

# SESLHD PROCEDURE COVER SHEET



**Health**  
South Eastern Sydney  
Local Health District

<b>NAME OF DOCUMENT</b>	Caring for COVID positive patients in the community
<b>TYPE OF DOCUMENT</b>	Procedure
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<b>FUNCTIONAL GROUP(S)</b>	Clinical Governance Clinical Access Medicine
<b>KEY TERMS</b>	COVID-19-HITH – Hospital in the Home CTAC – COVID-19 Telephone Assessment Clinic RMS – Remote monitoring service SHA – Specialised Hospital Accommodation TCC-COVID – TCC App specifically modified for use in monitoring of COVID-19.
<b>SUMMARY</b>	The document outlines the process, roles and responsibilities of the COVID-19 Community Management Centre (CMC) in the care of all COVID positive patients in the community.

## **COMPLIANCE WITH THIS DOCUMENT IS MANDATORY**

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#### 1. POLICY STATEMENT

This document is a procedural guide to the South Eastern Sydney Local Health District (SESLHD) process for the management of COVID positive patients that are clinically safe to be managed in the community. This policy adheres to the [ACI – Caring for adults with COVID-19 in the community guide](#).

#### 2. BACKGROUND

SESLHD has adopted the use of remotemonitoring of patients who are COVID-19 positive and clinically safe to be managed in the community. Management of patients in the community enables people to stay out of hospital and will contribute to preserving hospital capacity if demand for services increases.

People who test positive to COVID-19 may be managed safely in the community. Most people infected with the COVID-19 virus will experience mild symptoms and recover without requiring special treatment. However, some people will experience moderate or severe disease. Older people and those with underlying diseases or medical conditions (such as cardiovascular disease, diabetes, chronic respiratory disease and cancer) are more likely to develop serious illness that require special care and treatment. However there have been cases of deterioration in the community that have been rapid and unexpected in patients who are otherwise well, therefore all COVID positive cases should be offered care by a clinical team, until they meet the criteria for release from isolation.

The COVID Community Management Centre (CMC) includes a remote monitoring service for COVID positive patients in SESLHD. COVID-19 positive cases will be assessed and triaged by the CMC clinical team to determine the risk of deterioration and/or hospitalisation at the time of referral at a district level. COVID-positive cases will be stratified according to clinical risk (Risk Matrix in Appendix A), with the highest risk patients assigned to the most geographically appropriate team.

Low/medium risk patients will be managed centrally by the COVID-CMC. High/very high risk patients will be managed by the local hospital COVID-19 Telephone Assessment Clinic (CTAC). GP shared care and communication pathways will be incorporated as a fundamental component of the low risk community care model.

All patients will receive a finger pulse oximeter and those suitable will be registered on the TCC-COVID App for remote monitoring at home. The Remote Monitoring Service (RMS) will function as a diagnostic service responsible for onboarding, alert validation and escalation of clinical deterioration to the clinical team within defined time frame. Patients who are not able to, or chose not to utilise the TCC-App will be assigned to their local clinical team who will contact regularly for manual reading using their oximeter.

The TCC-COVID system allows for the automated delivery of daily symptom questionnaires and the continuous remote monitoring of physiological data with real-time feedback to the patient and hospital-based RMS. At onboarding, the local treating COVID-19 team will prescribe individualised parameters for symptom

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deterioration, pulse rate and SpO2, and variances that will trigger an alert. Alerts will also be triggered if the patient fails to submit their physiological data.

The TCC Alert Management System has been designed to send all alerts to the RMS team who will validate the alert and then refer on to the local COVID-19 teams to action an appropriate care plan. The RMS will have oversight over these processes.

Each patient will be actively monitored via the TCC-COVID app for up to 14 days. Monitoring will cease when either (1) the patient meets clinical criteria for recovery and has been informed by the treating team that they can leave isolation; or (2) if the patient requires hospitalisation.

Service outcomes:

- Home monitoring of COVID positive patients to meet demand
- Reduced unnecessary ED presentation of COVID positive patients
- Reduced unplanned hospitalisation of COVID positive patients with unexpected deterioration
- Automated alerts for deterioration allowing the clinical team to prioritise the most at risk

**2.1 Definitions**

<b>Term</b>	<b>Definition</b>
<b>CHOC</b>	Community health and outpatient care program (electronic medical record system)
<b>CoPS</b>	COVID Practical Support Service: Allied Health led service providing practical support to patients to help with basic needs such as food and arrangements for pet care. This is a standalone service during periods of high activity. When COVID community activity is low this service is delivered by SHoC.
<b>COVID-19</b>	Coronavirus disease 2019. The name of the disease caused by the virus SARS-CoV-2.
<b>CMC</b>	Community Management Centre – COVID patients
<b>CTAC</b>	COVID-19 Telehealth Assessment Clinic
<b>ED</b>	Emergency Department
<b>eMR</b>	Electronic Medical Record
<b>GP</b>	General Practitioner
<b>HITH</b>	Hospital in the Home
<b>ID</b>	Infectious Diseases
<b>IPM</b>	Inpatient Manager
<b>Kiola</b>	Electronic Data Capture system used to collate self-reported patient measurements and assessments
<b>MRN</b>	Patients medical record number
<b>MyVC</b>	My Virtual care telehealth platform for audio-visual connection with clients
<b>NM</b>	Nurse Manager
<b>Pexip</b>	Customisable video conferencing software for telehealth

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<b>PFP</b>	Patient Flow Portal (new PFP build is the Community COVID list)
<b>PHU</b>	Public Health Unit
<b>POW</b>	Prince of Wales Hospital, Randwick
<b>RMS</b>	Remote monitoring service – monitoring and responding to alerts generated by patients using the TCC-COVID app to enter their data.
<b>RN</b>	Registered nurse
<b>SESLHD</b>	South Eastern Sydney Local Health District
<b>Service Event form</b>	Electronic form in CHOC for capturing of non-admitted patient activity to be completed by clinician
<b>SGH</b>	St George Hospital, Kogarah
<b>SHoC</b>	Social Harms of COVID: Social work led response team for supporting COVID positive cases and close contacts required to isolate. When COVID community numbers are low, this service incorporates the CoPs service to provides practical support to patients to help with basic needs such as food and arrangements for pet care.
<b>SpO2</b>	Peripheral oxygen saturation
<b>TCC-COVID</b>	TeleClinical Care (TCC) App specifically modified for use in monitoring of COVID-19 patients in the community
<b>TSH</b>	The Sutherland Hospital, Sutherland

### 3. RESPONSIBILITIES

#### 3.1 Clinical care team staff will:

- Conduct initial intake conversations for patients identified on the CMC intake list
- Coordinate triage of initial clinical risk level including documentation in eMR and patient flow portal – low, medium, high, very high
- Refer patients to the appropriate clinical team based on risk level
  - Refer low to moderate risk patients to RMS using the eOrder form
  - Refer high to very high-risk patients to local CTAC HITH +/- RMS
- Define and communicate to the RMS individual patient parameters at onboarding
- Schedule and conduct welfare check on patients isolating at home according to protocol risk matrix Appendix 1
- Complete social work referrals as required
- Team member on duty for escalations for CMC patients - to receive alert escalations and decide actions to take and refer to local CTAC HITH as required
- Decision to de-isolate and discharge from the CMC service
- Confirm when patient meets clinical criteria to discharge and complete paperwork

#### 3.2 Clinical Care team leaders will:

- Roster clinical care team
- Escalate any operational issues that require support / resourcing
- Manage the day-to-day activities including:
  - Leading the twice daily huddles
  - Monitoring the CMC intake list and allocating referrals for action

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- Monitoring the CMC patient list and allocating welfare checks and follow ups
- Allocating escalations team member each shift
- Manage staff access to all required systems and documentation locations
- Assess new clinical team members
- Complete of quality assurance audits to ensure admissions, progress, escalation and discharge reviews completed by clinical care team members are correct.

#### 3.3 Administration team will:

- Receive referrals from the patient flow portal (PFP)
- Undertake patient registration for COVID positive patients that do not have a SESLHD eMR
- Register new patients on the CMC intake patient list
- Schedule intake, follow up and discharge phone consultations
- Once intake is complete transfer patients from CMC intake list to either CMC patient list or admit to local CTAC
- Notify equipment hub when a new patient requires pulse oximeter. Send SMS for Appdownload and ID entry for RMS patients
- Answer and coordinate allocation of telephone calls
- Manage myVC waiting room; appointments and scheduling.

#### 3.4 Administration team lead will:

- Roster administration and equipment hub teams
- Escalate any operational issues that require support / resourcing
- Manage the day-to-day activities including:
  - Leading the twice daily huddles
  - Monitoring the patient flow portal and allocating referrals for eMR registration
  - Monitoring the CMC intake list and allocating completed assessments for further processing
  - Monitoring the oximeter stock management, levels and procurement
- Managing staff access to all required systems and documentation locations
- Assess new administration and equipment hub staff
- Complete quality assurance audits to ensure IPM registrations are correct.

#### 3.5 Equipment hub team will:

- Arrange for oximeters to be couriered to patient once they have received advice from admin team member
- Coordinate oximeter courier services
- Prepare patient info packages, oximeter, resource packs and return paid envelopes for delivery
- Test oximeters to ensure working prior to dispatching
- Clean returned pulse oximeters and replace batteries as required.

#### 3.6 RMS Operators will:

- Complete onboarding of new referrals onto the KIOLA system for monitoring
- Ensure the patient is able to submit the required information needed using the provided oximeter and understands the frequency and timing of submissions

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- Monitor a cohort of patients and acknowledge automated alerts within KPI timeframes
- Follow process to validate alerts, document and escalate accordingly
- Confirm that the clinical team has responded to the alert/escalation within set timeframe and enter data to close off the alert with response
- Work as part of a team to ensure delegated tasks and referrals are completed and all alerts are appropriately documented prior to the end of each shift
- Document appropriate information in medical record and KIOLA
- Escalate any alerts unactioned through team lead or shift supervisor to appropriate clinical team.

### 3.7 RMS team leaders will:

- Roster RMS Operators
- Escalate any operational issues that require support / resourcing
- Manage the day-to-day activities including:
  - Leading the twice daily huddles
  - Monitoring the TCC-COVID Inbox and allocating referrals for action
- Manage staff access to all required systems and documentation locations
- Assess new RMS Operators
- Complete quality assurance audits to ensure data transcriptions completed by RMS Operators are correct.

### 3.8 CMC Service Manager will:

- Assist clinical care, RMS and admin team leads with rostering of staff
- Ensure all staff are up to date with relevant training for their role in the CMC
- Audit CMC documentation compliance as determined by QARS schedule (in conjunction with clinical care NUM, admin and RMS team leads)
- Manage staff access to all required systems and documentation locations.

### 3.9 CMC Clinical Director will:

- Support CMC staff if there are clinical concerns or deterioration and assist in determination of patient suitability to remain at home
- Provide policy guidance.

### 3.10 IT Support will:

- Provide patient IT support for app use as required
- Support RMS staff with any level 1 IT support and equipment issues.

### 3.11 CTAC COVID HITH teams

- Define and communicate to the RMS individual patient parameters at onboarding and at any point in the patient journey as required
- Receive alert escalations and decide actions to take
- Confirm when patient meets clinical criteria to discharge
- Conduct welfare checks on patients isolating at home
- Review all yellow and red alerts, and escalate to the MO as required

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- Complete social work referrals as required
- Decide when patients are to de-isolate and discharge from the CTAC service.

#### 4. PROCEDURE

##### The CMC will:

- Receive referrals from the patient flow portal (PFP)
- Register new patients in IPM and the CMC intake patient list
- Perform intake assessment for all COVID positive patients in SESLHD
- Coordinate triage of initial clinical risk level including documentation in eMR and patient flow portal –medium, high, very high
- Refer patients to the appropriate clinical team based on risk level
- Arrange delivery of pulse oximeter and send SMS for App download and ID entry
- Monitor patients with COVID 19 whilst isolating at home via TCC-COVID app and welfare phone calls
- Escalate alerts to the appropriate clinical team for follow up
- Discharge patients from isolation

#### 4.1 Patient referral

On allocation from the PFP the SESLHD CMC administration team will register patients to eMR and the CMC intake list and schedule an intake appointment. The CMC clinical team will perform the intake/ admission assessment to the SESLHD COVID service. The CMC clinical team will risk assess the patient and refer according to the risk level: low/medium risk referred to the C M C community care model or high/very high risk referred to the hospital in the home (CTAC) model of care. If the patient is to be admitted to their local CTAC HITH, the clinical team should call for a verbal handover. The intake team will also decide if the patient is appropriate for referral to the RMS. The intake process will be documented in eMR. The Clinical care team member will check the patient out of their intake appointment after completion and notify the admin team via [SESLHD-CMC-admin@health.nsw.gov.au](mailto:SESLHD-CMC-admin@health.nsw.gov.au).

Once the intake appointment has been completed an admin team member will review the medical record. The admin team will remove the patient from the intake list and transfer to either the CMC patient list (if low/moderate risk) or admit to the local CTAC HITH. They will also notify the equipment hub team if pulse oximeter delivery is required and submit an eOrder for referral to the TCC-COVID RMS.

All SESLHD COVID positive patients will be sent a pulse oximeter (one per household). The pulse oximeters are couriered to patients via the equipment hub along with CTAC, RMS and wellbeing information packages, and a reply paid envelope for return of the oximeter on discharge.

Patients who require psychosocial or practical supports identified on intake and

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ongoing assessments will be referred accordingly to social harms of COVID (SHoC), practical supports in COVID (CoPs), mental health service, drug and alcohol services and child and family services as needed.

### 4.2 Daily assessment and monitoring

#### The monitoring activities for patients on the RMS arm include:

- Patient completes a wellbeing and symptom questionnaire, SpO2 and heart rate every morning at 8am and every afternoon at 4pm
- Automated educational messages sent daily to patient
- Alerts monitored daily using KIOLA by RMS Operators
- Alerts are validated and escalated as required
- All escalated and patient reported observations are documented in the patient's eMR as required

#### There are three types of alerts:

##### 1. Yellow Alerts:

- a. This includes temperature between 38°C or unable to record temperature but have felt feverish, feeling a lot worse, SpO2 between 90-94% inclusive, heart rate between 120-139bpm inclusive, diarrhoea/vomiting > 4 x per day, chest pain or 24 hours since last data entry (i.e. 1 missed assessment)
- b. Must be referred by RMS team within 2 hrs of alert generation to CTAC/CMC who must act within 4 hrs of alert generation (6 hrs overarching)

##### 2. Red Alerts:

- a. This includes temperature > 39.5°C, SpO2 < 90%, heart rate ≥ 140bpm, syncope or 32 hours since last data entry (i.e. 2 missed assessments)
- b. Must be referred by RMS team within 1h of alert generation to CTAC/CMC who must act within 2 hrs of alert generation (3 hrs overarching)

##### 3. Emergent Alert:

- a. This includes SpO2 ≤ 85%
- b. Must be followed up within 15 minutes of alert generation
- c. If alert confirmed follow steps in [4.3 Code Blue Telehealth assessment](#)

The CTAC HITH or CMC clinical care team (on advice of a MO as required) can request an amendment to the alert criteria for individual patients if a large number of alerts are received that are not considered clinically important, in relation to their concurrent medical conditions. To enable the altered criteria to be set for the patient on the app within KIOLA, this should be emailed to [SESLHD-TCC-COVID@health.nsw.gov.au](mailto:SESLHD-TCC-COVID@health.nsw.gov.au)

Patients will also receive phone calls to check on their welfare and health, the frequency will depend on their risk category and whether they are on the RMS or non-RMS arms as per the SESLHD risk matrix (see Appendix 1). Patients on RMS and CMC will receive welfare and wellbeing checks via phone or video calls low risk q7 days and medium risk q4 days. Non-RMS patients will be admitted to the local CTAC.



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The clinical team will educate the patient on the importance of maintaining home isolation. Patients should be provided with the details of the CMC to contact for advice or concerns during hours of 0800-2000hrs, 7 days per week

### 4.3 Code Blue Telehealth assessment & deterioration process

If staff are on a Telehealth assessment consult and the patient is clinically compromised and/or observations meet emergent alert criteria (SpO<sub>2</sub> ≤ 85%) staff should: Inform patient that you will be dialling Ambulance 000, and on the call to dispatch operator provide the following:

- Patient name, address and DOB and their contact details
- Who you are and that you are calling from CMC
- Inform the dispatch operator that the patient is COVID positive
- Inform of clinical symptoms as requested by the dispatch operator and any other additional information related to the patient.
- Inform the local hospital Emergency department (ED) and the bed manager if able to give pre-arrival information.

### 4.4 Escalation after hours

Patient will need to be informed that there is no after-hours remote monitoring.

If the patient feels worse after hours, they will need to call ambulance 000 and inform them that they are COVID-19 positive.

### 4.5 Communication with patients from culturally and linguistically diverse backgrounds

If a patient requires an interpreter the following services are available to CMC staff to utilise:

- Sydney Health Care Interpreter Service (SHCIS) - [www.slhd.nsw.gov.au/interpreters](http://www.slhd.nsw.gov.au/interpreters)
  - 24-hour, 7 day a week service
  - Bookings for an appointment must be made in advance by contacting the service on 9515 0030
  - Able to attend myVC video calls
  - Email contact SLHD-Interpreters@health.nsw.gov.au
- Translating and Interpreting Service (TIS)
  - National service with instant access to an interpreter (no need to book)
  - 24-hour, 7 day a week service
  - Phone calls only
  - Can be added to a video call manually – only from PEXIP refer to Appendix D for instructions on how to do this
  - Contact number = 131 450
  - Account details

<b>Name of account</b>	SESLHD COVID services
<b>ATIS account number</b>	659690
<b>ATIS access number</b>	1212

Current app languages: English

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Translations underway: You will be notified when these become available Arabic, Bengali, Simplified Chinese (for Mandarin and Cantonese speakers), Nepali, Portuguese and Spanish.

When the referral indicates that the patient has a preferred language other than English, the RMS Operator must first check that the app is available in the preferred language. If not, the RMS Operator must inform the referrer and cannot onboard. If the app is available in the relevant language, the RMS Operator must contact the patient using the Translating and Interpreting Service (TIS). To join TIS to a call you must use Pexip. Refer to the Operations Manual for detailed instructions and account details.

### 4.6 Discharge

Please note that due to the evolving situation/advice this document may not hold current information/direction. Last reviewed/updated Monday 29th September 2021. For most up to date information see [COVID-19 National guidelines for public health units](#).

Patients can be released from isolation and discharged from the CMC by a medical officer or registered nurse in the clinical care team if they meet any of the following criteria:

- If not significantly immunocompromised and has remained asymptomatic - release from isolation 14 days after the positive test
- If not significantly immunocompromised and symptomatic – release from isolation 14 days after the onset of symptoms, if no fever for at least 72 hours and acute respiratory symptoms have been substantially improved for 72 hours
- If not significantly immunocompromised and symptomatic but fever not resolved and/or acute respiratory symptoms not substantially resolved for three days, release from isolation 20 days after onset of symptoms.

The release from isolation should be documented in the patient's eMR and they should be sent a clearance from isolation letter (Appendix 2).

The RMS Operators will then discharge patients from KIOLA on advice from the referring clinical team. The admin team will discharge patients from the CMC client list on advice from the CMC clinical team.

### 4.7 eMR Documentation

- **eMR (PowerChart / CHOC)**

Document:

- Initial intake assessment
- For low and medium risk patients that are managed in the CMC model, document any alerts received and the action taken
- For high and very high risk patients that are managed in the HITH CTAC model at the relevant site, the RMS will document all daily observations and questionnaire responses submitted for each patient in the progress notes, including the action taken

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- Ongoing follow ups and wellbeing checks
- Release from isolation
- Discharge summary
- Service event form for all patient contacts in the CMC
  
- **KIOLA**  
 Document when:
  - An alert has been responded to
  - An escalation to the relevant clinical team has occurred
  - A confirmation of the action taken by the clinical team has occurred i.e. Admission, continued monitoring

Documentation will be audited regularly by the Service Manger (NM) and the team leads to ensure compliance with documentation standards.

### 5. DOCUMENTATION

Number	Policy/Procedure/Guideline/Business Rule
1	SESLHD CMC Operations Manual (Draft Version)
2	SESLHD RMS Operations Manual (Draft Version)
3	Clinical Excellence Commission (CEC) <a href="https://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19/COVID-19-IPAC-manual">https://www.cec.health.nsw.gov.au/keep-patients-safe/COVID-19/COVID-19-IPAC-manual</a>
4	NSW Ministry of Health Guideline GL2018_020 - Adult and Paediatric Hospital in the Home Guideline <a href="https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_020">https://www1.health.nsw.gov.au/pds/Pages/doc.aspx?dn=GL2018_020</a>

### 6. COMPLIANCE

- CMC staff will complete mandatory MHL learning module: Infection Prevention & Control Principles for Clinical Staff.
- CMC staff will complete MHL learning module: Between the Flags Tier 1 & 2.
- CMC staff will read this Procedure. CMC Service Nurse Manager will keep local compliance report.
- The CMC staff will keep up to date on systems changes and updates for eMR and KIOLA (for RMS staff)

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### 7. AUDIT AND REPORTING

Audit and Reporting Requirements	Frequency	Format	Relevant information
TCC-COVID Activity	<b>Monthly</b>	Activity report	Include: onboarding, discharges, average LOS, count of direct hospital admissions
No of patients who fit criteria for escalation to clinical teams	<b>On event</b>	Relevant clinical team notified via escalation process followed as per operations manual	Count of patients identified for escalation and action taken ie. Admitted to hospital or referred back to service for continued monitoring
Patient experience	<b>Bi-monthly</b>	Survey report generated via QARS	
TCC-COVID audit. This audit includes: - A check that data in KIOLA is in eMR correctly	<b>Monthly</b>	Report document	When a new RMS Operator is employed, a sample audit of their clinical documentation must occur in the first week. Ongoing, a monthly sample audit in line with the number of RMS Operators employed i.e. 40 RMS Operators = 40 sample audits
Clinical care team audits	<b>Monthly</b>	Report document	Completion of quality assurance audits to ensure admissions, progress, escalation and discharge reviews completed by clinical care team members are correct
Administration team audits	<b>Monthly</b>	Report document	Completion of quality assurance audits to ensure IPM registrations are correct

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### 8. REFERENCES

Number	Reference
1	<a href="#">SESLHD COVID-19 website</a>
2	<a href="#">NSW Health COVID-19 website</a>
3	COVID Community Care SESLHD Website: <a href="https://www.seslhd.health.nsw.gov.au/covid-community-care">https://www.seslhd.health.nsw.gov.au/covid-community-care</a>
4	TCC-COVID SESLHD Website: – <a href="https://www.seslhd.health.nsw.gov.au/tcc-covid">https://www.seslhd.health.nsw.gov.au/tcc-covid</a>
5	ACI - Caring for adults with COVID-19 in the community <a href="https://aci.health.nsw.gov.au/data/assets/pdf_file/0010/670528/ACI-Caring-for-adults-with-COVID-19-in-the-community.pdf">https://aci.health.nsw.gov.au/data/assets/pdf_file/0010/670528/ACI-Caring-for-adults-with-COVID-19-in-the-community.pdf</a>
6	<a href="#">Coronavirus Disease 2019 (COVID-19) CDNA National Guidelines for Public Health Units</a>
7	<a href="#">Agency for Clinical Innovation – Telehealth Guidelines (Telehealth in practice)</a>

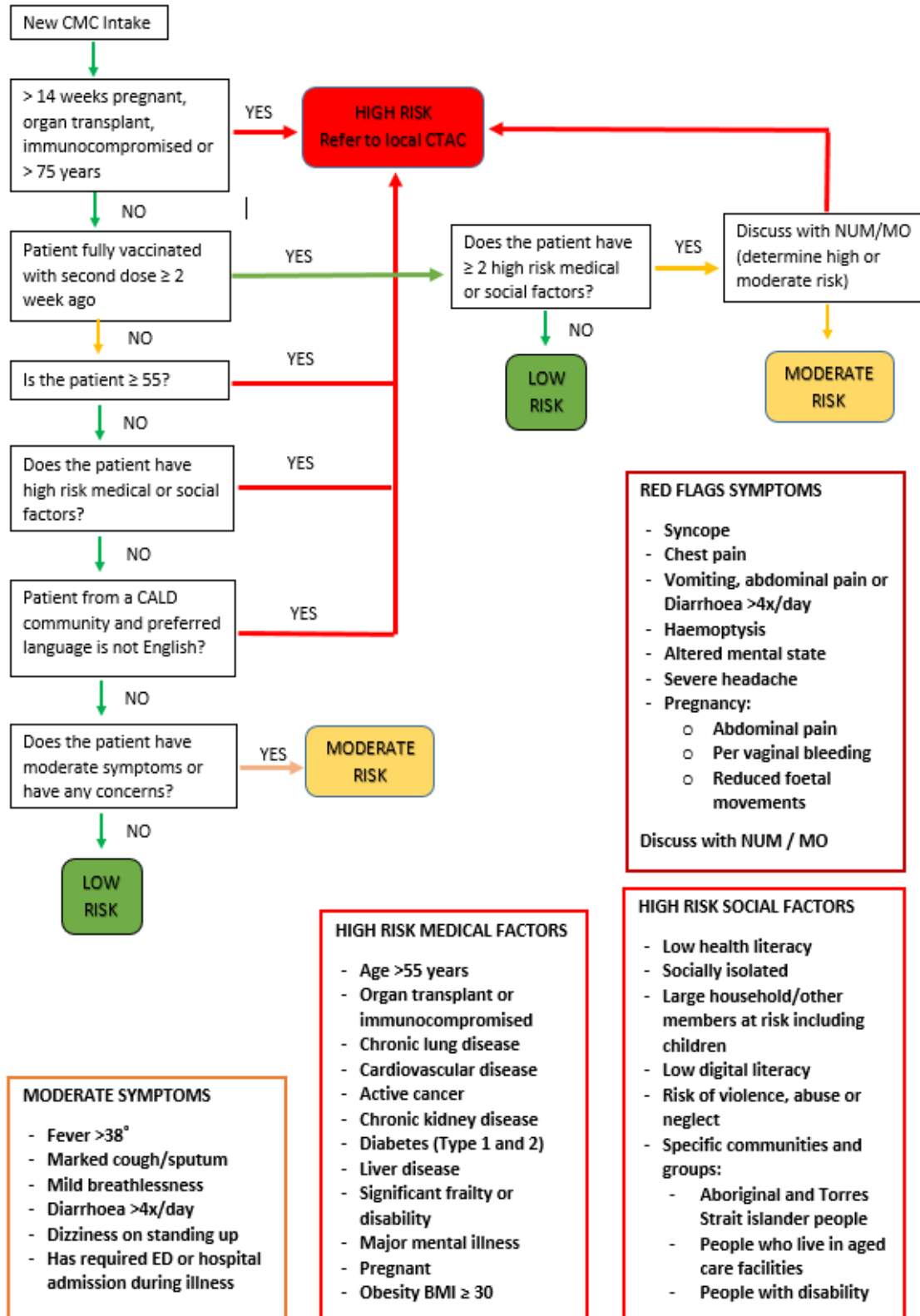
### 9. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
October 2021	1	Drafted by Kristen Overton and approved for interim publishing by Executive Sponsor to publish.
November 2021	2	Draft for comments period. Comments incorporated and final version approved by Executive Sponsor. To be tabled at Clinical and Quality Council for approval. Approved at Clinical and Quality Council.

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APPENDIX 1: Risk Matrix



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### APPENDIX 2: Isolation release paperwork

#### Medical Clearance Notice under *Public Health (COVID-19 Self-Isolation) Order (No 3) 2021 [NSW]*

To Whom It May Concern,

<<NAME>> DOB: <<DOB>> of <<Address>> was required to self-isolate under the *Public Health (COVID-19 Self-Isolation) Order (No 3) 2021 [NSW]*, or an order that remakes that order, (the Order) to prevent transmission of COVID-19.

This notice confirms <<NAME>> has been assessed under that Order as no longer infectious for COVID-19 and is medically cleared under the Order.

As <<NAME>> has been medically cleared from COVID-19, for 6 months from the date of this notice in NSW they:

- are taken, under any NSW public health order to be fully vaccinated,
- are taken, under any NSW public health order to have meet any testing requirements
- will not need to self-isolate as a close contact of COVID-19 case

However, if <<NAME>> is subject to a direction under a NSW Public Health Order requiring a person to show their vaccination evidence or testing documentation to certain persons, such as NSW Police, NSW Health, the occupier of the premises or the person's employer, this notice must be produced on request.

For further details, about this medical clearance notice see <https://www.health.nsw.gov.au/Infectious/factsheets/Factsheets/recovery.pdf>

Yours sincerely

<<NAME>>

Medical Practitioner / Registered Nurse

DATE: <<date of letter generation>>

