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

Queensland Health Discharge Letter

Date: .....

To whom it may concern,

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

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

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

1. ☐ LOW RISK
2. ☐ MODERATE RISK

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

Kind regards,

.....

(signature)

.....

(name, contact details)

Key Points

Actions on discharge for residents

Prior to discharge, assessment by treating Senior Medical Officer against the risk stratification domains in table 1 must be performed. All residents **must** have:

1. Communication with the accepting RACF and General Practitioner is to be undertaken to confirm transfer and clinical care requirements.
2. A letter confirming the resident's risk status completed by the responsible Senior Medical Officer or Medical Officer delegate. Letter should be faxed/electronically communicated to RACF and treating General Practitioner.
3. Discharging clinician is to communicate with the resident and the resident's next of kin regarding the plan for transfer.
4. Transfer is to be arranged as per local process.

Where a resident is assessed as **LOW RISK** and is ready for discharge, in addition to above requirements for all residents:

1. On return of the resident to the RACF, implement usual daily screening for symptoms or signs of COVID-19 that should be applied to all residents and staff during COVID-19 pandemic; no indication for isolation of resident unless develops new symptoms or signs of COVID-19.

Where a resident is assessed as **MODERATE RISK**, in addition to above requirements for all residents:

1. Discharge appropriateness should be considered on a case by case basis in consultation with RACF infection prevention and control personnel and the resident's usual General Practitioner, along with the local Public Health Unit and/or infectious diseases where required.
2. Screening for signs and symptoms of COVID-19 after discharge, should occur at a minimum of twice daily for 14 days to assess for new symptoms; isolation of the resident is not routinely required unless develops new symptoms or signs of COVID-19, or unless otherwise advised by local Public Health Unit/infectious diseases team.

Where a patient is deemed to be **HIGH RISK**:

1. A resident who has been tested for COVID-19 **will not** be discharged while the results of testing are pending.
2. A resident with confirmed COVID-19 will be managed in hospital and **will not** be discharged until no longer infectious, and only in consultation with infectious diseases and/or the local Public Health Unit.
3. Where a resident has tested negative for COVID-19, but there exists ongoing clinical concern about the possibility of COVID-19 (i.e. possible false negative test result), advice **must** be obtained from local infectious diseases specialist and/or Public Health Unit before the resident can be discharged.

Table 1: Risk stratification of resident influencing assigned risk

Risk assessment domain	Risk assessment criteria	Low risk if ALL "No"	Moderate risk if ANY "Yes"	High risk if ANY "Yes"
Clinical risk assessment	Does the resident have typical symptoms of COVID?	No	No	Yes
	Does the resident have atypical symptoms of COVID? (e.g. acute confusion or behavioural change/delirium, acute loss of appetite, fatigue, loss of taste or smell, diarrhoea, nausea, vomiting, headache, myalgia, arthralgia, or conjunctival congestion).	No	Yes – symptoms completely explained by definitive* non-COVID illness.	Yes – symptoms not completely explained by definitive* non-COVID illness.
	Does the resident have a fever?	No	Yes – fever with definitive* non-COVID cause.	Yes – fever without definitive* non-COVID cause.
	Cognitive impairment that precludes the ability to reliably assess for the presence or absence of symptoms AND the resident is from a RACF within a restricted local government area? (as defined by current Chief Health Officer Direction).	No	Yes – definitive* non-COVID diagnosis established as cause for presentation.	Yes – no definitive* non-COVID diagnosis established as cause for presentation.
Environmental risk assessment	Does the resident's RACF have a current suspected or confirmed COVID-19 outbreak? (consult with the local RaSS or directly with the RACF management if unsure).	No	No	Yes
	Is the RACF or the hospital in a restricted local government area (as defined by current Chief Health Officer Direction) or COVID hot-spot?	No	Yes	N/A
	Was there a close contact or significant casual contact with a confirmed COVID +ve case within the last 14 days.	No	No	Yes – potential or confirmed close contact.

*Assessment of fever must follow best practice recommendations specific to evaluation of this cohort, particularly for suspected UTI – see *"Therapeutic Guidelines – antibiotics: UTI in residents of aged care facilities"*.

Table 2: Recommendations for the management of the resident, according to resident's assigned risk level

Considerations		Low risk	Moderate risk	High risk
COVID testing	COVID PCR.	Not indicated.	Not indicated.	Indicated.
Discharge considerations	Personal Protective Equipment during 14 days after discharge.	Standard precautions.	Refer to current Personal Protective Equipment information for RACF staff.	Refer to current Personal Protective Equipment information for RACF staff.
	Additional precautions, review and monitoring for 14 days to assess for new symptoms.	Daily screening for symptoms and signs of COVID-19.	Minimum twice daily screening for symptoms and signs of COVID-19.	As directed by medical team on discharge. Residents with confirmed COVID 19 will remain in hospital and will not be discharged until no longer infectious. Discharge planning should occur in consultation with Infectious Diseases +/- Public Health Unit. If close contact with a confirmed case has been confirmed by public health the resident will need to be quarantined for 14 days from last date of exposure and managed in consultation with the public health unit.

*Assessment of fever must follow best practice recommendations specific to evaluation of this cohort, particularly for suspected UTI – see *"Therapeutic Guidelines – antibiotics: UTI in residents of aged care facilities"*.