

Our reference: CHSFOI21-22.25

Dear [REDACTED]

### DECISION ON YOUR ACCESS APPLICATION

I refer to your application under section 30 of the *Freedom of Information Act 2016* (FOI Act), received by Canberra Health Services (CHS) on **Thursday 10 March 2022**.

This application requested access to:

*‘What is ACT Health’s treatment for Covid-19:*

- *During hospitalisation?*
- *During non-hospitalisation?*

*What “vital Covid treatments” are patients missing out on if they don’t report their RAT results?’*

I am an Information Officer appointed by the Chief Executive Officer of Canberra Health Services (CHS) under section 18 of the FOI Act to deal with access applications made under Part 5 of the Act. CHS was required to provide a decision on your access application by **Friday 8 April 2022**.

I have identified one document holding the information within scope of your access application. The document released to you is provided as Attachment A to this letter.

In reaching my access decision, I have taken the following into account:

- The FOI Act;
- The contents of the documents that fall within the scope of your request;
- The views of relevant third parties; and
- The *Human Rights Act 2004*.

#### Decisions on access

I have decided to grant full access to the one document within scope of your application. This identified document is the Clinical Management of Adults with COVID-19 Guideline and is subject to changes according to the Australian Technical Advisory Group on Immunisation (ATAGI) advice.

To supplement the document, please refer to the below link for an additional source of information relating to treatments for people who test positive for COVID-19:

<https://www.covid19.act.gov.au/stay-safe-and-healthy/information-for-people-who-test-positive-for-covid-19#Am-I-eligible-for-the-new-COVID-19-treatments->

With regards to missing vital treatment when not reporting RAT tests, CHS does not change the management of COVID-19 dependant on reporting test results. However, the provision of important information specific to comorbidities maybe hampered if CHS is not aware of COVID-19 cases.

### **Charges**

Processing charges are not applicable to this request.

### **Disclosure Log**

Under section 28 of the FOI Act, CHS maintains an online record of access applications called a disclosure log. The scope of your access application, my decision and documents released to you will be published in the disclosure log not less than three days but not more than 10 days after the date of this decision. Your personal contact details will not be published.

<https://www.health.act.gov.au/about-our-health-system/freedom-information/disclosure-log>.

### **Ombudsman review**

My decision on your access request is a reviewable decision as identified in Schedule 3 of the FOI Act. You have the right to seek Ombudsman review of this outcome under section 73 of the Act within 20 working days from the day that my decision is published in ACT Health's disclosure log, or a longer period allowed by the Ombudsman.

If you wish to request a review of my decision you may write to the Ombudsman at:

The ACT Ombudsman

GPO Box 442

CANBERRA ACT 2601

Via email: [ACTFOI@ombudsman.gov.au](mailto:ACTFOI@ombudsman.gov.au)

Website: [ombudsman.act.gov.au](http://ombudsman.act.gov.au)

### **ACT Civil and Administrative Tribunal (ACAT) review**

Under section 84 of the Act, if a decision is made under section 82(1) on an Ombudsman review, you may apply to the ACAT for review of the Ombudsman decision. Further information may be obtained from the ACAT at:

ACT Civil and Administrative Tribunal

Level 4, 1 Moore St

GPO Box 370

Canberra City ACT 2601

Telephone: (02) 6207 1740

<http://www.acat.act.gov.au/>

**Further assistance**

Should you have any queries in relation to your request, please do not hesitate to contact the FOI Coordinator on (02) 5124 9831 or email [HealthFOI@act.gov.au](mailto:HealthFOI@act.gov.au).

Yours sincerely

A handwritten signature in blue ink, appearing to read 'C O'Neill', written in a cursive style.

Cathie O'Neill  
**Chief Operating Officer**  
Canberra Health Services

22 March 2022

# COVID-19 Guideline Clinical Management of Adults with COVID-19

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## Purpose

To provide Canberra Health Service (CHS) staff guidance on how to care for adult patients who test positive for SARS-CoV-2 (COVID-19).

## Scope

The procedure applies to all CHS staff members caring for patients with COVID-19.

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## Section 1 – Clinical Assessment for patients with COVID-19

ASSESSMENT	
HISTORY	EXAMINATION
<p><b>Admission</b></p> <p>Review history taken elsewhere (i.e., no need to repeat questions if information is known).</p> <p>Include:</p> <ul style="list-style-type: none"> <li>• symptoms – type, duration</li> <li>• risk factors for acquisition of disease, e.g., international travel, sick contacts, residential aged care contact</li> <li>• risk factors for severe disease</li> <li>• relevant past medical history</li> <li>• medications and allergy</li> <li>• COVID Vaccination status</li> <li>• living situation and ADLs</li> <li>• Next of Kin</li> <li>• goals of care and Advanced Care Directive.</li> </ul> <p><b>Daily Review</b></p> <ul style="list-style-type: none"> <li>• Ongoing symptoms.</li> <li>• Exercise tolerance.</li> <li>• Oxygen requirement.</li> <li>• Oral intake (especially fluids).</li> </ul>	<p>Limit examination to what is required to:</p> <ol style="list-style-type: none"> <li>1. assist with diagnosis</li> <li>2. assess severity of illness</li> <li>3. manage complications of disease/treatment</li> </ol> <p>In general, need to assess:</p> <p>Respiratory system</p> <ul style="list-style-type: none"> <li>• Respiratory Rate (RR), Oxygen Saturations (O2 sats), accessory muscle use, chest auscultation.</li> <li>• Able to speak in sentences?</li> <li>• Are they tiring out? Cardiovascular system</li> <li>• HR, BP, fluid status, evidence of heart failure</li> <li>• Level of alertness</li> <li>• Drowsiness is a sign of severity.</li> </ul>

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## Section 2 – Clinical Assessment and Risk Stratification

ASSESSMENT/RISK STRATIFICATION	
SEVERITY	CLINICAL AND DIAGNOSTIC CRITERIA FOR ADULTS >16YEARS
MILD ILLNESS	<p>Person not presenting any clinical features suggestive of moderate or severe disease or a complicated course of illness.</p> <p><b>Characteristics:</b></p> <ul style="list-style-type: none"> <li>no symptoms, or</li> <li>mild upper respiratory tract symptoms, or</li> <li>cough, new myalgia or asthenia without new shortness of breath or a reduction in oxygen saturation.</li> </ul>
MODERATE ILLNESS	<p>Stable patient presenting with respiratory and/or systemic symptoms or signs. Able to maintain oxygen saturation above 92% (or above 90% for patients with chronic lung disease) with up to 4L/min oxygen via nasal prongs.</p> <p><b>Characteristics:</b></p> <ul style="list-style-type: none"> <li>prostration, severe asthenia, fever &gt; 38°C or persistent cough</li> <li>clinical or radiological signs of lung involvement</li> <li>no clinical or laboratory indicators of clinical severity or respiratory impairment.</li> </ul>
SEVERE ILLNESS	<p>Patients meeting any of the following criteria:</p> <ul style="list-style-type: none"> <li>respiratory rate <math>\geq</math> 30 breaths/min</li> <li>oxygen saturation <math>\leq</math> 92% at rest despite O<sub>2</sub> at 4L/min (FiO<sub>2</sub> 36%) by nasal prongs</li> <li>arterial partial pressure of oxygen (PaO<sub>2</sub>)/ inspired oxygen fraction (FiO<sub>2</sub>) <math>\leq</math> 300.</li> </ul>
CRITICAL ILLNESS	<p>Patient meeting any of the following criteria:</p> <ul style="list-style-type: none"> <li>Respiratory Failure</li> <li>Occurrence of severe respiratory failure (PaO<sub>2</sub>/FiO<sub>2</sub> ratio &lt; 200), respiratory distress or acute respiratory distress syndrome (ARDS). This includes patients deteriorating despite advanced forms of respiratory support (NIV, HFNO) OR patients requiring mechanical ventilation. OR other signs of significant deterioration:                             <ul style="list-style-type: none"> <li>hypotension or shock</li> <li>impairment of consciousness</li> <li>other organ failure.</li> </ul> </li> </ul>

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## Section 3 – Investigations and Treatment

INVESTIGATIONS AND TREATMENT BASED ON CLINICAL SEVERITY				
	MILD	MODERATE	SEVERE	CRITICAL
<b>SWABS</b>	<p>SARS-CoV-2 Nucleic Acid Detection combined throat-bilateral deep nasal swab</p> <p>If SARS-CoV-2 PCR is negative and strong clinical suspicion for COVID-19 remains:</p> <ul style="list-style-type: none"> <li>• continue isolation and treatment of patient as provisional COVID-19 diagnosis;</li> <li>• repeat SARS-CoV-2 swab;</li> <li>• discuss with the Clinical Microbiologist on-call for alternative diagnostics (e.g. respiratory panel)</li> </ul> <p>If the patient has been diagnosed by a swab performed at a non-ACT Pathology laboratory, please repeat the swab on admission</p>			
<b>BASELINE BLOODS</b>	Not routinely	FBC, UEC, CRP, Troponin, Hepatitis B serology (HBsAg, HBsAb; HBcAb), Hepatitis C Ab, Ferritin, LDH, D-dimer, VBG, Coagulation profile		
<b>ADDITIONAL BLOOD TESTS</b>	No	<p>Blood cultures if febrile, haemodynamically unstable and/or clinical suspicion of bacteremia (e.g. recent IV drug use)</p> <p>Refer to the “Opportunistic Infection Screening section” for guidance on Strongyloides and TB testing</p>		
<b>CHEST XRAY (CXR)</b>	No (unless specific indication)	<p>Yes (IF NOT ALREADY TAKEN)</p> <p>Repeat only if considering alternate diagnosis or deteriorating</p>		
<b>CT CHEST</b>	No	<p>Routine CT will not change management.</p> <p>Only if considering alternative diagnosis, comorbid illness, complications, etc.</p>		
<b>ECG</b>	No	<p>Yes: At <u>baseline</u> and <u>if chest pain, troponin rise, concern</u> regarding heart failure, acute coronary syndrome</p>		

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<b>O<sub>2</sub> THERAPY</b>	No	<p><b>Aim: Sats &gt;92% or lower based on usual baseline (e.g. 88–92%)</b> Give supplemental oxygen, starting with nasal prongs (0.5–3 L/min) if O<sub>2</sub> sats &lt;92% or significantly below baseline</p> <p>If below target O<sub>2</sub> sats, commence HFNP at the lowest concentration and titrate to target O<sub>2</sub> sats</p>
		<p>If still below target O<sub>2</sub> sats or increasing work of breathing with FiO<sub>2</sub> at 40%, refer ICU for consideration of early intubation, if appropriate (see ICU Admission Criteria below)</p> <p><b>Be alert to “silent hypoxia” where low saturation does not cause patient distress. Normal oxygen saturation should be targeted despite lack of symptoms in these patients.</b></p>
<b>HIGH FLOW NASAL PRONGS (HFNP)</b>	No	<p>Minimise use if possible (aerosolization risk)</p> <p>Maximum therapy: 40L/minute</p> <p>Titrate to individualised O<sub>2</sub> sats goal</p> <p><b>Ideally used in a negative pressure room</b></p>
<b>PRONE POSITIONING</b>	No	<p>Prone positioning of patients with an oxygen requirement has been shown to reduce the risk of subsequent intubation</p> <p>Aim for a minimum of 8 hours proning each day (does not need to be continuous)</p> <p>Indications: patient alert, cooperative, able to independently change position in the bed</p> <p>Contra-indications: confusion, haemodynamic instability, late pregnancy, spinal/chest wall injuries, unable to self-prone</p> <p><b>For further information see the <a href="#">‘Awake Proning in COVID 19 Patients’</a> document</b></p>
<b>NON-INVASIVE VENTILATION (NIV)</b>	No	<p><b>Consider using NIV for respiratory failure ensuring it is used with caution &amp; strict attention paid to staff safety and appropriate PPE. Ideally used in a negative pressure room.</b></p>
<b>TREAT FOR COMORBID ILLNESS</b>	As clinically indicated. Prescribe usual medications	
<b>FLUIDS</b>	Aim for euvolaemia. If NBM may require maintenance fluids only. If hypotensive may require referral to ICU for consideration of vasopressor support	

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<p><b>ANTIBIOTICS</b></p>	<p>No</p>	<p>Prescribe antibiotics for bacterial pneumonia if hypoxic (&lt;92%), pleural effusion or purulent sputum as per eTG for CAP (first 72 hours) or HAP (&gt;72 hours)</p> <p>Prescribe antibiotics for other sources of sepsis that may occur concurrently with COVID 19</p>	
<p><b>DVT PROPHYLAXIS</b></p>	<p>Not required for mild COVID illness</p>	<p>Use prophylactic doses of anticoagulants, preferably low molecular weight heparin (LMWH) (e.g. enoxaparin 40 mg once daily), unless there is a contraindication, such as risk for major bleeding.</p> <p>Where the estimated glomerular filtration rate (eGFR) &lt; 30 mL/min/1.73m<sup>2</sup>, unfractionated heparin or clearance-adjusted doses of LMWH may be used (e.g. enoxaparin 20 mg once daily).</p>	
<p><b>PRE-EMPTIVE THERAPIES</b></p>	<p>Consider <b>SOTROVIMAB</b> and/or <b>INHALED BUDESONIDE</b> for patients early in the illness and with risk factors for deterioration, see criteria on page 8</p>	<p>Not recommended in hypoxic patients</p>	
<p><b>SYSTEMIC CORTICOSTEROIDS</b></p>	<p>If required for the management of an underlying condition i.e. exacerbation of asthma, COPD</p>	<p><b>Start or continue DEXAMETHASONE in adults who are receiving oxygen</b></p> <p>Adult Dose: 6mg/day IV (or oral) Child Dose: 0.15mg/kg/day</p> <p>Dexamethasone can be discontinued after 10 days or upon discharge from hospital, whichever is sooner (NIH recommendation)</p>	
<p><b>REMDESIVIR (ANTIVIRAL)</b> See note 1</p>	<p>No</p>	<p><b>Start REMDESIVIR (antiviral) in adults who are receiving oxygen</b></p> <p>Dose (age 12 and over): 200mg IV on Day 1, then 100mg daily for a maximum of 5 days. It can be ceased on discharge if the patient is admitted for less than 5 days.</p> <p>Only prescribe Remdesivir if:</p> <ul style="list-style-type: none"> <li>• Age over 12 years</li> <li>• Weight ≥ 40kg</li> </ul>	<p>Continue REMDESIVIR if commenced PRIOR to ventilation.</p> <p>Not recommended initiating following ventilation</p>

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		<ul style="list-style-type: none"> <li>• ALT &lt; 5x ULN, and/or</li> <li>• ALT &lt; 3x ULN and bilirubin &lt; 2x ULN</li> <li>• eGFR ≥ 30mL/min</li> </ul>	
<p><b>BARICITINIB (JAK INHIBITOR)</b> For nonpregnant adults See medication note 2 and 4</p>	No	<p><b>Add BARICITINIB* (JAK inhibitor):</b></p> <p><b>Adult patient requiring oxygen</b> <b>Not pregnant</b> <b>Neutrophil count &gt; 1x10<sup>9</sup>/L; lymphocyte count &gt; 0.2x10<sup>9</sup>/L</b></p> <p>If the patient is on pre-existing immunosuppressant medication, discuss with the on-call ID Consultant</p> <p><b>Dose: 4mg daily</b></p>	<p>Low evidence of efficacy for invasive Ventilation or ECMO</p>
		<p><b>Renal dose reduction required:</b></p> <p>GFR 30-60mL/min    2mg daily    GFR 15-30mL/min    2mg on alternate daily</p> <p><b>Duration:</b> Baricitinib is continued for up to 14 days or until discharge from hospital. If progressive clinical deterioration occurs despite baricitinib, earlier cessation can be considered</p>	

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<p><b>TOCILIZUMAB (IL-6 ANTAGONIST)</b> For children and pregnant adults See medication note 3</p>	<p>No</p>	<p><b>TOCILIZUMAB*</b> should ONLY be considered in:</p> <ul style="list-style-type: none"> <li>• Pregnant or breastfeeding women</li> <li>• Children or adolescents (&lt;18 years)</li> <li>• Critically ill patients directly admitted to ICU for mechanical ventilation who are not already on baricitinib</li> </ul> <p><b>Given critical shortage of TOCILUZIMAB, it can only be prescribed with authorisation of the Infectious Diseases Consultant – on call via CHS Switchboard</b></p> <p><b>Dose: Single IV infusion over 60 minutes</b></p> <table border="1" data-bbox="679 763 1267 1144"> <tr> <td>Weight ≥ 90kg</td> <td>800mg</td> </tr> <tr> <td>Weight &gt; 65kg &amp; &lt; 90kg</td> <td>600mg</td> </tr> <tr> <td>Weight &gt; 40kg &amp; &lt; 65kg</td> <td>400mg</td> </tr> <tr> <td>Weight ≤ 40kg (including children ≥ 30 kg)</td> <td>8 mg/kg (max of 800 mg)</td> </tr> <tr> <td>Children weight ≤ 30 kg</td> <td>12mg/kg</td> </tr> <tr> <td>Infants ≤ 1 year:</td> <td>12mg/kg</td> </tr> </table> <p>*Baricitinib and tocilizumab perform a similar immunomodulator role in systemic inflammation and <u>should not be used in combination.</u></p>	Weight ≥ 90kg	800mg	Weight > 65kg & < 90kg	600mg	Weight > 40kg & < 65kg	400mg	Weight ≤ 40kg (including children ≥ 30 kg)	8 mg/kg (max of 800 mg)	Children weight ≤ 30 kg	12mg/kg	Infants ≤ 1 year:	12mg/kg
Weight ≥ 90kg	800mg													
Weight > 65kg & < 90kg	600mg													
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Weight ≤ 40kg (including children ≥ 30 kg)	8 mg/kg (max of 800 mg)													
Children weight ≤ 30 kg	12mg/kg													
Infants ≤ 1 year:	12mg/kg													
<p><b>OPPORTUNISTIC INFECTION SCREENING</b></p>		<p>All patients receiving baricitinib or tocilizumab should undergo baseline testing for HIV, hepatitis B and C serology</p> <p>In patients with severe COVID infection and prolonged immunomodulation and an epidemiological risk of TB, a Quantiferon Gold test can be considered (submit at least 5ml of blood in a single heparin tube 7am – 3pm Mon to Thursday), however treatment with baricitinib or tocilizumab should not be delayed while awaiting the result.</p> <p>In patients treated with dexamethasone who have risk factors for Strongyloides infection (e.g. migrant from rural areas of Africa, Asia, Central or South America, Oceania, Indigenous Australian), consider serology testing and pre-emptive treatment with ivermectin. Consult with the infectious diseases team.</p>												
<p><b>PALLIATIVE CARE INTERVENTION</b></p>	<p>All patients should have Goals of Care form filled</p>	<p>Liaise with palliative care team if reaching ceiling of care and not suitable for ICU</p>												

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**Criteria for ICU referral:**

- Has increased work of breathing or needing more than 40% FiO<sub>2</sub> on High Flow Nasal Prongs or has PaO<sub>2</sub>/FiO<sub>2</sub> ratio < 250.
- Needing NIV, intubation and ventilation.
- Hypotensive needing vasopressor support.
- Deranged other organ function (e.g. renal needing renal replacement therapy).

## Notes on Medications

### 1. Remdesivir

- *Mode of Action:* is a nucleoside analog used to inhibit the action of RNA polymerase which has broad antiviral effects including SARS-CoV-2.
- Available from the National Stockpile.
- Currently there is no direct evidence for the use of remdesivir in children aged less than 12 years

### 2. Baricitinib

- *Mode of Action:* Baricitinib is a Janus kinase (JAK) inhibitor (used in rheumatoid arthritis) with immunomodulatory effects and multiple proposed mechanisms of action in COVID, including anti-cytokine effects and inhibition of host cell viral propagation.
- It has moderate evidence for all-cause mortality; and low evidence for invasive ventilation or ECMO) based on the results of the ACTT-2 trial and the COV-BARRIER trial, suggesting that baricitinib probably reduces the risk of death.
- *Administration:* Tablets can be dispersed to allow administration via nasogastric/gastrostomy tube

### 3. Tocilizumab

- *Mode of Action:* Tocilizumab inhibits the action of IL-6, a key cytokine involved in infection-induced cytokine storm as observed with COVID-19.
- Inhibits the production of CRP, a reduction in CRP should not be used as a marker of clinical improvement.
- *Handling Precautions:* The occupational hazard of intermittent low dose exposure to tocilizumab is not known. Wear a mask and gloves when preparing the infusion solution to minimise exposure.

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- *Given the critical national shortage of tocilizumab, this medication can only be prescribed with approval of the Infectious Diseases Physician (contact CHS Switch)*
- Routine repeat dosing is not recommended due to critical supply constraints.
- Baricitinib and tocilizumab perform a similar immunomodulator role in systemic inflammation, however tocilizumab is in critical short supply (Oct-21) and should only be given to hospitalised patients when baricitinib is not suitable

**4. Sotrovimab**

- *Mode of Action:* Antiviral monoclonal antibody against SARS CoV2 spike protein and is designed to block the virus' attachment and entry into human cells.
- *Dose and Administration:* Give as a 500mg IV infusion over 1 hour. Need to observe for 60 minutes post infusion
- *Handling Precautions:* The occupational hazard of intermittent low dose exposure to sotrovimab is not known. Wear a mask and gloves when preparing the infusion solution to minimise exposure.
- Sotrovimab needs to be infused in a single room preferably in a negative pressure environment (i.e. negative pressure room or under a medihood). Infusions will be organized by the COVID Care at Home team or by the COVID ward team using established protocols

**Criteria for sotrovimab:**

- Patients who are unvaccinated (defined as less than 2x vaccine doses) with mild symptomatic COVID-19 who do not require oxygen therapy and are within 5 days of the onset of symptoms AND
- Patient aged over 55 years OR aged between 18 and 55 years with one risk factor for progression to severe COVID-19:
  - ✦ Diabetes requiring medication
  - ✦ BMI > 30
  - ✦ Chronic kidney disease, GFR < 60 ml/min/1.73m<sup>2</sup>
  - ✦ Congestive heart failure: NYHA class II or greater
  - ✦ COPD or moderate-severe Asthma
- Sotrovimab can be considered in fully vaccinated patients who are immunocompromised on a case by case basis. Discuss with on call Infectious Diseases Consultant.
- This may include patients with:
  - ✦ Active haematological malignancy

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- ✦ Non-haematological malignancy undergoing current active treatment (eg. chemotherapy)
- ✦ Solid organ transplant with immunosuppression
- ✦ Haematopoietic stem cell transplant recipients or chimeric antigen receptor T-cell (CAR-T) therapy within 2 years
- ✦ Immunosuppressive therapies: prednisolone >20mg/day for >14 days in a month
- ✦ Mycophenolate, methotrexate (≥10 mg/week), leflunamide, azathioprine (≥ 1mg/kg day), 6-mercaptopurine (≥ 0.5mg/kg/day), alkylating agents (e.g. cyclophosphamide, chlorambucil), and systemic calcineurin inhibitors (e.g. cyclosporin, tacrolimus)
- ✦ Biologic and targeted therapies anticipated to reduce the immune response to the COVID-19 vaccine
- ✦ Primary immunodeficiency including combined immunodeficiency and syndrome, major antibody deficiency (eg. common variable immune deficiency (CVID) or agammaglobulinaemia), defects of innate immunity, defects of immune regulation, complement deficiencies and phenocopies of primary immunodeficiencies
- ✦ Advanced or untreated HIV with CD4 count < 250 cells/μL
- ✦ Long term haemodialysis or peritoneal dialysis

5. Budesonide

- *Mode of Action:* Inhaled corticosteroid
- *Dose and Administration:* Inhaled budesonide 800mcg bd for a maximum of 14 days or until symptom resolution

**Criteria for inhaled budesonide:**

- Patients aged over 65 years with mild symptomatic COVID-19 who do not require oxygen therapy and are within 14 days of the onset of symptoms AND
- With at least one risk factor for progression to severe COVID-19
- Not indicated for patients already taking inhaled corticosteroids

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*Policy Team ONLY to complete the following:*

<i>Date Amended</i>	<i>Section Amended</i>	<i>Divisional Approval</i>	<i>Final Approval</i>
09 Sep 2021	New Document	CHS Chief Operating Officer	CHS COVID-19 Response Committee
28 October 2021	Multiple sections	CHS Chief Operating Office	COVID Executive Leadership Group
7 February 2022	Section 3 and Notes on medications	CHS Chief Operating Office	COVID Executive Leadership Group on 7 Feb 2022

*This document supersedes the following:*

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