



RACGP

Royal Australian College of General Practitioners

*Home-care guidelines  
for patients with  
COVID-19*



## Home-care guidelines for patients with 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.*

## *Acknowledgements*

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The update of these guidelines has been undertaken by The Royal Australian College of General Practitioners (RACGP) in collaboration with the [HealthPathways Community](#). A clinical pathway has been written alongside this guidance to reflect local environments and services, and is published on local [HealthPathways sites](#). This collaboration aims to support general practice teams to collaborate with local hospital services in the care of patients with COVID-19.

The RACGP acknowledges the work of the National COVID-19 Clinical Evidence Taskforce (of which the RACGP is a member) in developing [living guidelines](#) and [clinical flowcharts](#) for the assessment and management of COVID-19.

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# Background

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People who test positive for COVID-19 are most likely to only experience mild symptoms (80% of patients) and recover without requiring special treatment or hospitalisation, especially if fully vaccinated.<sup>1</sup>

This guide contains information for general practitioners (GPs) who are providing home-based care in a private residential home (including public or community housing), in residential aged care facilities and supported accommodation, for patients who have tested positive for COVID-19 but are not deemed to be high risk for severe disease or hospitalisation.

Caring for patients with COVID-19 in their homes allows the provision of appropriate holistic care, minimises the impact on the healthcare system, frees up hospital beds for patients with severe illness (or who otherwise require hospitalisation) and minimises the risk of transmission within a hospital setting.

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, or where a hospital-led program or health service is arranging GP care.

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

This document provides general guidance for GPs, and should be used to support any local or other more contemporaneous advice, such as the [National COVID-19 Clinical Evidence Taskforce guidelines](#) and [HealthPathways](#). It can be used in conjunction with [Managing COVID-19 at home with assistance from your GP – A guide, action plan and symptom diary for patients](#).

## *Vaccination status*

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The Therapeutic Goods Administration (TGA) defines a [fully vaccinated person](#) as one who 'has received the required dose(s) of a COVID-19 vaccine under the national COVID-19 vaccination program ... in accordance with the recommendations made by the Australian Sponsor of the relevant vaccine'.<sup>2</sup>

All vaccines currently available for use in Australia require a minimum of two doses. The Australian Technical Advisory Group on Immunisation (ATAGI) [recommends](#) that individuals who are severely immunocompromised receive a third vaccine dose as part of their primary course, 2–6 months after their second dose. It is [recommended](#) that adults aged 18 years and older receive a booster dose six months after their second dose.<sup>3</sup>

Optimal protection is 7–14 days after the final dose in the course.<sup>4</sup>

For the purposes of public health orders in Australia, two doses of a COVID-19 vaccine are required.

While people vaccinated against COVID-19 can still contract the SARS-CoV-2 virus, they are significantly less likely to suffer severe disease or require hospitalisation.

While vaccination significantly reduces the risk of severe disease and hospitalisation, care must be provided based on clinical presentation and medical and social risk factors.

Ensure you are up to date with the [latest clinical guidance on COVID-19 vaccines in Australia](#), as these are updated frequently.

## *Patient results and notification*

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GPs might become aware of one of their patients being diagnosed with COVID-19 through the receipt of:

- a positive result following GP-initiated testing
- notification from the local public health unit/state or territory Department of Health after testing initiated by another agency
- a local health service seeking to arrange home-based care
- discharge notification regarding a patient hospitalised with COVID-19
- notification by the patient or their carer.

COVID-19 is a notifiable disease in all states and territories. Pathology providers who process the SARS-CoV-2 nasopharyngeal testing are responsible for notifying the local public health unit (or relevant authority) of a positive result. The methods of notification of a positive result to a patient and their GP vary significantly across states and local services. These methods are likely to continue to change as the care of this condition moves further into general practice.

## Rapid antigen testing

The TGA has approved a number of [COVID-19 point-of-care test kits](#) and [COVID-19 self-tests](#) for use in workplaces, industry and the home. These are readily available through pharmacies and supermarkets.

The best use of these tests is still being determined, as they have lower sensitivity and specificity than laboratory polymerase chain reaction (PCR) testing. Symptomatic patients must not rely on a rapid antigen test (RAT) for exclusion of COVID-19 because of the risk of a false-negative result. The use of these tests might be most appropriate for frequent repeated surveillance testing of asymptomatic people with workplace exposure risks. However, with the likely widespread availability of tests following this approval, RATs are likely to be used in the community for a range of reasons, whether or not appropriate, including self-testing by people with COVID-19 symptoms.

The first notification of a patient's possible COVID-19-positive status might be through self-reporting of their RAT result.

If a patient reports a positive result from a point-of-care test or self-test, this must be confirmed with PCR testing. Ensure these patients are immediately referred for COVID-19 PCR testing at the same time as ensuring any urgent clinical needs are addressed.

The patient should be managed on the assumption they will return a positive result on PCR testing, and [appropriate personal protective equipment](#) (PPE) should be worn when consulting these patients.

The patient must self-isolate until the PCR result is available. The patient can be released from isolation with a negative result. If a positive result is returned, the patient must self-isolate in accordance with public health directives.

## Responding to patient notification

Patients might be distressed when notified they have tested positive to COVID-19.

Delivering a positive COVID-19 test result should be undertaken in a similar manner to delivering other bad news – by building rapport and using clear and empathic communication.

Investigate the meaning of a positive diagnosis for your patient and their household to manage your patient and their potential close contacts.

For patients with a trauma or custodial history, the need to isolate could trigger significant mental distress. A trusted therapeutic relationship and a sensitive explanation of the reasons behind isolation are important when engaging with these patients.<sup>5</sup>

Mental health support is available through the [National Coronavirus Helpline](#) (1800 020 080) and [Head to Health](#).

If an interpreter is required for consultations, practices can use the Australian Government's Translating and Interpreting Service (TIS) Doctors Priority Line. General practices are eligible for a free TIS code. If not already registered, call 1300 131 450 or visit the [TIS website](#). The Royal Australian College of General Practitioners (RACGP) has developed a [fact sheet](#) to provide guidance on, and support with, providing telehealth consultations with patients who require an interpreter.

## *Patient triage and clinical care overview*

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If a patient tests positive for COVID-19, the severity of their illness (refer to boxes 1 and 2) will need to be determined to ensure appropriate care is provided in the appropriate location. Local factors, such as remoteness, resources, escalation pathways, local clinician expertise and workload, and access to health services, will influence this decision, as will social factors, such as appropriateness of housing, ability to self-isolate, access to a carer and patient preference. Many regions will have local processes documented on their [HealthPathways website](#).

Patients are only to be referred to GPs from hospitals, triage services or other care providers if the GP has accepted care for the patient. Patients are not to be given general advice to see their GP for ongoing care during their acute infectious period, unless the GP has been consulted and accepted care, and a handover of that patient is provided. Patients might present to a GP following a positive home RAT.

Options for the location of care for patients with mild and moderate 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 by their GP, a commissioned health service or a hospital-led service
- admission into an in-home hospital-led program, such as Hospital in the Home (HITH) or ‘virtual’ HITH
- 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, and a GP’s ability to provide the necessary care.

GPs who are not involved in COVID-19 management processes should still manage the patient’s usual healthcare. It is important to confirm who is clinically responsible for the patient in such circumstances. It is also important for the GP to be aware of the jurisdictional arrangements regarding whether a patient being managed through the hospital-led service is classified as an inpatient or outpatient. If classified as an inpatient, the GP is not able to provide Medicare Benefits Schedule (MBS)-funded services related to COVID-19 management during that admission, and could face some challenges proving that any care provided is unrelated to their admission. For this reason, many hospital-led services are using an outpatient model, which enables ongoing GP support. Arrangements might differ across jurisdictions or change as COVID-19 community care evolves. Depending on where your practice is, there could be scope for MBS services to be provided for non-COVID-19-related services for admitted patients.

Before providing care to patients admitted to hospital (whether physically or under virtual care models), or as part of hospital-led programs, GPs should check with the hospital and their local primary health network (PHN) about any specific local arrangements for MBS billing involving these patients, both for COVID-19- and non-COVID-19-related issues. Information is also available from the Australian Government Department of Health via its AskMBS service, accessible via [askMBS@health.gov.au](mailto:askMBS@health.gov.au)



## *Home-care suitability assessment*

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Currently, in the majority of Australian regions, home-care suitability is determined by public health units/state or territory health services or commissioned providers and the local hospital-supported community care processes. With increasing disease prevalence, the role of the GP in patient home-care assessment and care is of increasing importance. GPs, local hospital services, PHNs, public health units and commissioned health services should collaborate in determining an individual's home-care suitability. GPs can seek advice and support from these services, as required.

Models of care might include GP shared care for patients being supported in a hospital-led program, or full GP management without hospital involvement. Both models provide an important measure to ease pressure on the hospital system. The principles remain the same, irrespective of the model.

The following factors are currently used to determine location of care and care protocol.

### **Disease severity**

Refer to boxes 1 and 2 for the current disease severity definitions.\*

Currently, the majority of patients cared for in the community have mild illness. GPs might increasingly care for moderately ill patients depending on access to, and availability of, tertiary health services, their own abilities and capabilities and the patient's willingness to be cared for in hospital.

There might be circumstances where, by choice of the patient or where access to hospital services is limited, GPs could be caring for severely ill people in the community. This guide does not provide guidance for care of severely ill patients in the community. Care of severely ill patients should be in collaboration with a hospital-led service.

\*Local [HealthPathways](#) might use different criteria to define disease severity.

**Box 1. Definition of disease severity for adults**

<b>Mild illness</b>	<p>Adults not presenting any clinical features suggestive of moderate or severe disease, or a complicated course of illness.</p> <p>Characteristics:</p> <ul style="list-style-type: none"> <li>• No symptoms</li> <li>• Mild upper-respiratory tract symptoms</li> <li>• Cough, new myalgia or asthenia without new shortness of breath or a reduction in oxygen saturation (SpO<sub>2</sub>)</li> </ul>
<b>Moderate illness</b>	<p>Stable adult patients presenting with respiratory and/or systemic symptoms or signs. Able to maintain SpO<sub>2</sub> above 92% (or above 90% for patients with chronic lung disease) with up to 4 L/min oxygen via nasal prongs.</p> <p>Characteristics:</p> <ul style="list-style-type: none"> <li>• Respiratory rate &lt;30 breaths/min, severe lethargy/weakness, fever &gt;38°C or persistent cough, vomiting and diarrhoea, dehydration or dizziness on standing</li> <li>• Clinical or radiological signs of lung involvement</li> <li>• No clinical or laboratory indicators of clinical severity or respiratory impairment</li> </ul>
<b>Severe illness</b>	<p>Adult patients meeting any of the following criteria:</p> <ul style="list-style-type: none"> <li>• Respiratory rate ≥30 breaths/min</li> <li>• SpO<sub>2</sub> ≤92% at a rest state</li> <li>• Arterial partial pressure of oxygen (PaO<sub>2</sub>)/inspired oxygen fraction (FiO<sub>2</sub>) ≤300</li> </ul>
<b>Critical illness</b>	<p>Adult patient meeting any of the following criteria:</p> <p>Respiratory failure</p> <ul style="list-style-type: none"> <li>• Occurrence of severe respiratory failure (PaO<sub>2</sub>/FiO<sub>2</sub> &lt;200), respiratory distress or acute respiratory distress syndrome, including patients deteriorating despite advanced forms of respiratory support (non-invasive ventilation, high-flow nasal oxygen) or patients requiring mechanical ventilation</li> </ul> <p>OR</p> <p>Other signs of significant deterioration</p> <ul style="list-style-type: none"> <li>• Hypotension or shock</li> <li>• Impairment of consciousness</li> <li>• Other organ failure</li> </ul>

Reproduced with permission from National COVID-19 Clinical Evidence Taskforce. Australian guidelines for the clinical care of people with COVID-19. 2021 (version 45.1). Available at <https://covid19evidence.net.au>

**Box 2. Definition of disease severity for children and adolescents**

	<b>Feeding/hydration/ conscious state</b>	<b>Respiratory/vital signs</b>	<b>Oxygen requirement</b>
<b>Mild illness</b>	Normal or mildly reduced feeding	No or mild upper respiratory tract symptoms OR No or mild work of breathing	No supplemental oxygen required to maintain oxygen saturation (SpO <sub>2</sub> ) >92%
<b>Moderate illness</b>	Poor feeding, unable to maintain hydration without nasogastric or IV fluids AND Normal conscious state	Moderate work of breathing OR Abnormal vital signs for age (tachycardia, tachypnoea), but does not persistently breach early warning criteria (eg medical emergency team [MET]) OR Brief self-resolving apnoea (infants)	Requires low-flow oxygen (nasal prongs or mask) to maintain SpO <sub>2</sub> >92%
<b>Severe illness</b>	Poor feeding, unable to maintain hydration without nasogastric or IV fluids OR Drowsy/tired, but easily rousable	Moderate–severe work of breathing OR Abnormal vital signs for age (tachycardia, tachypnoea) with breaches of early warning criteria (eg MET) OR Apnoea needing support/stimulation (infants)	Requires high-flow oxygen at 2 L/kg/min to maintain SpO <sub>2</sub> >92%
<b>Critical illness</b>	Poor feeding, unable to maintain hydration without nasogastric or IV fluids OR Altered conscious state/ unconscious	Unable to maintain breathing or prevent apnoea without advanced modes of support OR Abnormal vital signs for age with persistent breaches of early warning criteria (eg MET) OR Haemodynamically unstable without inotropic or vasopressor support OR Other organ failure	Requires advanced modes of support to maintain oxygenation High-flow nasal oxygen at >2 L/kg/min OR Non-invasive ventilation OR Intubation and mechanical ventilation OR Extracorporeal membrane oxygenation

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## Patient health factors

- Is the patient fully vaccinated against COVID-19 (therefore less likely to develop severe disease) or previous confirmed infection with SARS-CoV-2 in the past six months?
- Does the patient have any risk factors for adverse outcomes or severe COVID-19? (Refer to [Box 4](#).)
- What other health conditions need to be monitored and managed?
- Are there any cultural or social factors that might affect help-seeking, treatment and the ability to isolate?
- Does the patient have any drug or alcohol dependencies that need management so they can effectively isolate?
- Does the patient have any mental health issues that might affect their ability to isolate or be significantly worsened by isolation?
- Does the patient or their carer have an adequate understanding of their illness and the risk of deterioration (health literacy)?
- How easily can the patient be moved if their condition deteriorates?
- Does the patient have a preference for home or hospital-based care?

## Accommodation/household factors

- Are other members of the household vaccinated against COVID-19?
- Does the patient have suitable accommodation and access to food, medicines and essential supplies?
- If needed, is there a caregiver (who is not at high risk of severe COVID-19 infection) 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?
  - Are any household members at greater risk of contracting (ie children and the unvaccinated) or of having severe disease from COVID-19?
  - Is there space in the house for the patient to effectively isolate?
  - 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 the isolation requirements while they are at home?
- Does the patient have care responsibilities, including caring for children, that might be affected by their diagnosis?

## Monitoring/communication factors

- Will the patient be able to undertake telehealth consultations? Do they have access to a telephone, tablet, computer or other device that supports video consultations? Are they able to use the technology?
- Will the patient be able to use technologies that will support care (ie pulse oximeter)?

- 
- Will the patient be able to self-monitor and communicate deterioration of symptoms?
    - Is the patient from a culturally and linguistically diverse (CALD) community?
    - If the patient is not fluent in English, do they or their caregiver know how to, and are they able to, contact 000 in the event of deteriorating symptoms, or TIS if emergency care is not required?
  - Is tertiary care support available for increased home surveillance requirements?

### **Geographical/transport factors**

- Where is the closest emergency medical care, if needed?
- Where is the nearest COVID-19-equipped care environment?
- Does the patient have access to private transport?

## *Determining the appropriate monitoring protocol*

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Once a person has been deemed appropriate for home care, to determine the most appropriate home monitoring protocol, including frequency of review:

- assess – Does the patient have any red flag symptoms? Red flag symptoms and vital signs are suggestive of severe disease, and these patients should be immediately escalated to the jurisdictional hospital-led COVID-19 service for management
- assess – What are the patient's medical and social risk factors?
- determine the patient's current symptom severity and clinical observations.

You will then need to develop and implement a customised management plan.



### Box 3. Red flag symptoms<sup>6-8</sup>

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Vital signs of concern:

- Persistent tachycardia >120 bpm, or in the red or yellow zone of a [standard paediatric observation chart for children](#)\*
- Respiratory rate >30 breaths/min, or in the red or yellow zone of a [standard paediatric observation chart for children](#)
- Pulse oximetry oxygen saturation <92% on room air
- Fever >38°C

Vital symptoms of concern:

- New or worsening breathlessness
  - Syncope or light-headedness
  - Chest pain or tightness
  - Blue lips or face
  - Cold and clammy, or pale and mottled skin
  - Vomiting, significant abdominal pain, or diarrhoea >4 times a day
  - Poor oral intake with significant drop in urine output
  - New onset confusion or carer concern
  - Haemoptysis
  - Severe headache, particularly in children
- 

\*Each state and territory Department of Health might have their own acceptable paediatric observation range.

**Box 4. Risk factors**

<b>Medical risk factors<sup>8,9</sup></b>	<b>Social risk factors<sup>10</sup></b>
<ul style="list-style-type: none"> <li>• Unvaccinated or only partially vaccinated against COVID-19</li> <li>• Age ≥65 years</li> <li>• Aboriginal and/or Torres Strait Islander</li> <li>• Pregnant</li> <li>• Comorbidities:               <ul style="list-style-type: none"> <li>– lung disease, including COPD, asthma or bronchiectasis</li> <li>– cardiovascular disease, including hypertension</li> <li>– obesity (body mass index &gt;30 kg/m<sup>2</sup>)</li> <li>– immunocompromising conditions*</li> </ul> </li> <li>• Chronic kidney disease</li> <li>• Diabetes (type 1 or 2)</li> <li>• Liver disease</li> <li>• Significant neurological disorders, such as stroke or dementia</li> <li>• Some chronic inflammatory conditions and therapies</li> <li>• Significant frailty or disability</li> <li>• Severe mental health conditions</li> </ul>	<ul style="list-style-type: none"> <li>• Low health literacy</li> <li>• Low digital literacy or access to technology</li> <li>• Social isolation</li> <li>• Large household or other members at risk (including carers or children)</li> <li>• Homelessness</li> <li>• Substance use</li> <li>• Risk of violence or neglect</li> <li>• Geographical difficulty in accessing rapid medical support</li> <li>• Specific communities and groups:               <ul style="list-style-type: none"> <li>– people living in aged care facilities</li> <li>– people with a disability</li> <li>– people from culturally and linguistically diverse communities, or with language barriers</li> </ul> </li> </ul>

**Immunocompromising conditions\***

- Primary or acquired immunodeficiency:
  - haematologic neoplasms: leukaemia, lymphoma, myelodysplastic syndromes
  - post-transplant: solid organ (on immunosuppressive therapy), haematopoietic stem cell transplant (within 24 months)
  - immunocompromised due to primary or acquired (HIV/AIDS) immunodeficiency
- Other significantly immunocompromising conditions:
  - immunosuppressive therapy (current or recent)
  - chemotherapy or radiotherapy
  - high-dose corticosteroids (≥20 mg of prednisone per day, or equivalent) for ≥14 days
  - all biologics and most disease-modifying anti-rheumatic drugs (DMARDs)

\*Modified with permission from National COVID-19 Clinical Evidence Taskforce. Pathways to care for adults with COVID-19 (version 1.0). Available at [https://covid19evidence.net.au/wp-content/uploads/FLOWCHART-1-PATHWAYS-TO-CARE-V1.0.pdf?\\_=211104-233547](https://covid19evidence.net.au/wp-content/uploads/FLOWCHART-1-PATHWAYS-TO-CARE-V1.0.pdf?_=211104-233547)

## Symptom severity and clinical observations

Refer to boxes 1 and 2 in 'Home-care suitability assessment' section.

### Box 5. Monitoring protocol

Risk	Definition	Monitoring protocol
Low	<ul style="list-style-type: none"> <li>• Patient aged from 12 years to &lt;65 years (or aged &lt;50 years if Aboriginal and/or Torres Strait Islander) who is fully vaccinated, has no medical or social risk factors and is asymptomatic or has mild symptoms</li> <li>• Patient aged from three months (corrected for prematurity) to &lt;12 years (not yet vaccine eligible), with no risk factors, is asymptomatic or has mild symptoms</li> </ul>	<p>This could be developed in partnership with the patient and carer and should include the following:</p> <ul style="list-style-type: none"> <li>• Activating supports for people in isolation, including medicines, food, mental health services and financial aid – local councils could be engaged to provide these services</li> <li>• Providing information to enable the patient to:               <ul style="list-style-type: none"> <li>– monitor symptoms with <a href="#">daily symptom diary</a></li> <li>– confirm that a support person or carer will be checking on them at least twice a day</li> <li>– request telehealth review if symptoms worsen or if the patient or their carer is concerned</li> </ul> </li> <li>• Telehealth consultation frequency will depend on:               <ul style="list-style-type: none"> <li>– symptoms</li> <li>– patient confidence</li> <li>– clinical judgement</li> </ul> </li> <li>• Consider a brief wellbeing check from the practice every three days if the patient remains symptom free, and increase to daily if symptomatic. This could be carried out by nursing staff and include questions, such as 'Are you okay, better or worse? Would you like a check with the doctor?' – If the patient is feeling worse, or is not improving, a clinical review should be undertaken by the GP</li> <li>• Arrange telehealth (telephone or video) consultation on predicted date for release from isolation to confirm that it is appropriate to release and provide education regarding re-exposure and post-COVID-19 symptoms</li> </ul>

**Box 5. Monitoring protocol (continued)**

Risk	Definition	Monitoring protocol
Medium	<ul style="list-style-type: none"> <li>• Patient aged from 12 years to &lt;65 years (or aged &lt;50 years if Aboriginal or Torres Strait Islander), fully vaccinated, asymptomatic or mild symptoms, but has one medical or social risk factor</li> <li>• Patient aged from 12 years to &lt;50 years, not fully vaccinated, but has no risk factors and is asymptomatic or has mild symptoms</li> <li>• Patient aged &gt;65 years (or aged &gt;50 years if Aboriginal and/or Torres Strait Islander), fully vaccinated with no risk factors and is asymptomatic or has mild symptoms</li> </ul>	<p>This could be developed in partnership with the patient and carer and should include the following:</p> <ul style="list-style-type: none"> <li>• Activating supports for people in isolation, including medicines, food, mental health services and financial aid – local councils could be engaged to provide these services</li> <li>• Arrange for patient to have access to pulse oximeter, and provide education on how to use, and what value to look for, and how and when to report</li> <li>• Ensure patient has written instructions for self-monitoring and symptom reporting</li> <li>• Advise the patient to: <ul style="list-style-type: none"> <li>– monitor symptoms twice daily using a <a href="#">daily symptom diary</a> and pulse oximeter</li> <li>– have a carer phone to check on them twice daily</li> <li>– request telehealth review if self-monitoring suggests deterioration</li> </ul> </li> <li>• Arrange daily brief wellbeing checks from the practice. This could be carried out by nursing staff and include questions, such as ‘Are you okay, better or worse? Would you like a check with the doctor?’ – If the patient is feeling worse, or is not improving, a clinical review should be undertaken by the GP</li> <li>• Arrange telehealth video consultation every 2–3 days or, if symptomatic, at least daily</li> <li>• Arrange telehealth consultation on predicted date for release from isolation to confirm that it is appropriate to release and provide education regarding re-exposure and post-COVID-19 symptoms</li> </ul>
High	<ul style="list-style-type: none"> <li>• If the patient does not meet the criteria for either low or medium risk</li> </ul>	<ul style="list-style-type: none"> <li>• Escalate to the jurisdictional hospital-led COVID-19 service</li> </ul>

Adapted with permission from Community HealthPathways – NSW Collaboration on COVID-19 Case Management – Full Care, 2021.

**Developing and implementing a management plan**

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 might (but not always) include a formal collaboration between the GP and a hospital-led service,\* and should include the following:

- Establishing the date of symptom onset as day zero (or the date of testing, if asymptomatic)
- Educating the patient about indicators for disease progression; in particular, discussing the risk of deterioration in the second week after symptom onset
- The use of a TGA-approved pulse oximeter to self-monitor oxygen saturation (SpO<sub>2</sub>) for patients at higher risk of complications. These might be provided by the hospital-led program or the PHN, or are available for purchase in pharmacies if not provided
- [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, as determined by the monitoring protocol and as per changes in symptoms, 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 '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
  - Consider the availability of other GPs/nurses in the practice
  - Provide contact details for after-hours/medical deputising services or other after-hours services formed in collaboration with the local health district/network
  - Provide details of the National Coronavirus Helpline (1800 020 080) or service engaged for additional care of COVID-19 patients in your jurisdiction, and refer to the online [healthdirect COVID-19 symptom checker](#)
  - If the patient has low English literacy, advise the patient to ring TIS National on 131 450 and ask to be connected to the National Coronavirus Helpline
- Creating an [action plan](#) for the patient and their carers to monitor their symptoms and know when and how to escalate support
- Discussing the care arrangement for other household members and extended family/community members, if the entire household test positive
- Determining if the patient has an advance care directive/plan and/or enduring power of attorney in the event the patient becomes unwell and cannot express their care wishes
- Uploading a shared health summary and sending a medical summary to the hospital-led COVID-19 service (if admitted to such) if the patient has a My Health Record
- Providing the patient written materials reinforcing matters discussed, including monitoring and managing symptoms, medicine management, infection prevention and control procedures, contact details for the practice and contact details for if the treating GP is not available and how and when to seek emergency assistance. The relevant hospital or commissioned health service might already have appropriate material to provide to patients, or you can use the [RACGP's guide, action plan and symptom diary for patients](#). This can be emailed or printed and picked up by a support person for delivery to the patient's home

\*In a rural or remote setting, it might be appropriate to collaborate with all local health service providers (with the patient's consent), including the local hospital, ambulance service and community nurses, in managing COVID-19-positive patients in the community. This ensures all service providers are aware of the patients under surveillance and are part of the support structure.

### **Additional considerations when providing GP shared care for patients admitted to a hospital-led program**

Additional considerations when developing a management plan:

- The patient should be informed that, as the GP, you are providing care for their pre-existing conditions and mental health – all COVID-19-related issues are managed by the hospital-led program team.
- The patient should have the contact details of the hospital-led program and know how to contact them, if needed.
- The patient should be educated that, if their COVID-19 symptoms worsen, they need to contact the hospital-led program (or 000, if necessary).



- The patient should have access to self-monitoring devices, such as pulse oximeters, through the hospital-led program. The patient should be educated by the program on how to use these devices and demonstrate an understanding of what results should be reported and to who.

### **Additional considerations when caring for patients from CALD communities**

If the patient has low English literacy, they can access in-language assistance from the National Coronavirus Helpline by calling TIS National on 131 450 and asking to be connected to the helpline.

Patients, including those from CALD communities, might be fearful of going to hospital (if escalation is required) without the presence of other family members due to COVID-19 restrictions. Encourage patients and their families to ask questions about potential outcomes of COVID-19 early in the diagnosis so that they are fully informed prior to making decisions about their care.

### **Prescription management**

Make sure the patient has access to their regular medicines.

Prescriptions can now be sent directly to patients via SMS or email using electronic prescribing (or uploaded to their Active Script List if they are enrolled). Read more about electronic prescribing and access fact sheets for GPs and patients on the [RACGP website](#). Patients can forward their electronic prescription to their local pharmacy for dispensing and request the medicine is delivered, or forward to a family member or carer to pick up.

Patients can also arrange for a family member or carer to pick up a paper prescription from the practice and have it delivered (ensuring isolation requirements are maintained).

### **Mental health support**

- Assess the patient's mental health and general wellbeing and facilitate additional [COVID-19 support](#) if needed:
  - [In your language](#) resources have been developed by the Transcultural Mental Health Centre for CALD communities
  - Patients from CALD communities can also access language support through the National Coronavirus Helpline by calling TIS National on 131 450
- Encourage patients to remain physically active within their homes during isolation (and within the limitations of their symptoms and disease severity).
- Encourage patients to maintain social contact through phone or video calls. Virtual and phone-based support might be available through local community groups for isolated patients.
- Provide culturally appropriate care.

### Using apps and digital tools to support patient care

A number of apps have been developed to support the care of patients with COVID-19, including remote monitoring.

These apps could be used by hospital-led programs or public health units. Speak with your local public health unit to see if apps are being used to support patients in your area.

If your practice is participating in remote monitoring of patients using digital tools, see the RACGP's [mHealth in general practice](#) resource to ensure effective and secure use of mobile devices.

### Tracking spreadsheet for COVID-19 patient cohort

You or your practice might consider using a patient tracking spreadsheet to give visibility over your COVID-19 patient cohort and tracking their progress.

An example template is [available here](#), and can be adapted for your use.

### Record-keeping

In addition to all clinical consultations, assessments and investigations, GPs should keep a record of all communications with patients and other parties.

## Managing symptoms and medicines

### Box 6. COVID-19 symptoms<sup>1</sup>

The most commonly reported symptoms of COVID-19	Other symptoms
<ul style="list-style-type: none"> <li>• Cough</li> <li>• Dyspnoea</li> <li>• Malaise</li> <li>• Fatigue</li> <li>• Loss of taste and/or smell</li> <li>• Sputum/respiratory secretions</li> </ul>	<ul style="list-style-type: none"> <li>• Headache</li> <li>• Sore throat</li> <li>• Shortness of breath</li> <li>• Myalgia</li> <li>• Rhinorrhoea</li> <li>• Chills</li> <li>• Nausea/vomiting</li> <li>• Diarrhoea</li> </ul>

The current recommendation from the National COVID-19 Clinical Evidence Taskforce is to manage mild COVID-19 in a similar way to seasonal influenza and advising patients to rest.<sup>6</sup>

- Refer to the latest National COVID-19 Clinical Evidence Taskforce clinical flowcharts for the management of adults with mild and moderate–severe COVID-19.
- Make sure the patient continues to receive care for pre-existing conditions:
  - Use inhaled or oral steroids for the management of people with co-existing asthma or chronic obstructive pulmonary disease (COPD) and COVID-19 as you would normally for viral exacerbation of asthma or COPD. Do not use a nebuliser<sup>11</sup>

- Do not discontinue angiotensin-converting enzyme inhibitors or angiotensin II receptor blockers in patients already receiving these medications unless contraindicated<sup>12</sup>
- In people with suspected or confirmed COVID-19, the use of other treatments such as insulin, other diabetes medications, or statins should continue as usual<sup>6</sup>
- In patients with suspected or confirmed COVID-19, only cease or change the dose of long-term immunosuppressants, such as high-dose corticosteroids, chemotherapy, biologics or disease-modifying antirheumatic drugs, on the advice of the treating specialist<sup>6</sup>
- Review the use of oral oestrogen-containing therapies, taking into consideration the patient's disease severity. Patients should not need to stop their gender-affirming hormone therapy<sup>13</sup>

- Consider referring the patient for treatments that are recommended by the National COVID-19 Clinical Evidence Taskforce for patients who meet the criteria and who do not require oxygen. The initiation of these medicines is time-critical, so early assessment and intervention are vital. This could be done in collaboration with the commissioned triaging health service, hospital or infectious disease specialists.
- An antipyretic is generally not required for mild COVID-19, but paracetamol or ibuprofen, as appropriate, can be considered for symptomatic relief. If a patient takes non-steroidal anti-inflammatory drugs for a chronic condition, they should continue taking these.<sup>6</sup>

- Do not prescribe treatments that are not recommended by the National COVID-19 Clinical Evidence Taskforce, including ivermectin.
- Do not initiate dexamethasone or other systemic corticosteroids for the mild treatment of mild COVID-19.<sup>6</sup> However, patients can be discharged from hospital on these, and the GP might need to manage the weaning of such medications, as per the discharge instructions/summary.

- When appropriate, consider simple interventions for mild symptoms according to clinical judgement:
  - intranasal decongestants, isotonic nasal/sinus rinse or intranasal ipratropium for rhinosinusitis
  - keep air warm and humid
  - manage hydration carefully through small regular sips of fluid, and consider oral rehydration salts
- Patients with asthma or COPD should refer to their action plan to guide the use of relievers and when to escalate.
- Patients with diabetes should follow their sick day plans (or have a sick day plan developed), check blood glucose levels (BGLs) more frequently and call for medical advice if BGLs are unstable (noting some patients might be discharged from hospital on oral steroids post-admission for COVID-19).
- Consider pharmacological management of drug or alcohol dependencies if withdrawal is likely during isolation.

## *Ongoing patient symptom monitoring*

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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.<sup>6</sup>

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.<sup>6</sup>

If symptoms do worsen, this is most likely to occur in the second or third week of illness.<sup>6</sup> A checklist to monitor symptoms during follow-up consultations could include the following:

- General observation
  - What is their general appearance?
  - What is their colour?
  - What is their level of comfort or distress?
- Shortness of breath
  - What is the observed respiratory rate?
  - What is the SpO<sub>2</sub>?
  - 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)?
  - Is the patient experiencing diarrhea, vomiting or loss of appetite?

- 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 6](#))
  - 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 the last review? How?
  - Does patient care need to be escalated/de-escalated or continued as is?
- Patients can record and track their symptoms using a [symptom diary](#), and escalate care according to their [action plan](#).



## *Escalating care*

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Patients, other household members and caregivers should be advised to contact the patient's GP or hospital-led service via telephone for advice if symptoms worsen or there are any red flag symptoms (refer to [Box 3](#)). It would be helpful to give patients written information about symptoms to watch out for. 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 must be aware of the patient's COVID-19 status and will relay this to the receiving emergency department.

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

- SpO<sub>2</sub> less than or equal to 92%, even if feeling well
- worsening shortness of breath or difficulty breathing
- blue lips or face
- pain or pressure in the chest
- cold and clammy, or pale and mottled skin
- confusion or fainting
- becoming difficult to rouse
- little or no urine output
- coughing up blood.<sup>6</sup>

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

- ensure they have an [action plan](#) in case of rapid deterioration
- increase the frequency of surveillance
- consider referral to a hospital-led COVID-19 service.

When patients are being cared for in the community by GPs, GPs, the patient and the patient's family/supports can escalate care to ambulance or hospital if they have any concerns, regardless of whether they meet the criteria outlined above.

## Conducting telehealth consultations

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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
- Education and health promotion, including the use of pulse oximetry
- Capturing changes in symptoms of, and trends in, SpO<sub>2</sub>
- Early detection of deterioration requiring hospital admission
- Referral for investigations and surveillance testing
- Screening for the need for an in-home assessment
- 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

Frequency and mode of telehealth consultation (phone or video) will be determined by the management protocol selected based on the patient's identified risk using clinician discretion. It might be appropriate for a nurse to conduct welfare checks and telehealth consultations depending on the severity of illness, the patient's risk factors for deterioration and the practice's business model. Care should be escalated and a clinical review be conducted by the GP if the patient shows any signs of deterioration or if they are not improving.

Additional MBS items are available for services provided for people required to isolate because of a state or territory public health order, [including longer telephone consultations](#), and an [exemption from the 12-month face-to-face rule](#). GPs should be familiar with the MBS requirements for these items – refer to COVID-19 Temporary MBS Telehealth Services information, available at [www.mbsonline.gov.au](http://www.mbsonline.gov.au)

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.

## *Conducting face-to-face consultations*

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Patients receiving home-based care might need a face-to-face consultation. Face-to-face consultation should be limited to when absolutely necessary, to reduce the risk of transmission. While these consultations can be conducted at the patient's home or at a general practice, the public health ramifications of visiting or having a COVID-19-positive patient on site at a practice must be considered in light of requirements in your jurisdiction, including isolation requirements for close contacts and cleaning/decontamination requirements.

Practices should only consider face-to-face consultation with COVID-19-positive patients if the practices have appropriate facilities to enable patient and staff streaming, so as to avoid any direct contact and contamination of areas of usual patient assessment. Clear training and procedures should be in place to avoid any breach of PPE.

GPs who have risk factors for severe COVID-19 should not conduct face-to-face consultations with patients with suspected or confirmed COVID-19. These consultations should only be conducted by healthcare workers who are fully vaccinated.

Prior to conducting face-to-face consultations with COVID-19-positive patients in the practice, the practice should update their risk assessment, taking into consideration the potential impacts of transmission within the practice to staff or other patients.

An [MBS item number](#) has been introduced to support GPs in providing safe face-to-face consultations for COVID-19-positive patients where necessary in the practice, and during home visits and aged care visits.

### **Infection prevention and control**

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

- Consider whether a consultation outside might be practicable. If not practicable:
  - enhance air flow by opening windows and doors (where and when appropriate), and optimising fresh air flow by reducing or avoiding air recirculation
  - consider possible ways to avoid patient contact with staff and other non-COVID-19 patients – this could include having the patient use an allocated entry, waiting in the car until the GP is ready to consult and clearing corridors prior to patient entry
- Prior to seeing a patient with COVID-19, the GP must don appropriate PPE, which must include:
  - gloves
  - P2/N95 mask
  - gown
  - eye protection (goggles or a face shield)<sup>14</sup>

- Consider:
  - the most appropriate location to don and remove PPE
  - how to safely dispose of PPE after the consultation.
- Ensure the patient is wearing a surgical mask.
- Conduct as much of the assessment as possible remotely, and spend only the minimum amount of time as possible in the assessment area with the patient. Maintain physical distancing of at least 1.5 m 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.

### **Additional considerations for face-to-face consultations at a general practice**

If an in-practice consultation is deemed necessary, contact with the patient should be limited only to essential clinicians who have donned [appropriate PPE](#).

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
- remove all soft furnishings (if possible)
- tape a line on the floor 1.5 m 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 might 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, including non-contaminated gloves, a surgical mask and eye protection, before cleaning the consultation room
- removing and disposing of, or laundering, removable fabric items, such as curtains
- 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, and allowing to dry
- wiping down any touched surfaces (including door handles, desktops, stethoscopes and otoscopes)
- mopping the floor
- steam cleaning soft furnishings
- disposing of contaminated waste appropriately in contamination bins
- removing PPE, performing hand hygiene and reapplying PPE to clean reusable cleaning equipment, such as mop handles
- removing PPE and performing hand hygiene.<sup>15</sup>

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

## *De-escalating care*

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- The monitoring protocol and frequency of review can be modified as the patient's condition improves.
- Continue to monitor the patient until they have completed their isolation period and their symptoms have resolved or are mild.
- Arrange follow up with the patient within six weeks to assess for ongoing symptoms and the need for additional support. This is also an opportunity to update management of pre-existing conditions or screening, which might have been impacted by their illness.



## *Providing release from isolation*

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The [Communicable Diseases Network Australia \(CDNA\) National Guidelines for Public Health Units](#) provides criteria for release from isolation:

- Follow the release from isolation requirements in your jurisdiction. Make contact with the local public health unit if you have concerns or queries related to the release. Release from isolation processes differ between jurisdictions, and in some jurisdictions is not within the remit of GPs.
- PCR swabbing is not required for release from isolation, unless indicated or patients are immunocompromised.
- Provide education on the end of isolation and the ongoing relevance of public health orders/directions.
- The CDNA guidelines state that 'routine PCR testing post-release from isolation is not recommended unless the person re-develops clinical features consistent with COVID-19'. However, post-infection testing for new-onset symptoms differs between jurisdictions. Advise the patient accordingly.<sup>1</sup>

## *Vaccination following infection*

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- [ATAGI](#) advises that people with SARS-CoV-2 can be vaccinated as soon as they have recovered from their acute illness or can defer vaccination for up to six months after onset of SARS-CoV-2 if preferred. Some public health orders might mandate earlier vaccination in those who have fully recovered.
- During recovery, patients might require temporary exemption from COVID-19 vaccination – you can record a patient's temporary vaccination exemption to the Australian Immunisation Register using the [immunisation medical exemption form \(IM011\)](#). Refer to the [ATAGI Expanded Guidance on temporary medical exemptions for COVID-19 vaccines](#) for further information on appropriately recording exemptions.

## *Handover to a patient's usual GP*

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If you have provided care for a COVID-19 patient and you are not their usual GP, provide handover back to their usual GP.

## *General advice for the care of pregnant or breastfeeding patients*

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The [Royal Australasian and New Zealand College of Obstetricians and Gynaecologists](#) notes:

- pregnant patients with COVID-19 have a higher risk of morbidity and mortality compared with non-pregnant patients with COVID-19 of the same age, and are more likely to be hospitalised, be admitted to an intensive care unit (ICU) and to require invasive ventilation
- pregnant patients who are overweight or obese (body mass index >30 kg/m<sup>2</sup>), have pre-existing hypertension or diabetes (type 1 or 2) are more likely to suffer severe COVID-19 than women without these conditions
- an increased risk of miscarriage has not been identified for women trying to conceive or those in early pregnancy.<sup>16</sup>

The current recommendations for pregnancy and perinatal care from the [National COVID-19 Clinical Evidence Taskforce](#) (noting these would be considered in collaboration with obstetrics) include the following:

- The use of antenatal corticosteroids for women at risk of preterm birth is supported as part of standard care, independent of the presence of COVID-19.
- The use of magnesium sulfate in pregnancy for fetal neuroprotection for women at risk of preterm birth is supported as part of standard care, independent of the presence of COVID-19.
- The use of magnesium sulfate in pregnancy for the management of severe pre-eclampsia or eclampsia is supported as part of standard care, independent of the presence of COVID-19.
- 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. Respiratory deterioration due to COVID-19 might prompt urgent delivery on an individual basis.
- Early skin-to-skin contact after birth and during the postnatal period is supported, independent of the presence of COVID-19. However, parents with COVID-19 should use infection prevention and control measures (mask and hand hygiene).
- Breastfeeding is supported, irrespective of the presence of COVID-19. However, 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, support rooming-in of mother and newborn in the birth suite and on the postnatal ward when both mother and baby are well. However, women with COVID-19 should use infection prevention and control measures (mask and hand hygiene).<sup>17</sup>

## *General advice for the care of children with COVID-19*

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Currently, no COVID-19 vaccine is TGA-approved for use in Australia for children under 12 years of age.

In Australia, to date, there have been very few hospital admissions required for children due to COVID-19 illness severity. Many children with COVID-19 will be asymptomatic. Common symptoms are similar to those of adults, including rhinorrhoea, cough, sore throat, fever and gastrointestinal symptoms. They might also suffer headaches, myalgia, or loss of taste or smell. They are much less likely to suffer breathlessness, and this symptom should escalate clinical assessment.

While children are significantly less likely to suffer severe COVID-19 than adults, a condition provisionally named 'Paediatric Inflammatory Multisystem Syndrome Temporally associated with SARS-CoV-2' (PIMS-TS) has been described in settings with significant community transmission. PIMS-TS usually presents 2–6 weeks after the acute infection, and should be suspected in a child or adolescent with persistent fever (lasting more than 72 hours) and inflammatory symptoms with a background of recent or current COVID-19 infection. It has been described as severe illness with fever and significant inflammation, often with abdominal pain, rash or shock.<sup>18</sup>

If PIMS-TS is suspected, early transfer to a paediatric hospital with ICU facilities should be considered due to potential for rapid deterioration.

The [National COVID-19 Clinical Evidence Taskforce](#) provides recommendations for children and adolescents in regard to disease-modifying treatments, chemoprophylaxis and respiratory support.

In most cases, only children meeting criteria for the low-risk monitoring protocol (refer to [Box 5](#)) should be managed in the community. It might be appropriate for GPs to care for children with moderate risk factors depending on local requirements, resources and escalation pathways.

## *Additional resources*

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### **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](#)

### **Australian Government 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](#)
- [ATAGI clinical guidance on COVID-19 vaccine in Australia in 2021](#)
- [Australian Government's Translating and Interpreting Service \(TIS\)](#)

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