review? How?
  - Does patient care need to be escalated/de-escalated or continued as is?

8. Escalating care

Patients, other household members and caregivers should be advised to contact the patient's GP via telephone for advice if symptoms worsen. If the GP is not immediately available, they must call emergency services on 000 and **clearly communicate the patient's COVID-19 status to the phone operator.** The ambulance crew and receiving emergency department must be aware of the patients COVID-19 status.

Transfer to hospital is recommended if the patient develops symptoms or signs suggestive of moderate or severe COVID-19, such as:

- symptoms or signs of pneumonia
- worsening shortness of breath
- reduced oxygen saturation
- blue lips or face
- pain or pressure in the chest
- cold and clammy or pale and mottled skin
- confusion or fainting not associated with a premorbid condition
- becoming difficult to rouse
- little or no urine output
- coughing up blood.[3]

If a patient with minimal or mild symptoms shows signs of deterioration, particularly breathlessness, without the above signs:

- ensure they have an action plan for rapid deterioration
- increase the frequency of surveillance
- consider seeking assistance with care from a hospital-supported monitoring service.

9. Conducting telehealth consultations

Telehealth consultations between the patient and their usual GP can be used for the following purposes:

- Assessment of disease status
- Identification of risk factors for severe disease
- Management of associated symptoms
- Management of pre-existing illnesses
- Early detection of deterioration requiring hospital admission
- Referral for investigations and surveillance testing
- Screening for the need for an in-home assessment
- Education and health promotion
- Assessment of adequacy of in-home support
- Review of the patient diary
- Provision of mental health support
- Welfare check in the home
- Provision of an updated action plan

Refer to the RACGP's Guide to providing telehealth and video consultations in general practice for more information. For patients requiring an interpreter, refer to the RACGP's Telehealth consultations using an interpreter.

Patients undertaking telehealth consultations should be afforded the same privacy as if they had presented to a general practice. Therefore the patient should be directed to undertake the consultation in a private space, away from other household members. This will give them the opportunity to raise any concerns with the GP regarding their welfare at home.

10. Conducting a face-to-face consultation

Patients receiving home-based care may need a face-to-face consultation. This can be conducted at the patient's home or at a general practice.

GPs who have risk factors for severe COVID-19 should not conduct face-to-face consultations with patients with suspected or confirmed COVID-19.

10.1 Infection prevention and control

The following steps should be taken to minimise spread of COVID-19:

- Prior to seeing a patient with COVID-19, the GP must don appropriate personal protective equipment (PPE), which must include
  - gloves
  - P2/N95 mask
  - gown/apron
  - eye protection (goggles or a face shield).[8]
- Consider
  - the most appropriate location to don and remove PPE
  - how to safely dispose of PPE after the consultation.
- Ask the patient to put on a surgical mask (if they are not already wearing one).
- Maintain physical distancing of at least 1.5 metres when possible.
- If the necessary PPE is not available, do not undertake a face-to-face consultation. Instead, contact your local public health unit or hospital for advice on where to direct the patient. Refer to the Department of Health's Guidance on the use of personal protective equipment (PPE) for health care workers in the context of COVID-19 for detailed advice on PPE selection.

10.2 Additional considerations for face-to-face consultations taking place at a general practice

Staff should prepare the space for face-to-face consultations in a general practice. Before seeing any patients:

- remove all non-essential items from exposed surfaces
- tape a line on the floor 1.5 metres from the doctor's/nurse's chair/desk as a physical indicator to maintain social distancing when possible
- ensure PPE is available, including spare items
- check the room has handwashing facilities/hand sanitiser
- place a clinical waste disposal bin in a location appropriate for PPE removal (ie near an exit)
- ensure all relevant pathology forms, examination tools and other necessary items are

available in the consultation room to avoid exiting and entering the room during the consultation

- have the following health and follow-up information ready to give the patient
  - COVID-19 information
  - isolation guidance
  - referral information
  - any follow-up details that may be required.

Cleaning the consultation room after seeing a COVID-19-positive patient should include:

- general practice staff removing PPE immediately to avoid cross-contamination
- donning new PPE, non-contaminated gloves, a surgical mask and eye protection before cleaning the consultation room
- a combination of mechanical action, application of detergent and water, then drying to be effective
- wiping down surfaces with both a detergent and a disinfectant – use a cleaning detergent followed by a disinfectant, or use a two-in-one product with both cleaning and disinfecting properties
- wiping down any touched surfaces (including door handles, desktops, stethoscopes and otoscopes) between patients
- cleaning fabric surfaces with bleach
- disposing of contaminated waste appropriately in contamination bins.

Once surfaces have dried, the room can safely be used for the next standard patient consultation.

Refer to the Department of Health's Environmental cleaning and disinfection principles for health and residential care facilities fact sheet for detailed advice.

11. General advice for pregnant or breastfeeding patients

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists advises that at this time, pregnant women do not appear to be more severely unwell if they develop COVID-19 infection than the general population. It is expected that the large majority of pregnant women will experience only mild or moderate cold- or flu-like like symptoms.[9]

A handful of very recent case reports suggest that the virus may pass from the mother to the baby (vertical transmission); however, the preliminary data are very early and have not been confirmed.

The current recommendations from the National COVID-19 Clinical Evidence Taskforce advise:

- the mode of birth should remain as per usual care, and currently no evidence supports that a caesarean section for women with COVID-19 reduces the risk of vertical transmission to the newborn
- currently no evidence indicates breastfeeding increases the risk of vertical transmission to the newborn – given the substantial known benefits for breastfeeding, women should be supported to initiate or continue breastfeeding
- women with COVID-19 who are breastfeeding should use infection prevention and control measures (mask and hand hygiene) while infectious
- for women with COVID-19 who have given birth, rooming-in of mother and newborn is recommended and infection prevention and control measures (mask and hand hygiene) should be in place while the mother is infectious.[10]

Additional resources

RACGP resources

- COVID-19 infection control principles
- Infection prevention and control standards (5th edition)
- How to don personal protective equipment
- How to remove and dispose of personal protective equipment

Federal Department of Health resources

- Isolation for coronavirus (COVID-19)
- COVID-19 infection control training
- CDNA national guidelines for public health units

- Coronavirus (COVID-19) environmental cleaning and disinfection principles for health and residential care facilities
- Guidance on the use of personal protective equipment (PPE) for health care workers in the context of COVID-19

Other resources

- National COVID-19 Clinical Evidence Taskforce
- General Practice Mental Health Standards Collaboration (GPMHSC) COVID-19 resources

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