ASSESSMENT FOR SUSPECTED COVID-19

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

LEGEND

EBR: Evidence-Based Recommendation
CBR: Consensus-Based Recommendation
PP: Practice Point

Living guidance

Not prioritised for review

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INITIAL SCREENING

Likelihood of COVID-19

GENERAL

Assessment via telehealth
Where possible, undertake initial screening and assessment over the phone or by video. Video is preferred as it provides additional visual cues and therapeutic presence and may prevent the need for an in-person visit. **PP** [BMJ]

Speak to the affected person if possible, rather than their carer or a family member. **PP** [BMJ]

Assessment in-person
If a person with symptoms suggestive of COVID-19 presents to a clinic without a prior telehealth assessment, undertake the initial screening outside the clinic or in an area away from other people. **PP** [Taskforce]

SYMPTOMS AND SIGNS

Ask about the following:

- date of onset of symptoms
- key symptoms: fever, shortness of breath, dry cough, muscle aches, tiredness
- other symptoms: sore throat, headache, runny nose, diarrhoea and nausea.

PP [BMJ]

EPIDEMIOLOGY

For people in the community
Ask about the following in the 14 days prior to illness onset:

- Close contact with a confirmed or probable case of COVID-19
- International or interstate travel
- Passengers and crew who have travelled on a cruise ship
- Healthcare, aged or residential care workers and staff with direct patient contact
- People who have lived in or travelled through a geographically localised area with elevated risk of community transmission, as defined by public health authorities. **PP** [CDNA]

For hospitalised patients
Suspect COVID-19 where no other clinical focus of infection or alternate explanation of the patient's illness is evident. **PP** [CDNA]

Access to care
This flowchart should be applied after considering features of the individual patient, their preferences and the context in terms of rurality/remoteness, public health responses and proximity to higher-level care. Application of the flowchart will vary with local current COVID-19 prevalence and availability of testing. Early transfer to a major centre should be considered for those at risk of deterioration. Use of virtual care, including telehealth, should be considered. **PP** [Taskforce]

FOLLOW UP

LABORATORY TESTING

Refer to local testing criteria for SARS-CoV-2, noting that testing criteria may differ between States and Territories. **PP** [Taskforce]

Arrange for both oro- and nasopharyngeal testing (with sputum collection where this can be collected spontaneously and safely). **PP** [Taskforce/CDNA]

Other clinical factors

Potential risk factors for more severe illness
Older Age
Indigenous
History of smoking

Comorbidities:

- lung disease, including COPD, asthma, or bronchiectasis
- cardiovascular disease, including hypertension
- immunocompromised states (e.g. diabetes, chronic kidney or liver disease, taking chemotherapy, steroids, or other immunosuppressants).

PP [Taskforce/BMJ]

Symptom severity
Assess the degree of breathlessness by asking the person to describe:

- their presenting problem in their own words, whilst assessing the ease and comfort of their speech.
- the impact of their symptoms on their usual daily activities. Focus on any changes in breathing from normal, such as a new audible wheeze.

PP [BMJ]

Be aware of differential diagnoses

- Serious differential diagnoses include bacterial pneumonia, meningitis, and sepsis
- Influenza is more likely to produce body aches, whilst COVID-19 is more likely to produce shortness of breath.

PP [BMJ]

IN PERSON

Symptoms and signs
Only follow up with an in-person assessment if a diagnosis of moderate or severe illness cannot be confidently excluded via telehealth assessment or by initial face-to-face screening.
PP [Taskforce]

Managing risk of infection
Follow national advice for use of PPE in non-inpatient healthcare settings during the COVID-19 outbreak.
PP [Taskforce/ICEG; NHMRC]

Examination
Undertake the in-person assessment as per **Other clinical factors** and in addition:

- check temperature, pulse, respiratory rate and effort, degree of cough, and presence of sore throat
- assess oxygen saturation (SaO2), and if normal, consider repeating after gentle exercise (e.g. walking around the clinic carpark).

PP [Taskforce]

Care pathway

COVID-19 UNLIKELY

- Epidemiology, symptoms and signs are not suggestive of COVID-19

Alternative diagnosis made

Management

- The person may need reassurance if they are worried about the possibility of COVID-19
- Consider describing COVID-19 symptoms as reasons to re-present
- Advise the individual to self-isolate until symptoms have resolved, or they have received a negative SARS-CoV-2 test result (if swabbed).

PP [Taskforce]

MILD (SUSPECTED) COVID-19

- Epidemiology, symptoms and signs are consistent with COVID-19
- No symptoms or signs of pneumonia
- Normal (or unchanged) oxygen saturation

Notes:

- 4 out of 5 people with COVID-19 will have mild disease
- moderate/severe disease usually develops in the 2nd or 3rd week of illness

Refer to **MANAGEMENT OF MILD COVID-19** Clinical Flow Chart

Notification
Notify local public health unit of a confirmed case. **PP** [Taskforce]

MODERATE (SUSPECTED) COVID-19

- Epidemiology, symptoms and signs are consistent with COVID-19

plus any one of the following:

- symptoms or signs of pneumonia
- breathlessness
- SpO_2 > 92% at rest[1]

SEVERE (SUSPECTED) COVID-19

- Epidemiology, symptoms and signs are consistent with COVID-19

plus any one of the following:

- severe shortness of breath or difficulty breathing
- blue lips or face
- pain or pressure in the chest
- cold, clammy or pale and mottled skin
- new confusion or fainting
- becoming difficult to rouse
- little or no urine output
- coughing up blood
- SpO_2 < 92% at rest[2]

TRANSFER TO HOSPITAL

- Check the person's wishes regarding transfer, and whether they have an Advanced Care Directive for proceeding with hospital management.
- If the person wishes to stay in their place of residence, discuss care arrangements with the patient, their carers and family. Involve their GP, and local palliative care services if available. Note that this may only be possible if infection control can be guaranteed.
- If the person wishes to be admitted to hospital, advise the carer or family member to call an ambulance and to notify the paramedics that the person has suspected or confirmed COVID-19.

PP [Taskforce]

1 & 2 – Specified O_2 levels apply only to patients who do not have underlying lung diseases associated with resting hypoxaemia.

Sources

BMJ – Covid-19: a remote assessment in primary care. BMJ 2020;368:m1182 doi: 10.1136/bmj.m1182 (25 March 2020)

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National COVID-19 Clinical Evidence Taskforce/ICEG – Australian guidelines for SARS-CoV-2 infection prevention and control of COVID-19 in healthcare workers V1.0. https://app.magicapp.org/#/guideline/ERWdzj

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