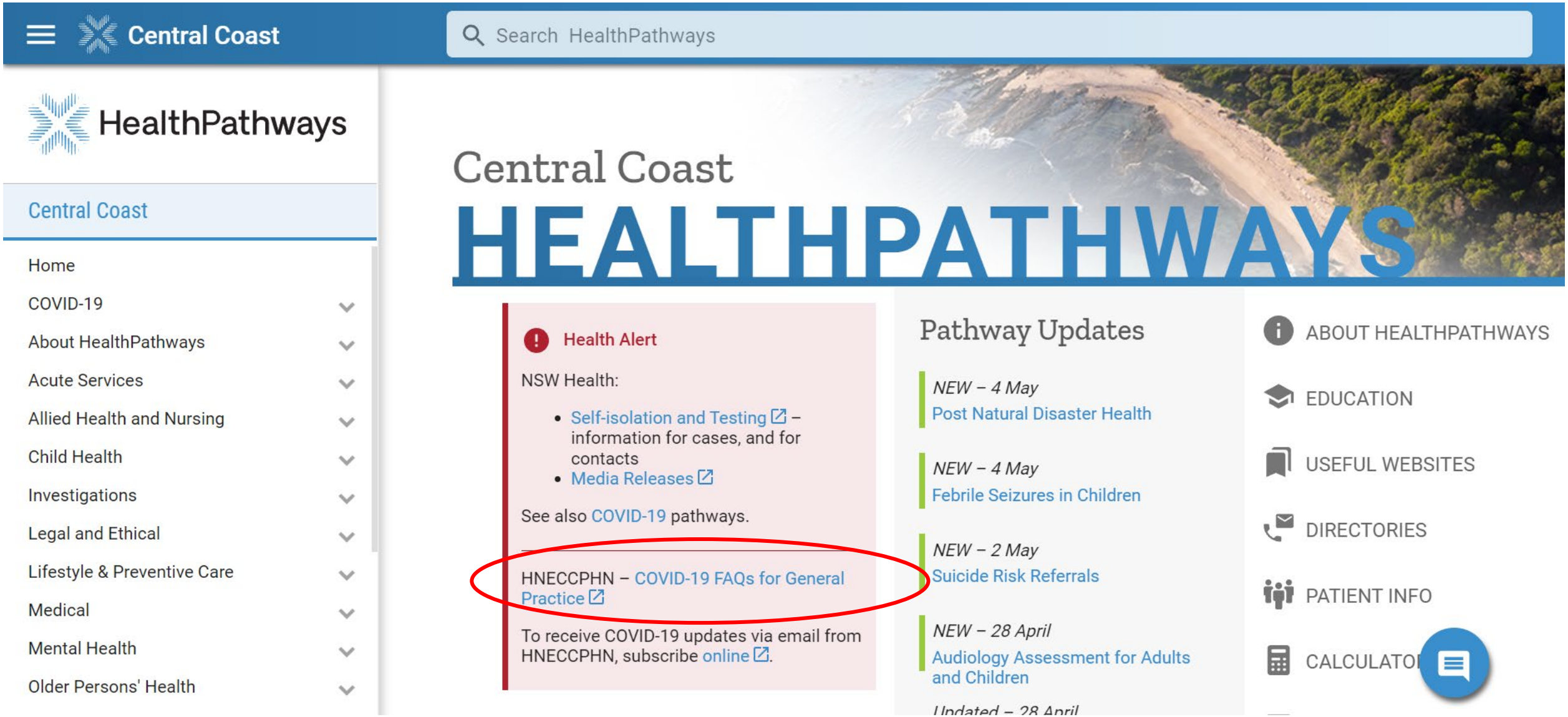
COVID-19 Hot Topics

17th May 2022

Dr Michelle Redford
GP Blackbutt Doctors New Lambton
GP lead for “Living with Covid” at HNECC PHN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Search HealthPathways
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Home
COVID-19
About HealthPathways
Acute Services
Allied Health and Nursing
Child Health
Investigations
Legal and Ethical
Lifestyle & Preventive Care
Medical
Mental Health
Older Persons' Health
Central Coast
HEALTHPATHWAYS
Health Alert
NSW Health:
Self-isolation and Testing – information for cases, and for contacts
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NEW – 4 May
Febrile Seizures in Children
NEW – 2 May
Suicide Risk Referrals
NEW – 28 April
Audiology Assessment for Adults and Children
ABOUT HEALTHPATHWAYS
EDUCATION
USEFUL WEBSITES
DIRECTORIES
PATIENT INFO
CALCULATOR

Community HealthPathways

Care of COVID-19 Positive Adult Patients in the Community

Last reviewed: 3 May 2022

What's changed? Read about new and important changes.

This pathway is about general practice involvement in the management of patients aged 18 years and over with known or presumed COVID-19 in the community. For:

- clinical advice, contact COVID Care in the Community (CCiC) – phone **(02) 4923-6195** from 8.00 am to 4.30 pm, 7 days a week.
- patients aged under 18 years, see Care of COVID-19 Positive Paediatric Patients.
- up-to-date answers to questions about COVID-19, see HNECCPHN – COVID-19 FAQs for General Practice.

Red flags

What's changed?

Notification of higher risk patients to GPs– antiviral eligibility

Evidence of reduced efficacy of sotrovimab against omicron BA.2

Paxlovid on PBS

No routine testing for 12 w post covid

Household contacts no longer required to isolate– HCW implications

Winter boosters and other immunisation changes

Notification

Questionnaire identifies higher risk pt

SMS to patient

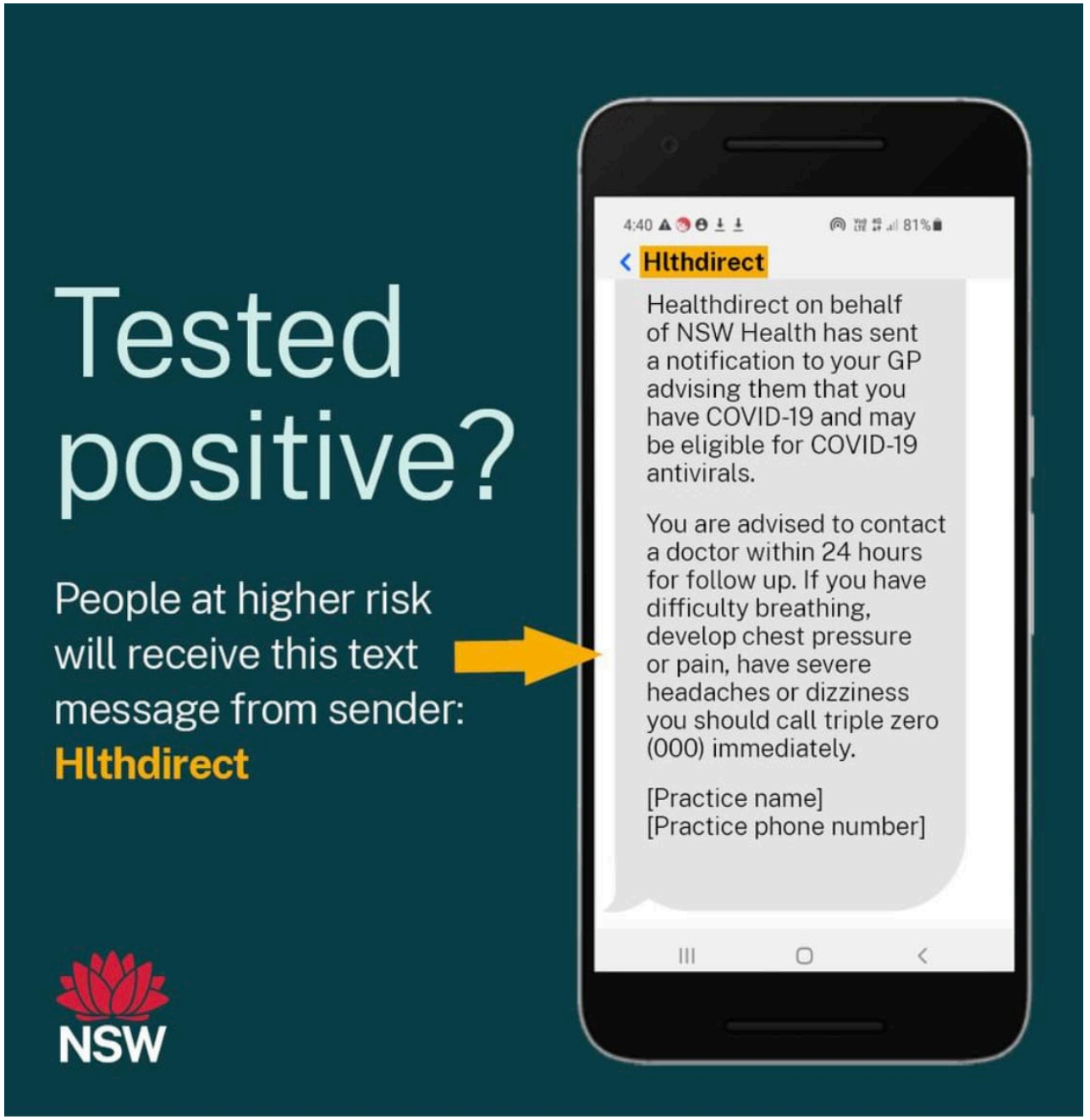
Secure messaging – practice inbox
Follow up phone call

Assess within 24 hours

Not “instruction to prescribe”

Consider pulse oximetry / clinical follow up

[NSW model of care | healthdirect]



A journey through the COVID-19 Care Pathway for anti-viral treatment in primary care

healthdirect Australia

System Enablers

- Service NSW
- Healthdirect
- Local Health Districts
- GPs, GPRCs & ACCHS
- PHNs
- Community Pharmacies

Registration & Assessment

Result & Registration

Result

Positive Polymerase Chain Reaction (PCR) result notification via SMS.

Or

Positive Rapid Antigen Test (RAT)

Registration

PCR registered with NSW Health. Patient provided a link from NSW Health via SMS to complete a risk assessment questionnaire.

Or

Self-registration of positive Rapid Antigen Test through the Services NSW App or website includes the risk assessment questionnaire from NSW Health.

Survey includes consent and GP nomination

Risk assessment

Screening criteria

The assessment identifies cases for GP follow up:

- Within 5 days of symptom onset
- Reduced immunity (unvaccinated, vaccination not up to date, or immunocompromised)
- Pregnant
- Aboriginal or Torres Strait Islander
- At least 2 COVID19-specific risk factors

Assessment outcomes

Cases meeting criteria for GP follow-up to assess eligibility for COVID-19 antiviral therapy are automatically passed through to Healthdirect and then subsequently communicated to GPs.

Cases not meeting criteria for GP follow-up are provided with self-care guidance and resource links

Notification

GP Notification

Connecting to care

Using the information provided in the risk assessment, Healthdirect populates a Notification Template and sends this to the patient's GP using Secure Messaging. Healthdirect call the General Practice to alert them to the notification having been sent.

Healthdirect then send an SMS to the patient advising that the notification has been sent to the GP, and encourage them to reach out to the practice for a priority appointment.

If the patient does not have a GP, the GP is closed on weekends and it is a Friday, or GP does not utilise secure messaging for information exchange, Healthdirect will send the notification template to a GPRC and advise the patient of these details. Healthdirect will also call the GPRC to alert them of the notification being sent.

Care & Management

Care

Continuous quality improvement

GP manages ongoing care and escalates as appropriate.

In cases where patients are connected to a GPRC, Healthdirect will identify the patient's regular GP in the notification letter to support close-loop communications between the GPRC and the patient's regular GP.

Where a GP does not have secure messaging, Healthdirect will advise practice details to the local PHN. PHNs will assist general practices to implement secure messaging technology.

A week after the notification letter is sent to a GP, Healthdirect will undertake an outbound call to the patient, to identify which patients were able to access anti-viral treatment. This data will be provided to the Commonwealth and NSW Health as feedback on the health system's response to rapidly identify and dispense anti-viral treatment to eligible patients and will support COVID policy and program development.

Example patient profile

Name: Joanne Harbour
Age: 38
Gender: Female
Result: Positive
Vaccination status: 3 vaccinations
Health condition: Mild Symptoms, chronic respiratory issues, obesity, immunocompromised

Notification

Jo registers a positive Rapid Antigen Test on the Service NSW app

→

Registration

Jo completes the risk assessment questionnaire, nominates her GP and provides consent for notification

→

Risk assessment

The assessment determines that Jo requires GP follow-up

→

Notification

Healthdirect notifies the nominated GP and calls the GP to alert them of the notification

→

Care

Jo's General Practice manager makes contact with her and books a priority telehealth appointment within a day. After clinical assessment by her GP, Jo receives a prescription for Paxlovid and has it dispensed at her local pharmacy.

Changes from previous model

GP notification via secure messaging

- A notification advising the consumer is eligible for antiviral treatment will be sent via secure messaging to a Primary Care Provider
- Consumers who do not have a regular GP, their regular GP does not use secure messaging to support information exchange, or their GP has limited capacity to see them within 24 hours (i.e. weekend challenges etc) will be referred to a GPRC
- If Healthdirect are unable to send a notification to a regular Primary Care Provider or GPRC, Healthdirect will send to NSW Health COVID Care Team for follow up

Outbound call to Primary Care Provider

- Healthdirect will contact Primary Care Provider within a 2 hour timeframe (between 8:00am – 5:00pm) and advise a notification has been sent via secure message
- If outside of business hours Healthdirect will make follow up call the next business day (call will be made within 2 hours the following business day)
- Healthdirect will be notifying the practice that a notification has been sent via secure messaging for a patient who may be eligible for COVID-19 antivirals.

SMS to consumer

- Healthdirect will send an SMS to the consumer advising a notification has been sent to a Primary Care Provider, GPRC and/or NSW Health

Establishment of central website for antivirals approach

- Supporting access to antiviral treatment in NSW | healthdirect

Consumers can contact NSW Health if unable to connect with Primary Care Provider within 24 hours

- 1800 960 933

GP notifications

GP notifications are sent via clinical secure messaging. The minimum requirements for practices (including GPRCs) to receive notifications are:

Practices must have installed and configured one of the following compatible secure messaging services - Healthlink, Argus or Referral Net.

Practice details, including name and address are correct and up-to-date in their secure messaging vendor(s) provider directory and the National Health Services Directory.

- Healthdirect sends notifications to the practice – not named doctors. Most practices have secure messaging configured with the practice listed in the provider directory. This endpoint is generally monitored by the practice manager or a designated doctor.
- Practice-level communication is more reliable as consumers likely know the name of their usual practice, but not necessarily their doctor at the practice. Many consumers will see different doctors at a practice based on availability.

For further information, please refer to Australian Digital Health Agency - Secure Messaging Implementation Guide

Example Notification Template

COVID-19 Patient - Notification from Healthdirect on behalf of NSW Health

Dear Doctor [name],

Your patient has COVID-19 and may be eligible for COVID-19 antivirals.

[Patient information: First name, surname, date of birth, gender, phone number, risk factors, COVID test date and symptom onset date]

NSW Health survey screening pathway conducted on [submit_date] identified that your patient may be eligible for antivirals as they are currently symptomatic and have risk factors for developing severe COVID-19. They have been advised to contact a doctor within 24 hours. We have advised them to monitor their symptoms closely and to contact a doctor urgently if symptoms worsen or attend their nearest emergency department or call triple zero (000) in an emergency.

The GP is advised to confirm that the patient meets the current prescription guideline through a consultation within 24 hours as these treatments need to be used within 5 days of onset of COVID-19 symptoms, to be effective.

[Links to specific resources]

The patient has consented to notification to their usual GP, relevant health service providers and authorities.

After COVID-19

No isolation or routine testing for 12 weeks

If respiratory illness develops consider other causes

Wait 3 months before giving next dose of COVID-19 vaccine

No need to delay other immunisations

Exemption IM011 if needed

Sotrovimab and omicron BA.2

Oral antivirals now first line

TGA receives application for an increased dose of GlaxoSmithKline's COVID-19 treatment sotrovimab (XEVUDY) for the BA.2 Omicron sublineage

7 April 2022

The Therapeutic Goods Administration (TGA) has received an application from GlaxoSmithKline (GSK) Australia Pty Ltd for a higher (1000 mg) dose of its COVID 19 treatment, sotrovimab (XEVUDY). This higher dose will be considered for treatment of patients suspected to have infection caused by the Omicron BA.2 sublineage.

Currently, this monoclonal antibody treatment is provisionally approved by the TGA for the treatment of adults and adolescents (aged 12 years and over and weighing at least 40 kg) with COVID 19 who do not require initiation of oxygen and who are at increased risk of progression to hospitalisation or death. The approved dose is 500 mg administered as an intravenous infusion.

Recent reports, based on antibody neutralisation activity, have suggested that the 500 mg dose is unlikely to be effective against the Omicron BA.2 sublineage, which is now dominant in Australia and many other countries. On 5 April, the US Food and Drug Administration revoked the authorisation of sotrovimab.

The NEW ENGLAND JOURNAL of MEDICINE

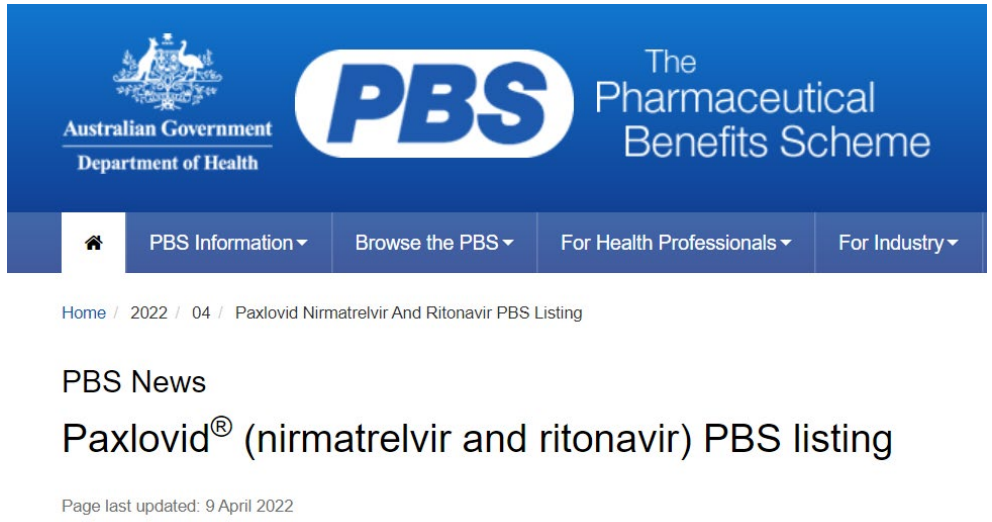
CORRESPONDENCE

Efficacy of Antiviral Agents against the SARS-CoV-2 Omicron Subvariant BA.2

THE EDITOR: The omicron (B.1.1.529) variant
evere acute respiratory syndrome coronavirus
ARS-CoV-2), which is responsible for corona-
s disease 2019 (Covid-19), has spread rapidly

receptor-binding domain of the S protein, as compared with the Wuhan/Hu-1/2019 reference strain (Table S1 in the Supplementary Appendix, available with the full text of this letter at NEJM.org).

Paxlovid (nirmatrelvir plus ritonavir) now on PBS



1st line

Drug interactions

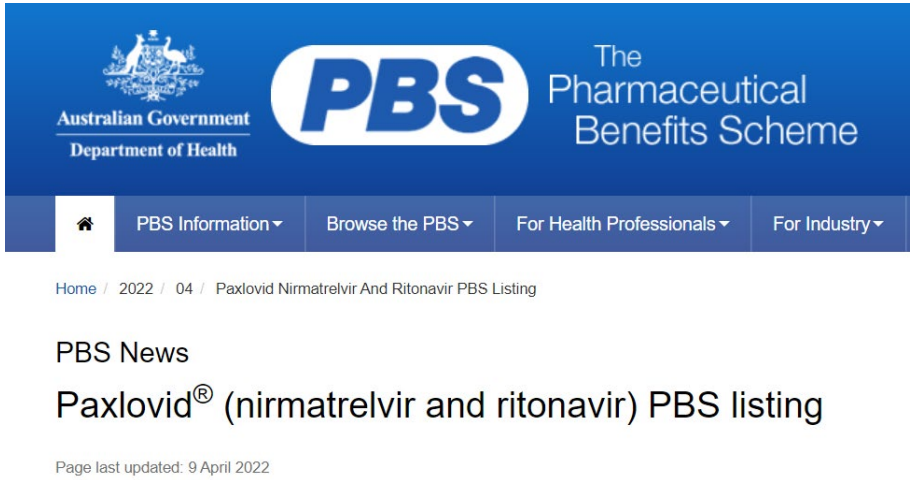
Liverpool COVID-19 Interactions (covid19-druginteractions.org)

Lagevrio (molnupiravir) second line

Private scripts discouraged

Talk to your patients – plan in advance

PBS antivirals



Positive PCR or RAT notified to NSW Health AND

Symptomatic, within 5 days of symptom onset AND

not requiring hospitalisation AND

Age 65+ with 2 risk factors OR

Age 75+ with one risk factor OR

Aboriginal and/or Torres Strait Islander age 50+ with 2 risk factors OR

Age 18+ and immunocompromised as per ATAGI definition

PBS risk factors

- The patient has received less than 2 doses of SARS-CoV-2 vaccine
- The patient is in residential aged care or residential disability care
- Neurological conditions, including stroke and dementia
- Respiratory compromise, including COPD, moderate or severe asthma (required inhaled steroids), and bronchiectasis
- Congestive heart failure (NYHA Class II or greater)
- Obesity (BMI greater than 30kg/m^2)
- Diabetes Types I and II, requiring medication for glycaemic control
- Renal failure (eGFR less than 60mL/min)
- Cirrhosis, or
- The patient has reduced, or lack of, access to higher level healthcare and lives in an area of geographic remoteness classified by the Modified Monash Model as Category 5 or above

Box 1: People with the following immunocompromising conditions and therapies for which a 3rd primary dose is recommended

N.B. This list is not exhaustive. Clinicians may use their judgement for conditions or medications that are not listed, and which are associated with severe immunocompromise.

- Active haematological malignancy
- Non-haematological malignancy with current active treatment (e.g. chemotherapy, whole body irradiation)
- Solid organ transplant with immunosuppressive therapy
- Haematopoietic stem cell transplant (HSCT) recipients or chimeric antigen receptor T-cell (CAR-T) therapy within 2 years of transplantation.
  - These patients require *revaccination with 3 additional doses* of COVID-19 vaccine, irrespective of doses given prior to transplantation, commencing generally ≥3-6 months after their transplant after discussion with their treating specialist.
  - Those beyond 2 years from transplant should discuss with their treating specialist about the need for a 3rd dose.
- Immunosuppressive therapies including:
  - High dose corticosteroid treatment equivalent to >20mg/day of prednisone for ≥14 days in a month, or pulse corticosteroid therapy.
  - Multiple immunosuppressants where the cumulative effect is considered to be severely immunosuppressive.
  - Selected conventional synthetic disease-modifying anti-rheumatic drugs (csDMARDS):
    - including mycophenolate, methotrexate (≥10 mg/week), leflunomide, azathioprine (≥ 1mg/kg day), 6-mercaptopurine (≥ 0.5mg/kg/day), alkylating agents (e.g. cyclophosphamide, chlorambucil), and systemic calcineurin inhibitors (e.g. cyclosporin, tacrolimus).
    - excluding hydroxychloroquine or sulfasalazine when used as monotherapy.
  - Biologic and targeted therapies anticipated to reduce the immune response to COVID-19 vaccine. Refer to **Table 2** below for examples. However, clinicians may use their judgement for medications which are not listed.
- Primary immunodeficiency including combined immunodeficiency and syndromes, major antibody deficiency (e.g. common variable immune deficiency (CVID) or agammaglobulinemia), defects of innate immunity (including phagocytic cells), defects of immune regulation, complement deficiencies and phenocopies of primary immunodeficiencies.
- Advanced or untreated HIV with CD4 counts <250/μL or those with a higher CD4 count unable to be established on effective anti-retroviral therapy.
  - a 3rd primary dose is not required for people living with HIV, receiving ART with CD4 counts ≥250/μL.
- Long term haemodialysis or peritoneal dialysis.

Severe immunocompromise (ATAGI)

Table 2(a): A 3rd dose is recommended for people taking the following biologics

Class	**Examples**
Anti-CD20 antibodies	rituximab, obinutuzumab, ocrelizumab, ofatumumab
BTK inhibitors	ibrutinib, acalabrutinib, zanubrutinib
JAK inhibitors	tofacitinib, baricitinib, ruxolitinib
Sphingosine 1-phosphate receptor modulators	fingolimod, siponimod
Anti-CD52 antibodies	alemtuzumab
Anti-complement antibodies	eculizumab
Anti-thymocyte globulin	anti-thymocyte globulin

Table 2(b): A 3rd primary dose is not recommended for people taking the following biologics*

Class	**Examples**
Anti-integrins	natalizumab, vedolizumab
Anti-TNF-α antibodies	infliximab, adalimumab, etanercept, golimumab, certolizumab
Anti-IL1 antibodies	anakinra
Anti-IL6 antibodies	Tocilizumab
Anti-IL17 antibodies	secukinumab, ixekizumab
Anti-IL4 antibodies	dupilumab
Anti-IL23 antibodies	ustekinumab
Immune checkpoint inhibitors	nivolumab, pembrolizumab, ipilimumab, atezolizumab

Immunisation

Primary course

Interval between first and second doses of Pfizer or Moderna in adults now 8 weeks

AZ still 12 weeks, Novavax still 3-8 weeks

Boosters

Winter boosters introduced for selected groups

No boosters for 12-15 year olds

Moderna and Pfizer preferred, AZ if mRNA CI (only if not already had 2xAZ)

Novavax if no other vaccine is suitable (not TGA approved)

Delay next dose of COVID-19 vaccine for 3 months post COVID-19 infection

Winter boosters

4 months after the first booster (at least 3 months from COVID-19 infection)

- Adults aged 65 years and older
- Residents of aged care or disability care facilities – GPs role
- People aged 16 years and older with severe immunocompromise (this will be dose 5)
- Aboriginal and Torres Strait Islander people aged 50 years and older

Severe immunocompromise – adult schedule with mRNA vaccine

Primary 1 < 8 weeks> Primary 2 <2 months> Primary 3 <3 months> Booster 1

<4 months> Winter booster

Australian Technical Advisory Group on Immunisation (ATAGI) recommended COVID-19 vaccines and doses

The table below summarises the Australian Technical Advisory Group on Immunisation (ATAGI) recommendations relating to COVID-19 vaccines and required doses.

GROUP	VACCINES	PRIMARY COURSE	BOOSTER	WINTER DOSE
GENERAL POPULATION				
5 years	Pfizer (COMIRNATY) (For Ages 5 to <12)	FIRST DOSE → SECOND DOSE	Not approved or recommended.	Not approved or recommended.
6 – 11 years	Pfizer (COMIRNATY) (For Ages 5 to <12) Moderna (SPIKEVAX)^	FIRST DOSE → SECOND DOSE	Not approved or recommended.	Not approved or recommended.
12 – 15 years	Pfizer (COMIRNATY) Moderna (SPIKEVAX)	FIRST DOSE → SECOND DOSE	Pfizer (COMIRNATY): approved but not recommended. Moderna (SPIKEVAX): not approved or recommended	Not approved or recommended.
16 – 17 years	Pfizer (COMIRNATY)* Moderna (SPIKEVAX)	FIRST DOSE → SECOND DOSE	BOOSTER *ONLY PFIZER APPROVED* *3 months after Primary Course*	Not approved or recommended.
18 – 64 years	Pfizer (COMIRNATY) Moderna (SPIKEVAX) Novavax (NUVAXOVID)** AstraZeneca (VAXZEVRIA)	FIRST DOSE → SECOND DOSE	BOOSTER *3 months after Primary Course*	Not approved or recommended.
65+ years	Pfizer (COMIRNATY) Moderna (SPIKEVAX) Novavax (NUVAXOVID)** AstraZeneca (VAXZEVRIA)	FIRST DOSE → SECOND DOSE	BOOSTER *3 months after Primary Course*	WINTER DOSE *From 4 months after Booster*
SPECIAL POPULATION				
5 years Severely immunocompromised	Pfizer (COMIRNATY) (For Ages 5 to <12)	FIRST DOSE → SECOND DOSE → THIRD DOSE Third dose 2 months after second dose	Not approved or recommended.	Not approved or recommended.
6 – 11 years Severely immunocompromised	Pfizer (COMIRNATY) (For Ages 5 to <12) Moderna (SPIKEVAX)^	FIRST DOSE → SECOND DOSE → THIRD DOSE Third dose 2 months after second dose	Not approved or recommended.	Not approved or recommended.
12 – 15 years Severely immunocompromised	Pfizer (COMIRNATY) Moderna (SPIKEVAX)	FIRST DOSE → SECOND DOSE → THIRD DOSE Third dose 2 months after second dose	Pfizer (COMIRNATY): approved but not recommended. Moderna (SPIKEVAX): not approved or recommended	Not approved or recommended.
16-17 years Severely immunocompromised	Pfizer (COMIRNATY)* Moderna (SPIKEVAX)	FIRST DOSE → SECOND DOSE → THIRD DOSE Third dose 2 months after second dose	BOOSTER *ONLY PFIZER APPROVED* *3 months after Primary Course*	WINTER DOSE *ONLY PFIZER APPROVED* *From 4 months after Booster*
18+ years Severely immunocompromised	Pfizer (COMIRNATY) Moderna (SPIKEVAX) Novavax (NUVAXOVID)** AstraZeneca (VAXZEVRIA)	FIRST DOSE → SECOND DOSE → THIRD DOSE Third dose 2 months after second dose	BOOSTER *3 months after Primary Course*	WINTER DOSE *From 4 months after Booster*
Pregnant, breastfeeding or planning pregnancy	Pfizer (COMIRNATY)* Moderna (SPIKEVAX) Novavax (NUVAXOVID)** *(18+)* AstraZeneca (VAXZEVRIA) *(18+)*	FIRST DOSE → SECOND DOSE	BOOSTER *3 months after Primary Course*	Not approved or recommended.
Residents of aged care or disability care facilities	Pfizer (COMIRNATY)* Moderna (SPIKEVAX) Novavax (NUVAXOVID)** *(18+)* AstraZeneca (VAXZEVRIA) *(18+)*	FIRST DOSE → SECOND DOSE	BOOSTER *3 months after Primary Course*	WINTER DOSE *From 4 months after Booster*
Aboriginal and Torres Strait Islander people aged 50+ years	Pfizer (COMIRNATY) Moderna (SPIKEVAX) Novavax (NUVAXOVID)** AstraZeneca (VAXZEVRIA)	FIRST DOSE → SECOND DOSE	BOOSTER *3 months after Primary Course*	WINTER DOSE *From 4 months after Booster*

Notes

^ There is no separate paediatric formulation of the Moderna vaccine – children aged 6 to 11 years receive half the adult dose (50µg in 0.25 mL). ATAGI recommends that providers are vigilant about the potential for dosing errors, including overdosing, with the Moderna vaccine in children.

* For people aged 16 to 17 years, Pfizer COVID-19 vaccine is the only vaccine registered for use as a booster.

** Novavax can only be used as a booster if no other COVID-19 vaccine is suitable.

Information current as at 29 April 2022. Detailed information on ATAGI clinical guidelines for administration of COVID-19 vaccines is available at: www.health.gov.au/initiatives-and-programs/covid-19-vaccines/advice-for-providers/clinical-guidance/clinical-recommendations

https://www.health.gov.au/resources/publications/atagi-recommended-covid-19-doses-and-vaccines

Up to date with COVID-19 vaccination

General population

Age 5-15	received 2 dose primary course
Age 16+	received 2 dose primary course and booster unless < 6 months since 2nd dose

Severely immunocompromised

Age 5-15	received 3 dose primary course
Age 16+	received 3 dose primary course and booster unless < 6 months since 2nd dose

Influenza

Can co administer any COVID-19 vaccine with any flu shot

Do not delay flu vaccine – season has started early

Pharmacy can give all NIP vaccines this year including Fluad Quad (Over 65s)

NIP funding in NSW this year includes BMI 30+

Know your brands!

- No Afluria for under 5s
- No Fluad Quad for under 65s

Can be billed as separate item if both descriptors met

Not mandatory to bulk bill NIP vaccines

Billing for Flu vaccinations, Covid vaccinations and Nurse-Led clinics

Vaccine	Attendance	Bulk Billing eligibility	Private Billing eligibility
Flu vaccine only	Assessed by GP Administered by GP or Nurse (ANI/RN/EN) with GP order	Yes, consult can be bulk billed a GP attendance item +/- 10997/10987 for Nurse visit IF flu vaccination is consistent with goals of GPMP/ TCA/ 715HA	Yes, flu vaccine consult can be privately billed (+cost of vaccine if patient is not eligible for an NIP funded flu vaccine)
Flu vaccine only	Assessed and administered by Authorised Nurse Immuniser (ANI) Does not see GP	Not eligible for bulk billing as no GP attendance +/- 10997/10987 for Nurse visit IF flu vaccination is consistent with goals of GPMP/ TCA/ 715HA	Yes, flu vaccine consult can be privately billed (+cost of vaccine if patient is not eligible for an NIP funded flu vaccine)
Covid vaccine only	Assessed by GP Administered by GP or Nurse (ANI/RN/EN) with GP order	Yes, Covid vaccine MUST be bulk billed See Medicare Support for COVID-19 Vaccination scenarios	Not permitted
Covid vaccine only	Assessed and administered by Authorised Nurse Immuniser on behalf of GP per MBS requirements Does not see GP	Yes, Covid vaccine MUST be bulk billed See Medicare Support for COVID-19 Vaccination scenarios	Not permitted
Flu & Covid vaccines co-administered	Assessed by GP Administered by GP or Nurse (ANI/RN/EN) with GP order	Covid vaccine MUST be bulk billed Yes, flu vaccine consult can be bulk billed GP attendance item +/- 10997/10987 for Nurse visit IF flu vaccination is consistent with goals of GPMP/ TCA/ 715HA	No charge for Covid vaccine permitted Yes, flu vaccine consult can be privately billed (+cost of vaccine if patient ineligible for NIP funded flu vaccine)
Flu & Covid vaccines co-administered	Assessed and administered by Authorised Nurse Immuniser on behalf of GP per MBS requirements Does not see GP	Covid vaccine MUST be bulk billed Not eligible for bulk billing for flu vaccine as no GP attendance +/- 10997/10987 for Nurse visit IF flu vaccination is consistent with goals of GPMP/ TCA/ 715HA	No charge for Covid vaccine permitted Yes, flu vaccine consult can be privately billed (+cost of vaccine if patient ineligible for NIP funded flu vaccine)

NCIRS Administration of vaccines – Scope of practice for healthcare professionals should be referred to for any questions regarding Nurse scope of practice

Household contacts

https://www.nsw.gov.au/covid-19/management/household-contacts

No isolation if confirmed COVID-19 in past 12 weeks

Confirmed cases and contacts with symptoms still need to isolate

Asymptomatic household contacts do not need to self-isolate but rules apply

- No high-risk settings for 7 days after the last person in their house had a positive COVID-19 test
- Work or study from home. Employer risk assessment
- Age 12 + must wear a mask in indoor setting that is not own home
- Masks encouraged at home
- Avoid contact with people at high risk of severe illness
- Avoid large or crowded indoor gatherings with contact with groups of people from outside the household
- Take RAT if you need to attend an indoor gathering with people you don’t live with

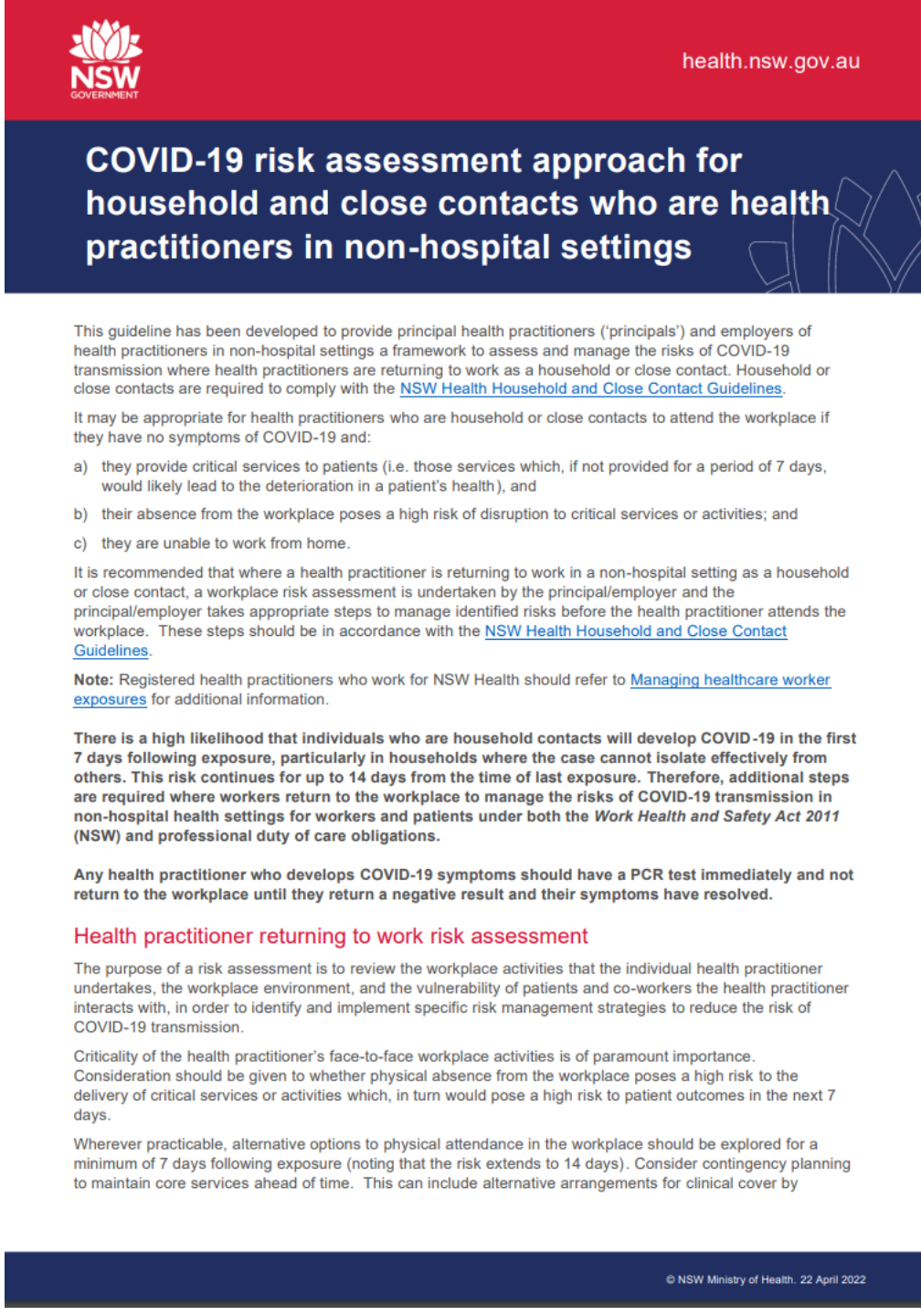
HCW household contacts

Isolate and WFH 7-14 days

Asymptomatic critical worker who cannot WFH

- risk assessment considering their workplace activities, workplace environment, patient and co-worker vulnerability, and
- risk mitigation strategies to reduce the risk of transmission e.g. P2/N95, daily RAT, reduce contact with colleagues

https://www.health.nsw.gov.au/Infectious/covid-19/communities-of-practice/Documents/covid-risk-assessment-household-close-contacts.pdf



NSW GOVERNMENT

health.nsw.gov.au

COVID-19 risk assessment approach for household and close contacts who are health practitioners in non-hospital settings

This guideline has been developed to provide principal health practitioners ('principals') and employers of health practitioners in non-hospital settings a framework to assess and manage the risks of COVID-19 transmission where health practitioners are returning to work as a household or close contact. Household or close contacts are required to comply with the NSW Health Household and Close Contact Guidelines.

It may be appropriate for health practitioners who are household or close contacts to attend the workplace if they have no symptoms of COVID-19 and:

a) they provide critical services to patients (i.e. those services which, if not provided for a period of 7 days, would likely lead to the deterioration in a patient's health), and

b) their absence from the workplace poses a high risk of disruption to critical services or activities; and

c) they are unable to work from home.

It is recommended that where a health practitioner is returning to work in a non-hospital setting as a household or close contact, a workplace risk assessment is undertaken by the principal/employer and the principal/employer takes appropriate steps to manage identified risks before the health practitioner attends the workplace. These steps should be in accordance with the NSW Health Household and Close Contact Guidelines.

Note: Registered health practitioners who work for NSW Health should refer to Managing healthcare worker exposures for additional information.

There is a high likelihood that individuals who are household contacts will develop COVID-19 in the first 7 days following exposure, particularly in households where the case cannot isolate effectively from others. This risk continues for up to 14 days from the time of last exposure. Therefore, additional steps are required where workers return to the workplace to manage the risks of COVID-19 transmission in non-hospital health settings for workers and patients under both the *Work Health and Safety Act 2011* (NSW) and professional duty of care obligations.

Any health practitioner who develops COVID-19 symptoms should have a PCR test immediately and not return to the workplace until they return a negative result and their symptoms have resolved.

Health practitioner returning to work risk assessment

The purpose of a risk assessment is to review the workplace activities that the individual health practitioner undertakes, the workplace environment, and the vulnerability of patients and co-workers the health practitioner interacts with, in order to identify and implement specific risk management strategies to reduce the risk of COVID-19 transmission.

Criticality of the health practitioner's face-to-face workplace activities is of paramount importance. Consideration should be given to whether physical absence from the workplace poses a high risk to the delivery of critical services or activities which, in turn would pose a high risk to patient outcomes in the next 7 days.

Wherever practicable, alternative options to physical attendance in the workplace should be explored for a minimum of 7 days following exposure (noting that the risk extends to 14 days). Consider contingency planning to maintain core services ahead of time. This can include alternative arrangements for clinical cover by