Remote assessment and management summary for ALL adults, including those with suspected Covid-19

- All patients should be managed **remotely** wherever possible; we **support you** to be **courageous**
- Remember the importance of building **rapport, empathy and listening**
- **Remember to consider/ explore non-Covid serious differentials and red flags** [page 5]

Covid-19: BNSSG Primary Care guidance
(v5) 24.4.20 [review due 8.5.20]; see full document for further details
Blue text in document highlights updates since v4

If critically/ severely ill, check ceiling of care/ ReSPECT/ DNAR status. If admission appropriate, call/advise 999 (ensure SWASFT aware if Covid-19 suspected).
Frail and/ or multimorbid patients - palliative care in the community will be the most appropriate management for many as unlikely to benefit from hospital treatment [page 2].
CPR [page 5]: Resuscitation Council guidance 15.4.20. Call 999, defibrillation if indicated. Chest compressions and airway manoeuvres are aerosol generating so avoid in primary care.

Covid-19 clinical features Fever, cough, fatigue, myalgia. Breathlessness seems to start/ worsen at 7-10 days. Atypical chest pain is common. Other symptoms include sputum, headache, nausea/ vomiting, diarrhoea or anosmia.

Consider risk factors **Elderly, cardiovascular disease,** diabetes, pregnancy, smoking, CKD, liver disease. Patients with solid organ transplants, specific cancers, severe respiratory conditions, immunosuppression, pregnant women with significant heart disease, rare diseases/ metabolic conditions increasing risk of infections – all are considered extremely vulnerable.

For the majority of patients with mild or moderate Covid-19 symptoms

Close the case on the telephone with reassurance, reiterate importance of self-isolation and advice re household contacts.
If available, observation ranges apply to ≥16 years; please factor in fever, anxiety, medical history and use clinical judgement.

Mild

- Completing full sentences, **no** SOB or chest pain, able to do usual ADLs
- Advanced: RR 12-20, HR 51-110, sats ≥ 96%

Management:

- Regular paracetamol, fluids, rest, clear safety netting
- Use NHS111 online if symptoms worsen (call 111 only if no internet). Contact own practice if in hours

Moderate

- Completing full sentences, some **new** SOB and/or atypical chest pain, able to do ADLs but lethargic
- Advanced: RR 21-24, HR 111-130, sats ≥94%

Management as for mild, plus:

- Consider arranging remote follow-up e.g. if vulnerable
- If known asthma/ COPD, see guidance [page 15]
- If clinical judgement is of community acquired pneumonia (CAP) consider antibiotics (see purple box)

For anyone you consider may need face-to-face ensure you have [page 10]

- Used the triage guidance to maximise scope for managing over the telephone
- Sought advice from a senior clinical colleague (the clinical coordinator if working in IUC) to support remote management
- Offered/ undertaken scheduled telephone follow up (preferably with the same clinician) to support self-care
- Considered video consultation

More unwell patients who may require face-to-face in primary care +/- admission

- See NICE markers of severe Covid illness [p 5]
- **Significant deterioration** in SOB, based on a detailed history over the last 2-6 hours +/- SOB at rest +/- unable to complete sentences
- Advanced: RR ≥25, HR ≥131, sats < 94%

Management

- Assess frailty, use Charlson Comorbidity Index and admission guidance [page 2]. Discuss/ document ceilings of care, and consider palliative care in the community [see BNSSG EOL guidance published 9.4.20]
- Consider antibiotics in the community
- Consider face to face review in primary care within 2 hours (with interim safety netting), or consider referral/ 999
- Consider close follow up within primary care, eg ring back in 1-2hrs

If in person's best interests, consider admission if requires oxygen, IV antibiotics for secondary infection, to support organ failure
If admitting, refer to medical team; do not send to ED unless asked to do so

Utilise video consultation if one or more of the following criteria met [p12]

- Anxiety
- Acutely housebound (e.g. self-isolating/ shielding but would otherwise come in for face to-face)
- Children ideally needing face-to-face
- Difficulty assessing the severity or nature of illness
- To avoid the need for face-to-face, including discussions about advanced planning

IF appointment or home visit still needed in primary care [page 12]

- Ensure PPE available, follow local processes
- Do not examine oropharynx in adults or children

Antibiotic treatment

- See page 9 for when to consider antibiotics
- First line: doxycycline 200mg day 1, then 100mg od for 4 days
- See details on page 9 for alternative antibiotics and second line options.

Guide to hospital admission for ALL patients, with or without suspected Covid-19

Compassionate communication and shared decision-making should form the basis of any decision to admit to hospital. We **support you** to be courageous in your decision making.

1. Think about what interventions are only available by admission.

- For cases of Covid-19, in-hospital management will be based on oxygen support, IV antibiotics for secondary infection, supporting organ failure and potentially mechanical ventilation
- Consider whether treatment in the community might be possible and/or sufficient

2. **You must consider the person's medical history, comorbidities and risk of mortality, using the Charlson Comorbidity score which is visible in Connecting Care**[1]

- The score may under-estimate Covid-19-associated mortality* but it is well validated, and includes factors known to be associated with severe Covid-19 illness[2].
- Though difficult to quantify, consider also post Covid-19 morbidity and chance of full recovery
- Atypical cases such as those with home non-invasive ventilation or high multimorbidity despite young age may need discussing with the relevant hospital specialist, where feasible

Charlson score	In-patient mortality (%)	10-year mortality (%)
0	0	2
1	3	4
2	6	10
3	11	23
4	14	47
5	15	79
6	24	98
>= 7	-	100

3. Share the decision-making process

- In-hospital Covid-19 mortality is much higher than for a typical admission (estimated 50% if age > 80*)
- Consider discussing your decision with a colleague especially for 'borderline' decisions
- A community-based approach including supportive and/or palliative care should be the normal route when people are unlikely to benefit from hospital admission (and may be harmed) such as those with
    - Serious progressive life limiting neurological diseases in an advanced stage e.g. dementia
    - End-stage single organ failures: cardiac, renal, liver and lung.
    - Severe frailty: Clinical Frailty Scores (CFS, also known as a Rockwood score) 8 and 9[3]

Treatment in the community requires proactive discussions about resuscitation status, agreed ceilings of care and prescribing for symptoms at the end of life.

4. Document your decision-making process

Make use of the recommended Covid-19 admission template within EMIS (see GP TeamNet and daily primary care Covid-19 bulletins for release date and updates), which includes guidance on the use of the Charlson Score. In IUC, log discussion and decisions in the Adastra records. Complete a ReSPECT form.

[1] Scores will be available within electronic patient records (see daily primary care Covid-19 bulletins for release date and updates) and or use www.mdcalc.com/charlson-comorbidity-index-cci or the associated MedCalc smartphone app
[2] i.e. age and cardiovascular conditions (Charlson et al. 1987, Sundararajan et al. 2004)
*on current best evidence as of 27th March 2020
[3] CFS 8 and 9 are associated with inpatient mortality rates of 24 and 31% respectively

BNSSG Primary Care Assessment and Management guidance for people with Covid-19 symptoms, and non-Covid problems

(v5) 24.4.20, review due 8.5.20

Medical Directors' statement

"Stiffen up the sinews, summon up the blood", so said Shakespeare's Henry V when faced with the Battle of Agincourt. Well, here we are, five centuries later, with the Battle of Covid.

I write on behalf of the primary care and community medical directors of BNSSG, to share this guidance to support primary care clinicians in assessing and managing patients (both Covid and non-Covid) in this strange and challenging world.

As some of you know, I have, in the pre-Covid world, articulated the concepts of "fear-based medicine" and "courage-based medicine". The former is where fear influences, or even dictates, clinical decision-making – and it is often semi-conscious or sub-conscious. Fear of many things: getting it wrong, looking stupid, having a complaint, being sued and so on. The latter, courage-based medicine, is not about anything clever or super-heroic. It's about recognising, owning and understanding our fears and, despite them, making the best decision for the patient in any given scenario. Courage-based leadership must enable courage-based medicine.

The primary care and community medical directors, along with all of Clinical Cabinet (the senior clinical leaders across the whole of BNSSG) staunchly support all primary care clinicians to practise courage-based medicine in the Battle of Covid. We stand with linked arms and a common purpose; to continue to deliver the best patient care we can through this troubled time; to support each other in acknowledging and meeting the challenges along the way, both personal and professional; to, despite it all, to retain a sense of humour (Knock knock. Who's there? Corona…); and to simply recognise our common humanity and public service in this hour of need. "Once more unto the breach, dear friends, once more…."

Dr Kathy Ryan, Medical Director, BrisDoc

On behalf of:

Drs Martin Jones and Peter Brindle, Medical Directors BNSSG CCG
Dr Jake Lee, Medical Director One Care
Dr Kate Rush, Medical Director, Sirona

27 March 2020

Please note that changes made in this version are highlighted as blue text throughout this document.

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Background

This aims to support consistent and appropriate decision-making and courage-based medicine in urgent primary care in this time of Covid-19. Please remember that 90% of the clinical information we need to make a plan/ decision is in the history in any case. This guidance is aligned with the PHE Guidance and NICE for Primary Care available at the time of writing, and has been developed in conjunction with available evidence and with clinical colleagues across the BNSSG system.

The government guidance on social distancing, means that everybody should remain at home wherever possible to avoid transmission between households. There is also guidance about shielding people defined on medical grounds as extremely vulnerable to Covid-19. There must be a *very* clear clinical need for all patients – including those with non-Covid 19 symptoms – to be seen face-to-face at an appointment or at a home visit. Therefore, face-to-face assessment for all patients should be minimised, and especially those with Covid-19 symptoms. This means we need to assess and close many cases over the telephone and/ or via a video consultation. However, it is important to remember that some patients will still require face-to-face assessment for both Covid and non-Covid urgent problems. The system is committed to 'parity of care' between patients who have Covid-19 and those with non-Covid urgent clinical needs.

Clinical information about Covid-19 in the community

The majority of people will be fine at home. Every effort should be made to follow the national guidance and support management at home without face-to-face clinical assessment in any setting. Risk factors for more serious illness include older age, cardiovascular disease, diabetes, pregnancy, smoking, CKD, liver disease, COPD and steroids/ immunosuppressants.

Breathlessness appears to worsen around 7-10 days, and this is the main concern rather than a sepsis picture. A key element in the history is therefore assessing the severity of that shortness of breath; many patients reporting shortness of breath will not need to be seen and we recognise that this may feel uncomfortable.

NICE advises that the following symptoms and signs help to identify patients with more severe Covid illness.

- severe shortness of breath at rest or difficulty breathing
- coughing up blood
- blue lips or face
- feeling cold and clammy with pale or mottled skin
- collapse or fainting (syncope)
- new confusion
- becoming difficult to rouse
- little or no urine output.

All of the above features do not require a physical face-to-face assessment, or observations. Clinical examination of the chest does not aid assessment of illness severity for patients with Covid-19.

Cardiopulmonary Resuscitation

There is contrasting national guidance about whether chest compressions are, or are not, aerosol generating. The Resuscitation Council UK (RCUK) advises that both chest compressions and airway manoeuvres/ ventilation are aerosol generating, and therefore require Level 3 PPE including FFP3 masks (not available in the community). Primary care clinicians should proceed with early 999 and early defibrillation (if indicated), wearing fluid resistant face mask, visor/ goggles, gloves and apron. Please note that PHE guidance advises that chest compressions are not aerosol generating and therefore that Primary Care PPE is adequate for chest compressions (but not airway intervention).

We view the RCUK as the subject matter experts, but it is reasonable to make a case-based risk assessment 'in the moment' as outlined by PHE. *If* commencing chest compressions in the community, use the maximum available PPE. It seems sensible to consider applying a fluid resistant face mask to the patient to reduce any risk of aerosol generation/ spread. We do not support the use of any airway procedures, unless they are undertaken by emergency services with Level 3 PPE.

Remember that many patients will find breathlessness and/ or chest pain worrying, so anxiety may well be a factor in the clinical presentation. Gaining a good rapport with the patient and being empathic and supportive are essential in enabling telephone assessment and management. As clinicians, many of us are are also very concerned about Covid-19. However, **please ensure that you explore the clinical features which may suggest other serious/ life threatening/ urgent differentials when assessing patients** to avoid becoming 'blinkered' by Covid-19.

Children and Covid-19

It seems that Covid-19 is more likely to be a mild illness in children, and they are more likely to be asymptomatic carriers. Therefore, if at all possible, avoid face-to-face consultations about Covid or non-Covid 19 problems. However, there are concerns about serious illness in children being missed during the pandemic. **Serious or potentially serious illness in children should be managed as usual.** An example from colleagues in Wales demonstrates that they have diagnosed significantly fewer children with type 1 diabetes in recent weeks. Late presentations of DKA in children have been reported elsewhere in the UK.

Please take a 'normal' history in children, to include presenting complaint, feeding, urine output, general energy and so on. Febrile young babies still need to be seen in secondary care.

Ensure that you consider non-Covid diagnoses, and see or refer the patient if required. This includes, for example, fever or reported fever in babies < 12 weeks old. The BCH ED advice line (0117 342 8078) remains available to discuss cases if there is uncertainty about the most appropriate next steps. In children with other comorbidities, we suggest that a lower threshold for seeking advice is appropriate. Consider liaising with an experienced GP colleague or the Clinical Coordinator for advice about the management of children.

Tips for taking a history and assessing illness severity in adults with possible Covid-19, on the telephone

We all have our natural patterns and rhythms of history-taking. This is not a prescriptive 'order of service', but the following points should be covered:

- As always, seek to **speak with the** patient where possible and not solely with a family member – this adds to the clinical information obtainable
- When did symptoms start? What **day of the illness** are they now? Are they likely to be near the peak of their illness (days 7-10), or are they at, or past that? Or are you concerned that they are already quite unwell, but not yet at the peak of the illness? This information is relevant for safety-netting too.
- Explore **breathlessness**.
    - What is the patient's normal level of exercise capacity? What makes the patient breathless now? At rest, when talking, on the flat, on stairs? Can they get to the toilet? Can they undertake ADLs?
    - Monitor breathlessness as the patient is speaking. Full sentences?
    - Consider obtaining collateral history from family/ carer if needed.
    - "Is your breathlessness worse today than it was yesterday?" If so, how has the breathlessness changed over the last 2-6 hours (as an indicator of deterioration)?
    - Anxiety may be a significant element in breathlessness. You may notice variability in the breathing pattern/ rate during your conversation in this situation
    - The Roth score should not be used. It is not validated in Covid-19 pneumonia (although it has been included in Covid guidance published elsewhere in the country, clinicians are now advised not to use it).

    - For children, you can ask the parent to hold the telephone microphone next to the child's mouth/ nose so you can attempt to hear the breathing and obtain a respiratory rate. Consider asking to speak directly with the child
- Ask about **other symptoms**: eg cough, fever, sore throat, sputum, headache, vomiting, diarrhoea etc. The cough associated with Covid-19 seems to be dry in nature though sputum is not uncommon. Mild haemoptysis can occur as a result of trauma from coughing, but explore this carefully – more significant haemoptysis can be a marker for severe illness. In addition, has there been syncope? Dizziness? Confusion?
- **Skin appearance** – pink, pale, blue, clammy etc?
- Have they taken **paracetamol and/ or ibuprofen**? How much and when? Check it is the full dose and regularly – it makes a difference. The Chief Medical Officer wrote to clinicians on 15.4.20 about the use of ibuprofen, advising that there is "currently insufficient evidence to establish a link between use of ibuprofen, or other nonsteroidal anti-inflammatory drugs (NSAIDs), and contracting or worsening of COVID19".
- Ask about **hydration**. Fluid intake over the last 4 hours? When did they last pass urine? Good amount? Good hydration is important and helps symptoms
- **PMH** – consideration of comorbidities is important (noting the recognised at-risk groups). Have a low threshold for looking at EMIS in IUC. Don't forget that the presentation may be atypical in patients who are **immunosuppressed** – we are seeking further details on this clinical picture
- Explore whether the patient is **frail**. See page 2.
- Is there a **DNAR and/or Respect form or TEP**?
- **Drug history especially immunosuppressants**
- **Social and household** situation. Confirm that the household is self-isolating if one or more people have Covid symptoms. If consulting about a patient with non-Covid symptoms, confirm the Covid status of others in the household.
- **Consider if there may be safeguarding concerns.** It is recognised that self-isolation is potentially a high -risk time for domestic violence and safeguarding concerns.
- Explore mental/emotional wellbeing; understandably anxiety can be a significant factor, recognise this and offer support
- The patient may have equipment at home to check their own BP, thermometer, heart rate and/ or saturations. Smart watches/ fitness devices can provide a heart rate, but there is specific advice not to use smart devices to obtain oxygen saturations.
- **Ideas, concerns, expectations** – what is the patient seeking? What are the relatives/ carers seeking? While they may be seeking something that it is not appropriate to offer (eg. face-to-face assessment), it is helpful to acknowledge the expectation with something like "I understand that you would like to be seen. Let me get some more information so we can work out how best to help you."

The BMJ Covid-19 infographic is a helpful resource to support remote (telephone or video) assessment, in primary care. However, please use the thresholds for observations outlined in the advanced assessment in the BNSSG primary care pathway, as follows:

	Mild Covid-19 illness	Moderate Covid-19 illness	More unwell	Critically/ seriously unwell
History on the telephone	• Completing full sentences • No chest pain • No SOB • Able to do usual ADLs	• Completing full sentences • Some new SOB and/or atypical chest pain • Able to do ADLs but lethargic	• NICE markers of severe illness [p 5] • Significant deterioration of SOB over last 2-6 hours • +/- SOB at rest • +/- unable to complete sentences	• Clammy, sweaty, pale • Overt and significant respiratory distress including unable to speak • Confusion or drowsiness • Clinical judgement
Advanced assessment (if available)	• RR 12-20 • HR 51-110 • sats ≥ 96%	• RR 21-24 • HR 111-130 • sats ≥94%	• RR ≥ 25 • HR ≥ 131 • sats < 94%	

Advanced assessment criteria apply to people aged ≥16 years, but will **not** be available for most patients (as they, for the most part, will not be seen face-to-face). Green/moderate illness reflects a NEWS2 of 1 point for each parameter outlined. Amber/ more unwell advanced assessment thresholds reflect a NEWS2 of 2 points for each parameter.

Please ensure that you consider fever and anxiety in interpreting the numerical values, if an advanced assessment is available. Both are likely to increase the heart rate and potentially the respiratory rate. Similarly, comorbidities may influence the observations (see EMIS for baseline information for the individual patient). Take care in patients who are on medications which may impact on physiological parameters (eg salbutamol causing tachycardia, beta blockers masking this). Be aware that very fit, younger people may have a low baseline heart rate and so the thresholds for concern may be lower than those outlined. In essence, perform a holistic clinical assessment.

Take care not to assume that all patients with cough and/ or fever and/ or shortness of breath and/ or chest pain have Covid-19. Consider other differential diagnoses for this illness, particularly with reference to the patient's PMH. Examples might include worsening heart failure, PE, sepsis, LRTI, cardiac chest pain etc. Explore usual red flags for other serious illness/ differentials.

Consider frailty and comorbidities for *all* adults (see hospital admission guidance on page 2)

- It is **very important to assess comorbidities and frailty to guide appropriate next steps in assessment and management**. Please use the Charlson score to inform decision making and discussion with the person and/or their family/relatives (see hospital admission guidance, page 2). Charlson scores are now visible in Connecting Care at the top of the main dashboard.
- We should consider that frail patients, including patients in care and nursing homes, are unlikely to benefit from hospital treatment and would not be eligible for intensive care therapies. Covid-19, and serious non-Covid illness, may well be a terminal diagnosis in this cohort of patients. It is therefore important to factor this highly into decision-making for frail and multimorbid patients.

- As such, primary care (including IUC) has a vital role in supporting advanced care planning, DNAR and discussing this with the family in anticipation that the patient may deteriorate.
    - In hours, this should be logged in the EMIS Covid-19 template and/ or ReSPECT.
    - In IUC, end of life discussions can be documented in Adastra, DNAR and Respect forms can be completed, and end of life/ just in case medications prescribed for very unwell or rapidly deteriorating patients
- We are most familiar with having advanced care planning discussions with patients and/ carers/ family at a face to face assessment. At this time, it is reasonable to make end of life decisions over the phone and/or video consultation with remote prescribing. Therefore, patients who may require end of life decisions do not necessarily require a visit.
- Document discussion with the patient/ family/ carers about appropriate ceilings of care, and factor those views and preferences into the decision making. **Please ensure that you make clinical decisions in the best interests of the patient**. There may be occasions where this contrasts with the family's expressed preferences. Careful and sensitive discussion is required in such circumstances and it may be helpful to discuss the case with an experienced GP or the Clinical Coordinator. It is helpful to remember that:
    - Admission to hospital brings significant clinical risk. This includes the high risk of acquiring Covid-19 in hospital for patients who do not already have it. It is likely that family will be very restricted in visiting
    - For frail patients, it will be kinder, and in the patient's best interests, to care for them in familiar surroundings, with family and/or staff they know providing best supportive care
    - More broadly, we need to consider the wider needs of the population. It is vital that the hospitals retain as much capacity as possible to be able to manage the significant increase in admissions which are anticipated over the coming weeks, including for usually fit and well patients with no comorbidities
- Prescribe end of life medications proactively. End-of-life guidance for managing palliative Covid-19 patients in the community is being developed and will be published week commencing 6th April. In the short run, manage as per the symptom picture and with appropriate advice where needed.

When to consider antibiotics, and antibiotic choice

More likely viral cause	More likely bacterial cause
• History of Covid-19 symptoms for about a week • Severe muscle pain • Loss of smell • Breathlessness but no pleuritic pain • History of exposure to Covid-19	• Rapidly unwell after only a few days of symptoms • Does not have a history of typical Covid-19 symptoms • Pleuritic pain • Purulent sputum • If advanced assessment available: fever ≥38°C, RR >20, HR >100 and new confusion – each increases the likelihood of CAP

NICE guidance published on 4.4.20 advises not to offer antibiotics if Covid-19 is likely to be the cause and symptoms are mild. The guidance advises offering antibiotics if:

- Likely cause is bacterial (see above)
- Unclear if viral or bacterial and symptoms are more concerning

- High risk of complications eg old or frail, pre-existing comorbidity such as immunosuppression, significant heart or lung disease, history of severe illness following previous lung infection

Antibiotic choice, if appropriate to prescribe

- First line: Doxycycline 200mg day 1 then 100mg od for 4 days (5 days total course).
- Alternative (if pregnant, breastfeeding, allergic to doxycycline or require liquid medication) amoxicillin 500mg tds for 5 days.
- If pregnant and allergic to penicillin, use erythromycin 500mg qds for 5 days
- If needing liquid, or breast feeding and penicillin allergic, use clarithromycin 500mg bd for 5 days. Avoid Clarithromycin if known cardiac issues as it can prolong QT interval or patient is on interacting medication.
- If deteriorating on first line antibiotics and not for hospital admission: Co-amoxiclav 625mg tds 5 days. If penicillin allergic Co-trimoxazole 960mg bd for 5 days (Levofloxacin 500mg od 5 days could be used but there are supply problems)

In addition

- Discuss antibiotic usage for patients with bronchiectasis or interstitial lung disease with respiratory or medical microbiologist.
- If admitting the patient, do not start antibiotics

Closing Covid-19 cases with advice and safety netting on the telephone

- **We support you to be courageous**. The needs of our patients and the population require us to manage many more patients with advice and reassurance over the phone, even when there may be overt evidence of shortness of breath and our usual practice might have been to see the patient
- Antibiotics, if indicated by the guidance above, can be prescribed over the telephone
- The threshold for Covid a*nd* non-Covid patients in primary care to be seen is therefore high, and there must be a **very clear need**. The patient would need to be unwell enough that you are considering whether they require *admission* to hospital. Patients who are not as unwell as this should be managed with advice over the telephone, +/- video consultation. See flow chart for information about managing mild/ moderate Covid cases, and more unwell or critically ill cases
- Remember that many patients will be understandably anxious whatever their symptoms. The importance of undertaking a calm, thorough assessment can in itself be helpful for patients, and **reassurance and clear advice/ safety netting is vital**. As with all patients we see in primary care there is a risk that they *may* deteriorate to become more seriously unwell, but most will not. Safety netting for deterioration should include specific advice about what to watch for:
    - **Red flag symptoms** to monitor for include severe SOB at rest, cold/ clammy/ pale/ mottled skin, new confusion, difficult to rouse, blue lips or face, little or no urine output, haemoptysis PLUS red flags for other conditions (eg. meningism)
    - Significant deterioration in breathlessness for patients with Covid-19 appears to progress over hours

    - Consideration of the **illness timeline** (as above); it is reasonable to talk this through with the patient
    - If they worsen during the 'in hours' period, the person should **contact their own GP** practice (not 111 by phone or online). This may change over the coming weeks with the arrival of the National Covid Clinical Assessment Service (CCAS).
    - During the 'out of hours' period, the person should use NHS111 online. Only if they do not have internet access, advise telephoning NHS111 (but there can be delays getting through because demand is high)
- Emphasise **the importance of self-isolation** as per the latest government guidance, both for the patient and household contacts
- Advise regular paracetamol, and good fluid intake.
- If the patient lives alone or is otherwise **vulnerable, seek to arrange that someone will check on them regularly**. Consider arranging telephone follow up if concerned or this is not possible.
- In IUC, the **patient line may be helpful for <u>some</u> patients**, particularly where family/ carer or patient anxiety appear to be a factor. However, there is no 111 assessment via the patient line so a severely ill patient could wait too long if this is relied upon. Therefore, most patients with possible/ likely Covid-19 should be advised to use NHS111 online if they worsen.

When you are considering physical face-to-face assessment

Critically ill patients

- If you consider that the patient is **critically ill (red on the pathway) *and* not frail or multimorbid, arrange 999**. Ensure that the ambulance service is advised about the concerns about Covid-19, whether you call 999 or the patient/ relative/carer does
- If critically ill or very unwell but also frail/ multimorbid, discuss ceilings of care, TEP and ReSPECT. Consider remote palliative care.

Patients with amber features on the pathway

- If the patient is not critically ill, but is unwell (amber features on the pathway), they may be more likely to need a physical face-to-face for advanced assessment to determine any next steps. Advanced assessment should be considered if the patient has features suggesting more severe illness (as defined by NICE, page 5).
- We are aware that clinicians have been concerned about the possibility of 'silent hypoxia' in Covid-19, (describing low saturations in a patient who is not breathless). Based on the experience and recommendations of respiratory, medical and intensivist colleagues in BNSSG, and current national guidance, primary care clinicians should manage patients on the basis of symptoms and history, as outlined in this guidance.

Mild or moderate Covid 19 illness

- The large majority, if not all, patients with mild or moderate illness (green on the pathway) should be managed with reassurance and advice over the telephone.

If you consider that face-to-face assessment may be needed, please do all of the following:

- **Liaise with a senior colleague (the Clinical Coordinator in IUC) for advice** and support to help close the case with advice over the telephone. They will seek to support you being appropriately courageous in your decision making

- **Share decision making about the risks and benefits of being seen face-to-face with the patient**. It is helpful to be explicit about the risks to them, and others; seeing patients brings potential risk of infection to the patient and their carers if they do not currently have Covid-19. In addition, it is likely that seeing a patient will not add to or change their treatment/ management unless you consider that they may need admission to hospital. Laying this out for patients can be helpful in agreeing a watchful waiting approach with appropriate safety netting
- **Consider prescribing over the telephone if indicated (using EPS), even if your usual practice would be to see the patient face-to-face**. For example:
    - Antibiotics for tonsillitis. These patients should not be brought in. It is possible to obtain a Centor or Fever Pain score from most patients over the telephone. Please note the latest guidance that clinicians should not examine the oropharynx face-to-face because of the increased risk of passing infection on. Therefore, do not bring any patients in for throat examination.
    - Antibiotics for bacterial chest infection, following the guidance above. Productive cough with purulent sputum *may* suggest this, but CAP is more likely if any one of temperature ≥38°C, RR >20, HR >100 and new confusion are present. Prescribe over the phone rather than bring the patient in for chest auscultation.
    - Oral steroids for patients with COPD/ asthma, with or without antibiotics, if this is indicated to treat an exacerbation. See additional information from the British Thoracic Society about people with asthma and COPD (page 10)
- **Offer/ undertake scheduled telephone follow up**. This should be undertaken by the same clinician before the end their shift. If this is not possible, the case should be handed over to the clinician covering the following shift. This approach can mean that patients and carers/ family feeling supported to continue self-care and monitoring at home. It is particularly helpful if, for example, symptomatic treatment has not already been tried (eg to manage fever) or patient/ carer anxiety is likely to be a factor
- If all of these have been explored/ undertaken, **consider video consultation**

Undertake video consultation (if available, and particularly if one or more of the following criteria are met):

- **Anxiety** is a significant factor and face-to-face connection is likely to be helpful in providing reassurance
- The patient is unwell enough to need face-to-face and would not usually meet the home visit criteria but is considered **acutely housebound** (eg at risk patients who have received a letter advising them to remain at home for 12 weeks)
- **Children** needing face-to-face. They are more likely to be asymptomatic Covid-19 carriers, so avoid face-to-face assessment if at all possible.
- **Difficulty assessing the severity or nature of illness**, and clinically 'eye balling' the patient could make a difference eg pallor/ colour change. This is particularly helpful where visual assessment will affect management eg rash, bites, cellulitis, possible respiratory distress.
- **Discussions about advanced planning**/ DNAR/ EOLC if this avoids the need for a visit.
- **To avoid face-to-face assessment (home visit or appointment)**

Video consultations

- Utilise local systems/ processes for this.
- The primary aim is to provide additional visual information to support clinical decision making, and to support building relationship and rapport with the patient
- Wherever possible, video consultation is likely to be most effective if undertaken by the same person who has undertaken the initial telephone assessment. This avoids the patient needing to repeat their history and supports continuity
- The BMJ Covid-19 infographic is a helpful resource to support remote assessment, including video consultations, in primary care. However, **please utilise the thresholds for observations outlined in the advanced assessment in the BNSSG primary care pathway** (page 1)
- It is possible to look at the throat using video consultation. This should be avoided at a physical face-to-face because of the increased risk of passing on infection.
- Video consultations can also support remote discussion and assessment for patients who are frail and would not be appropriate for hospital admission. This could incorporate discussion with the family/ carers, and discussions about end of life prescribing.

If, after telephone +/- video consultation, physical face-to-face is still required

- If you consider that the patient is **critically ill *and* not frail or multimorbid, arrange 999**. Ensure that the ambulance service is advised about the concerns about Covid-19, whether you call 999 or the patient/ relative/carer does
- If critically ill or very unwell, but also frail/ multimorbid discuss ceilings of care, TEP and ReSPECT. Consider remote palliative care.
- If the patient is not critically ill, but you consider that they are unwell enough that they **may** require hospital admission (amber on the pathway and/ or NICE markers of severe illness are present), consider physical face-to-face in primary care to undertake the advanced assessment. Your triage notes must include:
    - **"Isolation/ PPE required"** on the first line (in IUC)
    - Focused but comprehensive information covering the elements of the history outlined above, and any other pertinent information. Please add the key reason(s) why you feel physical face-to-face is needed. This will ensure that the face-to-face clinician can minimise the time they spend consulting with the patient in the isolation room.
    - If the patient requiring face-to-face does not have Covid symptoms, but the household is self-isolating because others do, the consultation will require PPE in the isolation room.
- Remember the government advice that patients **should not use taxis or public transport**
- Children are more likely to be asymptomatic carriers, so encourage patients not to bring children/ others with them to appointments.
- If a child requires face-to-face for Covid or non-covid problems, they will need to be brought to an appointment by one parent (even if the household is in self-isolation because of Covid symptoms)

If you are considering arranging physical face to face for 'non-Covid' 19 patients

- **Please be aware that acute/ urgent non-Covid serious conditions are still out there**
- If you consider that the patient is **critically ill *and* not frail or multimorbid, arrange 999**
- If critically ill or very unwell, but also frail/ multimorbid discuss ceilings of care, TEP and ReSPECT. Consider remote palliative care.
- Please be aware that cough and fever are not the only symptoms of Covid. If a patient does not have cough or fever, but does have other URTI/ viral symptoms, manage as per Covid.
- Again, the threshold for seeing **all** patients is much higher than usual. This reflects the government's guidance that everyone should remain at home, and that social distancing is vital. We also know that many people with Covid-19 are infectious before they develop symptoms, particularly children
- Ensure that PPE is available (see updated government PPE guidance, published on 2.4.20).
- If bringing a non-Covid patient in for a physical face-to-face assessment, confirm and document that they do not have either a cough or temperature. In addition, confirm that no one in the household has these symptoms. Ensure that the patient brings a maximum of one person with them, to support social distancing.
- For patients with non-Covid illness, there may be concerns about coming to a clinical setting. Again, the shared decision-making approach can be helpful (see above) as they too may opt to self-manage with appropriate safety netting, to avoid being exposed to Covid-19
- Consider the strategies outlined for managing Covid-19 patients over the telephone including seeking advice/ support from a senior GP colleague (the Clinical Coordinator in IUC), sharing decision making with the patient, lower thresholds for prescribing over the telephone, timed telephone follow up etc
- Video consultation may, of course, also be helpful in managing non-Covid patients. This is especially so if the visual assessment can affect diagnosis and management eg rashes, bites, cellulitis
- Do not bring patients in to collect prescriptions. Use EPS

Undertaking physical face-to-face assessments for Covid-19 patients at the practice/ IUC base, and on home visits

- Follow local processes for ensuring that patients with possible Covid-19 are seen in an appropriate setting, minimising contact with both staff and other patients. In IUC, the process is detailed on the Clinical Toolkit
- Ensure that **PPE is available**, following the government guidance for the primary care setting
- PHE guidance published on 15.4.20 outlines how to dispose of PPE used at home visits in the household's domestic rubbish. This states that you must securely store the PPE waste in disposal rubbish bags. You must place these bags in another bag. You must tie this bag securely and keep it separate from other waste. This waste must be set aside for at least 72 hours before being put in the usual external household bin for non-recyclable waste.
- **Do not examine the oropharynx** in symptomatic or asymptomatic patients. There is an increased risk of passing infection on, and some patients are asymptomatic carriers
- Unwell/ amber on the pathway patients (patients being seen face-to-face in the community should, for the most part, be in this category)

- If the patient is unwell enough to require admission, and is not frail/ elderly (see admission guidance), refer to medical team. Do not send the patient directly to ED
- Discussion about next steps if the patient deteriorates further is important, and particularly whether hospital care would be appropriate
- For frail patients ensure appropriate ceilings of care have been discussed and documented with proactive DNAR decisions and EOL care/ prescribing. Follow palliative care guidance (BNSSG Covid-19 palliative care guidance to be published week commencing 6.4.20)

Specific patient cohorts

Frail adults, and those with risk factors

- See guidance above, and admission guidance.

Safeguarding, domestic violence and vulnerable people

Household self-isolation is recognised to be a period of increased risk around domestic violence and safeguarding concerns. Be vigilant for this. If you have concerns, discuss these with a senior colleague and/ or refer as you usually would. There is updated IRIS guidance around domestic violence here.

People who are shielding or isolating but do not have a social or family network of support are potentially vulnerable. They may, for example, not be able to obtain food. You can complete an online safeguarding referral on the relevant Council website. In hours, consider linking the patient with your social prescriber and/ or local/ neighbourhood support networks.

Adults with Covid-19 and asthma

See the BTS guidance relating to asthma and Covid-19, from which this information is taken:

- For most people with well-controlled asthma, having asthma does not seem to increase the risks associated with Covid-19. A key message for patients with asthma is therefore to optimise their baseline asthma control; ensure their inhaler technique is good, and they have adequate (but not excess) supply of inhalers at home to ensure they can continue their medications. There is no evidence that inhaled corticosteroid increases the risks of getting Covid-19.
- The management of asthma exacerbations is unchanged if the patient has Covid-19 symptoms, and would usually follow the patient's personal asthma action plan. As for all other patients, however, more will need to be managed over the telephone or video consultation. If a course of oral steroids is indicated, it should not be withheld. Add antibiotics only for increased volume or thickness of sputum, or change in colour. If the patient has good understanding of their illness and/ or exacerbates frequently, consider providing a rescue pack.
- People with severe asthma are classed as extremely vulnerable in the government guidance about shielding. There is new Covid-19 NICE guidance for people with severe asthma.

Adults with Covid-19 and COPD

See BTS guidance about Covid-19 in patients with COPD, and NICE guidance for community-based care of COPD.

In brief, NICE advises:

- Continue established inhaled and oral corticosteroid treatment
- Treatment of exacerbations according the patient's individualised self-management plan.
- Tell patients not to start a course of steroids and/ or antibiotics for symptoms of Covid19

End of life care, death verification and certification

Updated national guidance for the pandemic period changes the requirements for issuing the Medical Certificate of the Cause of Death (MCCD). Please familiarise yourself with this. Sirona are working to support 'any suitable person' being able to verify death as outlined in the updated legislation. BNSSG End of Life guidance was published on 9.4.20 and is available via GP Teamnet or Remedy.

Finally, we reiterate that we fully support you being courageous in these challenging times – it is important that we consider the needs of the whole community/ population, as well as those of the individual patient.

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