# COVID-19 Assessment Clinics

## Guideline for the Establishment and Operation of COVID-19 Assessment Clinics

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| **Consultation**     | Respiratory Community of Practice  
                        Emergency Department Community of Practice  
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| **Endorsed by**      | Joanne Edwards, Deputy Incident Controller, State Health Emergency Operations Centre (SHEOC) – COVID-19 |
| **For use by**       | This document provides guidance for the establishment and operation of COVID-19 Assessment Clinics (CACs) for NSW Health facilities during the COVID-19 response, which we anticipate will overlap with seasonal influenza in NSW. These guidelines recognise that individual facilities and local health districts (LHDs) will need to tailor their response to local patterns of disease and available resources. For those facilities that elect to establish a CAC, this document provides high level guidance. These guidelines should be used by NSW Health LHDs and facilities to support pandemic planning for the COVID-19 response. |
OVERVIEW

About this document

COVID-19 Assessment Clinics (CACs), are similar to a fever or flu clinic concept. They provide an acute respiratory infection clinic pathway which diverts mild to moderate cases of respiratory illness from the emergency department (ED).

CACs had the following functions when community transmission of pandemic influenza was widespread:

1. Providing care at a time when General Practice capacity is also stretched
2. Providing easier access to testing to those with COVID-19 symptoms who are at risk of severe illness, for both individual and population health benefits
3. Minimising the transmission of COVID-19 within the emergency department

Unlike an influenza pandemic, there is currently no specific antiviral treatment recommended for COVID-19 and therefore the function of CACs is focused on functions 1 and 3. However, with the potential overlap between COVID-19 and seasonal influenza in NSW, CACs may still play a role in supporting diagnosis and management of seasonal flu with antivirals.

All Local Health Districts (LHDs) and Specialty Health Networks (SHNs) need to plan for how they will manage a significantly increased level of ED presentations for respiratory illnesses over a 10-12 week period which may coincide with peak influenza season at all their EDs. Community spread of COVID-19 may impact different areas of the state at different times, and as such, LHDs and SHNs are responsible for monitoring the need for these additional pathways and ensuring they are promptly activated. The establishment of a CAC may be appropriate, and all LHDs, facilities and EDs should consider how they would establish and manage a CAC and the related support functions in their planning.

It is not appropriate to divert all patients with COVID-19 symptoms to a separate clinic if they require specialist ED care for another reason or are seriously ill with respiratory distress (e.g. trauma, cardiac arrhythmia, and mental health issues). EDs and health facilities will need to have appropriate plans to manage such patients. It should be recognised that patients presenting with other symptoms may also have COVID-19. Hence it is important that there is an enhanced focus on infection prevention and control in the ED.

An important learning from the 2009 pandemic is that staff will need to be sourced from areas with less demand. This also applies to the staffing considerations for the CAC. Operational support to the ED should be prioritised to support the healthcare outcomes of all patients presenting to the ED at a time of increased demand. LHDs and SHNs will need to allocate staffing resources accordingly.

The Public Health Emergency Department Surveillance System and Patient Flow Portal will be monitored during the response to assist in identifying areas that may be under increased stress.
Considerations

The COVID-19 virus is likely to co-circulate with influenza and other viruses causing respiratory disease. As such, it is unlikely that a patient presenting with influenza like illness (ILI) will be able to have a definitive diagnosis based on symptomatology alone. As such, clinics should be alert to alternate diagnoses, including:

- influenza
- bronchiolitis
- croup, and
- bacterial pneumonia.

The anticipated increase in demand on critical care facilities due to the impact of COVID-19 also places greater importance on early initiation of antiviral treatment in patients with influenza.

OBJECTIVES

The objectives of a CAC or respiratory assessment pathway for autumn/winter 2020 is to:

- decrease patient presentations to EDs, thereby allowing these departments to continue their core business and reduce the risk of transmission to staff and patients within ED settings
- minimise the risk of spread of disease in hospitals, and to ensure that those staff who are allocated to the assessment and care of COVID-19 and influenza patients maintain optimal infection control.

GOVERNANCE

Each facility hosting a CAC needs to assign responsibility for governance of the clinic to an appropriate clinical service.

In general, this responsibility should not be placed on the ED as the aim of the clinics is to unburden EDs, rather than placing an additional burden upon them. EDs may be particularly busy during the COVID-19 response due to a higher-than-normal case load than previous winters of patients who are severely ill, directly or indirectly related to COVID-19 or seasonal influenza.

Wherever possible, staff for the COVID-19 clinic should not be sourced from EDs.

ACTIVATION

Activation of a CAC is considered in alignment with an emergency response.

Operations should commence when the numbers of people presenting with an ILI impedes the capacity of the ED to properly function. In any particular facility, this may vary from week to week, and health services need to have the flexibility to establish, and stand down, a CAC short notice.
OPERATIONS

The operational model for clinics will be one more similar to a primary care clinic than a hospital ED.

The collection of samples will be undertaken by the CAC clinical staff.

Patient assessment and management will be determined by the clinical condition of the patient. If patients require further investigation such as medical imaging or admission, they should be transferred to the ED or internal inpatient teams for ongoing management.

Times of Operation

The operating hours of clinics will depend on usual ED attendance patterns and local availability of staffing.

Operational Requirements

All CACs will be required to:

- screen all attendees to ensure they are catering for lesser acuity respiratory tract infections
- obtain and document full set of physical observation including blood pressure
- provide patients with a surgical mask and alcohol-based hand gel prior to entering the CAC
- adhere to management algorithms
- supply suitably qualified clinical staff to:
  - assess the patient
  - provide appropriate management, and
  - decide on their disposition (discharge to a home setting with appropriate advice, transfer to the ED, or arrange a direct-to-ward admission)
- have access to interpreter services and speaker phones for the discussion to occur.
- transfer patients who need a higher level of emergency care to the ED or hospital ward, if required

All EDs will require:

- a process to screen patients and triage through regular ED processes or
- refer patients directly to the CAC location so they do not enter main ED area (this may be a physical screening station or displaying prominent signage).

Site Selection and Layout

When assessing potential sites for CACs, consideration should be given to the following:

- **Location**: CACs may be located in either a temporary or existing structure, ideally located within the hospital, or multi-purpose services.
• **Waiting areas:** Waiting areas should be protected from the elements and be set up in such a way that suspected cases are encouraged to remain at least 1.5 metre apart.

• **Layout:** Where possible, the layout should encourage a unidirectional flow of people to prevent infectious patients (patients with COVID-19) from re-entering lower risk areas, such as waiting areas or ED.

• **Utilities:** A reliable water and electricity supply, adequate hand washing facilities, a telephone and reliable internet access (see ‘Material Resources’ below).

• **Accessibility:** Nearby parking facilities are required and wheelchair access is desirable.

**Case Definition (for Testing)**


The case definition for COVID-19 patients evolves as new evidence emerges. CACs will need to monitor the case definition to ensure they are appropriately managing patients during the pandemic response.

**EQUIPMENT**

Minimum requirements for CACs include:

• adequate supplies of consumables to perform primary assessment, diagnosis and management in accordance with clinical protocols. This includes the following:
  
  o surgical masks for patients
  o personal protective equipment for staff
  o tympanic thermometers
  o pulse oximeters
  o sphygmomanometers
  o examination tables and privacy curtains
  o wheelchairs and patient trolleys
  o hand hygiene products
  o clinical waste and linen bags
  o tissues
  o surface cleaning products
  o signage and information sheets (signage and resources for the CAC can be found via the Health Protection Website [here](#)).

• swabs for taking patient specimens and pathology collection process

• resuscitation equipment

• medication standing orders for all appropriate medications

• protocol for response to high risk resuscitations or deteriorating patient (CODE BLUE)

• oxygen and the means for delivering it to patients

• adrenaline and equipment for administering it
• bag-valve mask with appropriate sized masks
• toilet facilities for patients
• staff facilities for toileting, meal and rest breaks
• methods for communication. This may include:
  o telephones
  o at least one facsimile machine
  o computer workstations with connections to the hospital network to allow
    access to electronic medical record, email and the NSW Health intranet
    (and/or Internet) to enable efficient data collection and exchange.

STAFFING

The staffing model for CACs should have in-built flexibility to allow timely scaling up or
down, according to demand. It is recognised that staffing may need to include agency
staff in order to ensure appropriate staffing levels are maintained to operate the clinic.

Equipment and Training

All staff will attend mandatory training to work in the CAC. This includes the Infection
Prevention and Control Practices and Hand Hygiene.

All staff will be required to have necessary PPE to work within the CAC. Please refer to
the guidelines from the Clinical Excellence Commission.

Clinical Staff

Two main groups of clinical staff to work in CACs. Their responsibilities and minimum
training requirements, are listed below.

CAC Manager

The main responsibility of the CAC Manager will be to activate and manage the CAC.
This will include ensuring adequate equipment is available at all times and that adequate
staff have been booked to cover the CAC during operating hours.

Wherever possible, the CAC Manager should not be staffed from the ED or ICU.

Screening Staff

The main responsibility of the screening staff is to determine if the patient fulfils a
screening case definition for COVID-19. Screening staff should be registered nurses
trained in the use of an COVID-19 case definition.

Clinical Assessment Staff

The main responsibilities of the clinical assessment staff are to assess patients against a
management algorithm, provide any necessary treatment and decide on their disposition
(discharge to a home setting, with appropriate advice, or transfer to the ED). These staff
should primarily be registered nurses who are suitably trained to carry out the tasks listed
above.
A medical officer must be available to support the clinic at all times, in particular to make an assessment in more complex cases. Depending on the size of the CAC, the medical officer could be situated full-time in the clinic or be available using an on-call arrangement. Depending on local arrangements, the doctor could arrange the transfer to the ED or organise a direct-to-ward admission, as appropriate.

GPs may be involved in staffing CACs, particularly in rural and remote areas. Where this occurs, LHDs should plan in conjunction with GPs to ensure that the primary care role of the GP is maintained.

**Non-Clinical Staff**

The non-clinical staff requirements for CACs are listed below.

**Administration Officers**

Responsibilities include clerical functions such as registration of patients, data entry of clinical and epidemiological details, daily entry and upload of aggregated data, and to provide other administrative and logistic support.

**Security Staff**

Responsibilities include maintaining order and ensuring the smooth flow of patients into and out of the clinic, as required.

**Hospital Porters**

Responsibility is to transfer patients from the CAC to the ED or hospital ward, as required and patient specimens to Pathology Services.

**Cleaning Staff**

Responsibility is to support cleaning of CAC facilities. Terminal cleaning may be required more often in this space than in general clinical locations.

**MANAGEMENT OF PRESENTING PATIENTS**

Patients should be managed as per the *Management Algorithm for People Presenting to NSW CACs* (Appendix One).

Patients are likely to present at the stand-alone CAC through the following mechanisms:

- directly to the CAC
- after being screened at the ED and triaged to the CAC
- referral from GP to attend the CAC.

Clear signage should be installed directing patients to the CAC away from the ED entrance.
**Documentation**

NSW Health COVID-19 Clinic forms are available from the NSW Health state forms catalogue. This includes Patient Registration, Assessment and Medical Certificate/Discharge Advice forms. The Form can be found at Appendix 3.


Product codes: NH700583 (POD item) and NH700583A (Self-Print).

**ASSESSMENT AND MANAGEMENT**

Assessment and management of patients should follow the Operating Procedures for NSW CACs (Appendix Two).

**Clinical Assessment and Pathways of Paediatrics and Infants**

Staff should follow the same pathway for paediatrics and infants.

Staff with the appropriate skills can perform the swab or should be supported to learn the appropriate procedure.

Alternatively, CACs should ensure they have access to appropriately skilled staff or set up an alternate pathway to test children and infants that present to the CAC.

**MEDICAL EMERGENCIES**

For any patient that deteriorates and requires a bed an ambulance must be called to the CAC via 000 or local emergency protocols if the facility is on site. Ambulance staff must be informed that the patient requires droplet/contact precautions for transport. If aerosol producing procedure needs to be performed suctioning airborne and contact precautions must be used.

Patients who are safe to transfer to ED by wheelchair should be done promptly with an escort and porter.

Staff should manage any medical emergencies as per Code Blue Response System.

**RESULT FOLLOW UP**

**Positive Results**

All positive COVID-19 results will be managed by the NSW Public Health Unit.

Patients who test positive are given priority and their results are reported immediately to the referring doctor and public health unit in line with high risk results procedures.
Patients should be provided with re-education about preventing spread, symptomatic treatment and re-presentation if their symptoms worsen. Patients should also be instructed to self-isolate for 14 days.

**Negative Results**

NSW Health Pathology has developed an information technology solution to deliver negative results to patients.

If a test returns negative the patient should be informed that they will need to continue to self-isolate for 14 days after returning from any overseas travel or contact with someone known to have COVID-19.

If a patient’s condition worsens they should be instructed to contact their GP or go to their closest Emergency Department or CAC.

**CLEANING**

Cleaning and disinfection is recommended to decontaminate the environment using a product capable of a two in one step clean for hard surfaces (chairs, tables). Two in one disinfectant wipes should be used for medical equipment.

- Clinic room chair and observation equipment should be cleaned with universal wipes in-between each patient
- Cleaners should observe contact and droplet precautions
- Ensure adherence to the cleaning product manufacturer’s recommended contact time
- Use products with demonstrated efficacy against enveloped viruses (as the easiest class of microorganisms to kill)
- Terminal Clean on discharge from room
- Minimise equipment and items in the patient areas

All linen should be handled as per normal processes. Staff must be wearing PPE when handling linen (contact and droplet precautions).

Grossly contaminated/ soiled linen should be placed in a soluble plastic bag and then placed in the linen skip or the linen skip should be lined with a plastic bag for coiled linen.

**DEACTIVATION**

There may be times when the facility CAC will need to cease operations. This may vary from week to week, and health services will need to have the flexibility to stand down a CAC at short notice.

**Reduced Capacity**

CAC staff are responsible for monitoring supply and availability of required equipment to continue running operations. This includes ensuring there is the appropriate staffing available.
Clinical staff should continue to monitor their supplies and determine if they have the necessary equipment to continue operations for the next 72 hours. This should be checked daily. Staff should liaise with local equipment officers and product teams if it supply runs low.

If it is determined that the CAC cannot operate for any identified reason, staff will close the CAC temporarily. A decision will need to be made to re-allocate any equipment to nearby CACs.

The CAC may be activated again once it is determined it is able to.

**Planned Closure**

The aim of the CAC is to decrease patient presentations to ED and minimise the risk of spread of disease in hospitals. A facility may make the decision to close the CAC (either temporarily or permanently) if it is determined that there will be no additional burden to the ED.

Once a CAC has been closed appropriate cleaning and infection control processes should be undertaken.

**APPENDIX LIST**

1. Management Algorithm for People Presenting to NSW CACs
2. Operating Procedure for NSW CACs
3. COVID-19 Assessment Forms
Attachment 1: Management Algorithm for People Presenting to NSW CACs
Appendix Two: Operating Procedure for NSW CACs

Patients are likely to present at the stand-alone CAC via the following mechanisms:
1. directly to the CAC
2. after being screened at the ED and triaged to the CAC
3. referral from GP to attend the CAC.

The following three steps should be followed.

1: SCREEN
All patients and accompanying persons attending the CAC or ED must be screened for influenza like illness (ILI), using the latest case definition.

Patients will be screened into one of four groups:

1. **Does not meet the case definition** for ILI and are **otherwise well** (i.e., the “worried well”). This group should be sent home with advice and written information for self-management.

2. **Does not meet the case definition** for ILI but have **some other medical condition**. This group should be instructed to proceed through the ED system as normal.

3. **Meets the case definition** but are **in need of treatment in the ED**. This group should be provided with a surgical mask, asked to use alcohol-based hand gel, and directed to the ED. The patient should be advised to practice social distancing when waiting in ED for further treatment.

   The transfer of any patient must only occur following a discussion with the emergency department senior nursing or medical staff.

   Any patient being redirected to an emergency department for a higher level of care, must be escorted by appropriate clinician using PPE and be handed over to the emergency the receiving senior nursing staff or clinician using ISBAR

4. **Meets the case definition** and are **not in need of treatment in the ED** should be provided with a surgical mask, asked to use alcohol-based hand gel, and directed to the CAC.

The NSW CAC Assessment Form can be used as a screening tool by clinicians. It can be copied into electronic medical records as a clinician template. It collects demographic information, symptoms of COVID-19, and red flag symptoms of potentially serious conditions that may mimic influenza (e.g., meningococcal disease, ischaemic heart disease).

Step 2: ASSESS
The patient will be assessed by a suitably qualified registered nurse using:

- information prompted by the *NSW CAC Assessment Form*
- vital signs (note normal vital signs for children in table below)
Normal vital signs for children (adapted from the NSW Health Standard Paediatric Observation Charts)

<table>
<thead>
<tr>
<th>Age (years)</th>
<th>Respiratory rate (breaths per minute)</th>
<th>Heart rate (beats per minute)</th>
<th>Systolic BP (mmHg)</th>
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<tr>
<td>Under 3 months</td>
<td>30-55</td>
<td>110-160</td>
<td>60-100</td>
</tr>
<tr>
<td>3-12 months</td>
<td>30-45</td>
<td>100-160</td>
<td>70-110</td>
</tr>
<tr>
<td>1-4</td>
<td>20-40</td>
<td>90-140</td>
<td>90-110</td>
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<tr>
<td>5-11</td>
<td>20-30</td>
<td>80-120</td>
<td>60-100</td>
</tr>
<tr>
<td>&gt;12</td>
<td>15-20</td>
<td>90-110</td>
<td>90-120</td>
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Patients will be categorised into one of three groups:

1. ‘mild – moderate illness, not in vulnerable group’ (can be discharged home; may require additional treatment, written advise about management at home)
2. ‘mild - moderate illness, from vulnerable group’ (can be discharged home; may require additional treatment or consideration of admission, written advise about management at home)
3. ‘more severe illness, regardless if in vulnerable group’ (need to be further assessed in ED or hospital ward for likely admission).

**Step 3 TREAT**

Provide patients with confirmed COVID-19 any necessary treatment. Target groups are those in the categories ‘mild illness, in vulnerable group’; ‘Moderate illness, regardless if in vulnerable group’ or ‘more severe illness, regardless if in vulnerable group’.

All patients discharged to a home environment will need to be given verbal advice and a completed *NSW CAC Discharge Advice* form and provide the COVID-19
Appendix Three: COVID-19 Assessment Forms

COVID-19/Flu Client Registration
COVID-19/Flu Assessment
COVID-19/Flu Medical Certificate and Discharge Advice