Managing the risks related to provision of in-person essential allied health primary care services during the COVID-19 pandemic

Report for the Australian Government Department of Health

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Executive Summary

Allied health services are a core component of primary health care in Australia. Services such as physiotherapy, optometry, dietetics, podiatry, occupational therapy, chiropractic, osteopathy and exercise physiology, enhance and maintain the function, health, and quality of life of patients in a range of primary care settings, including private practices, community health facilities, hospitals and in-home care. Patients receiving remedial and preventative treatment through allied health care are less likely to require hospitalisation and emergency healthcare.

As Australia responds to the COVID-19 pandemic, it is essential that in-person allied health primary care services continue to be available to the community. At the same time, risk of COVID-19 transmission needs to be minimised while providing culturally safe in-person care.

While levels of community transmission of COVID-19 in Australia are presently low, this could change with lifting of social distancing and containment measures, as recently seen in Victoria. It is therefore necessary to consider the potential risks of COVID-19 transmission during allied health in-person service provision, and options for minimising and mitigating these risks, at each possible stage of the pandemic.

Study purpose

This study aimed to develop and pilot the evaluation of an evidence-informed model of care for allied health service providers to minimise the risk of COVID-19 transmission via in-person practice and home care settings. The risk management model of care was informed by the tools currently in use by the collaborating allied health service clinic, the Canberra City Health Network (CCHN), and has been developed in collaboration with the offices of the Australian Capital Territory Chief Allied Health Officer, South Australian Chief Allied and Scientific Health Officer, and the Australian Government Department of Health.

Method of data collection and analysis

The study involved 1) a rapid evidence review of national and international practice guidelines to inform a risk-management model of care and provider checklist; 2) development of a model of care and checklist; and 3) piloting the application of the model and checklist in the collaborating allied health service clinic for adherence and staff acceptability of the guidelines.

Data from direct observations of practitioner consultations with patients, and interviews of practitioners and clinic staff were collected in a Canberra-based allied health clinic (CCHN) between May 13 – May 15, 2020. This study focused on the provision of three allied health services delivered by this clinic: osteopathy, physiotherapy, and exercise physiology.

The study team also reviewed reception register notes on patient screening processes recorded between 04/05/2020–18/05/2020 to inform understanding of how risks of COVID-19 transmission were managed through screening and triaging.
policies. Ethics permissions were granted from the ACT Health and ANU ethics committees prior to data collection.

**Overview of findings**

We found practitioners and staff had consistently high adherence to the risk-management guidelines piloted at CCHN. We observed rigorous implementation of infection control protocols, including enforcing appropriate physical distancing measures in the clinic and fastidious routine cleaning procedures. The clinical environment was further adapted to enhance infection control measures, such as installation of reception desk sneeze guards and replacement of linen with medical grade plastic bedding surfaces. Rigorous, routine patient screening processes had also been implemented to filter patients who may be experiencing COVID-19 symptoms and determine the level of risk in providing in-person care in each case.

All practitioners and staff interviewed found the checklist useful and appropriate in the current context. Respondents considered the checklist an imperative tool to mitigate the risks of COVID-19 transmission.

However, the majority of respondents noted that community transmission context was an important factor when considering the feasibility and efficacy of the risk-management protocols. They considered the guidelines to be effective and appropriate in the Canberra setting where only one case of community transmission of COVID-19 has been recorded to date. Respondents agreed that protocols would need to be revised in a context in which community transmission was high, or where there was a greater risk of community transmission occurring due to increased rates of transmission in other areas of the country, such as in bordering states.

Interviews with practitioners and staff highlighted the important role that allied health primary care services play in supporting and maintaining both the physical and mental health and wellbeing of the population. Provision of such care was found to be particularly critical during the current COVID-19 pandemic as people experience lower overall health and wellbeing, and where the public health system is under significant strain.

**Draft recommendations**

The following draft recommendations for refining checklist and protocols based on staff and practitioner feedback are to be discussed and developed with expert collaborators:

- More uniform, evidence-based, clear guidance for use of PPE specifically targeting allied health professionals as applicable at each possible stage of pandemic risk. This could include clearer guidance in checklist in addition to other multimedia educational resources (e.g., instructional videos or posters)

- Clearer guidance on the need for patients to use PPE, with considerations of the challenges that this may present to practitioners in providing care
• Guidance on use of PPE with consideration of practitioner, staff and patient diversity, including the need to cater to persons with disabilities

• Bins with foot pedals could provide greater infection control by minimising contact with contaminated substances. A foot pedal bin could also be placed in the reception standing zone for patients to dispose of masks and other hygiene items (e.g., tissues) upon exiting clinic

• Foot pedal bins could also be provided in treatment rooms for disposal of used towels and/or linen. This could strengthen infection control by reducing the need for staff and practitioners to handle used items when carrying them to the laundry.

• Checklist and protocols should respond to various stages of pandemic risk. Practitioners, staff and patients would benefit from staged guidelines outlining best practice recommendations for risk mitigation protocols tailored to specific stages of pandemic risk, as defined by a uniform national framework.

• Practitioners, staff and patients would benefit from more diverse and engaging presentations of the checklist and protocols including through multimedia resources such as infographics, posters, videos, and flowcharts. These resources could encapsulate specific components of the checklist, for example, cleaning protocols or patient screening processes.

• Guidance for practitioners on how they might approach the topic of mental and wellbeing of their patients while providing physical services. This guidance should include referral information for patient support.

Introduction

Allied health, including services such as physiotherapy, optometry, dietetics, podiatry, occupational therapy, chiropractic, osteopathy and exercise physiology, are a core component of primary health care in Australia providing both preventative and curative services across a wide range of demographics. Allied health encompasses a range of professions, skills, backgrounds and practices including registered and unregistered (self-regulated) and unregulated professions.\textsuperscript{1} Allied health professionals provide services to “enhance and maintain functions of their patients (clients) within a range of settings including hospitals, private practice, community health and in-home care.”\textsuperscript{2} Patients receiving these allied health services will less likely utilise hospitals and emergency settings. As Australia responds to the COVID-19 pandemic, it is essential that allied health primary care services continue to be available to the community, while at the same time minimising the risk of transmission of COVID-19 during the provision of culturally safe in-person care.\textsuperscript{3–5}

At present, the majority of allied health primary care services in Australia are permitted to continue the provision of in-person care to patients throughout the pandemic.\textsuperscript{6} Allied health professionals are therefore faced with the challenges of caring for patients requiring essential in-person care, while minimising the risks of possible COVID-19
transmission. With no existing national or state/territory guidelines for managing the risks of COVID-19 transmission during the provision of in-person allied health services, some allied health practices have initiated their own risk-minimisation guidelines, such as deferring treatment of patients at high risk of infection or of developing serious illness from COVID-19.7,8

This study aimed to develop and pilot the evaluation of an evidence-informed model of care for allied health service providers to minimise the risk of COVID-19 transmission via in-person practice and home care settings. The risk management model of care is informed by the tools currently in use by the collaborating allied health service clinic, the Canberra City Health Network (CCHN), and has been developed in collaboration with the offices of the Australian Capital Territory Chief Allied Health Officer, South Australian Chief Allied and Scientific Health Officer, and the Australian Government Department of Health.

**Rapid evidence review**

Current literature on maintaining allied health services during the COVID-19 pandemic is limited. There are no current standardised guidelines in the Australian context that provide a risk-management informed model of community care for practitioners and allied health professionals and their practices during the COVID-19 pandemic. This study was undertaken to inform development of such guidelines.

We conducted a rapid evidence review with a focus on national and international practice guidelines in order to:

a. Identify principles for guiding decision-making on when it is essential to provide an in-person/face-to-face allied health service in the context of the COVID-19 pandemic (particularly in relation to physiotherapy, osteopathy and exercise physiology)

b. Broadly define risks of COVID-19 transmission during allied health service provision, based on: (i) type of service (categorised by potential for generation of aerosols and required proximity), (ii) patient factors, (iii) practitioner factors.

c. Assess home-based service provision and COVID-19 related risks and their appropriate mitigation based on available guidance from sectors such as home-based primary care and aged care services.

d. Develop targeted identification of risk mitigation options, if available, based on the above defined risks.

1. **Identifying principles for decision-making on when it is essential to provide an in-person/face-to-face allied health primary care service – focusing on physiotherapy, osteopathy and exercise physiology**

As countries respond to the COVID-19 pandemic with a range of social distancing and ‘lockdown’ measures, services deemed ‘non-essential’ are subject to significant restrictions, regulatory requirements, and closure. In Australia, the list of non-essential services excludes allied health primary care services,9 yet it is unclear
whether in-person provision of these services would continue to be classified as essential if levels of COVID-19 were to increase in the community. Further, there is no current criteria to indicate how an allied health service may be determined as essential or non-essential at any stage of the pandemic.

Many allied health services have begun adopting or expanding telehealth services in order to minimise the risk of transmission between patients, practitioners and staff.\(^3\) This shift has been supported by the Australian government, with provisions made for eligible patients to utilise bulk-billed telehealth services.\(^10\) While telehealth services are a critical component of maintaining care during the COVID-19 pandemic and should be utilised where possible, there remains a need for patients requiring essential in-person care to be able to receive this type of care.\(^4,11\)

We conducted a rapid review of national and international policy and guidelines on in-person provision of primary care services during the COVID-19 pandemic to assess existing classifications of essential and non-essential health services across a range of settings affected by varying levels of COVID-19 transmission. We also scoped scholarly peer-reviewed literature on client prioritisation in allied health primary care services in Australia to assess how allied health providers determine urgent or essential need of care in standard practice.

**Determining ‘high priority’ of care in standard allied health primary care practice**

Our review found little evidence on the processes used to determine priority of client access to allied health services in Australian primary care settings.\(^12\) One study published in 2011 showed that prioritisation of clients seeking access to physiotherapy in Victorian community health services largely occurred without a uniform, evidence-based prioritisation process to guide practitioner decision-making.\(^12\) The authors noted that this absence of cohesive guidance at the state-level was reflective of the complexity involved in determining the need of access to services, in addition to the ‘lack of research and validated tools to assist in decision making.’\(^12\)

Based on the findings of Brown and Pirotta’s (2011) study, the Victorian Government Department of Health developed a set of tools to guide community health services (CHSs) in determining a client’s priority level for treatment. These tools are used in conjunction with Initial Needs Identification (INI), the initial screening process that explores a client’s presenting and underlying issues and helps determine if referral to other services is needed. The INI is not a detailed or diagnostic assessment but is used to ‘identify the client’s needs and determine their level of risk and priority for assessment and service.’\(^13\)

The guidelines from the Victorian government include a ‘generic priority tool,’ and ‘clinical priority tools’ adapted to a range of allied health services to determine the level of priority of care. The generic priority tool is used to identify people who require priority for a service because they ‘belong to a population group known to have poor health status, suffer disadvantage or are at risk.’ Some examples of ‘high priority’ clients include Aboriginal and Torres Strait Islander people, people who are homeless, and refugees.\(^13\) The ‘clinical priority tools’ are used to assess patients outside these high risk groups on the basis of their clinical presentation.\(^13\)
For adult physiotherapy services, the guidelines offer the following criteria for ‘high priority’ clients:\textsuperscript{13}

- who have had broken bones or surgery related to muscle or joint problems in the last three months
- with chest infections requiring physiotherapy
- who have experienced a fall in the last six months, or who are at risk of falling or have restricted their activities because they are worried about falling or are dizzy
- with a physical problem that impacts on their ability to care for dependents
- experiencing difficulty performing daily activities independently either:
  - where this difficulty is significant, and they require maximum assistance
  - with moderate difficulty and experiencing severe pain.

Evaluation of the application of these tools could not be found in our review and the guidelines do not appear to have been updated since 2009. While the above criteria provide a useful framework for identifying principles for decision-making on when it is essential to provide an in-person allied health service, this list is non-exhaustive and does not account for the broad range of presenting factors which may inform clinical reasoning for delivering treatment in-person.

\textit{‘Essential’ primary health care services during the COVID-19 pandemic}

Current government advice on practice-level decision-making about delivering face-to-face or non-face-to-face care in primary health care settings considers the need for practitioners to employ their clinical discretion when determining the mode of care delivery in each individual case. The Royal Australian College of General Practitioners (RACGP), with consideration of Commonwealth advice regarding risks of COVID-19 transmission, offers guidance for these clinical decision-making.\textsuperscript{14}

The RACGP also provides guidance for specialist general practitioners (GPs) and broader practice teams to provide safe and effective telephone and video consultations during the COVID-19 pandemic, and to implement these measures. Their guidelines include:

\textbf{When not to use a telephone or video consultation}\textsuperscript{14}

The RACGP recommends that video or telephone consultations should generally not be used, and arrangements made for an in-practice face-to-face consultation:

- for assessing patients with potentially serious, high-risk conditions requiring a physical examination, particularly for patients with chronic disease who are unable to self-monitor appropriately and patient groups deemed high risk for poor outcomes from COVID-19
- when a physical/internal examination is required/cannot be deferred to support clinical decision making
• where a patient’s ability to communicate by telephone or video consultation is compromised and they do not have a support person to assist them during the consultation, impacting clinical quality and patient safety
• in situations where there is any doubt about the clinical appropriateness of a telephone or video consultation (in these instances, attending the practice in person for a face-to-face consultation is preferable).

However, they acknowledge that GPs may need to exercise a judgement as to the balance of these risks with the risks of a physical examination.

‘Essential’ in person allied health primary care services during the COVID-19 pandemic

Our review of national and international guidelines found wide variance among definitions of ‘essential’ in-person allied health primary care services (see Annex 1 and Annex 2). Guidance from Australian federal and state departments was found to be largely non-prescriptive, with advice for allied health practitioners to employ their professional judgement to determine essentiality of in-person care.

Specific advice for allied health practitioners has been outlined in a series of webinars published by the Department of Health from 26 March 2020 to 9 April 2020.3,15,16

In the last of these webinars, all primary health and allied health care workers were advised to continue providing care to people with a chronic disease and/or acute conditions.15 Concurrently, practitioners have been directed to base their decisions about delivering care on the following considerations—is treatment ‘absolutely necessary today’ and ‘does the person seeking care have COVID-19’?15 Though these statements are open to interpretation, guidance on determining essentiality of a service can be seen as pivoting on two primary factors: 1) the acuteness and/or chronicity of a patient’s condition, where providing care is essential to helping those patients with their functioning and recovery,16 and 2) the level of risk of COVID-19 transmission between the patient and practitioner. Providers are also required to adhere to social distancing guidelines and to ensure only one person per 4 square metres in reception and consulting rooms and 1.5 metres distance between reception and patients.16

In countries where COVID-19 community transmission is high, or risk of community transmission is identified as high, common practice has been to restrict provision of allied health services to those that respond to ‘acute’ or ‘emergency’ cases.16,2315,22 For example, the Belgian Society of Osteopathy currently advises the complete closure of all osteopathy practices with exceptions applying to acute cases – patients who cannot function because of their pain.19 Determining case acuteness involves conducting a telephone pre-history and screening questions related to risk of COVID-19. Those patients identified as having acute conditions may only receive in-person care if the practice can ensure the following:
That neither the patient nor their relatives, the osteopath or their relatives, have any respiratory symptoms (cold, fever, cough), and;
That the practice has adequate safety equipment: hydroalcoholic gel, FFP2 or FFP3 masks, gloves, and;
That systematic cleaning of all surfaces that the patient and practitioner come into contact with is carried out, and;
That patient consults are spread out into 15-minute intervals to ensure room ventilation between patients, and;
That there is no use of the waiting/reception room: when one patient leaves, the next does not enter the practice until 1/4 hour later, to allow disinfection and aeration.¹⁹

Speech Pathology Australia has developed the following guiding questions for deciding if face to face consultation is essential/necessary:²⁰

What are the risks of not undertaking the assessment or intervention now? Is it urgent / can it be delayed?

Is it clinically necessary to undertake this consultation face to face or can it be achieved safely and effectively remotely? e.g. telehealth

What are the risks of undertaking the intended specific activities with that specific client? – are the activities / client cohort low risk? what are the modifications that will further mitigate risk?

Determine the client’s COVID-19 status before any face-to-face consultation as per previously outlined risk assessment.²⁰

With wide variation among COVID-19 affected contexts, including levels of access to PPE and risks of community transmission, broad prescriptive criteria for determining an essential in-person allied health service is likely to be inappropriate. Determining the need for delivery of an in-person allied health service must consider the context in which care is delivered with regard to current and possible risks of community transmission at each stage of the pandemic.

2. Principles for guiding decision-making on what is an ‘essential’ in-person allied health primary care service in the context of the COVID-19 pandemic

Based on the evidence reviewed to date and guidance from the expert collaborators involved in this study, we have developed the following principles for guiding decision-making on what may be an ‘essential’ in-person/face-to-face allied health primary care service in the context of the COVID-19 pandemic. These principles consider risks based on Phases 1, 2, and 3 of the Australian Government’s COVID-19 response framework.²¹,²²
Principles for guiding decision-making on what may be an ‘essential’ in-person allied health primary care service in the context of the COVID-19 pandemic

- An essential in-person allied health primary care service may be that which responds to acute and/or chronic care needs of individuals who require in-person/face-to-face treatment for their conditions, as determined by a clinician/practitioner.

- In-person allied health primary care services may be considered essential where not providing services in-person would put the patient’s safety at risk, or where there is potential for harm or adverse patient outcomes (for example, hospital admission, long-term incapacity, deterioration of physical and/or mental wellbeing, or harm).27

- In-person allied health primary care services may be considered essential where the practitioner assesses that provision of a telehealth service is not an appropriate substitute for in-person treatment.

- An essential in-person allied health primary care service may include in-practice and in-home or residential care services.

- Where an allied health practitioner determines through clinical reasoning that a patient/client requires manual or in-person treatment, and that the benefits of providing in-person treatment outweigh the risks, this should be considered an essential service.

Application of these guiding principles should be based on the treating practitioner’s judgment.

A non-exhaustive list of examples of conditions/situations that may be considered as an essential in-person allied health primary care service is included in Annex 3. These examples may be used to inform general guidance for allied health services, however clinicians should follow a patient-centred approach to determine the need for in-person treatment on a case-by-case basis.

3. Risks of COVID-19 transmission during allied health in-person service provision

Table 3 below outlines guidance on specific risk factors and related mitigation measures in the provision of in-person allied health care during the COVID-19 pandemic from a range of international contexts where levels of community transmission are varied. The risks identified are targeted to considerations of factors specific to practitioners, to patients, and to the type of service provided categorised by potential for generation of aerosols and required proximity.
<table>
<thead>
<tr>
<th>Service</th>
<th>Risks</th>
<th>Mitigation measures</th>
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| Physiotherapy | Aerosol-generating procedures (AGPs) including intubation/extubation, bronchoscopy, high-flow nasal oxygen use, non-invasive ventilation, tracheostomy, cardiopulmonary resuscitation prior to intubation, nebuliser treatments, procedures that induce sputum (e.g. respiratory physiotherapy, swallowing, moving patients around)²³,²⁴ | - Avoid AGPs where possible  
- Practitioner to determine when PPE is necessary  
- Travel to (including transit through) a country considered to pose a risk of transmission in the 14 days before the onset of illness; close or casual contact in 14 days before illness onset with a confirmed case of COVID-19; fever or acute respiratory infection with or without fever¹⁶  
- Have a screening process over the phone - questions about symptoms, international travel or even domestic travel, to determine whether the patient should be seen face-to-face in clinic or in-home settings.²⁵  
- Share message with patients to remind them not to come to the clinic if they are experiencing symptoms.²⁵  
- Symptomatic workers should not go into work at the clinic or visit patients in-home.¹⁶  
- Workers should be released of obligation to perform duty and placed in home quarantine if a) employee had direct contact with infected people (under 1.5 m, over 15 min) or their secretions without protective equipment; b) employee had contact with infected people without protective equipment or was in a risk area/particularly affected area; and c) employee contact with infect person with protective clothing and shows symptoms of a cold.²⁶  
- Respiratory droplets, especially for those with co-morbidities could lead to hypersecretions or ineffective cough; mobilisation or therapy that can result in coughing or expectorations of mucus.²³  
- Spend as little time as possible to complete the service¹⁶ |
| Osteopathy   | Respiratory droplets carrying infectious pathogens can transmit infection when they travel directly from the respiratory tract of an infectious individual to susceptible mucosal surfaces of a recipient, generally over | - Patients should receive services through telehealth where possible to minimise these risks.²⁷–²⁹  
- Patients who have, or whose relatives have, any respiratory symptoms (cold, fever, cough) |
This can be in the form of sneezing, coughing or speaking.

If practitioners decide not to provide in-person services and that telehealth services are not appropriate, they are advised to refer patients to alternative sources of care, for example, a general practitioner. When community transmission is high, limit care to patients with acute conditions as much as possible. Determining case acuteness involves conducting a telephone pre-history and screening questions related to risk of COVID-19. Those patients identified as having acute conditions may only receive in-person care if the practice can ensure the following:

- That neither the patient nor their relatives, the osteopath or their relatives, have any respiratory symptoms (cold, fever, cough), and;
- That the practice has adequate safety equipment: hydroalcoholic gel, FFP2 or FFP3 masks, gloves, and;
- That systematic cleaning of all surfaces that the patient and practitioner come into contact with is carried out, and;
- That patient consults are spread out into 15 minute intervals to ensure room ventilation between patients, and;
- That there is no use of the waiting/reception room: when one patient leaves, the next does not enter the practice until 1/4 hour later, to allow disinfection and aeration.

| Exercise physiology | Transmission through direct contact | There is currently no limit to the amount of time for a face-to-face consultation, but it is important to |
keep direct contact time to a minimum.30
- Exercise physiologist are to exercise their own judgement as to whether they should be treating a client with or without PPE.30
- If a practitioner has been travelling or may be symptomatic, it is important that they do not attend home visits or see patients.3
- Professionals should not conduct home visits if they are in doubt of their own health or their patient’s health.31
- Have a screening process over the phone - questions about symptoms, international travel or even domestic travel, to determine whether the patient should be seen face-to-face in clinic or in-home settings.25
- Share message with patients to remind them not to come to the clinic if they are experiencing symptoms.26

| Elderly patients are less likely to be able to use Telehealth but may be more vulnerable. They may also be less able to report symptoms and therefore may not know or be able to identify to their exercise physiologist that they are ill.3 | Check-in with elderly and at-risk patients regularly over the phone; refer them to GP, fever clinic, or relevant local health unit if experiencing symptoms. |

Risk-management tools and checklist for allied health services

A risk-management checklist was developed with the collaborating allied health service clinic, the Canberra City Health Network (CCHN), based on infection control protocols and guidelines initiated and implemented by this clinic over the course of the COVID-19 pandemic in Australia. See Annex 4 to view the complete checklist.

Methodology of pilot study

A pilot study of the application of the risk-management checklist was undertaken to assess adherence to these guidelines and checklist by participating allied health care providers, and practitioner and staff acceptability of the guidelines. Data were collected in a Canberra-based allied health clinic providing a range of primary care services between May 13 – May 15, 2020. This study focused on the provision of three allied health services delivered by this clinic: osteopathy, physiotherapy, and exercise physiology. Researchers conducted direct observations
of practitioner consultations with patients in addition to interviews with practitioners and staff of the clinic. The study team also reviewed reception register notes on patient screening processes recorded between 04/05/2020–18/05/2020 to inform understanding of how risks of COVID-19 transmission were managed through screening and triaging policies.

**Development of the model of care and checklist**

The risk management model of care and related checklist was developed in collaboration with the ACT and SA Chief Allied Health Officers, based on the tools currently in use in an allied health service nominated by the DoH, the Canberra City Health Network (CCHN) City Clinic (see Annex 1), who collaborated closely on this study. These tools covered the following aspects:

- a) does the patient meet the criteria for requiring “urgent and essential in-person care”?
- b) what are the individual risks of the patient and provider, for both acquiring and transmitting COVID-19 infection?
- c) what are the patient flow and procedural risks?
- d) what is the recommended mitigation/management based on these above factors? And
- e) has recommended mitigation/management been implemented for all identified patient, provider and procedural risks?

**Participant recruitment**

A combination of convenience and purposive sampling was used to identify the sample. The selected private practice was identified as both a convenient and appropriate sample due to its interdisciplinary focus on the three allied health services the study is directly concerned with, its physical proximity to the research team in Canberra, and the willingness of the practice to collaborate in the study. Allied health experts from ACT Health and the Commonwealth Department of Health verified the appropriateness of the selected practice and deemed it suitable for the pilot study.

The Director of Clinical Education Programs at CCHN solicited interest from CCHN physiotherapists, osteopaths and exercise physiologists in participating in the study. Clinicians who expressed their interest in the study were screened according to the inclusion and exclusion criteria described below. Those eligible to participate (which included all clinicians practicing at CCHN) were recorded on a list by the CCHN Director of Clinical Education Programs and Practice Manager. Clinicians were informed they could request that individual patients not be contacted for recruitment in where their participation would not be appropriate.

Patients who had booked in-clinic appointments during the period for which on the days data collection were scheduled were asked by the practice receptionist if they
are happy to have their consultation observed when they present to the practice, providing appropriate details on the purpose of the study. Those who agreed were taken through the consent process by the study team prior to their consultation.

Inclusion criteria: patients

A patient was eligible to be included in the study if s/he met the following criteria:

- Is a patient currently receiving care in physiotherapy, osteopathy, or exercise physiology with CCHN, and;
- Is currently receiving care from a CCHN practitioner at the CCHN city clinic, or in their home in Canberra, and;
- Her/his participation in the study is considered appropriate by the practitioner;

Exclusion criteria: patients

A patient may NOT be included in the study if s/he meets the following exclusion criteria:

- Is NOT a patient currently receiving care in physiotherapy, osteopathy, or exercise physiology with CCHN;
- Is NOT currently receiving care from a CCHN practitioner at the CCHN city clinic, or in their home in Canberra;
- Her/his participation in the study is not considered appropriate by the practitioner;

The primary outcome measures were:

- Adherence to the model of care guidelines and checklist by allied health practitioners
- Participating practitioners adhere to all guidelines and completion of checklist in the application of the model of care.

The secondary outcomes measured were:

- Acceptability of model of care guidelines and checklist by allied health practitioners
- Participating practitioners verify the acceptability and efficacy of the model of care and related checklist.

Data Collection

Primary data collection was through direct observation of the checklist and model of care application in clinic and in-home settings and qualitative semi-structured
interviews with participating practitioners. Ethics permission were granted from the ACT Health (2020/ETH00881) and ANU (2020/241).

Observation: Three members of the study team from the ANU, using observation tools developed with project collaborators and based on the model of care and checklist being tested, observed the reception area practices and consultations. Each consultation was observed separately by individual observers to ensure adherence to physical distancing protocols. Observers recorded data on a form which listed the items to be observed and providing spaces to record observations, based on the checklist (See Annex 5).

Interviews: Interviews with practitioners were undertaken following observation to gather detailed feedback on the model of care and checklist. Interviews were conducted using a topic guide (see Annex 6). Interviews were audio recorded with the consent of participants. In addition, interviewers took written notes concerning the interview. Interview questions will be based on a pre-defined interview guide, with a combination of closed and open-ended questions.

All data, including observation and interview data, were de-identified. Study participants were assigned a unique identifying number. This unique identifying number was written on all study forms, audio files and transcriptions. Data were entered on password-protected computers only accessible to study staff.

**Data analysis**

Observation: Data from observation of adherence to the model of care guidelines and checklist by allied health practitioners were analysed using a combination of quantitative and qualitative methods. Data from close-ended questions from the observation forms were analysed using basic frequency counts and cross-tabulations. Other field notes made during observation were qualitatively analysed using analytical principles from grounded theory, adding richness of insight into the data.

Interviews: The study team used open inductive qualitative methods to sort through interview data, labelling ideas and phenomena as they appeared and reappeared. The trends that emerged were critically analysed. All interviews were transcribed and coded. A coding framework was developed based on themes pre-identified by the study team as well as those emerging during the interviews. Codes and sub-codes were refined during the analysis.

Researchers from the ANU conducted the data analysis, in consultation with other investigators.

**Results/Findings**
Patient screening processes

We reviewed CCHN reception register notes recorded between 04/05/2020 – 18/05/2020 to assess processes implemented to screen patients for COVID-19 symptoms and risk of transmission.

At the time of the research, the clinic had implemented routine screening of each patient for risk of COVID-19 prior to accepting an appointment, and on presentation to the clinic reception desk. The process at the time of data collection is summarised in the flowchart below. Annex 7 documents CCHN’s COVID-19 patient questionnaire used at the time of research.

When presenting to the clinic on the day of appointment, reception staff ask the patient the COVID-19 screening questions at the reception desk (maintaining physical distancing) and follow the screening procedures again.
Flowchart of patient screening process implemented by CCHN during the COVID-19 pandemic

Patient calls to book an appointment

Receptionist asks the following questions

Contact with a confirmed or suspected COVID-19 case in past 14 days?

YES

Book telehealth appointment or reschedule in-person appointment to 14 days from last contact with COVID-19 case, return from overseas or last symptoms.

NO

Returned from overseas in past 14 days?

YES

Book telehealth appointment or reschedule in-person appointment to 14 days from last contact with COVID-19 case, return from overseas or last symptoms.

NO

Returned from overseas in past 14 days?

YES

Experienced fever, cough, sore throat or shortness of breath in past 14 days?

YES

Refer patient to COVID-19 hotline, fever clinic, or GP; require medical confirmation that symptoms are not COVID-19 related for appt.

NO

Experienced fever, cough, sore throat or shortness of breath in past 14 days?

YES

Refer patient to COVID-19 hotline, fever clinic, or GP; require medical confirmation that symptoms are not COVID-19 related for appt.

NO

Experienced fever, cough, sore throat or shortness of breath in past 14 days?

YES

Refer patient to COVID-19 hotline, fever clinic, or GP; require medical confirmation that symptoms are not COVID-19 related for appt.

NO

In-person appointment may be booked

Receptionist asks symptom screening questions (See Annex 7) and logs responses

YES

Practitioner discusses symptoms with patient via phone and assesses level of risk

YES

Patient’s symptoms considered to be possibly COVID-19 related?

NO

Patient answers "yes" to one or more screening questions?

YES

Practitioner discusses symptoms with patient via phone and assesses level of risk

NO

Patient’s symptoms considered to be possibly COVID-19 related?
Results
Seven hundred and fifty-two patients presented to CCHN between 04/05/2020 – 18/05/2020. Allied health services accessed in the clinic at the time of research were osteopathy, physiotherapy, massage therapy, and exercise physiology. Of these patients, 488 received osteopathic treatment; 135 received massage therapy; 119 received physiotherapy; and 10 were exercise physiology patients. Given the substantive number of patients receiving massage therapy services, we included screening forms completed by these patients in the sample, in addition to those completed by patients receiving care in the three services of focus in this study. A review of reception records of patient screening forms found that of the 752 patients treated by the clinic in the sample period, 67 had answered ‘yes’ to one or more of the COVID-19 screening questions.

Basic descriptive statistical analysis of the data found that of these 67 patients, 51 (76%) selected yes to only one screening question, followed by 12 (18%) with two affirmative responses, and 4 (6%) with three affirmative answers.

No patients reported having a fever, and 59 (88%) of the 67 patients did not report having a cough or sore throat. Of this sample, 5 (7.5%) of patients reporting having a cough but no sore throat, while 3 (4.5%) of patients reporting having a sore throat but no cough. None of these patients reported having a cough and a sore throat simultaneously.

The most commonly reported symptoms observed in patient screening forms were muscle aches (75.76%) and headaches (23.76%), followed by fatigue (11.94%), cough (7.46%) and sore throat (4.48%). Fever and loss of smell were not reported. Further, no patients reported having had contact with a person returning from overseas travel or with a person with a suspected or confirmed case of COVID-19.

![Figure 1](image_url)

**Figure 1. Proportion of patients answering ‘yes’ or ‘no’ to COVID-19 screening questions**
Muscle ache and headache were generally associated with ongoing, chronic conditions or musculoskeletal complaints commonly experienced by patients receiving treatment in the clinic, particularly those receiving osteopathic physiotherapy and massage therapy treatment.

Of the 67 patients answering ‘yes’ to one or more of the screening symptom questions, only one was declined an in-person appointment due to perceived risk of possible COVID-19 infection. On the COVID-19 screening form, this patient had ticked that someone in her household had been feeling unwell. This was noted by the clinician, and reception staff asked the patient for details regarding the household member’s condition. The patient informed reception that their child had been home sick with a cold for the last two weeks and had been advised by a GP to be tested for COVID-19 but had not yet been tested at the time of booking. The reception staff member informed the patient that in-person treatment would not be possible and advised the patient to reschedule their appointment at a later date.

Observational data

Reception and waiting area observations

The CCHN arranged their appointments to minimise patient crowding in the waiting area and to meet the physical distance measures. We note that approximately 60% of the time, the waiting area had one patient. When two or more patients were present, all patients were spatially segregated based on seating designation designed by CCHN to ensure at least 1.5 metres distance was maintained between all persons in the reception area.

The clinic provided TGA approved hand sanitiser at the front desk, waiting room, and treatment rooms and all patients were asked to use the hand sanitiser and put on a mask upon entering the facility. CCHN removed pens from the waiting area, but had clearly defined canisters of ‘clean’ and ‘dirty’ pens present at the registration desk for check in. Pens from the ‘dirty’ pile were regularly disinfected and returned to the ‘clean’ pile. All touchable materials from the waiting area were removed and non-touchable COVID-19 informational material was present. All patients were seen to pay cashless. Sneeze guards had also been installed on the reception desk to partition reception staff from patients as part of physical distancing measures. These activities were implemented by the reception staff and supervised by the practice manager.

Cleaning guidelines by CCHN staff

Staff were fastidious in their cleaning procedures. Non-disposable plastic coverings and treatment tables were disinfected after each patient. Gloves and gowns were worn throughout the cleaning procedure, with the exchange of gloves after handling used items like towels to ensure fresh items were handled with new gloves.

Hourly cleaning procedures to disinfect door handles, staircase railings, lift buttons and other areas of common use occurred throughout the day and recorded to ensure the procedure was carried out. Reception staff regularly cleaned the telephone, eftpos/hicap machines, and registration counters following each patient.
Treatment room observations

All patients wore masks for the duration of their visit. Some patients were asked to lower their masks for lipreading purposes when speaking to a practitioner who is hearing impaired; and were then asked to cover their nose and mouth after speaking. Appropriate physical distancing was observed during such instances.

Inside the treatment room, all patients were positioned at least 1.5 metres away from practitioners during consultation until a touch assessment was required. All practitioners were observed to follow the guidelines of not shaking hands with patients or touching their faces.

Masks and gloves were the primary form of PPE utilised in the clinic, however, use of PPE is discretionary and based on the clinician’s sound clinical judgement. Gowns were also available in treatment rooms and the majority of patients wore gowns during consultations. Approximately 48% (13 of 27) of the observations indicated that practitioners wore masks when consulting with patients. Gloves were not used by the practitioners during patient consultations. We observed that all practitioners used proper hand hygiene before treating the patient. All CCHN treatment rooms include a sink with soap and hand sanitiser for the practitioners to use before and after treating a patient.

Of the times that PPE was used, there was high adherence to the immediate removal of PPE (83%; 10 of 12) and proper disposal of PPE (92%; 11 of 12). We observed high adherence of the practitioners practising good hand hygiene after removing PPE/end of consult (80%; 19 of 24).

Interviews

Formal individual interviews were conducted with ten CCHN employees over three days: 2 physiotherapists, 1 exercise physiologist, 5 osteopaths, 1 reception staff member, and the practice manager. Informal conversations with the CCHN director, staff and clinicians further informed the findings of the research.

Interviews with staff and practitioners highlighted the significant impacts of the COVID-19 pandemic on the allied health professions of focus and patients of these allied health primary care services.

Staff and practitioners cited a number of significant changes to service delivery and provision of care at the practice level, in addition to impacts on individual workload, patient wellbeing, and management.

At the practice-level, the COVID-19 pandemic has prompted substantial organisational and perceptional changes. These changes are summarised in the following table with reference to the following major categories: infection control; patient screening processes; triage and decision-making about mode of treatment; workload; and patient wellbeing and mental health.
### Table 2. Summary of major changes in CCHN clinic during the COVID-19 pandemic

<table>
<thead>
<tr>
<th>Infection control</th>
<th>Enhanced cleaning processes: routine hourly cleaning of clinic is now conducted by staff and documented through a cleaning roster.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Hand sanitiser is available in every room and all are required to use hand sanitiser upon entering a room. Patients are required to sanitise their hands upon arrival at the reception desk. Education materials on hand hygiene were present in the clinic.</td>
</tr>
<tr>
<td></td>
<td>- All patients are required to don a mask at the reception desk</td>
</tr>
<tr>
<td></td>
<td>- Practitioners may still choose to wear PPE where deemed clinically appropriate, however, use of masks during treatment has become more commonplace</td>
</tr>
<tr>
<td></td>
<td>- Staff and practitioners are required to wear mask, gloves, and gown when cleaning treatment rooms</td>
</tr>
<tr>
<td></td>
<td>- Linen has been removed from treatment tables and pillows have been replaced with medical grade plastic pillowcases, which are sterilised after use.</td>
</tr>
<tr>
<td></td>
<td>- Treatment table covers have been replaced or repaired to ensure sterility</td>
</tr>
<tr>
<td></td>
<td>- Treatment rooms have designated laminated surfaces on which patients are asked to place their personal belongings when entering the room. Surfaces are disinfected after each consultation.</td>
</tr>
<tr>
<td></td>
<td>- Extra persons are not permitted in treatment rooms unless they are the patient’s carer and patients are requested to visit the clinic alone where possible.</td>
</tr>
<tr>
<td></td>
<td>- All diagnostic equipment is kept in plastic boxes in each treatment room to reduce risk of infection and for ease of cleaning</td>
</tr>
<tr>
<td></td>
<td>- Physical distancing policies are in place to ensure minimal number of people in waiting room and adherence to social distancing regulations</td>
</tr>
</tbody>
</table>

| Patient screening processes | All patients are routinely screened for COVID-19 symptoms and risk factors by reception staff |
|                           | Screening processes are thoroughly and routinely documented |

| Triage and decision-making about mode of treatment | Practitioners have begun providing telehealth services where clinically appropriate and physical assessment and manual treatment is not required |
|                                                   | All clinicians reported heightened awareness of risks associated with treating patients face-to-face, and the need to use clinical reasoning to determine need for in-person treatment |

| Workload | While the number of patients seen has reduced, staff and clinician workload has increased. This is due to 15-30 minute gaps being designated between patients in order to clean treatment rooms thoroughly, necessitating expansion of clinic hours to meet patient demand. |
|          | Thorough hourly cleaning of clinic requires a significant amount of effort in addition to normal workload of staff and clinicians |

| Patient wellbeing and mental health | Notable deterioration in physical health and function in patients due to non-attendance of appointments and/or unsuitable work-from-home environments |
|                                    | Exacerbation of musculoskeletal conditions noticed due to impacts of unhealthy working environments, stress, and disruption to ‘normal’ activities such as exercise classes and gym |
|                                    | Noticeable changes in emotional presentation of some patients, prompting heightened awareness of patient mental wellbeing among clinicians and staff |
|                                    | Patients communicating concern and anxiety about possible closure of allied health services due to COVID-19 |
Feasibility of checklist and risk mitigation protocols

All practitioners and staff interviewed found the checklist useful and appropriate in the current context. Respondents considered the checklist an important tool to mitigate the risks of COVID-19 transmission through a systematic approach.

It is noteworthy, however, that most of the respondents considered the feasibility and efficacy of the checklist as applicable in the setting of Canberra, where there has been only one case of community transmission of COVID-19 to date and where a range of social distancing measures—though gradually being relaxed—remain in place. Additionally, only 4 new cases had been recorded from the month prior to our observations.

Community transmission and pandemic context

When asked to reflect upon the efficacy of the checklist in the context of a potential outbreak or where community transmission was significant, most respondents agreed that additional, or more stringent, risk mitigation measures would need to be encompassed by these protocols. For example, practitioners questioned whether more personal protective equipment should be used by both staff and patients in the event of significant community transmission in Canberra. Others indicated that there could be a need to further reduce the number of staff working in a single clinic, and to expand patient screening processes to include screening questions related to risks such as interstate travel. Some respondents also raised the possibility of enforcing stricter physical distancing policies in the clinic, such as staggering appointments to reduce patient flow and requiring patients to wait outside or in their vehicle rather than in the waiting room.

Screening procedures and risks of transmission

Thorough, routine, and targeted screening of patients was considered paramount to all risk mitigation procedures. Most respondents associated the major risks of transmission of COVID-19 in a clinical setting with lax screening policies and processes that could permit infectious persons to enter the clinic undetected. As one respondent described:

… from the time the phone rings to the time that the patient enters the room, they've been asked multiple questions about COVID-19. Also, with the steps that we've put in place at the front desk, they get screened very heavily, because I think if one patient walked into the clinic with the virus we’re shut. So if they’re here, if they made it to the room, I'm in trouble as a clinician.

In a possible scenario of high community transmission, some practitioners considered there could be a need to screen patients for COVID-19 symptoms and conduct temperature checks at the entrance of the clinic using a non-contact temperature gun.
While vigilant screening protocols were considered essential, respondents agreed that the strict infection control protocols outlined in the checklist were fundamental to mitigate the risk of transmission through asymptomatic carriers of COVID-19:

…even with active cases in the community, most of them won’t get through the door let alone through reception. And the checklist is probably just protecting us for that rare instance that an asymptomatic person walks through.

**Personal protective equipment (PPE)**

All CCHN staff and practitioners currently have access to personal protective equipment including masks, gloves, and gowns. Staff and clinicians wear PPE when cleaning, while clinicians use clinical reasoning to determine whether it is appropriate to wear PPE during treatment. This reasoning differed between practitioners and was made on a case by case basis. Some practitioners followed more general rules of using PPE during the COVID-19 pandemic, however. For example, some practitioners preferred to wear a mask when treating higher risk patients, such as those who may be immunocompromised or elderly. Others indicated that they may wear a mask when treating patients with anxieties around the virus in order to ease their concerns. Use of gloves was widely considered challenging, particularly for osteopaths and physiotherapists when conducting physical assessment and manual treatment. The efficacy of using gloves when proper hand hygiene was being routinely practised was also questioned by some practitioners. Feedback from respondents indicated desire for clearer guidance on when to use PPE in allied health settings—particularly those necessitating ‘hands on’ manual treatment—and which PPE is necessary in such settings.

Current CCHN protocols require all patients to wear surgical masks while being treated. Patients are provided with masks by reception staff upon presenting to the clinic and are instructed by staff on how to wear the mask appropriately. Feedback from respondents indicated that this protocol may have assisted in reducing concern and anxiety among staff, practitioners and some patients about risks of infection. In particular, some respondents indicated that the requirement for patients to wear masks helped mitigate the risk of infection from potential “silent carriers” of COVID-19.

Patient adherence to wearing masks was also seen to minimise the risk of other non-COVID-19 viruses or infections. This was a critical consideration for some practitioners, since presenting any respiratory symptoms may prompt alarm at the clinic and individual levels, with far-reaching consequences. As one respondent described:

…I say wear a mask because if I have a cough, we shut down.
While patient use of masks and availability of PPE was considered an important component of risk mitigation protocols, respondents also expressed a desire for clear, evidence-informed guidance around these measures. Some respondents also questioned the sustainability of this protocol in the long-term. In addition, staff and practitioners noted that while patients were compliant with these policies, some expressed frustration about being required to wear a mask and questioned the appropriateness of the protocol.

**Importance of allied health as a primary health care service**

Discussions with practitioners and staff illuminated the pivotal role allied health professionals play as primary health contacts supporting and maintaining the health and wellbeing of the community.

Respondents reported noticeable anxiety among a number of patients around accessing other primary care services due to fear of being infected with COVID-19. For example, some practitioners reported that patients had been unwilling to visit their GP due to their concerns about risk of transmission in GP clinics. These patients saw the allied health clinic as a comparatively safer environment where they could access essential care. This attitude was highlighted in discussion with an osteopath:

> I think that people have been coming in more so than going to their GPs because they don't really want to be going to their GPs to sit in waiting rooms full of suspected cases… Also, while we have always worked closely with GPs, that communication has become more routine and frequent during this time. And we've noticed that GPs are referring a few more patients to us to reduce a little bit of load on the on the GP clinics.

Far from disjointed from or adjunct to primary health services, such allied health services are vitally interconnected within the primary care ecosystem. As one physiotherapist noted:

> As a practitioner we can write ultrasound referrals, x rays, medical imaging, [and] also send [patients] off to other areas such as nutrition and psychology. We’re more than just hands on…it's the managing the patient in their overall health and wellbeing, I think that's what we do every day with every patient.

In a climate of community anxiety about accessing basic health care, the role of allied health practitioners in supporting the general health and wellbeing of patients may acquire pronounced importance. In particular, patients at higher risk of severe disease from COVID-19 may be less likely to access care where there is a perceived risk of infection, leaving them vulnerable to a range of health problems if unable to access treatment. Practitioners discussed the critical role allied health professionals play in supporting the overall function and wellbeing of individuals living with such underlying vulnerabilities:

> …those vulnerable people, they're often living with autoimmune conditions, [and] chronic degenerative stuff. Often many comorbidities together as well, too. And being
a primary health contact, it’s part of our job to monitor those things and then send off [to a GP] when we think it’s an issue as well.

One osteopath estimated that at least fifty percent of his patients included those that required such monitoring of chronic and/or significant health conditions.

Some practitioners also reported increased contact with other primary care contacts, for example, GPs and surgeons. While such contact is a routine part of allied health care, the important role that allied health professionals play in facilitating and supporting the general wellbeing of the community has in many ways come into focus over the course of the COVID-19 crisis, as was apparent through observations in the allied health clinic and interviews with clinicians and staff.

**Patient wellbeing and mental health**

Over the course of the pandemic, practitioners have observed a “heightened awareness” of patients’ mental health and considered this to be a critical aspect of providing face-to-face care. Pandemic-related factors such as social isolation, unemployment and economic hardship, disruption to important activities such as exercise, and unsuitable work-from-home environments, were seen as major contributors to patients’ physical and mental health, with notable observations of stress, anxiety and low mood among some patients, particularly those with pre-existing vulnerabilities to mental illness. Clinicians noted that since the onset of the pandemic, they have been routinely monitoring patients’ mental health.

I think we’re much more aware of doing that [since COVID-19] to make sure that that person’s mental health is going well, or you know, ‘is your job well?’; ‘how’s isolation been?’; ‘if you are isolated do you have support?’

Many respondents highlighted the significant social and emotional benefit face-to-face treatment can provide patient, especially those who may lack supportive social or family networks. While these factors have always been important components of allied health care, practitioners and staff emphasised the need to maintain patients’ access to this support during the pandemic.

There are some people who come in here who don't have anybody at home. Their family might have passed away so it's just them and they don't have much contact, so they do come in here for that verbal contact. What we're trying to do is just make sure they're still feeling welcomed and safe and they’ve got everything that they need. And then other people are just feeling really, really exhausted. So you have to try and get them to talk about their mental health a little bit more, which has been something that we have all noticed we've been doing a lot more of since COVID-19…

Supporting patients’ mental health and wellbeing was considered fundamental to ensuring a patient-centred approach to providing essential primary health care. As two respondents summarised:

…yes there are the acute cases where you’ve fallen over and you’ve sprained something or you’ve done something to yourself; but then there’s the people that just
need to see people; and I think they are just as essential as the people with acute illnesses, or acute conditions, because they’re the people who don’t see people otherwise, and this is their primary health care. And I think they’re just as important as people with acute musculoskeletal problems.

…that ability to be part of a collaborative care approach to that patient and maintain that standard of care is really important…we're monitoring mental health illnesses as well. So that ability for someone to have a bit of physical touch and have a chat to someone or even be just in the presence of someone in a safe environment, I think is really important.

**Triage and decision-making about mode of treatment (telehealth/in-person)**

In addition to the enhanced patient screening processes implemented by reception staff, the COVID-19 pandemic has prompted practitioners to make notable adjustments to the ways they practice and to triaging processes. This includes determining the most appropriate mode and delivery of providing care, primarily through either in-clinic, in-home, or telehealth services.

*Telehealth*

Since the COVID-19 pandemic, CCHN practitioners have expanded their services to include the option of telehealth where clinically appropriate. CCHN has provided all clinicians with the option of using telehealth services. While all of the practitioners we interviewed offered telehealth services, only three (two physiotherapists and one exercise physiologist) had delivered care via telehealth since the option was introduced.

Among the three services of focus in this study, exercise physiology was found to be most amenable to providing care via telehealth services. As this service does not require a hands-on approach, it was considered a “good option” for exercise physiologists to consider in order to reduce patient flow in the clinic and minimise risks of possible transmission. The exercise physiologist interviewed in this study noted the benefits of using telehealth during a pandemic. In particular, they observed that telehealth was useful for treating high-risk patients, especially those who cannot or do not want to leave their homes.

I definitely see that it will be part of my normal practice now, to offer that, particularly for reviews—because quite a lot of exercise physiology is kind of health coaching. There’s a lot of talking and a lot of motivational interviewing and that kind of stuff. It can quite easily be done over telehealth. Initial assessments are probably preferable in person, but telehealth after that is quite good. And it can be quite convenient, it can cut down some barriers. People can do it at lunch time at work rather than coming in. It can be quite useful.

As the respondent describes, it remains preferable for initial patient assessments to be conducted in person rather than via telehealth. In addition, this respondent highlighted a number of reasons why telehealth may not be an appropriate form of care, for example, in the following cases:
Where there may be a language barrier between the patient and the practitioner
– When treating patients with more complex musculoskeletal conditions, chronic pain, and comorbidities
– When treating patients with anxieties around movement and pain
– When a patient does not feel safe or comfortable being treated via telehealth

A combination of providing in-person and telehealth services was considered a useful approach, while considering the needs and preferences of the individual patient:

…If it was for just general lifestyle advice and I just wanted to get them moving, it wouldn’t be so important to have them come in. But the more musculoskeletal issues there are involved—like they might have diabetes and they might be overweight, they might have knee pain in both knees and they’ve hurt their shoulder; in this practice we get a lot of chronic pain, people with chronic pain seem to go to osteo quite a lot. And so we do get people who are quite dysfunctional in their movement and they have kind of longstanding anxiety in their movement exacerbating pain, and that’s a lot more complex. Being in the same room…you get a better look at body language and facial expressions, and the way somebody’s reacting when they’re moving; particularly that first time when you’re trying to get to know what’s going on with somebody. And I think what could also work well to have like an initial assessment and then maybe some telehealth and then come back in to get an eyes-on look and then you can do some more telehealth. A combination I think is probably going to be really good.

Telehealth was considered to be a viable and effective tool for physiotherapy treatment in some instances, particularly for delivering educational components of care or rehabilitation. Both physiotherapist respondents were providing both in-person and telehealth services at the time of the research. One of these respondents had recently returned to the clinic after a period of providing services exclusively via telehealth following the introduction of COVID-19 restrictions in the ACT. This respondent noted that in the earlier phases of the pandemic when the risk of community transmission was perceived to be higher, they did not feel comfortable providing treatments face-to-face. With the introduction and enhancement of infection control and screening protocols in the clinic, however, they now felt safe providing face-to-face care in the clinic. This respondent also noted that their clinical reasoning for the best mode of treatment necessarily factored in levels of risk in the community. With high levels of community transmission, they indicated that they may return to telehealth as the primary mode of treatment, however in-person treatment would continue to be necessary if it could be safely delivered:

[if there was high community transmission] I’d go back to the telehealth, depending on what their presenting complaint is to begin with. If it was like a flare up of a back pain, but it's not debilitating, I'd encourage them to do telehealth. If it was a post-op, depending on what the post-op is, how serious it is, then I would personally look over all the triage stuff. Do I feel like I need to see this person face to face? The best form of treatment for this patient right here right now can only be to delivered face to face? If I'm happy to do it with implementing all of these things, I would do that if it is best for the patient.
Both physiotherapist respondents highlighted the importance of using clinical reasoning to determine the best mode of treatment for the patient, with consideration of context-specific risks.

The provision of osteopathic care via telehealth was found to be most challenging due to the structural, hands-on approach central to osteopathic treatment. However, respondents agreed that telehealth was an important service for osteopathy patients to be able to access, particularly during the pandemic. In addition, telehealth may be an important tool for practitioners at higher risk of severe disease, or who live with person/s who are.

Some respondents noted that telehealth could be useful tool for osteopaths to use for triaging or for reviewing patient results. As one respondent described, phone or telehealth consultations could be a feasible option for discussing results, particularly with at-risk patients:

…I had an elderly patient wanting to come in to discuss results of scans… I essentially had a phone consult with her but it was before I was properly set up so it wasn't officially telehealth. And that was—for me it was a perfect example of when in my capacity as an osteopath, you know, we tend to be quite manual, so the whole osteopath doing telehealth wasn't as easy a process as like a physio or an EP. But that was a situation where it was so much easier and better, particularly for the patient to do that rather than have her come into the clinic and just sit there and talk about the results of MRIs and x-rays.

All respondents considered the continuation of hands on treatment an essential component of providing care and maintaining the wellbeing of patients. Respondents agreed that at present, the risks of transmission of COVID-19 were low in Canberra and that hands-on therapies could be safely performed with appropriate screening and infection control protocols in place. If community transmission were to occur at a significant level, respondents reiterated the need to use clinical reasoning to determine the need for a patient to be treated in person while assessing the level of risk to the patient and the practitioner.

**Home visits**

Three of the practitioners interviewed had conducted home visits to treat patients in their homes, and two of these had conducted home visits during the COVID-19 pandemic. Home visits were considered rare among respondents, largely required for patients who are immobile or whose functional decline limits their capacity to visit the clinic for essential in-person treatment. For high-risk exercise physiology patients, home visits were also considered an important means of assessing the patient’s environment and its safety and suitability for prescribed treatments.

All respondents found the protocols related to home visits outlined in the checklist useful and appropriate in the current context. There were differing opinions on the feasibility of safely conducting home visits if community transmission were to be a significant risk, however. For example, one respondent considered that in a climate of high community transmission of COVID-19, home visits would pose significant risk to the practitioner that would outweigh the potential benefits:
I think if transmission got to a point where it was significantly bad, I think there'd be a point where you would have to say no to home visits completely. Because I think the risk that it puts to you as a practitioner, as a staff member, or to make sure that you're doing everything right to make one slip up, or one mistake, yeah, at the end of the day, can be quite costly, as we've seen evidenced in lots of other places, a lot of hospitals and that kind of stuff. And I think in the hospital system, it's a little bit different where they're really kind of managing the risk and they do that every day and that's kind of very structured. I don't think it would be worth putting myself at risk if it got worse. I would probably say no to that and maybe that's where you try and point towards telehealth.

Conversely, another practitioner suggested that home visits could become more important in a context of high community transmission in order to maintain the care of at-risk patients and minimise patient flow in the clinic:

I think that home visits might actually increase and there would be a greater need to do so if community transmission was increasing… However, that would need to be done in a safe way by making sure that the practitioner is isolating themselves or has been tested recently to then know that they're not infectious. But I do think that there's a big opening for more home visits to be done, particularly with elderly, or those who are immunocompromised and who shouldn't be leaving the house. Home visits could also help to ensure that those who need care can receive the care they need when they need it rather than having to wait for an appointment, since the number of patients and staff in the clinic might need to be reduced and therefore there would be a longer waitlist.

Respondents indicated that while the present checklist provides appropriate guidance for home visits in the current context, more comprehensive protocols may be necessary to ensure practitioner and patient safety in the event of high community transmission.

Summary of results

We found high adherence to and feasibility of the risk-management guidelines piloted in the participating allied health clinic. Practitioners and staff observed a consistently high level of adherence to the checklist and protocols in place. Results from observations indicated high uptake and rigorous implementation of infection control protocols, including enforcing appropriate physical distancing measures in the clinic and fastidious routine cleaning procedures. The clinical environment was further adapted to enhance infection control measures, such as installation of reception desk sneeze guards and replacement of linen with medical grade plastic bedding surfaces.

Qualitative results from interviews with practitioners and staff raised important considerations for the development of a national guideline for allied health professionals operating during the COVID-19 pandemic.

CCHN practitioners and staff indicated that the checklist and protocols currently observed are comprehensive and feasible in the present context of Canberra where
little community transmission has been recorded to date. There was broad consensus however that these protocols would need to be revised in a context in which community transmission was high, or where there was a greater risk of community transmission occurring due to increased rates of transmission in other areas of the country, such as in bordering states.

Discussions with clinicians and staff highlighted the essential role that in-person allied health services play in supporting and maintaining the physical and mental health and wellbeing of the population. These services form a critical component of primary health care in Australia, providing remedial and preventative treatments to individuals with a range of health conditions that impact their function and lives. Provision of such care is particularly critical during the current health crisis as people may experience lower overall health and wellbeing, and where the public health system is under significant strain.

**Conclusions / recommendations**

Australia has observed community transmission of COVID-19 in some jurisdictions, while in others, most cases are from, or linked to, returned international travellers. While levels of community transmission of COVID-19 in Australia are presently low, this could change with lifting of social distancing and containment measures, as recently seen in Victoria.\(^{32}\) It is therefore necessary to consider the potential risks of COVID-19 transmission during allied health in-person service provision, and options for minimising and mitigating these risks, at each possible stage of the pandemic.

While the protocols observed in this study were found to be effective and serve as a good practice model, guidance for allied health practices and professionals during the COVID-19 pandemic must be responsive to the context of transmission in which they are implemented. Staged, evidence-based guidelines responsive to levels of risk of the COVID-19 pandemic are therefore necessary to enable in-person allied health services to continue to provide essential care when risk of transmission may be higher.

Annex 8 provides a possible framework for a staged approach to COVID-19 risk mitigation protocols that could be further developed in consultation with the allied health sector. Draft recommendations for refining checklist and protocols based on staff and practitioner feedback [to be discussed with expert collaborators]:

- More uniform, evidence-based, clear guidance for use of PPE specifically targeting allied health professionals as applicable at each possible stage of pandemic risk. This could include clearer guidance in checklist in addition to other multimedia educational resources (e.g., instructional videos or posters)

- Clearer guidance on the need for patients to use PPE, with considerations of the challenges that this may present to practitioners in providing care
• Guidance on use of PPE with consideration of practitioner, staff and patient diversity, including the need to cater to persons with disabilities

• Bins with foot pedals could provide greater infection control by minimising contact with contaminated substances. A foot pedal bin could also be placed in the reception standing zone for patients to dispose of masks and other hygiene items (e.g., tissues) upon exiting clinic

• A foot pedal bin could also be provided in treatment rooms for disposal of used towels and/or linen. This could strengthen infection control by reducing the need for staff and practitioners to handle used items when carrying them to the laundry.

• Checklist and protocols should respond to various stages of pandemic risk. Practitioners, staff and patients would benefit from staged guidelines outlining best practice recommendations for risk mitigation protocols tailored to specific stages of pandemic risk, as defined by a uniform national framework.

• Practitioners, staff and patients would benefit from more diverse and engaging presentations of the checklist and protocols including through multimedia resources such as infographics, posters, videos, and flowcharts. These resources could encapsulate specific components of the checklist, for example, cleaning protocols or patient screening processes.
### Annex 1. Criteria for essential and/or urgent primary health services by country

<table>
<thead>
<tr>
<th>Country</th>
<th>Criteria</th>
</tr>
</thead>
</table>
| **Australia** | Australia has not currently implemented a definitive description of essential health services. The Government has supported the use of Telehealth as a method of providing healthcare services, particularly in primary health. Information on essential services in primary health include any care involving patients with chronic symptoms who depend on services, as well as services provided in rural or remote areas where access is limited. Advice provided by the Government however is that if either a practitioner or patient meets the criteria for a potential infection, services should be immediately postponed. 

15. **New Zealand** | Essential services at Alert Level 4 in the health and disability system are those that meet one or more of the following six criteria:  
1. A health and disability service that provides direct support that maintains a person’s basic necessities of life.  
2. A health and disability service that responds to emergency and acute care needs (including emergency dentists, physiotherapy, radiography)  
3. Community, Disability Support Services (DSS)  
4. Aged care services including Home and Community Support Services (HCSS) and Mental Health and Addiction Services that supports high risk and vulnerable client groups.  
5. Emergency and crisis support for people who feel unwell or are unsafe (eg, Funded helplines, refuges and family violence services, sexual violence crisis services).  
6. Services are prioritised to those people most at risk of harm if those services were not provided. Each provider delivering these services must immediately identify those people most at risk. 

17. **Canada** | Canada’s current list of essential health services includes:  
– Caregivers (e.g., physicians, dentists, psychologists, mid-level practitioners, nurses and assistants, infection control and quality assurance personnel, pharmacists, physical and occupational therapists and assistants, social workers, counsellors, speech pathologists and diagnostic and therapeutic technicians and technologists)  
– Workers in other medical facilities (including ambulatory health and surgical, blood banks, clinics, community mental health, comprehensive outpatient rehabilitation, end stage renal disease, health departments, home health care, hospices, hospitals, long term care, procurement organizations, psychiatric facilities, and rural health clinics)  
– Health care professionals providing emergency care including dentists optometrists and physio-therapists  
– Workers that provide critical personal support services in home and also provide residential services for individuals with disabilities, including those who maintain equipment for those with disabilities. 

33. **UK** | Although the UK doesn't have a strict definition of essential health services, they have provided a list of services which must continue:  
- Community nursing services  
- Urgent Community Response/Rapid Response team  
- Out-of-hours GP services  
- 111 service  
- Walk-in centres |
<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>France</td>
<td>Currently, individuals are allowed to travel with a certificate to attend consultations and care that cannot be provided remotely and that cannot be deferred, such as care of patients with long-term conditions. While telehealth consultations are preferred, the government advises people not to postpone the consultations necessary for follow-up and prevention, especially in the event of chronic illness.</td>
</tr>
<tr>
<td>Germany</td>
<td>No definition of essential health services, however, current regulations deem “medically necessary treatments” are still possible. Service companies in the field of personal care including massage therapies, hairdressers, cosmetic studios, tattoo studios and similar companies are closed because physical proximity is essential in this area.</td>
</tr>
<tr>
<td>Singapore</td>
<td>Essential services/procedures refer to those, if not provided or performed, would result in significant or rapid deterioration of the patient’s medical condition, and potentially threaten their health and wellbeing. This includes all public and private acute hospitals, renal dialysis centres, residential care, etc.</td>
</tr>
</tbody>
</table>
Annex 2. Definitions of and criteria for essential and/or urgent primary health services by services – exercise physiology, physiotherapy and osteopathy

<table>
<thead>
<tr>
<th>Country</th>
<th>Services</th>
<th>Exercises Physiology</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Zealand</td>
<td>Physiotherapy is included in the list of essential services at Alert Level 4 as it is considered to be a service that responds to ‘emergency and acute care needs’</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td></td>
<td>The New Zealand Government has not included osteopathic healthcare under the category of ‘essential services’, and has mandated that all non-essential services are required to close. Osteopathic practices will be closed for face-to-face appointments while New Zealand remains at Alert Level 4.</td>
<td></td>
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</tr>
<tr>
<td>Canada</td>
<td>Physiotherapists providing ‘emergency care’ are included in the current list of essential health services. Emergency care is not defined.</td>
<td></td>
<td>Canada has not identified exercise physiology as an essential health service, however, exercise physiologists could be considered as essential if they meet the criteria of providing ‘critical personal support services in home, and also provide residential services for individuals with disabilities, including those who maintain equipment for those with disabilities.</td>
</tr>
<tr>
<td></td>
<td>Canada has not included osteopathy as an essential health service</td>
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<td></td>
</tr>
<tr>
<td>Australia</td>
<td>(11) Care should be given to patients who have chronic health conditions so that physiotherapy can help them with their functioning and recovery</td>
<td></td>
<td>Australia has suggested that practitioners should make their own assessment of whether a patient’s treatment is essential.</td>
</tr>
<tr>
<td></td>
<td>(12) Two important questions to ask if deciding whether physiotherapists should deliver care - a) Is this treatment absolutely necessary today? and then b) Does this person have COVID-19? This should influence how workers protect themselves</td>
<td></td>
<td>In addition, practitioners should consider the following as requiring essential services: - People with a chronic diseases and/or acute conditions - Where a patient cannot access appropriate technology to use Telehealth - Where the service provided is located in rural communities with limited access to exercise physiology services</td>
</tr>
<tr>
<td></td>
<td>(12) Remedial massage - no federal guideline on whether this is essential as this varies across jurisdictions. However,</td>
<td></td>
<td>Urgent and essential services will be reviewed regularly and therefore practitioners should prepare</td>
</tr>
<tr>
<td></td>
<td>N/A</td>
<td></td>
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</tr>
</tbody>
</table>
if registered under APHRA, and therapist says it is needed, then should be allowed. APA is working to get a clearer definition.

Use telehealth if possible, but have face-to-face services available for those who need essential care, especially those with chronic health conditions; up to clinicians to decide whether patient has a chronic illness (12)

<table>
<thead>
<tr>
<th>Country</th>
<th>Conditions for Face-to-Face Consultations</th>
</tr>
</thead>
</table>
| UK      | - They are in hospital and require physiotherapy.  
          - You have a high suspicion of risk of serious deterioration from underlying pathology and you are unable to determine this remotely.  
          - They have urgent rehabilitation needs, which if not met, will require care from General Practice, secondary care or social care agencies. This is particularly important if they are themselves a carer for someone who is vulnerable.  
          - They require rehabilitation to support their rapid discharge from secondary care.  
          - Prioritise urgent care needs.  
          - Stop medium and lower priority work  
          - Monitor rising risk of deferred work if disruption continues beyond 48 hours.  
          - Prioritise respiratory physiotherapy.  
| France  | They are in hospital and require physiotherapy.  
| Germany | You have a high suspicion of risk of serious deterioration from underlying | N/A | N/A |

The UK Department of Health and Social Care has advised us that osteopaths can ‘make a decision for themselves based on the guidance that has been published’. Osteopaths who consider that their work falls into this definition as ‘frontline health and social care staff… required to maintain the UK’s health and social care sector’ can regard themselves as a key worker for the purposes of this guidance.  

NHS guidance is as follows:

- Segmentation needed to prioritise urgent care needs.  
- Medium and lower priority work stopped.  
- Monitor rising risk of deferred work if disruption continues beyond 48 hours.

Segmentation needed to prioritise urgent care needs.  
Medium and lower priority work stopped.  
Monitor rising risk of deferred work if disruption continues.
pathology and you are unable to determine this remotely.

<table>
<thead>
<tr>
<th>Country</th>
<th>Description</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Singapore</td>
<td>They have urgent rehabilitation needs, which if not met, will require care from General Practice, secondary care or social care agencies. This is particularly important if they are themselves a carer for someone who is vulnerable.</td>
<td>N/A</td>
</tr>
<tr>
<td>Taiwan</td>
<td>They require rehabilitation to support their rapid discharge from secondary care.</td>
<td>N/A</td>
</tr>
</tbody>
</table>
Annex 3. Examples of conditions/situations that may be considered as an essential in-person allied health primary care service

A non-exhaustive list of examples of conditions/situations that may be considered as an essential in-person allied health primary care service include:

- incapacitating neuromusculoskeletal dysfunction or pain
- inability to care or withdrawal of care of patient leads to re-admission or imminent hospital admission
- post-operative care immediately following surgery when necessary for cardiorespiratory and essential functional mobilisation follow-up immediately post-discharge from hospital
- burn suffers that are incapacitating in nature
- patient is in essential services (e.g. health care provider) whose injury or condition requires in-person treatment to return to work safely as soon as possible.
- where not providing face-to-face care could result in harm to the patient

Note: This list is derived from a list published by the College of Physiotherapists of Ontario of ‘situations which could be considered urgent’ under the Government of Ontario’s definition of ‘urgent care’ in health care and social services. This is not an exhaustive list. There may be a range of other conditions/situations that could be considered as an essential in-person allied health primary care service. Practitioners may use these principles as a guide but should exercise their discretion when making decisions about provision of care.
### Annex 4. Checklists for allied health staff and practitioners while delivering face-to-face services during the COVID-19 pandemic

#### Checklist for practice/clinic settings

<table>
<thead>
<tr>
<th>Infection prevention and control – staff and management</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To be completed at the start of the day</strong></td>
<td></td>
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<tr>
<td>Have practitioner shifts been split to decrease the number of people in the clinic at any one time where possible?</td>
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<tr>
<td>Has the daily COVID-19 health check email been sent to all staff and completed by staff prior to each shift?</td>
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<tr>
<td>Have patients been advised to attend appointments alone (if they do not require carer’s support)</td>
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<tr>
<td>Is it likely that there will be more than 1 patient in the waiting room?</td>
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<tr>
<td>If yes, is there adequate physical distancing space in the waiting room? (at least 4 sq m/person and at least 1.5 metres apart)</td>
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<tr>
<td>Is alcohol based hand rub or sanitiser (ABHR) available for patients and staff in the waiting room?</td>
<td></td>
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<tr>
<td>Is there a sign for patients to use ABHR upon entering allied health service waiting room and upon departure from clinic?</td>
<td></td>
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</tr>
<tr>
<td>Are there non-touchable educational materials in the waiting room about COVID-19 about physical distancing, hand and respiratory hygiene, cough etiquette etc.?</td>
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</tbody>
</table>

#### Screening and triage processes – reception staff

<table>
<thead>
<tr>
<th>Screening and triage processes – reception staff</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>To be completed by reception staff for each appointment booking</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the receptionist asked the screening question of COVID-19 symptoms including fever, cough, sore throat or shortness of breath in the past 14 days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the receptionist asked the screening question of recent potential exposures based on guidelines for self-isolation? (e.g. contact with a confirmed or suspected COVID-19 case in the past 14 days? Travel to ‘hotspot’ areas? Symptoms of COVID-19 in past 14 days?)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If patients answer yes to the screening questions, have patients been asked to not be treated face-to-face until they are no longer required to self-isolate/quarantine and are fully recovered?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If patients answer yes to having symptoms of COVID-19, have they been advised to stay home, organise to get tested for COVID-19 and contact the COVID hotline at 1800 020 080, their GP or fever clinic should they require further information?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>If patient answers yes to the screen questions, has staff checked if the patient has recently been in the clinic and alerted the clinician and manager if so?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has there been an explanation to the patients for why face-to-face treatment is not possible at this time given their yes responses to the screening questions?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Have patients been asked to be treated via telephone or videoconference (telehealth) where possible?

<table>
<thead>
<tr>
<th>Infection prevention and control – practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**To be completed by practitioner for each consultation**

Is there ABHR in the treatment room?

Has the practitioner performed hand hygiene using ABHR or soap and water before meeting a client?

Has the practitioner followed standard infection prevention and control precautions and made a risk assessment to determine the level of PPE required, if any?

- Has the practitioner donned appropriate PPE prior to conducting the consultation?
- Has the practitioner practised hand hygiene before donning gloves, if gloves are necessary?

Has the practitioner followed hygiene rules by not shaking hands, or touching their eyes, nose, mouth, or face?

Are practitioners positioned at least 1.5 metres from a patient during consultation unless closer ‘touch’ assessment is required?

Is the practitioner limiting non-essential treatment to the face, TMJ, etc?

If treating the patient’s cervical spine, is the patient in prone and sidelying positions, with minimal time spent supine?

Has the practitioner removed PPE appropriately at the end of the consult?

- Has the practitioner stored or disposed PPE appropriately?
- Has the practitioner practised good hand hygiene after each step of removing PPE and then appropriately stored or disposed of PPE?

If practitioner is responsible for cleaning consult room:

- Has the practitioner worn gloves to clean the room?
- Has the practitioner cleaned the treatment table, contact surfaces and door handles with TGA approved detergent/disinfectant wipes or detergent/disinfectant product using disposable or laundry safe cloth, and changed linen for next patient?
- Have fabric table covers, disposable paper face covers, and towels been removed?

**Fomite transmission and cleaning**

| Yes | No | N/A |

**To be completed routinely (hourly each day)**

Have staff worn gloves to clean surfaces and surrounds?

If staff are responsible for cleaning consult rooms:

- Have staff cleaned the treatment table, contact surfaces and door handles with TGA approved detergent/disinfectant wipes or detergent/disinfectant product using disposable or laundry safe cloth, and changed linen between patients?
- Have used fabric table covers, disposable paper face covers, and towels been removed from consult rooms?
- Have all magazines, reading material and kids’ toys been removed from the waiting room?
Have pens been removed from reception desk?
Are the patients paying cashless only?
Are the reception staff regularly (include frequency) cleaning and disinfecting (e.g. combined detergent disinfectant product):
Surfaces and chairs in the reception area?
Telephones and EFTPOS/HICAPs machine at reception desk?
All door handles?
Buttons and railings of the practice lift?
Stair railings?
Toilet buttons and taps?
Any other high-touch surfaces?
Has the sign off sheet for cleaning been completed every hour and scanned at the end of the day?

<table>
<thead>
<tr>
<th><strong>Checklist for home settings</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Screening and triage processes – reception staff</strong></td>
</tr>
<tr>
<td>Has the receptionist asked the screening question of COVID-19 symptoms including fever, cough, sore throat or shortness of breath in the past 14 days on the phone?</td>
</tr>
<tr>
<td>Has the receptionist asked the screening question of recent potential exposures based on guidelines for self-isolation/quarantine? (e.g. contact with a confirmed or suspected COVID-19 case in the past 14 days? Travel to ‘hotspot’ areas? Symptoms of COVID-19 in past 14 days?)</td>
</tr>
<tr>
<td>If patients answer <strong>yes</strong> to the screening questions, have patients been asked to not be treated face-to-face until they are no longer required to self-isolate/quarantine and are fully recovered?</td>
</tr>
<tr>
<td>If patients answer <strong>yes</strong> to having symptoms of COVID-19, have they been advised to stay home, organise to get tested for COVID-19 and contact the COVID hotline at 1800 020 080, their GP or fever clinic should they require further information?</td>
</tr>
<tr>
<td>If patients answer <strong>yes</strong> to recent potential exposure, have patients been advised to stay home and contact the COVID hotline at 1800 020 080 for advice?</td>
</tr>
<tr>
<td>If patient answers <strong>yes</strong> to the screening questions, has staff checked if the patient has recently been in the clinic and alerted the clinician and manager if so?</td>
</tr>
<tr>
<td>Has there been an explanation to the patients for why face-to-face treatment is not possible at this time given their <strong>yes</strong> responses to the screening questions?</td>
</tr>
</tbody>
</table>
Have patients been asked to be treated via telephone or videoconference (telehealth) where possible?  
If the patient has requested treatment at home, has the receptionist booked an initial telehealth consult with a practitioner to assess need for face-to-face care?  
Have answers to screening questions been logged in the patient’s file?

<table>
<thead>
<tr>
<th>Screening and triage processes – practitioners</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the practitioner determined the need for in-home care to be provided in the initial telehealth consult?</td>
<td></td>
<td></td>
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<tr>
<td>Has the practitioner made a risk assessment about the need for PPE based on telehealth consult and made a record of this?</td>
<td></td>
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<td></td>
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<tr>
<td>Has the practitioner called the patient on the day of the appointment and asked the COVID-19 screening questions again?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>If patients answer <strong>yes</strong> to the screening questions, has the advice above been reiterated and face-to-face treatment deferred?</td>
<td></td>
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</tr>
<tr>
<td>If patients answer <strong>no</strong> to the screening questions, has the practitioner asked the following COVID-19 risk assessment questions about the household?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Will anyone else be present at the time of the consult? If so, who? Please ask all others who do not need to be present to be in a different part of the house/unit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have any members of your household been unwell with symptoms including fever, cough, sore throat or shortness of breath in the past 14 days?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have any members of your household been in contact with a confirmed or suspected COVID-19 case in the past 14 days?</td>
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</tr>
<tr>
<td>- Have any members of your household been in any ‘hotspot’ areas in the past 14 days?</td>
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<tr>
<td>- Would your room support the physical distancing measures of 4 sq m/person?</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Infection prevention and control and patient wellbeing</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the daily COVID-19 health check email been sent to all staff and completed by the practitioner prior to each shift and home visit?</td>
<td></td>
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</tr>
<tr>
<td>Has the practitioner followed standard infection prevention and control precautions?</td>
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<tr>
<td>- Has the practitioner donned appropriate PPE prior to entering the home?</td>
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<td></td>
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</tr>
<tr>
<td>- Has the practitioner practised good hand hygiene prior to donning any PPE?</td>
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</tr>
<tr>
<td>Has the practitioner followed hygiene rules by not shaking hands, or touching their eyes, nose, mouth, or face?</td>
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</tr>
<tr>
<td>Does the room contain only the practitioner and patient, unless the patient requires carer’s support?</td>
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<tr>
<td>Is the practitioner seated or standing at least 1.5 metres from the patient, unless for ‘touch’ assessment?</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
<td></td>
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<tr>
<td>---------------------------------------------------------------------------</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Is the practitioner limiting non-essential treatment to the face, TMJ, etc?</td>
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<tr>
<td>If treating the patient’s cervical spine, is the patient in prone and sidelying positions, with minimal time spent supine?</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Has the practitioner asked the patient the following patient wellbeing questions (if patient lives alone/self-isolating):</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- What supports do you have?</td>
<td></td>
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</tr>
<tr>
<td>- Are you aware of the government’s current advice and restrictions regarding COVID-19?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Are you in contact with friends/family/colleagues?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Do you have access to food and other essential items?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- Have you contacted your GP (if patient is exhibiting symptoms)</td>
<td></td>
<td></td>
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<tr>
<td>- Are you aware of the COVID-19 Action Plan that you can complete with your GP to help manage your COVID-19 risk?</td>
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</tr>
<tr>
<td>Has the practitioner removed PPE appropriately at the end of the consult?</td>
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</tr>
<tr>
<td>Has the practitioner disposed or stored PPE properly before entering the car?</td>
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</tr>
<tr>
<td>Has the practitioner used alcohol based hand rub <em>or</em> sanitiser (ABHR) after each step of removing PPE?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has the practitioner used ABHR before entering their vehicle?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Annex 5. Observation record form

**Structured observation record**

For observation of application of checklist for allied health service staff and practitioners while delivering services during the COVID-19 pandemic

<table>
<thead>
<tr>
<th>Allied health practice observation form</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Form number:</strong></td>
</tr>
<tr>
<td><strong>Date of observation:</strong></td>
</tr>
<tr>
<td><strong>Start time:</strong></td>
</tr>
</tbody>
</table>

**Service observed (circle):** physiotherapy, osteopathy, exercise physiology

<table>
<thead>
<tr>
<th>Observations in waiting room prior to consult</th>
<th>Yes</th>
<th>No</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there 1 or fewer patients in the waiting room?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If not, is there adequate social distancing in the waiting room? (4 sq m/person)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are TGA approved hand sanitizers available for patients and staff in the waiting room?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
<td>----------</td>
</tr>
<tr>
<td>Is there a <strong>sign for patients to use hand sanitiser</strong> upon entering allied health service waiting room and upon departure from clinic?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there non-touchable <strong>educational materials</strong> in the waiting room about COVID-19 about social distancing, transmission, etc.?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observation of consultations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Is there TGA approved hand sanitiser in the treatment room?</strong></td>
</tr>
<tr>
<td><strong>Has the practitioner washed their hands with soap and water before meeting a client?</strong></td>
</tr>
<tr>
<td><strong>Has the practitioner donned appropriate PPE prior to conducting the consultation?</strong></td>
</tr>
<tr>
<td>Write N/A if PPE is not necessary.</td>
</tr>
<tr>
<td><strong>Has the practitioner practised hand hygiene before donning gloves for ‘touch’ assessment?</strong></td>
</tr>
<tr>
<td>Write N/A if gloves are not necessary.</td>
</tr>
<tr>
<td>Question</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Has the <em>practitioner followed hygiene rules</em> by not shaking hands, or touching their eyes, nose, mouth, or face?</td>
</tr>
<tr>
<td>Are practitioners positioned at least 1.5 <em>metres</em> from a patient during consultation unless closer ‘touch’ assessment is required?</td>
</tr>
<tr>
<td>If treating the patient’s cervical spine, is the patient in prone and sidelying positions, with minimal time spent supine?</td>
</tr>
<tr>
<td>Has the practitioner <em>removed PPE immediately following the assessment?</em> Write N/A if PPE is not necessary.</td>
</tr>
<tr>
<td>Has the practitioner disposed of PPE appropriately? Write N/A if PPE is not necessary.</td>
</tr>
<tr>
<td>Has the practitioner <em>practised good hand hygiene</em> after removing PPE? Write N/A if PPE is not necessary.</td>
</tr>
<tr>
<td><strong>Observation of cleaning and disinfection</strong></td>
</tr>
<tr>
<td>Have staff worn gloves to clean surfaces and surrounds?</td>
</tr>
<tr>
<td>Have staff cleaned the treatment table, contact surfaces and door handles with TGA approved detergent/disinfectant</td>
</tr>
</tbody>
</table>
wipes or a detergent product using disposable or laundry safe cloth, and changed linen between patients?

Have fabric table covers, disposable paper face covers, and towels been removed?

Have all magazines, reading material and kids’ toys been removed from the waiting room?

Have pens been removed from reception desk?

Are the patients paying cashless only?

Is the reception staff regularly disinfecting:

- Surfaces and chairs in the reception area?
- Telephones and EFTPOS/HICAPs machine at reception desk?
- All door handles?
- Buttons and railings of the practice lift?
- Stair railings?
- Toilet buttons and taps?

Other comments:
Annex 6. Interview question guides

INTERVIEW QUESTION GUIDE – PRACTITIONERS

“Managing the risks related to provision of in-person essential allied health primary care services during the COVID-19 pandemic”

Prior to beginning the interview, check that informed consent has been given.

Check if participant has given consent for interview to be audio recorded, and ask them again if they are happy for the discussion to be audio recorded.

Remind the practitioner of the following:
You are free not to participate or to stop the interview at any time. You do not need to answer any questions you do not want to. You may also ask us any questions during the interview if you like.

Document informed consent if not already documented and Inform participants that you are going to turn on the audio recorder (if consent has been provided) and begin the interview.

<table>
<thead>
<tr>
<th>Interview/audio no:</th>
<th>Interviewer:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date:</th>
<th>Location:</th>
</tr>
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<tbody>
<tr>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Start time:</th>
<th>Finish time:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Practitioner field (circle): physiotherapy, osteopathy, exercise physiology

General questions on impacts of COVID-19

1. What kinds of services do you currently provide (in-practice, in-home, telehealth)?
2. How has the COVID-19 pandemic affected your work?
3. What impacts do you think the COVID-19 pandemic has had on your patients in terms of their treatment and wellbeing?
4. What do you see as the major risks of possible COVID-19 transmission in relation to your work?
5. How do you determine when it is essential to deliver care in person? (As opposed to via a telehealth service).

Questions about PPE

6. What PPE do you currently have access to?
7. Do you currently distribute PPE to patients at all? Has this changed since the beginning of the pandemic?
8. How do you decide when to use PPE and what PPE to use, if any?

Questions about checklist

9. Please describe your experience of using the checklist.
10. Did you find the checklist useful/appropriate/comprehensive?
11. Did you notice any particular difficulties or challenges when using the checklist and providing care?
12. Do you think that there are any components missing from the checklist that could help further minimise the risk of potential COVID-19 transmission?
13. What suggestions/recommendations do you have for improving the checklist?
14. What else, in addition to the checklist, is needed to minimise the risk of potential COVID-19 transmission when providing in-person care?
15. Do you think this checklist would be still be useful if levels of community transmission of COVID-19 increase?
16. Do you have any other feedback you would like to give us on the checklist, or other feedback you would like considered when the checklist is refined?

Possible questions on practitioner wellbeing (leave till end if asking home visit questions)

- Do you conduct debriefs at the end of the day with your colleagues?
- What are some measures you take to ensure your mental wellbeing?
- Are there measures you think your practice can take to support the mental and physical wellbeing of you and your colleagues?

[If practitioner does home visits, the following questions may also be included]

Home visits

1. How many home visits do you currently do per week on average?
2. Has this changed since the COVID-19 crisis? If so, how?
3. Is the profile of the patients you treat in-home quite varied or would you say there is a need for home-based services among a particular group in the population – for example, elderly people with mobility issues.
4. How do you assess the need for providing in-home care as opposed to in the practice or through a telehealth service?
5. When you or the receptionist does the initial patient screening, is the patient asked if they are currently isolating at home, or if anyone they live with is?
6. How do you assess the risks involved with each home visit? (To self, to patient, to household)
7. If they live with others, at what point do you ask questions about risk from other household members (if they have symptoms, have travelled, etc)?
8. In terms of the questions you ask the patient about their property before you arrive, what do you do if you get there and the information the patient has
given you is incorrect? For example, the room is smaller than expected, or multiple people are present in the space?

9. Could you talk me through the last home visit you did, and describe the whole process – from triage, to preparing for the visit, to entering the household and conducting the consult, to what you did when you left?

10. [If PPE is not raised in previous answer] Did you use any kind of PPE when you did your last home visit? If yes, could you describe what PPE you used, when did you use it and why?

11. Did the patient wear any PPE? If yes, what, and how did you facilitate this process?

12. Would you always use PPE when doing home visits while the pandemic is ongoing, or only in certain cases? [prompt to explain reasoning if only used in certain cases]

13. Do you think this checklist is appropriate to use when you provide treatment in patients’ homes?

14. Are there challenges specific to conducting home treatment that are not addressed in the checklist?

15. If community transmission of COVID-19 were to increase, do you think it would still be feasible to do home visits, and would this checklist still be useful?

16. Any other feedback specific to home visits you would like considered when the checklist is refined?

Possible closed questions:

[For last home visit]

- Did you wash your hands with soap or apply sanitiser before entering and after leaving the house? Y/N
- Was there a risk of splashes of blood or body fluids, and/or for contact with broken skin/rash/ mucous membrane during the consultation? Y/N [if yes, then ask the questions below]
  - Did you wear a surgical mask? Y/N
  - Did you wear gloves? Y/N
  - Did you wear a fluid resistant gown or plastic apron? Y/N
  - Did you wear eye protection? Y/N
  - Did you dispose of non-contaminated PPE in general waste? Y/N
  - Did you dispose any contaminated PPE appropriately? (Placed in a sealable plastic bag, transported and stored in a secure area, disposed of as clinical waste). Y/N
- [Ask in all cases] Did you disinfect all materials taken into the home and perform hand hygiene before entering your vehicle? Y/N

Possible questions on patient wellbeing:

- Are many of the patients you treat at home referred to you through a GP?
- When would you consider it appropriate to refer a home-based patient to a GP or other health professional?
- In many instances, allied health practitioners might be a patient’s primary health contact, particularly if they are self-isolating. When you do home visits, do you observe other factors that might indicate the patient’s general health and wellbeing?
• If yes to above, what observations do you take into account and what kind of questions do you ask if any?
• If you have concerns for a patient’s physical or mental health, what processes do you follow?

Possible questions on practitioner wellbeing (if not previously asked)

• Do you conduct debriefs at the end of the day with your colleagues?
• What are some measures you take to ensure your mental wellbeing?
• Are there measures you think your practice can take to support the mental and physical wellbeing of you and your colleagues?

INTERVIEW QUESTION GUIDE – STAFF

“Managing the risks related to provision of in-person essential allied health primary care services during the COVID-19 pandemic”

Prior to beginning the interview, check that informed consent has been given.

Check if participant has given consent for interview to be audio recorded, and ask them again if they are happy for the discussion to be audio recorded.

Remind the practitioner of the following:
You are free not to participate or to stop the interview at any time. You do not need to answer any questions you do not want to. You may also ask us any questions during the interview if you like.

Document informed consent if not already documented and Inform participants that you are going to turn on the audio recorder (if consent has been provided) and begin the interview.

<table>
<thead>
<tr>
<th>Interview/audio no:</th>
<th>Interviewer:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date:</td>
<td>Location:</td>
</tr>
<tr>
<td>Start time:</td>
<td>Finish time:</td>
</tr>
<tr>
<td>Staff role (ie., manager, receptionist):</td>
<td></td>
</tr>
</tbody>
</table>

General questions on impacts of COVID-19

17. How has the COVID-19 pandemic affected your work to date?
18. What impacts do you think the COVID-19 pandemic has had on the practice’s patients in terms of their treatment and wellbeing?
19. What do you see as the major risks of possible COVID-19 transmission in relation to your work?
20. How much have you had to change or adjust day to day processes over the course of the pandemic?

Questions about PPE

21. What PPE (if any) do staff currently have access to?
22. Do you currently distribute PPE to patients at all? Has this changed since the beginning of the pandemic?
23. How do you decide when to use PPE and what PPE to use, if any?

Questions about screening processes [for reception staff]

24. Could you talk me through your screening process for patients?
25. Have you found anything challenging or difficult in this process?

Questions about checklist

26. Please describe your experience of using the checklist.
27. Did you find the checklist useful/appropriate/comprehensive?
28. Did you notice any particular difficulties or challenges when using the checklist?
29. Have you encountered any challenges with enforcing social distancing either in relation to other staff members or clients?
30. Do you think that there are any components missing from the checklist that could help further minimise the risk of potential COVID-19 transmission?
31. What suggestions/recommendations do you have for improving the checklist?
32. Do you think this checklist would be still be useful if levels of community transmission of COVID-19 increase?
33. Do you have any other feedback you would like to give?

Possible questions on staff wellbeing

- Do you conduct debriefs at the end of the day with your colleagues?
- What are some measures you take to ensure your mental wellbeing?
- Are there measures you think your practice can take to support the mental and physical wellbeing of you and your colleagues?
Annex 7. CCHN patient screening form

In-clinic

Reception phone booking:
Patient wanting to book face-to-face appointments compulsory questions:
1. Have you been in contact with a confirmed or suspected COVID-19 case in the past 14 days?
2. Have you returned from overseas in the past 14 days?
3. Have you experienced a fever, cough, sore throat or shortness of breath in the past 14 days?

If the patient answers yes to any of the compulsory questions, the patient may book a telehealth appointment or reschedule their face-to-face appointment to 14 days from last contact with the COVID-19 case, the return from overseas or the last presentation of symptoms. They must be able definitively answer “No” to all of the compulsory questions before presenting to the clinic.

Screening form given to patients attending face-to-face appointments:

Name:

Have you had any of the following symptoms in the past 24 hours?
If so, please tick:
- Fever
- Cough
- Sore throat
- Difficulty breathing/shortness of breath
- Fatigue
- Loss of your sense of smell (without sinus obstruction)
- Diarrhea
- Headache
- Muscle aches
- Is anyone in your household/family feeling unwell or have had any of the above symptoms?
- Have you been in contact with another person who has recently returned from overseas?
- Have you been in contact with a known/confirmed COVID-19 case?

If you ticked any of the above, please consider rescheduling your appointment after 14 days of social isolation. There is no cancellation fee.

Thank you for your understanding.
Canberra City Health Network

Signature:

This form is to be scanned into the patient’s file at the commencement of each appointment.
## Annex 8. Summary of COVID-19 response stages in Australia, adapted to allied health sector context

### Response strategy for allied health primary care services based on COVID-19 pandemic phases in Australia*

<table>
<thead>
<tr>
<th>Pandemic phase</th>
<th>Aim</th>
<th>Possible measures – for practice management</th>
<th>Possible measures – for practitioners and staff</th>
</tr>
</thead>
</table>
| **Phase 1 – Preparedness**  
(COVID-19 is uncontrolled overseas but no cases have been identified in the Australian community) | Reduce the likelihood of a case in the community and facilitate allied health service preparedness | • Monitor government and state/territory advice and information regularly  
• Communicate government advice to staff regularly  
• Assess the status of PPE, equipment and cleaning supplies in the event of possible outbreak  
• Prepare for transition to telehealth services by ensuring availability of technology and training staff | • Follow COVID-19 patient screening processes (questions about travel in past 14 days)  
• All staff and practitioners to inform manager if they have recently travelled overseas  
• Follow cleaning and disinfecting procedures  
• Ensure TGA approved hand sanitizer is available in waiting room and consultation rooms, with sign for patients to use sanitizer as they enter  
• Follow standard PPE procedures |
| **Phase 2 – Suspected or initial cases in the community** | Minimise risks of COVID-19 transmission between staff and patients and prevent sustained community transmission | • Follow all measures from Phase 1 +  
• Place non-toughable educational materials on COVID-19 on display in waiting room  
• Remove all kids’ toys, magazines, and other materials from waiting room  
• Transition to telehealth services where possible | • Follow all measures from Phase 1 +  
• Enhanced COVID-19 patient screening processes  
• All staff and practitioners to complete the COVID-19 screening questionnaire before each shift  
• Limit consultations to telehealth where possible, as determined by practitioner  
• Strictly enforce social distancing in the practice/clinic/home care setting  
• All staff to complete DoH Infection Prevention and Control Training |
| **Phase 3 – Outbreak in the community**  
(multiple cases of sustained community transmission) | Minimise risks of COVID-19 transmission between staff and patients and prevent further community transmission | • Follow all measures from Phase 2 +  
• Communicate changes of practice to patients regularly (e.g. via phone, email, in clinic, social media)  
• Re-assess the status of PPE, equipment and cleaning supplies  
• Update educational materials on display if necessary | • Follow all measures from Phase 2 +  
• New staff to complete DoH Infection Prevention and Control Training |
| **Phase 4 – Stand down and evaluation**  
(outbreak is controlled) | Return to ‘business as usual’ and monitor government advice | • Monitor government and state/territory advice regarding a possible second wave of the pandemic  
• Review practice protocols and update based on lessons learned  
• Assess the status of PPE and equipment; restock resources as necessary  
• Assess workforce needs  
• Consider mental health consequences of the pandemic on staff and communicate appropriate resources/services that may be accessed | • Transition to normal work arrangements  
• Inform patients about transition processes  
• Continue to practise and promote good hand hygiene in the workplace |

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References


