COVID-19 screening tool implementation toolkit

For residential aged care services
What is this document about?

This document is about the COVID-19 screening tool for residential aged care services (RACS). It is a step-by-step guide to planning, implementing and evaluating the use of the screening tool in RACS.

This document contains:

- background on the development of the screening tool and the benefits of using it
- how to implement the screening tool, including shared experiences from pilot services
- how to evaluate the use of the screening tool using measurement.

This document is intended to be a ‘living’ document and will be reviewed regularly to support the rollout of the screening tool to Victorian residential aged care services.

WHO SHOULD READ THIS DOCUMENT?

This document is for all staff working in residential aged care services, including nurse unit managers and quality improvement staff. The document is a useful resource for those supporting the implementation of the screening tool as well as those using the screening tool every day.

Key

- Link to an appendix
- Question point
- Top tip
- Link to web resource

Related documents

<table>
<thead>
<tr>
<th>Document</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>COVID-19 screening tool for RACS</td>
<td>The screening tool supports RACS staff to identify typical and atypical signs of COVID-19 in the residents they are caring for.</td>
</tr>
<tr>
<td>COVID-19 screening tool for RACS data collection tool</td>
<td>This document supports the collection of data when using the screening tool.</td>
</tr>
</tbody>
</table>

FURTHER INFORMATION

For more information or to share your experiences of using the document, please email: olderpeople.clinicalnetwork@safercare.vic.gov.au.
Background

Older Victorians, who may also have co-existing illnesses, are at increased risk of serious complications if they contract COVID-19. Outbreaks of infectious illnesses such as COVID-19 can be a significant risk to residents, staff, families and the organisation. Research into COVID-19 highlights different symptoms may be present in older people. Instead of fever and sore throat, atypical signs such as seeming unwell, being upset or sleeping more may indicate illness and require further investigation. As a result, broader and regular screening of older people living in aged care is encouraged to ensure early identification and response to symptoms of deterioration that may indicate a resident should be tested for COVID-19.

In consultation with clinical experts, we have developed the COVID-19 screening tool for residential aged care service. The screening tool is based on evidence and includes the public health screening criteria for COVID-19. It also supports care staff to identify subtle changes in residents and be empowered to escalate these concerns.

DEVELOPMENT OF THE SCREENING TOOL

The development of this screening tool supports assessment for both atypical and typical COVID-19 symptoms that may be present in an older person. It builds on a ‘STOP AND WATCH’ type assessment tool that is already used by many RACS. The screening tool was piloted at 16 public and one private RACS with more than 1000 residents screened during this pilot phase. Feedback was sought about the usability of the screening tool, and how to support staff to use it.

On average, piloting services rated the usability of the screening tool 4 out of 5 and reported it took under five minutes to complete for each resident.

The screening tool, the typical and atypical symptoms list and advice on escalation of care for suspected cases was informed by feedback from Department of Health and Human Services (DHHS), VICNISS, health services and pilot facilities.

Benefits of using the screening tool

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving clinical outcomes</td>
<td>• Regularly check for typical and atypical signs of COVID-19.</td>
</tr>
<tr>
<td></td>
<td>• Facilitate a way for care staff to observe and report subtle changes in residents as part of an overall wellbeing assessment.</td>
</tr>
<tr>
<td></td>
<td>• Reassure staff, residents and family members that the facility is proactively screening residents for COVID-19.</td>
</tr>
<tr>
<td></td>
<td>• Identify other signs of deterioration in residents, not just COVID-19.</td>
</tr>
<tr>
<td>Continuous improvement planning</td>
<td>This toolkit and the family of measures are designed to support continuous improvement. The screening tool is evidence based and has been tested using continuous improvement methods by RACS to ensure it is easy to use and effective. Consider how the COVID-19 screening tool for RACS contributes to your quality management plan.</td>
</tr>
<tr>
<td>Accreditation</td>
<td>While the use of the screening tool is not an accreditation requirement, it may support services in demonstrating strategies for meeting the Aged Care Quality Standards, in particular Standard 2. Ongoing assessment and planning with consumers and Standard 3. Personal care and clinical care, as well as evidence of infection prevention measures.</td>
</tr>
</tbody>
</table>
Providers are invited to implement the screening tool using this toolkit and their existing quality improvement methods.

See Appendix 1: Implementation checklist.

1. Start a process map
Consider what processes you have in place for screening residents and what might need to change when you start using the screening tool. For example:

- Staffing profile and availability
- Timing of handover, huddles etc
- Documentation of care
- How care is escalated

2. Build a team
A variety of staff in RACS can support the implementation and use of the screening tool. Identify someone to lead the implementation of the screening tool and a support team that includes people who will help make the change. Clearly define what role each person will play.

For example, a quality manager may lead the implementation with the support of some key nursing and personal care staff.

3. Set a timeline
Set a timeline for the implementation and getting feedback from staff. Remember, you can start small and then increase to screening all residents.

4. Communication
Make staff, residents, visitors and visiting professionals (GPs, allied health) aware that you are implementing and using the screening tool. You can achieve this using a flyer or email newsletter.

Pilot facilities sent information about the COVID-19 screening tool for RACS to GPs and visiting professionals via an email newsletter.

5. Educate staff
Educate staff about the different symptoms and how to use the screening tool. Encourage them to use this toolkit as an educational resource.
6. Engage key stakeholders
All staff who care for residents in the facility will benefit from knowing about the screening tool. This includes, but is not limited to:

- GPs
- geriatricians
- allied health professionals
- residential in reach services
- visiting specialist services e.g. palliative care

During the development of the screening tool, residential in reach (RIR) services used the screening tool to support referral handover and staff education when they provided assessment of the resident.

Top ideas for change from pilot facilities:

- Start screening in the morning. Distribute screening across morning and afternoon shifts to help reach each resident every day.
- Use the screening tool to screen admissions, including those coming in for respite or emergency respite. The admissions staff member can use the screening tool the day before a new resident arrives with the referring service. The service can then use the form to screen for 14 days after admission.
- Enrolled nurse or nurse in charge to take all resident’s temperatures at one time.
- Use the screening tool to identify other signs of deterioration in residents.
- Hold a morning huddle to help with escalation of screening results.
- Consider ways to incorporate the screening tool with current electronic documentation systems.

7. Check equipment
Check you have the right equipment and staff know how to use it. This includes thermometers and PPE. Consider printing ‘donning and doffing’ flyers or lanyard cards.

8. Make the toolkit and screening tool readily available
Have copies of the screening tool and toolkit printed out for staff. Designate a place for completed screens to be placed and stored. This supports data collection.
9. **Monitor use of the screening tool**
It is important to monitor the use of the screening tool by collecting data. The family of measures (detailed on the next page) will help you do this.

10. **Evaluate**
Consider using quick surveys with staff to ask them how confident they feel using the screening tool and identifying symptoms. Collect ideas and feedback on how you can improve the implementation process.

Having a log of what worked is also useful for your quality management plan and for accreditation evidence.

- At a morning huddle or staff meeting consider asking staff questions such as:
  - Is the screening tool easy to use?
  - Do you feel confident (rate 1-5) using the screening tool?
  - Is the screening tool supporting you to escalate concerns about residents?
When implementing a new process or task, it is important to measure if it is working.

The below measures are easy ‘counts’ that services can collect to understand their progress when implementing the screening tool. We encourage services to record these percentages on a graph to visually represent improvement over time.

**Table 2: Family of measures**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Numerator</th>
<th>Denominator</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outcome measure</strong></td>
<td>Percentage of residents who receive a laboratory test</td>
<td>Number of residents who receive a laboratory test for COVID-19</td>
</tr>
<tr>
<td><strong>Process measure</strong></td>
<td>Percentage of residents who are screened using the clinical screening tool</td>
<td>Number of residents who are screened using the clinical screening tool</td>
</tr>
<tr>
<td><strong>Balance measure</strong></td>
<td>Number of residents who have care escalated who are COVID-19 negative</td>
<td>Number of residents with care escalated</td>
</tr>
</tbody>
</table>

To understand more about measurement visit: [www.ihi.org/resources/Pages/Measures/default.aspx](http://www.ihi.org/resources/Pages/Measures/default.aspx)

**DATA COLLECTION**

Data collection can be completed using the data collection tool.

**DATA SUBMISSION**

For public sector aged care services, VICNISS is currently developing a portal for collecting this data. This aligns with existing data collected by RACS.
Using the screening tool

- Screen every resident daily with the first three questions (Section 1):
  1. Is the resident ‘different’ to before? Are they ‘not themselves’ (compared to the past 24 hours)?
  2. Has the resident had a fall in the past 24 hours?
  3. Is the resident’s temperature greater than 37.5°C?

- If a resident is positive on the screening tool and/or has been tested for COVID-19, continue to screen the resident daily.

- If a resident has had a recent negative COVID-19 swab result, but has another positive on the screening tool, follow the escalation plan as below.

**Figure 1: Escalation plan**

If the resident has a CONFIRMED CASE of COVID-19, initiate your facility outbreak plan/protocol. Consider screening **daily** to support identification of deterioration.
**COMMON SCENARIOS WHEN SCREENING A RESIDENT**

<table>
<thead>
<tr>
<th>Scenario</th>
<th>How do I record the screen result?</th>
<th>What action is taken?</th>
<th>Should a swab be taken?</th>
<th>Which clinicians might be required?</th>
<th>Do I screen this resident again?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resident is screened all answers are NO in Section 1</td>
<td>NEGATIVE</td>
<td>Continue care for resident as normal</td>
<td>NO</td>
<td>PCA</td>
<td>YES, the next day</td>
</tr>
<tr>
<td>Resident is screened answered YES to questions in Section 1</td>
<td>POSITIVE</td>
<td>Staff (PCA or nurse) escalate result to nurse in charge who completes Section 2 of the screening tool</td>
<td>CONSIDER</td>
<td>PCA Nurse Nurse in charge</td>
<td>YES, the next day</td>
</tr>
<tr>
<td>Resident is screened answered YES to questions in Section 1 but answered NO in Section 2</td>
<td>POSITIVE</td>
<td>The nurse who completed Section 2 of the screen is encouraged to escalate the result to GP or RIR service</td>
<td>CONSIDER</td>
<td>PCA Nurse Nurse in charge GP RIR</td>
<td>YES, the next day</td>
</tr>
<tr>
<td>Resident is screened answered YES to questions in both Section 1 and Section 2</td>
<td>POSITIVE</td>
<td>The nurse who completed Section 2 of the screen escalates the result to GP or RIR service</td>
<td>STRONGLY ENCOURAGED</td>
<td>PCA Nurse Nurse in charge GP RIR Pathology service</td>
<td>YES, the next day</td>
</tr>
</tbody>
</table>
### Care plan for suspected or confirmed COVID-19 case

<table>
<thead>
<tr>
<th>Scenario</th>
<th>What action is taken</th>
<th>Should a swab be taken</th>
<th>Which clinicians might be required</th>
<th>Do I screen this resident again?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A resident’s care is escalated to the GP and/or RIR following a POSITIVE screen</td>
<td>A swab is taken by the pathology service. Pending the result, the facility follows infection prevention protocol including isolating the resident, wearing PPE (gloves, gown, goggles and mask)</td>
<td>YES</td>
<td>PCA, Nurse, Nurse in charge, GP, RIR, Pathology service</td>
<td>YES, the next day&lt;br&gt; If the resident is positive to the screen again (which is likely given they are unwell), record that a COVID-19 swab result is PENDING</td>
</tr>
<tr>
<td>A resident’s care is escalated to the GP and/or RIR following a POSITIVE screen</td>
<td>Continue to care for the resident, including screening them again the following day</td>
<td>NO</td>
<td>PCA, Nurse, Nurse in charge, GP, RIR, Pathology service</td>
<td>YES, the next day&lt;br&gt; If the resident is POSITIVE to the screen the next day, continue to escalate concerns</td>
</tr>
<tr>
<td>A resident’s care is escalated to the GP and/or RIR following a POSITIVE screen</td>
<td>A swab is taken by the pathology service. Pending the result, the facility follows infection prevention protocol including isolating the resident, wearing PPE (gloves, gown, goggles and mask)</td>
<td>YES</td>
<td>PCA, Nurse, Nurse in charge, GP, RIR, Pathology service</td>
<td>YES, the next day&lt;br&gt; If the resident is positive to the screen again (which is likely given they are unwell), record that an influenza swab result is PENDING</td>
</tr>
</tbody>
</table>
### COMMON SCENARIOS ONCE SWAB RESULTS ARE RETURNED

<table>
<thead>
<tr>
<th>Scenario</th>
<th>What action is taken?</th>
<th>Do I screen this resident again?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A resident’s swab result is POSITIVE for COVID-19 (confirmed case)</td>
<td>COVID-19 OUTBREAK</td>
<td>YES, the next day</td>
</tr>
<tr>
<td></td>
<td>Refer to:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identification of deterioration is important for people with COVID-19. If the resident continues to appear different than before, escalate your concerns</td>
<td></td>
</tr>
<tr>
<td>A resident’s swab results are NEGATIVE for COVID-19 but POSITIVE for Influenza</td>
<td>If three or more cases of influenza-like illness occur within a 72-hour period in residents or staff, this is a confirmed INFLUENZA OUTBREAK</td>
<td>YES, the next day</td>
</tr>
<tr>
<td></td>
<td>Refer to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identification of deterioration is important for people with influenza. If the resident continues to appear different than before, escalate your concerns</td>
<td></td>
</tr>
<tr>
<td>A resident’s swab results are indeterminate for COVID-19</td>
<td>Repeat the swab</td>
<td>YES, the next day</td>
</tr>
<tr>
<td></td>
<td>Record that a COVID-19 swab result is PENDING</td>
<td></td>
</tr>
<tr>
<td>A resident who was NOT screened is swabbed and the resident’s swab results are POSITIVE for COVID-19</td>
<td>COVID-19 OUTBREAK</td>
<td>YES, the next day</td>
</tr>
<tr>
<td></td>
<td>Refer to</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Identification of deterioration is important for people with COVID-19. If the resident continues to appear different than before, escalate your concerns</td>
<td></td>
</tr>
</tbody>
</table>
Before starting to use the screening tool

- **Start a process map**
  Map out your current process for screening residents and then consider how things might change when you use the screening tool.

- **Build a team**
  Identify a team of people to support the implementation of the screening tool, including a lead person and someone to collect data.

- **Set a timeline for implementation**
  When will you start to screen residents? What are your goals for the day, week, month?

Once the screening tool is in use

- **Communication**
  Remind all staff on shift that they will need to screen residents.

- **Monitor use of the screening tool**
  - Collect completed screening tools.
  - Record results on the data collection sheet.

- **Evaluate**
  - Conduct quick surveys with staff.
  - Collect ideas and feedback on how the implementation process can be improved. Keeping a log of what worked is also useful for your quality management plan and for accreditation evidence.

- **Education**
  Incorporate the screening tool into existing or future staff education.

- **Engage key stakeholders**
  Engage with all staff including those who visit the facility like GPs, RIR and allied health, letting them know you are implementing the screening tool.

- **Check equipment**
  Check equipment is available, and staff know how to use it.

- **Make the screening tool and toolkit available**
  - Print out a screening tool for each resident, for each day of the week ahead.
  - Ensure there are phone numbers for local services at hand (GP, RIR) and pathology service.
  - Consider putting the screening tool into your admission packs.
Georgina is an 82-year-old woman who has lived at the same residential aged care facility for three years following a mild stroke.

On Monday morning, care staff find Georgina still in bed. This is unusual as she normally gets out of bed herself and sits in a chair for breakfast, or waits for help to go to the dining room. Using Section one the screening tool, care staff ask Georgina a few questions and note she is having more trouble than normal answering ‘yes and no’ questions. Even though her temperature is below 37.5, they are worried. Georgina just doesn’t seem quite herself.

The care staff tell the nurse in charge immediately, who reports Georgina had a fall the night before. The nurse agrees something is not quite right and she completes Section two of the screening tool. Georgina keeps pointing to her throat saying, ‘can’t, painful’. The care staff and the nurse now understand why she didn’t want to get out for breakfast – Georgina has a sore throat.

What would Georgina’s result on the screening tool be?

Georgina is POSITIVE on both sections one and two of the screening tool. It is strongly encouraged that her care is escalated, and she has a swab test for COVID-19.

The nurse in charge calls the facility GP and he agrees that a swab for COVID-19 and Influenza should be taken. Georgina is showing typical and atypical signs of COVID-19 (increased confusion, loss of appetite, fall and sore throat) and it is best to also rule out influenza. He explains that even though she is not febrile, this is common in older people when they are unwell.

Who do you call to arrange a swab for COVID-19 for Georgina?

The Government has engaged Sonic Healthcare to provide a dedicated pathology service for rapid sample collection and testing for suspected cases of COVID-19 in residential aged care facilities. Call: 1800 570 573. Some facilities may have alternative arrangements for pathology service.

Now that Georgina has had a swab for COVID-19 and is defined as having a suspected case, what infection prevention is required?

Georgina should be isolated in her room if possible, or another appropriate space within the facility. All staff entering and providing care should wear gloves, gowns, masks and goggles.

Georgina’s swab results come back 36 hours later on Tuesday afternoon. Georgina does not have COVID-19 or influenza.

Staff continue to use the screening tool each morning both whilst awaiting the result and once it comes back negative. Georgina continues to answer ‘yes’ to questions in section one and section two on Tuesday but is not swabbed again as her results are still pending.

By Wednesday she is looking and sounding better. She eats a bigger breakfast and is communicating like she normally does. On Wednesday and Thursday Georgina is negative on the screening tool.

On Friday morning the care staff again complete the screening tool. Georgina appears confused and this time she also seems short of breath. Her respiratory rate is 27 breaths per minute.
The nurse in charge calls the GP immediately. They reassess following the protocol for a suspected case of COVID-19. They send through the pathology slip via fax and the nurse arranges the pathology service to take another swab for COVID-19 and influenza.

On Saturday afternoon the result returns as positive for COVID-19. Georgina has coronavirus. The staff also speak with Georgina’s family and connected her with them over a video call.

What steps should the facility take now that Georgina has a confirmed case of COVID-19?

Refer to the COVID-19 plan and Influenza plan.

Georgina continues to have mild symptoms associated with COVID-19 and after four to five days starts to feel and look better. She also screens negative on the screening tool two days in a row. The staff feel confident that Georgina will recover and that screening her symptoms has helped them communicate more effectively with the GP and public health officials.

Ideally, Georgina would be screened daily following her diagnosis of COVID-19. If this cannot happen, consider the most appropriate time to recommence screening e.g. after 14 days of isolation or on return from admission to hospital.

Georgina and her fellow residents continue to be screened daily using the screening tool to ensure there are no further cases of the virus. Georgina makes a full recovery and once she has been cleared by public health staff she starts returning to usual activities in her home.

Table 3: Georgina’s screening and test results

<table>
<thead>
<tr>
<th></th>
<th>Mon</th>
<th>Tue</th>
<th>Wed</th>
<th>Thu</th>
<th>Fri</th>
<th>Sat</th>
<th>Sun</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screened</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
<td>YES – to identify deterioration</td>
</tr>
<tr>
<td>Screen result</td>
<td>POSITIVE</td>
<td>POSITIVE</td>
<td>NEGATIVE</td>
<td>NEGATIVE</td>
<td>POSITIVE</td>
<td>POSITIVE</td>
<td>POSITIVE</td>
</tr>
<tr>
<td>Tested</td>
<td>YES</td>
<td>NO – suspected COVID-19</td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>NO – suspected COVID-19</td>
<td>NO – confirmed COVID-19</td>
</tr>
<tr>
<td>Test result</td>
<td>NEGATIVE</td>
<td>POSITIVE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Acknowledgements

We acknowledge the contribution of the following individuals and groups who provided input in developing the COVID-19 screening tool for RACS:

- **Professor Joseph Ibrahim** Geriatrician, Monash University/Ballarat Health Services
- **Associate Professor Noleen Bennett** Senior Infection Control Consultant, VICNISS/National Centre for Antimicrobial Stewardship
- **Professor Kirsty Buising** Infectious Diseases Physician and Acting Director for the Victoria Infectious Diseases Service (VIDS), Melbourne Health
- **Associate Professor Dr Lisa Clinnick** Director Aged Care Services, Ballarat Health Services
- **Dodie Bischoff** Director of Nursing Residential Service, Bendigo Health
- **Melissa Todd** Nurse Unit Manager Residential in Reach, Royal Melbourne Hospital
- **Catherine Klomp** Director of Care, Kew Gardens
- **Wendy Wallace** Aged Persons Mental Health Program, (North Western Mental Health
- **VICNISS Coordinating Centre** Melbourne Health/The Doherty Centre

With the oversight of the COVID-19 Expert Working Group - Older People/Palliative Care:

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- Therese Mirenda (Ballarat Health Service)
- Jane Newbound (Southern Metro Palliative Care Consortium)
- Amy Nobel (Royal Melbourne Hospital)
- Helen Richards (Monash Health Community)
- Siva Subramaniam (Goulburn Valley Health)
- Dr Claire White (Western Health)
- Dr Sarah Whiting (Alfred Health)
- A/Prof Leeroy William (Eastern Health)
- Theresa Williamson (DHHS)
Atypical symptom: Other reported symptoms of COVID-19 include: fatigue, loss of smell, loss of taste, runny nose, muscle pain, joint pain, diarrhoea, nausea/vomiting and loss of appetite.

Care escalated: The organisational response required to abnormal physiological measurements or other observed clinical deterioration.

Close contact: A close contact is defined as requiring:

- face-to-face contact in any setting with a confirmed or probable case, for greater than 15 minutes cumulative over the course of a week, in the period extending from 48 hours before onset of symptoms in the confirmed or probable case, or
- sharing of a closed space with a confirmed or probable case for a prolonged period (e.g. more than two hours) in the period extending from 48 hours before onset of symptoms in the confirmed or probable case.

Coronavirus (COVID-19): Coronaviruses are a large family of viruses which may cause illness in animals or humans. The most recently discovered coronavirus (COVID-19) is a new virus that can cause mild to severe respiratory illness in humans. An outbreak of COVID-19 has spread around the world and has been characterised as a pandemic.

Fall: An event that results in a person coming to rest inadvertently on the ground or floor or other lower level.

GP: General practitioner.

Influenza: It can be difficult to tell the difference between a respiratory illness caused by influenza and a respiratory illness caused by other viruses based on symptoms alone. Suspected influenza cases are referred to as ‘influenza-like-illness’ (ILI) until a causative pathogen is identified through diagnostic testing (for example, nose and throat swab collection).

Laboratory test (swab): A laboratory test for COVID-19 can be conducted by a trained healthcare worker and involves a nasopharyngeal swab. Consideration should be given to testing broadly for influenza and other common respiratory viruses in addition to COVID-19. The recommended test and methods of sampling for COVID-19 is outlined in the CDNA COVID-19 Interim National Guideline.

Nurse: Registered or enrolled nurse.

Pathology service: In addition to existing public health pathology services, the government has engaged Sonic Healthcare to provide a dedicated pathology service for rapid sample collection and testing for suspected cases of COVID-19 in RACFs. Results can be provided to the referring doctor/registered within 24 hours (metropolitan areas) or 48 hours (regional areas). Referring doctors can calling 1800 570 573 (8am–6pm) to:

- request and prioritise COVID-19 testing of residents and staff
- arrange for a specialised COVID-19 pathology collector to attend a facility as soon as possible (8am–8pm) and take samples for immediate testing
(if a result is positive) request a specialised COVID-19 collection team to collect samples from all staff and residents.

**Personal care attendant (PCA)/assistant/worker:** Is a member of the aged care workforce who assist residents with their personal care needs such as showering, dressing and eating; their mobility and communication needs; and observe and reports changes in patients' condition to nursing staff.

**Resident:** A resident is a care recipient as defined by the Aged Care Act 1997.

**Residential in reach service (RIR):** Residential in reach provides hospital-type care where appropriate and safe, to people living in residential aged care services. Residential in reach is staffed by nurses and doctors from the hospital, who may visit and provide care to people where they live where appropriate.

**Screening:** A process of identifying patients who are at risk, or already have a disease or injury. Screening gathers knowledge in order for a clinician to make a clinical judgement.

**Typical symptom:** Fever (≥37.5°C) or history of fever (e.g. night sweats, chills) or acute respiratory infection (e.g. cough, shortness of breath, sore throat).

**VICNISS:** VICNISS Coordinating Centre: Collects and analyses data and surveillance from hospitals with the aim to reduce healthcare associated infections in Victorian hospitals and public residential aged care facilities. For more information see [www.vicniss.org.au/](http://www.vicniss.org.au/)
Resources and references


Common symptoms of COVID-19
www.bmj.com/content/bmj/suppl/2020/03/24/bmj.m1182.DC1/gret055914.fi.pdf


