OOH's in the time of Covid-is this the new normal?

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Objectives

Map of Covid from primary care

What we have learned about remote assessment

Management

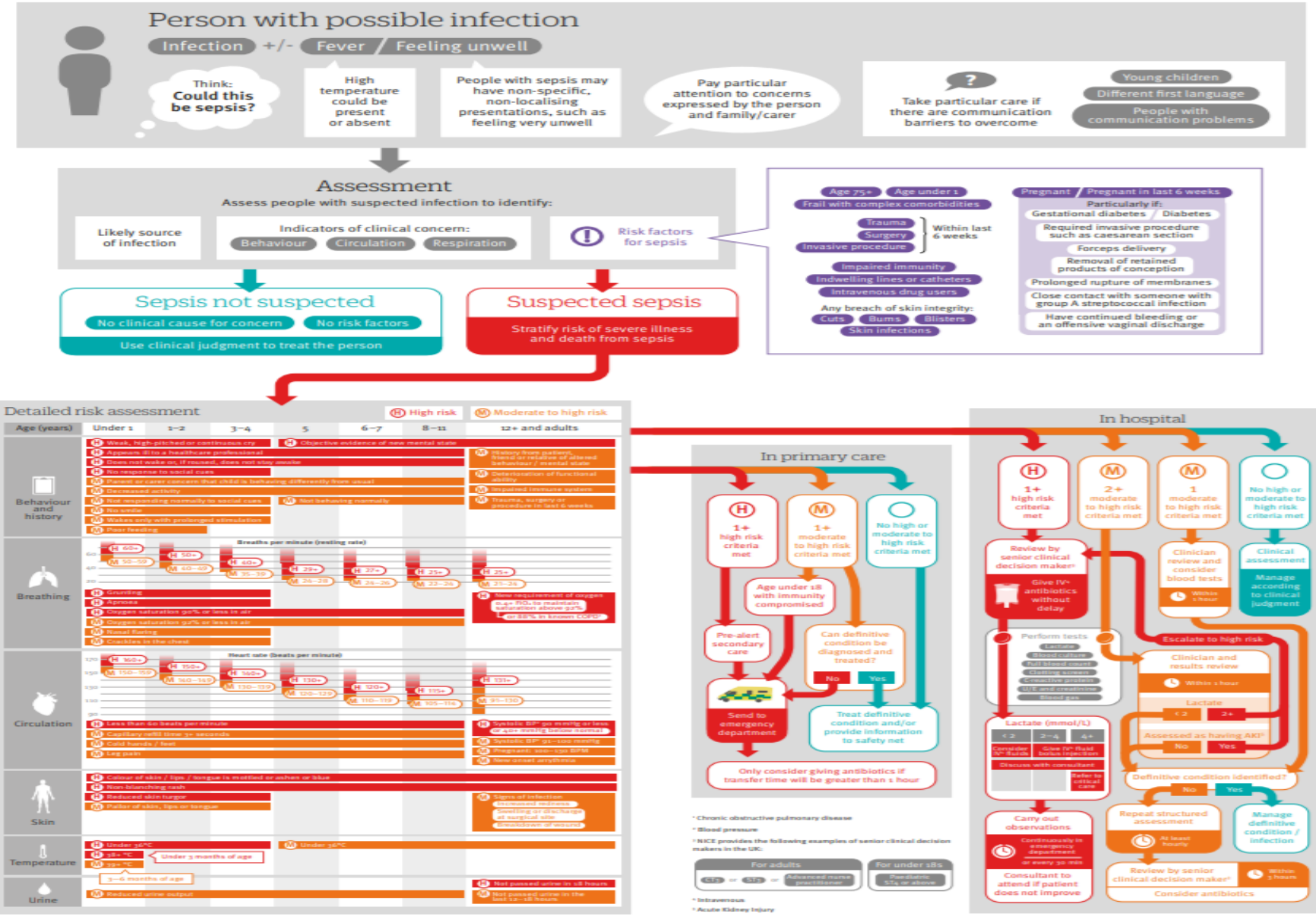
Challenges

Non Covid presentations in the time of Covid

NICE sepsis guidance

appropriate level of monitoring and management for suspected sepsis

Based on the opinion of the guideline development committee, supported by generally very low quality evidence



NEWS2 and treatment escalations

We recommend that these triggers should determine the urgency of the clinical response and the clinical competency of the responder(s).

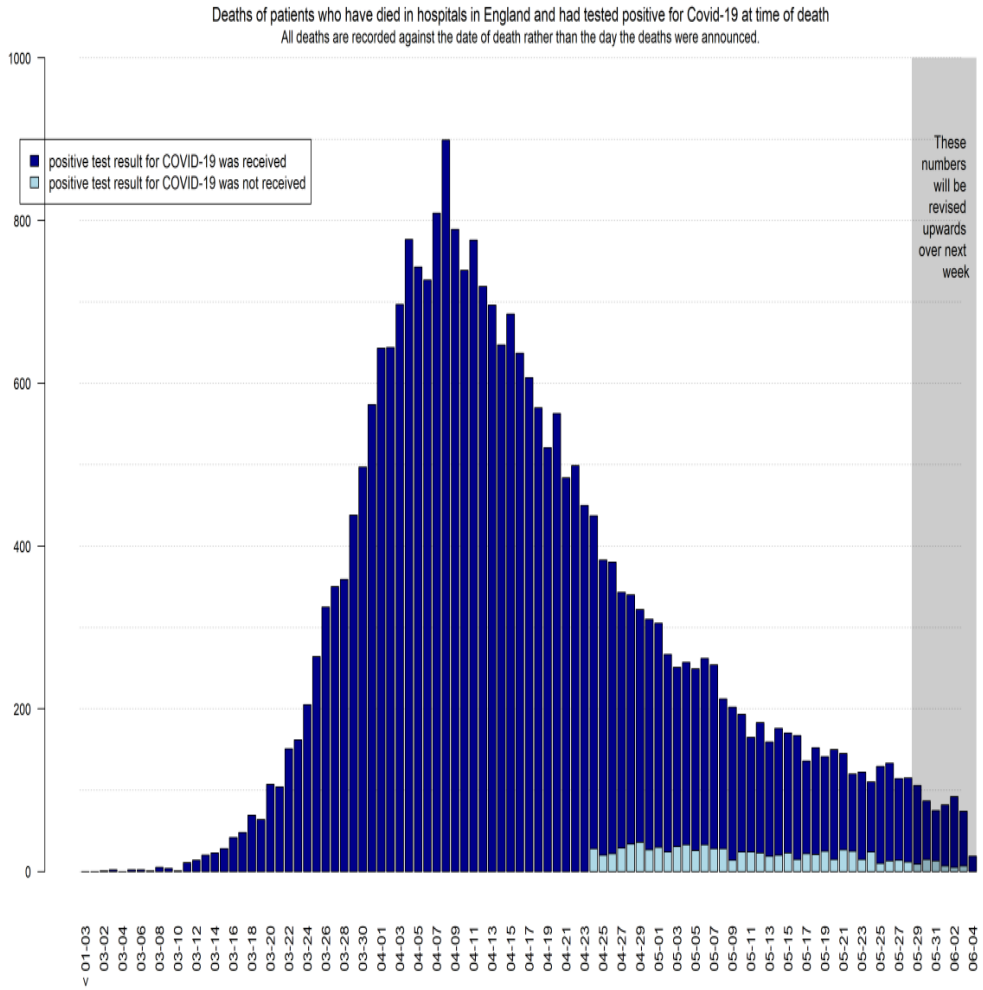
• A low NEW score (1–4) should prompt assessment by a competent registered nurse or equivalent, who should decide whether a change to frequency of clinical monitoring or an escalation of clinical care is required.

• A single red score (3 in a single parameter) is unusual, but should prompt an urgent review by a clinician with competencies in the assessment of acute illness (usually a ward-based doctor) to determine the cause, and decide on the frequency of subsequent monitoring and whether an escalation of care is required.

• A medium NEW score (5–6) is a key trigger threshold and should prompt an urgent review by a clinician with competencies in the assessment of acute illness – usually a ward-based doctor or acute team nurse, who should urgently decide whether escalation of care to a team with critical care skills is required (ie critical care outreach team).

• A high NEW score (7 or more) is a key trigger threshold and should prompt emergency assessment by a clinical team / critical care outreach team with critical care competencies and usually transfer of the patient to a higher-dependency care area

Primary care map of Covid from 111



31 1 20 first uk case confirmed in York,contracted overseas

16 2 20 first europeen death

28 2 20 first uk contracted case , enters surgery in Surrey

5 3 20 first uk death -Royal Berkshire, thought to have contracted in uk

10 3 20 continued busy period including ski trip returns from northern Italy

11 3 20 pandemic declared

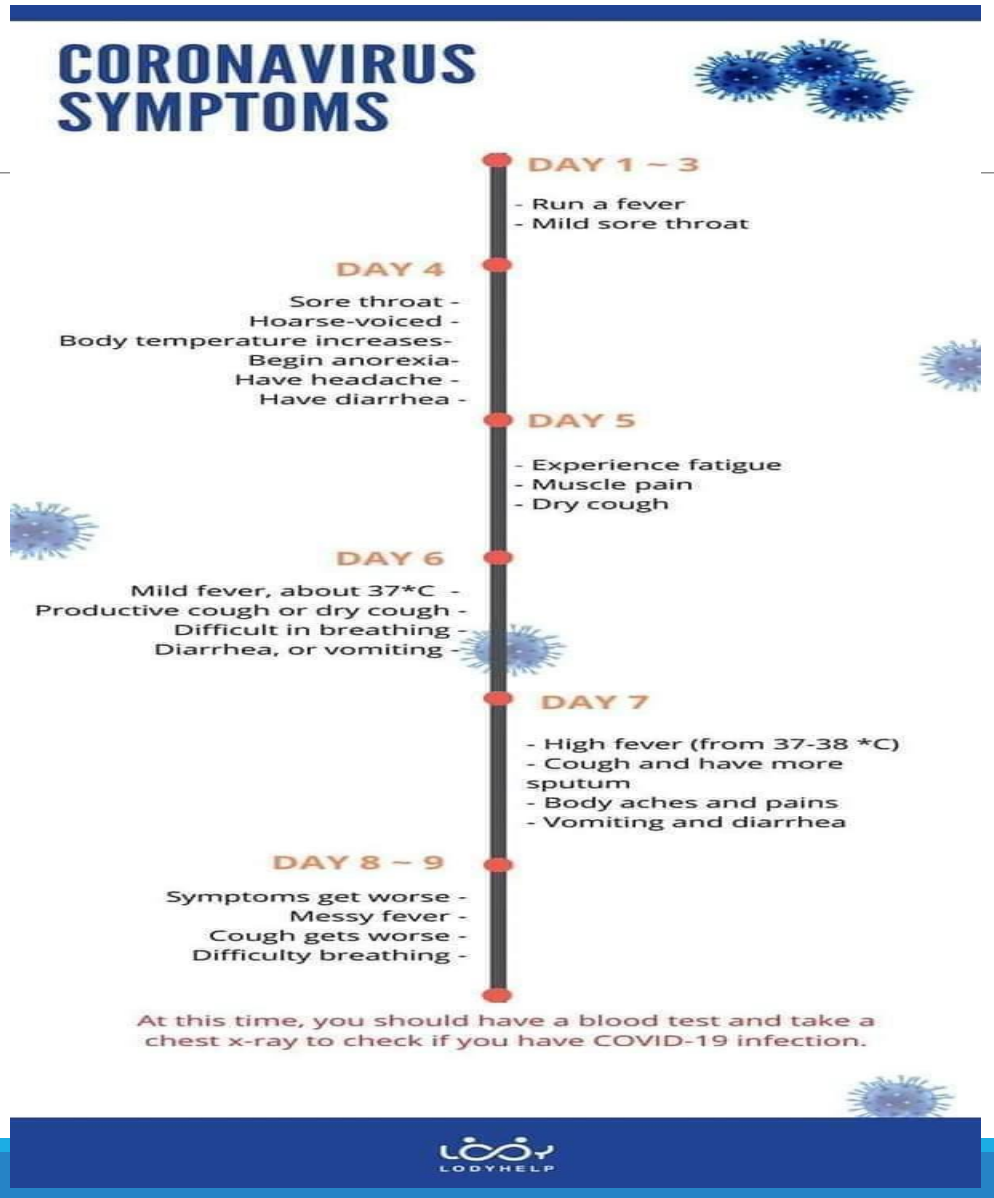
12 3 20 decision to stop contact tracing (still need to register)

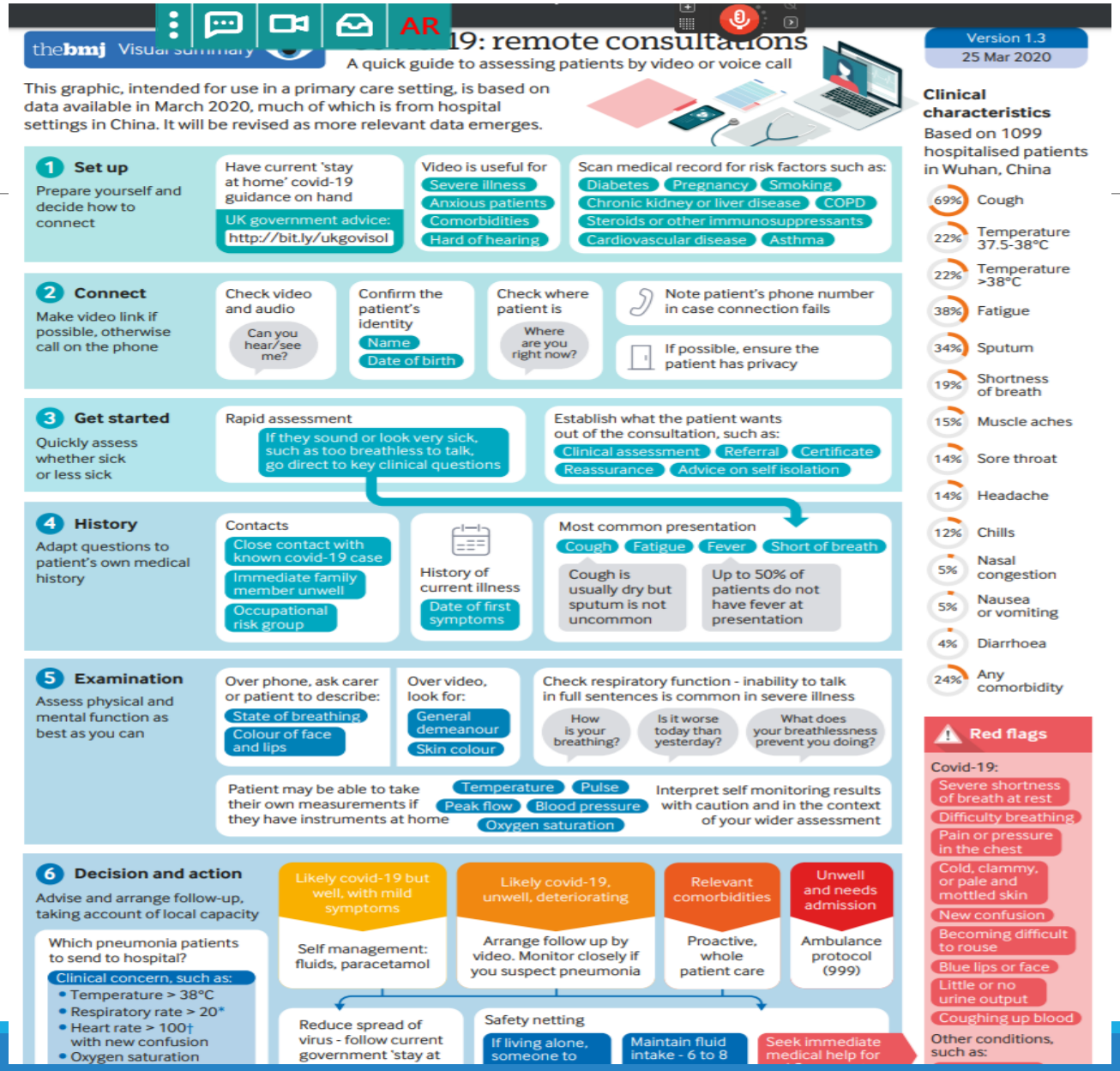
27 3 20 Priminster tweets tested positive for Covid

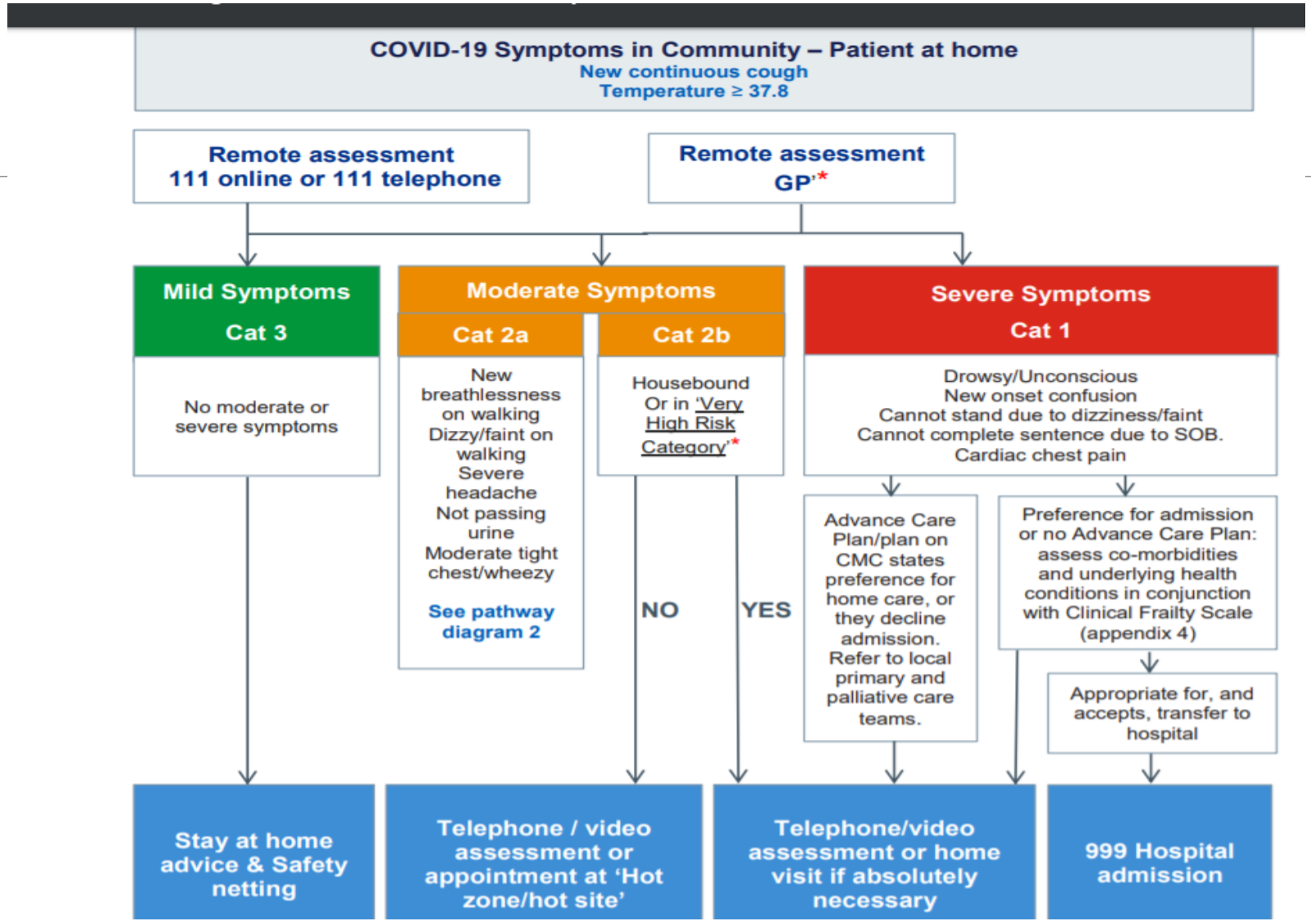
8 4 20- uk peak of Covid related deaths

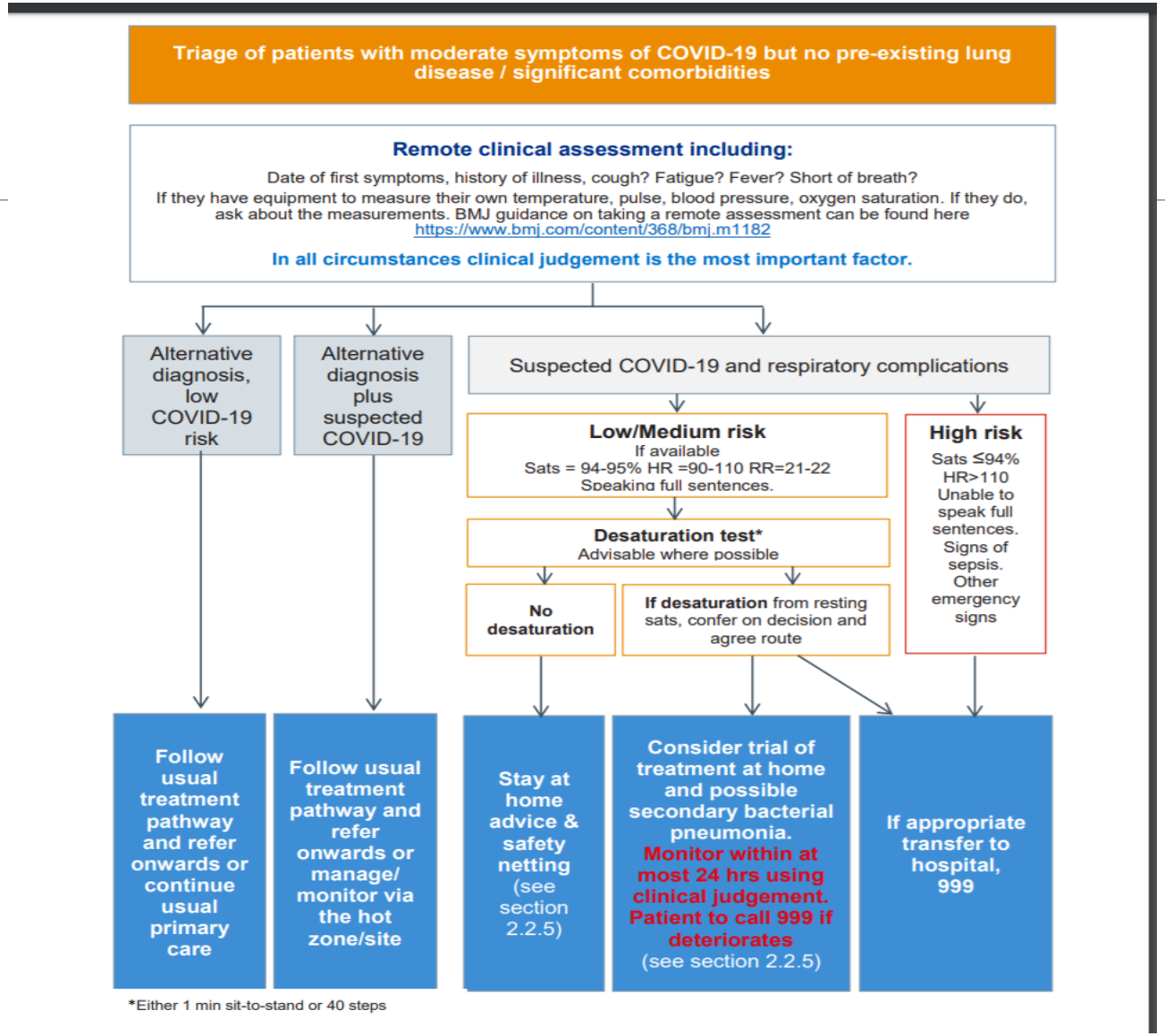
Ongoing high call volumes

https://www.gov.uk/health-protection-team


CORONAVIRUS SYMPTOMS
DAY 1 – 3
- Run a fever
- Mild sore throat
DAY 4
Sore throat -
Hoarse-voiced -
Body temperature increases-
Begin anorexia-
Have headache -
Have diarrhea -
DAY 5
- Experience fatigue
- Muscle pain
- Dry cough
DAY 6
Mild fever, about 37*C -
Productive cough or dry cough -
Difficult in breathing -
Diarrhea, or vomiting -
DAY 7
- High fever (from 37-38 *C)
- Cough and have more sputum
- Body aches and pains
- Vomiting and diarrhea
DAY 8 – 9
Symptoms get worse -
Messy fever -
Cough gets worse -
Difficulty breathing -
At this time, you should have a blood test and take a chest x-ray to check if you have COVID-19 infection.
LODYHELP


thebmj Visual summary
19: remote consultations
A quick guide to assessing patients by video or voice call
Version 1.3
25 Mar 2020
This graphic, intended for use in a primary care setting, is based on data available in March 2020, much of which is from hospital settings in China. It will be revised as more relevant data emerges.
1 Set up
Prepare yourself and decide how to connect
Have current 'stay at home' covid-19 guidance on hand
UK government advice: http://bit.ly/ukgovisol
Video is useful for
Severe illness
Anxious patients
Comorbidities
Hard of hearing
Scan medical record for risk factors such as:
Diabetes
Pregnancy
Smoking
Chronic kidney or liver disease
COPD
Steroids or other immunosuppressants
Cardiovascular disease
Asthma
2 Connect
Make video link if possible, otherwise call on the phone
Check video and audio
Can you hear/see me?
Confirm the patient's identity
Name
Date of birth
Check where patient is
Where are you right now?
Note patient's phone number in case connection fails
If possible, ensure the patient has privacy
3 Get started
Quickly assess whether sick or less sick
Rapid assessment
If they sound or look very sick, such as too breathless to talk, go direct to key clinical questions
Establish what the patient wants out of the consultation, such as:
Clinical assessment
Referral
Certificate
Reassurance
Advice on self isolation
4 History
Adapt questions to patient's own medical history
Contacts
Close contact with known covid-19 case
Immediate family member unwell
Occupational risk group
History of current illness
Date of first symptoms
Most common presentation
Cough
Fatigue
Fever
Short of breath
Cough is usually dry but sputum is not uncommon
Up to 50% of patients do not have fever at presentation
5 Examination
Assess physical and mental function as best as you can
Over phone, ask carer or patient to describe:
State of breathing
Colour of face and lips
Over video, look for:
General demeanour
Skin colour
Check respiratory function - inability to talk in full sentences is common in severe illness
How is your breathing?
Is it worse today than yesterday?
What does your breathlessness prevent you doing?
Patient may be able to take their own measurements if they have instruments at home
Temperature
Pulse
Peak flow
Blood pressure
Oxygen saturation
Interpret self monitoring results with caution and in the context of your wider assessment
6 Decision and action
Advise and arrange follow-up, taking account of local capacity
Which pneumonia patients to send to hospital?
Clinical concern, such as:
• Temperature > 38°C
• Respiratory rate > 20*
• Heart rate > 100† with new confusion
• Oxygen saturation
Likely covid-19 but well, with mild symptoms
Self management: fluids, paracetamol
Likely covid-19, unwell, deteriorating
Arrange follow up by video. Monitor closely if you suspect pneumonia
Relevant comorbidities
Proactive, whole patient care
Unwell and needs admission
Ambulance protocol (999)
Reduce spread of virus - follow current government 'stay at
Safety netting
If living alone, someone to
Maintain fluid intake - 6 to 8
Seek immediate medical help for
Clinical characteristics
Based on 1099 hospitalised patients in Wuhan, China
69% Cough
22% Temperature 37.5-38°C
22% Temperature >38°C
38% Fatigue
34% Sputum
19% Shortness of breath
15% Muscle aches
14% Sore throat
14% Headache
12% Chills
5% Nasal congestion
5% Nausea or vomiting
4% Diarrhoea
24% Any comorbidity
Red flags
Covid-19:
Severe shortness of breath at rest
Difficulty breathing
Pain or pressure in the chest
Cold, clammy, or pale and mottled skin
New confusion
Becoming difficult to rouse
Blue lips or face
Little or no urine output
Coughing up blood
Other conditions, such as:


COVID-19 Symptoms in Community – Patient at home
New continuous cough
Temperature ≥ 37.8
Remote assessment
111 online or 111 telephone
Remote assessment
GP'*
Mild Symptoms
Cat 3
No moderate or severe symptoms
Moderate Symptoms
Cat 2a
New breathlessness on walking
Dizzy/faint on walking
Severe headache
Not passing urine
Moderate tight chest/wheezy
See pathway diagram 2
Cat 2b
Housebound
Or in 'Very High Risk Category'*
NO
YES
Severe Symptoms
Cat 1
Drowsy/Unconscious
New onset confusion
Cannot stand due to dizziness/faint
Cannot complete sentence due to SOB.
Cardiac chest pain
Advance Care Plan/plan on CMC states preference for home care, or they decline admission. Refer to local primary and palliative care teams.
Preference for admission or no Advance Care Plan: assess co-morbidities and underlying health conditions in conjunction with Clinical Frailty Scale (appendix 4)
Appropriate for, and accepts, transfer to hospital
Stay at home advice & Safety netting
Telephone / video assessment or appointment at 'Hot zone/hot site'
Telephone/video assessment or home visit if absolutely necessary
999 Hospital admission


Triage of patients with moderate symptoms of COVID-19 but no pre-existing lung disease / significant comorbidities
Remote clinical assessment including:
Date of first symptoms, history of illness, cough? Fatigue? Fever? Short of breath?
If they have equipment to measure their own temperature, pulse, blood pressure, oxygen saturation. If they do, ask about the measurements. BMJ guidance on taking a remote assessment can be found here https://www.bmj.com/content/368/bmj.m1182
In all circumstances clinical judgement is the most important factor.
Alternative diagnosis, low COVID-19 risk
Alternative diagnosis plus suspected COVID-19
Suspected COVID-19 and respiratory complications
Low/Medium risk
If available
Sats = 94-95% HR =90-110 RR=21-22
Speaking full sentences.
High risk
Sats ≤94%
HR>110
Unable to speak full sentences.
Signs of sepsis.
Other emergency signs
Desaturation test*
Advisable where possible
No desaturation
If desaturation from resting sats, confer on decision and agree route
Follow usual treatment pathway and refer onwards or continue usual primary care
Follow usual treatment pathway and refer onwards or manage/ monitor via the hot zone/site
Stay at home advice & safety netting (see section 2.2.5)
Consider trial of treatment at home and possible secondary bacterial pneumonia.
Monitor within at most 24 hrs using clinical judgement.
Patient to call 999 if deteriorates
(see section 2.2.5)
If appropriate transfer to hospital, 999
*Either 1 min sit-to-stand or 40 steps

safety netting guidance for GP monitoring of Category 2a/2b patients

- Low risk - General advice and call NHS 111 if symptoms deteriorate

- Medium risk - Follow up with daily phone call via hot sites or GP – assess change in level of breathless at rest and with usual activity. Daily pulse oximetry (either supply patient with pulse oximeter or set up Mobile pulse oximetry service ensuring decontamination between patients).

Refer to secondary care with deteriorating saturations or if desaturating with exertion after conferring with colleagues

Discharge from follow up if symptoms improving and oxygen saturations stable or improving over 48 hours and treat as low risk

Challenges

Making news

Prolonged illness

Nursing homes

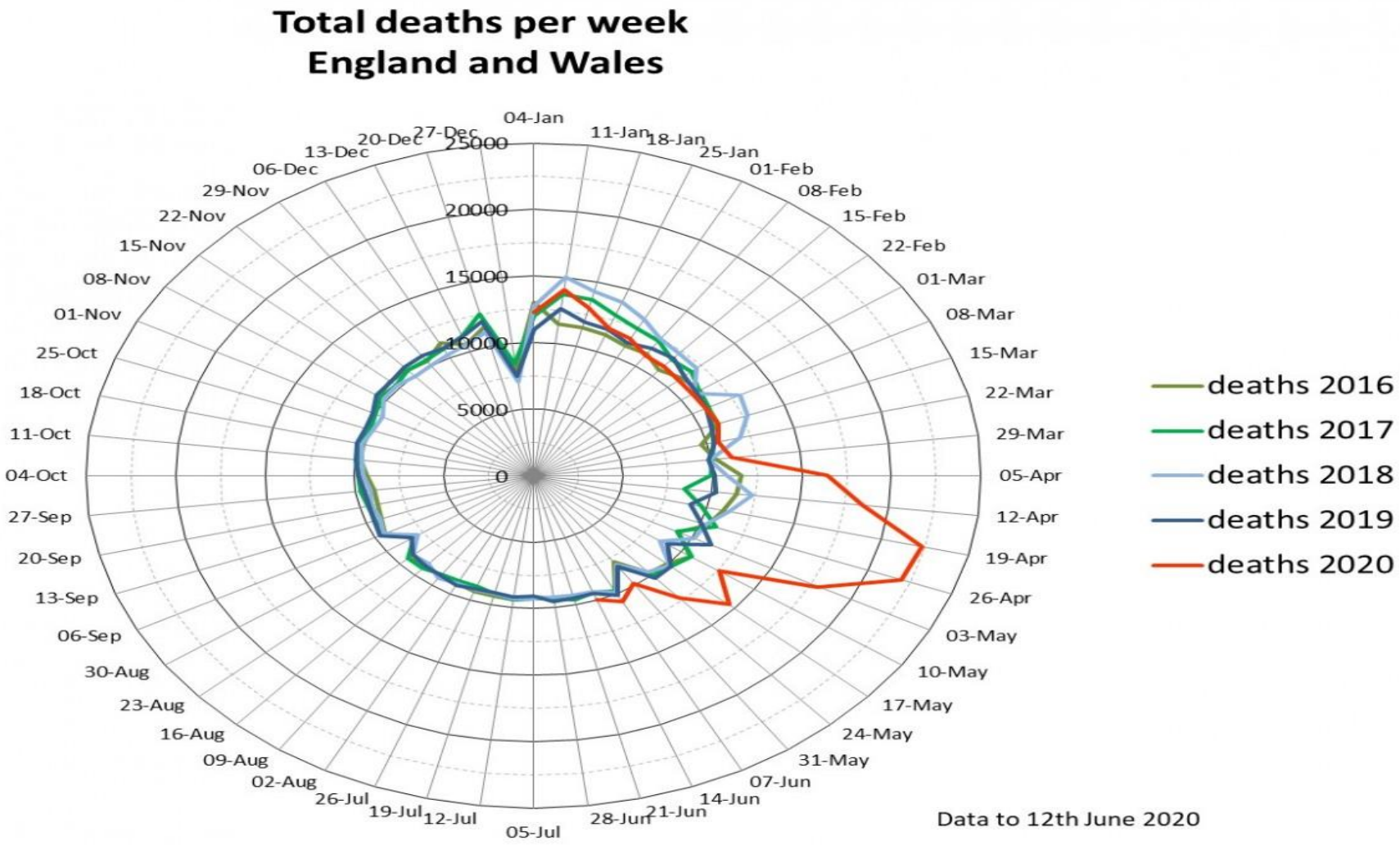
Ethical dilemmas - Case definitions & zoning & triaging for colleagues

Complex care pathways

Home visits –an example of IPC

‘in my experience ‘ for a Novel virus

Importance of accurate data



2.2.6. London guide and care pathway for suspected COVID-19 in Residential and Nursing Care Residents for use by care home staff

The following information is drawn from the London guide, which was designed to complement and not replace local guidance and professional judgement. It will be updated to align with other national and regional guidance once published. The guidance in this document is accurate as of 16th April 2020.

COVID-19 Symptoms in Community – in Residential and Nursing Care Residents

Suspected Cases

Consider COVID-19 infection in a resident with any of the following:

- New continuous cough, different to usual
- High temperature (≥37.8°C), shivery, achy, hot to touch

Care home residents may also commonly present with other signs of being unwell, or changes in usual behaviours. Please seek clinical advice. Record observations where possible: Date of first symptoms, Blood Pressure, Pulse respiratory rate and Temperature (refer to Thermometer instructions) – Remember to Maintain fluid intake

For more support, call the residents GP in the first instance
Call 111 Star*6 - dial 111 and select option 2 to access the NHS 111 Starlines for urgent clinical advice, or if the GP is not available – this will put you in contact with a Clinician in NHS 111

↓

Isolate and Monitor

- Resident to be isolated for 14 days in a single bedroom. Use Infection Control guidance
- Care for resident using PPE (what to use and how to wear and dispose)
- Due to sustained transmission PPE is to be used with all patients. Additional PPE is required for Aerosol Generating Procedures as described in the table.
- Use correct Handwashing technique (video)
- Consider bathroom facilities. If no en-suite available.
- Designate a single bathroom for this resident only
- Use commode in room
- Record observations if concerned to inform health services

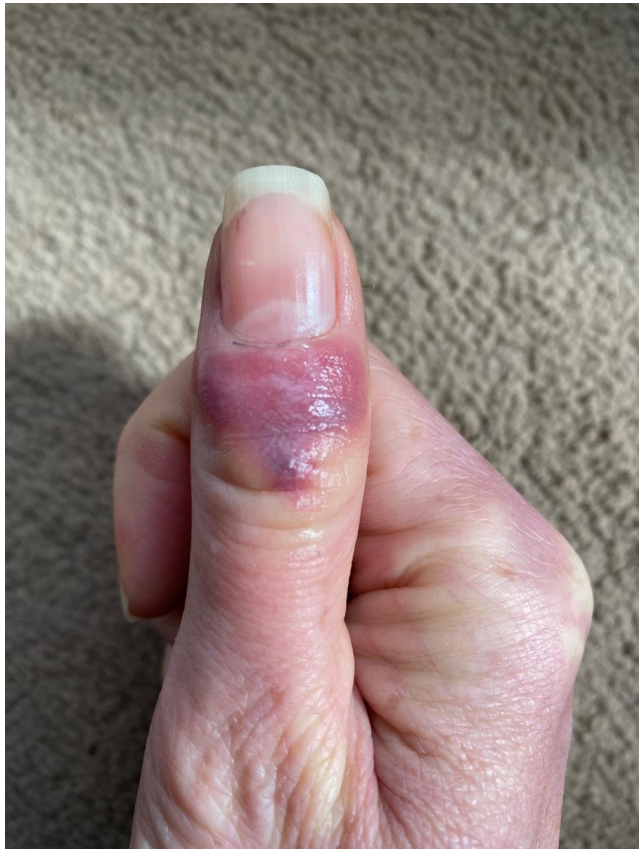
↓

If resident deteriorates at any stage – staff should escalate to 111* Star 6 or 999
Be explicit that COVID-19 is suspected and ensure you have easy access to the residents CMC plan

Box 3. Management of home visit / face to face contact in suspected COVID-19 +ve patients

- Only visit at home if there is no remote alternative. Discuss need to visit with senior colleague/peer. Consider what information will be gained from it that cannot be ascertained remotely and how this will change the outcome
- Review PPE guidance daily and adhere to the recommendations
- Ask the patient to wear a mask during the consultation to protect them and the case worker- Suggest passing mask through letterbox to patient prior to entry
- Minimise physical contact with the patient and carer and keep 2m distance if possible
- Do not perform for chest physiotherapy, spirometry, PEFR, CO monitoring or FeNO or any other aerosol generating procedure
- Sputum samples for management of bronchiectasis should be discussed with specialist
- Viral swabs should not be collected
- Monitor patients using SpO2, RR, HR (and BP if required)
- Discuss advance care plans and wishes if appropriate and seek consent to urgently document on Coordinate My Care (CMC).
- Escalate by calling 999 if required and appropriate according to treatment escalation plans/advance care plan. Otherwise, make a plan for future monitoring e.g. telephone / video or face to face
- Dispose of all PPE at visit end according to national guidance

https://covid19.joinzoe.com/post/covid-skinrash



Box 1. Remote Assessment/Telephone Triage with Patient or Carer

1. **Screen for symptoms of COVID-19 infection**
   - Do they have fever **>37.8?**
   - If no thermometer, have they felt shivery, achy, or are they hot to touch?
   - Do they have a new continuous cough, different to usual?

2. **Screen for severity of illness.** Suggested questions:
   - *"How is your breathing is today?"*
   - "*Do you have an oximeter at home or have you noticed any blue discolouration of your lips?"*
   - *"Are you so breathless that you are unable to speak more than a few words?"*
   - *"Are you more breathless than usual on walking or climbing stairs?*
   - "*Do you feel dizzy, faint or have a headache?"*
   - *"When was the last time you went to the toilet and passed urine?"*
   - Ask about other symptoms of severity e.g. collapse, chest pain, signs of sepsis, confusion?

   Please note that patients may be "comfortably hypoxic". When assessing, please check if there has been any deterioration in these question from the day before. There is no accurate way to assess hypoxia without pulse oximetry (unless patient is obviously cyanosed) - so consider how to do this (patient has own device, or deliver device to patient (mobile oximetry service), or patient to attend hot site for assessment and collect oximeter for home monitoring).

3. **Assess whether increased risk of severe illness** with COVID-19 against the list of conditions which lead to increased risk (see appendix 2)

4. **Do they have an established advance care plan? Is it documented on Co-ordinate My Care? If not, and it is appropriate, explore wishes and consider capacity.**

5. **Decide** whether for home management (see pathway diagram 1 below)

6. **Clinical judgement is crucial and overrides the pathway**