C&P Primary Care Protocol During Covid-19

NHS Cambridgeshire and Peterborough Clinical Commissioning Group

Telephone Triage
Patient with Covid19 symptoms

Category 1
Mild symptoms of Covid 19 self-isolate including household contacts, self-care advice, worsening advice ring back if becomes breathless

Category 2
Moderate symptoms: needs further assessment (includes patients on Shielding List)

Category 3
Severely unwell: Need to admit patient to hospital. Call ambulance and inform that Covid-19 risk. No need to telephone the medical registrar

Clinical judgement/ceilings of care override this pathway. Careful consideration of patients with co-morbidities e.g. COPD should be employed before considering an acute referral

Category 2A

Assessment
Completing full sentences. No SOB or chest tightness. Able to do ADLs. Able to get out of bed.

See page 2 for assessment of breathlessness.

RR 14-20 Adults
HR 50-100 Adults
O2 Sats >96%

Category 2B

Assessment
Completing full sentences. Some SOB on exertion. No chest tightness. Lethargic.

See page 2 for assessment of breathlessness.

RR 20-24 Adults HR 100-130 Adults O2 Sats >94%

Category 2C

Assessment
Not Completing full sentences. Worsening SOB on exertion (new). Mild chest tightness. Unable to do ADLS. Lethargic.

See page 2 for assessment of breathlessness.

RR >25 Adults
HR >130 Adults
O2 Sats ≤93%

Category 2B

Treat temperature: Paracetamol, Fluids

Offer oral antibiotic if pneumonia suspected and if unclear if viral or bacterial cause or at high risk of complications due to frailty or pre-existing co-morbidity or previous respiratory problems.

1st line: Doxycycline 100mg 2 stat and 1 daily x 5 days (total)

Or

2nd line (including pregnancy): Amoxicillin 500mg tds x 5 days

See BNF and NICE guidance for further dosing in specific populations

Do not offer steroids unless they have other conditions for which these are indicated e.g. Asthma or COPD (NICE NG165). Nebulisers can continue to be used where part of patient's normal management plan.

Worsening breathlessness tends to occur in week and deterioration can be fairly acute refer these patients to hospital as per Cat 3 above.

Telephone Triage
Patient with non-Covid19 symptoms

Initially manage all patients virtually by telephone or video consultation

LIST FOR COLD BUT ESSENTIAL e.g.

child immunisations AND urgent blood tests (e.g. essential drug monitoring like azathioprine, methotrexate, mycophenolate, cyclosporin, sirolimus, tacrolimus, warfarin, lithium)

Nothing else is essential, including an agreement with clinicians that smears are no longer essential while PPE is in shortage.

All other care should continue (6-week baby checks, diabetic clinics) but all must be done virtually

Practice to continue seeing their own COLD patients UNLESS a local cold hub is designated, even those that need F2F. These patients can wait 1-3 weeks for staff sickness to resolve as are not urgent.

NURSE/HCA

Start telephoning vulnerable or frail patients for welfare checks.

Signpost to Social Prescriber and local social volunteering services e.g. for food deliveries or collecting prescriptions and chronic disease checks.

BASE APPPOINTMENT

ALL patients must have had a remote consultation before face to face.

PPE must be worn for every single F2F appointment by the patient and the clinician

See you tube link for PPE use guide
https://www.youtube.com/watch?v=36UiJJBEfag&app=desktop

HOUSEBOUND PATIENTS

GP home visit only if clinically necessary & remote assessment not possible.

OR CPFT community hub for presentations where without input the patient is likely to deteriorate to an extent that may require a hospital admission or is a threat to life. 0330 726 0077 SPA number.

Please see the BMJ article Here on remote assessment of breathing in Covid 19 patients and extract below:

Remote assessment of breathlessness

There are no validated tests for the remote assessment of breathlessness in an acute primary care setting. A rapid survey of 50 clinicians who regularly assess patients by telephone revealed some differences of opinion. For example, most but not all rejected the Roth score (which times how long it takes for a patient to take a breath while speaking) on the grounds that it has not been validated in the acute setting and could be misleading.

However, there was consensus among respondents around the following advice:

1. Ask the patient to describe the problem with their breathing in their own words, and assess the ease and comfort of their speech. Ask open ended questions and listen to whether the patient can complete their sentences:
    - "How is your breathing today?"
2. Align with the NHS 111 symptom checker, which asks three questions (developed through user testing but not evaluated in formal research):
    - "Are you so breathless that you are unable to speak more than a few words?"
    - "Are you breathing harder or faster than usual when doing nothing at all?"
    - "Are you so ill that you've stopped doing all of your usual daily activities?"
3. Focus on change. A clear story of deterioration is more important than whether the patient currently feels short of breath. Ask questions such as
    - "Is your breathing faster, slower, or the same as normal?"
    - "What could you do yesterday that you can't do today?"
    - "What makes you breathless now that didn't make you breathless yesterday?"
4. Interpret the breathlessness in the context of the wider history and physical signs. For example, a new, audible wheeze and a verbal report of blueness of the lips in a breathless patient are concerning.
    - There is no evidence that attempts to measure a patient's respiratory rate over the phone would give an accurate reading, and experts do not use such tests. It is possible, however, to measure the respiratory rate via a good video connection. More generally, video may allow a more detailed assessment and prevent the need for an in-person visit.