Southwark COVID pathways

Managing patients with suspected COVID in the Community
and
Essential GP services

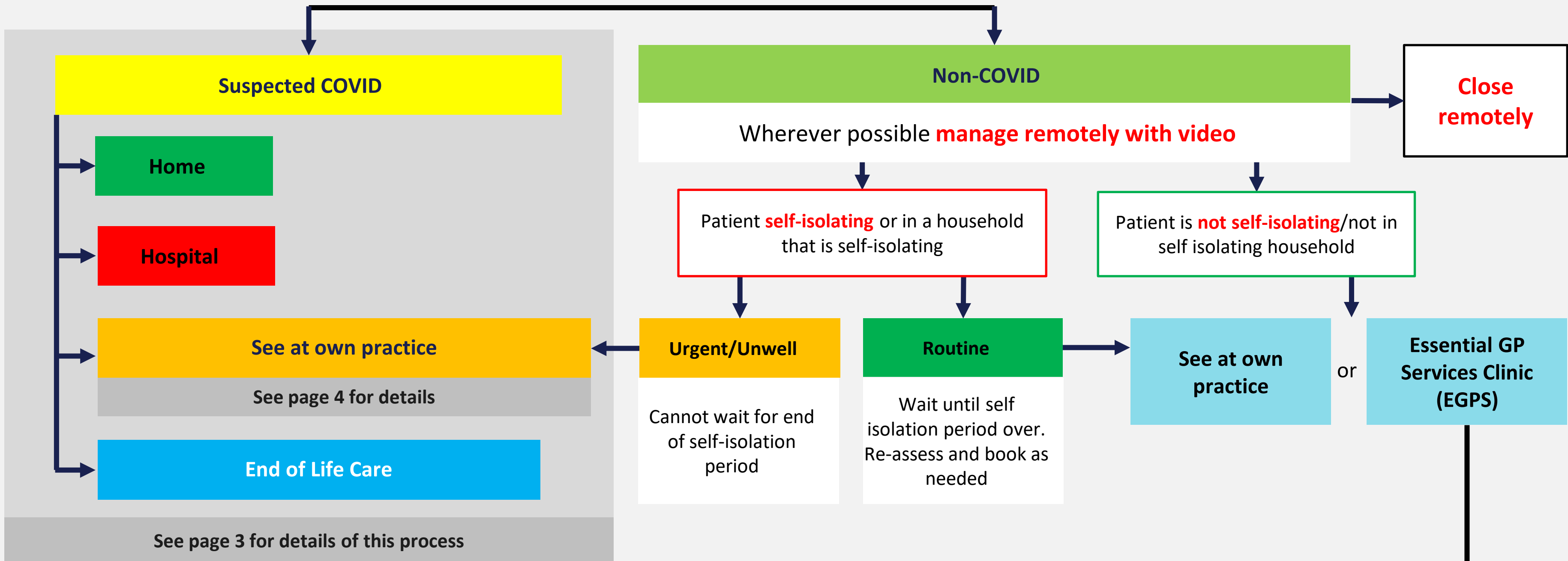
Originally Published 2/4/2020

Last Updated: 30/9/2020

We review information weekly and update regularly

Based on London Clinical Networks Primary Care Resource Pack for COVID-and NICE COVID guidance.
Developed by Clinical Effectiveness Southwark

Southwark GP services during COVID-19- Remote consulting



This pathway is for adults and children

Note though that any clinical parameters and drug doses are for adults only

If **referring patients to secondary care**, (including 2ww), please review current 'Outpatient pathways' guidance

Nursing Clinic

Book into timed appointment EMIS 'cross organisational slot' for 'NON-COVID Nurse Essential. Services subject to change but currently include:

- Childhood immunisations (including combined 8 week baby check, post-natal and immunisation clinic – **please book into specific slots for this**)
- Dressings
- Suture removal
- Administration of essential medicines
- Contraceptive procedures where these cannot wait
- Pneumococcal / Flu / Shingles vaccinations
- Cervical smears
- Ear syringing

GP

Face-to-Face Appointments available at North and South Southwark Sites

Book in on EMIS '**cross organisational slot'** only after confirming that a face-to-face appointment is needed and that the patient (and their household) are not required to self-isolate

All booked patients are reviewed by a clinician to ensure the referral is appropriate for a non-Covid site

This guidance will change frequently
Publication date: 30/9/2020

Suspected COVID Remote Assessment by GP

e.g. new continuous cough, change in sense of smell or taste, OR temperature ≥ 37.8

Always consider: is your patient at increased risk of severe illness from COVID-19? (see page 5)

Always use clinical judgement and shared decision making

MILD SYMPTOMS

No moderate or severe symptoms

MODERATE SYMPTOMS

- New breathlessness on walking
- Dizzy/faint on walking
- Severe headache
- Not passing urine
- Moderate tight chest/wheezy
- Clinical concern

SEVERE SYMPTOMS

- Drowsy/Unconscious
- New onset confusion
- Cannot stand due to dizziness/faint
- Cannot complete sentence due to SOB
- Cardiac chest pain or palpitations
- Any clinical signs of sepsis
- Clinical concern

MAXIMUM REMOTE GP assessment

See page 5 for further guidance on remote assessment

Always use EMIS **''Southwark Suspected COVID GP remote assessment**' template

Consider discussing with Consultant Connect (including Paediatrics)

Can your patient be managed remotely +/- follow up?

Consider remote pulse oximetry

Consider antibiotics e.g. if concerned about secondary pneumonia

End of Life Care

See below

Requires F2F assessment

See at own practice with appropriate PPE + infection control

HOME

- Remote management
- Stay at home and self care advice
- Safety netting (see p10)
- Patients with moderate disease will need to be followed up by own GP practice daily for 7-10 days. This can be done by other health care professionals at the practice. Use clinical judgement. See remote monitoring guidance

See page 4

HOSPITAL

999 or private vehicle

End of Life Care

Consider community care if unsuitable for admission, e.g. Advance/Emergency care plan, declines admission, Clinical Frailty Scale 5+ (criteria may change)

Consider palliative care needs (see here for guidance)

COVID-19 testing and Disease Notification

- **Testing** is available for patients to arrange directly through www.gov.uk/apply-coronavirus-test or 119
- Always **code 'Suspected COVID'** using the Southwark Suspected COVID template
- Testing eligibility: anyone with symptoms of suspected COVID (these criteria may be subject to change)
- Complete and submit a **Notification of Infectious Diseases** form (DXS) on suspicion of COVID-19

This guidance will change frequently
Publication date: 30/9/2020

Face-to-Face consultation

PPE and environmental risk mitigation needs to be in place if seeing patients face to face.

Always use clinical judgement in conjunction to this pathway, particularly for at risk patients. **Clinical judgement is the most important factor**

Please check http://gp.selondonccg.nhs.uk/ regularly for updates and for advice on PPE

LOW RISK

Sats ≥95% HR ≤90 RR ≤20
≈News 0-2

No other significant red flags

MEDIUM RISK

Sats 93-94% RR 21-24
HR 90-130
≈NEWS 3-4
Deteriorating symptoms
e.g. worsening breathlessness on exertion
Clinician concerned

HIGH RISK

Sats ≤92%, HR ≥ 131, RR ≥ 25
≈NEWS ≥5

Unable to speak full sentences
Signs of sepsis
Other emergency signs or symptoms

Desaturation Test (1 min sit-to-stand or 40 steps) – should not be attempted outside of supervised settings if Sats <96%. See NHS England Guidance
A 3% drop in pulse oximeter reading or desaturation to <93% on exercise is a cause for concern – discuss with a colleague, agree on route and usually transfer to hospital

RETURN HOME

Stay at home advice
+
Self care advice
+
Safety netting (see page 10)

Consider antibiotics to prevent secondary bacterial pneumonia

Adults: 'doxycycline 200mg STAT then 100mg od for 4 more days' **OR** 'amoxicillin 500mg tds 5 days'
In Pregnancy: First line: amoxicillin, if penicillin allergic: erythromycin 500mg QDS 5 days
Children: First line: amoxicillin, if penicillin allergic: clarithromycin (please see BNF for age related doses)
Duration: 5 days
Consider seeking advice from Consultant Connect (e.g., Respiratory)

HOME

Follow-up by own practice within 12-24 hours for 7-10 days

Discharge from follow up if symptoms improving and oxygen saturations stable or improving over 48 hours

End of Life Care

Consider community care if unsuitable for admission, e.g.: Advance/Emergency care plan, declines admission, Clinical Frailty Scale 5+ (criteria may change)

Palliative care (see here for guidance)

HOSPITAL

999 or private vehicle

Consider antibiotics while waiting

Please note that testing for COVID-19 is now available for patients to arrange directly through www.gov.uk/apply-coronavirus-test

Eligibility subject to change (see p3)

Complete and submit a Notification of Infectious Diseases form (DXS) on suspicion of COVID-19

This guidance will change frequently
Publication date: 30/9/2020

Further guidance on remotely assessing suspected Covid patients

Please take the time to view further resources and advice at : gp.selondonccg.nhs.uk, in particular:

- 'Suspected Covid' –for frequency of commonly seen symptoms
- **'Remote consulting'- for excellent BMJ resource on Covid consulting**

No scoring systems are validated in COVID.

Given these unprecedented times, take a pragmatic approach.
Clinical judgement is the most important factor.

Screening for Covid symptoms

New continuous cough OR Fever >37.8 OR loss/change to sense of smell or taste

- Other symptoms seen in Covid infections include: dyspnoea, shortness of breath, headache, fatigue, myalgia, chills, dizzy, URTI type symptoms, nausea or vomiting(but at present these are not criteria for testing)

Assessing breathlessness

Use video whenever possible

In conjunction with the symptoms set out on page 3 consider more formal quantification of shortness of breath. Tips include:
Ask open ended questions and listen to whether the patient can complete their sentences:

"How is your breathing today?"

Align with NHS 111 symptom checker

"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?"

Focus on change:

"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?"

Interpret the breathlessness in the context of the wider history and physical signs.

Consider risk

Is your patient at risk of developing severe illness from Covid?

Extremely vulnerable groups/Shielding

- Post-transplant
- Active chemo/radiotherapy cancer patients/immunotherapy
- Haematological cancers (at any stage of treatment)
- Severe chest conditions (CF, asthmatics/COPD)
- Rare diseases and inborn errors of metabolism that increase risk of infections including homozygous sickle cell disease
- On immunosuppressant therapy sufficient to increase risk of infection
- Pregnant with heart disease

High risk/Stringent social distancing

- Pregnant
- Over 70s, regardless of medical conditions
- Any adult who qualifies for a flu jab
- Chronic heart disease; kidney; liver disease
- Chronic neurological conditions or learning disability
- Diabetes
- Splenectomy/sickle cell disease
- Weakened immune system: HIV/AIDS, long-term steroids/DMARDs/biologics, having chemotherapy
- Severe obesity (BMI≥40)

NICE COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community

Diagnosing pneumonia

Where physical examination and other ways of making an objective diagnosis are not possible, the clinical diagnosis of community-acquired pneumonia of any cause in an adult can be informed by other clinical signs or symptoms such as:

- temperature > 38°C
- respiratory rate > 20 breaths/minute
- heart rate > 100 beats/minute
- new confusion

Assessing severity when suspected pneumonia

Assessing severity

Use the following symptoms and signs to help identify patients with more severe illness to help make decisions about hospital admission:

- 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

Be aware that patients with Covid may be at a higher risk of pulmonary embolus (PE)

Differentiating viral COVID-19 from bacterial pneumonia

It is difficult to determine whether pneumonia has a COVID-19 viral cause or a bacterial cause (either primary or secondary to COVID-19) in primary care, particularly during remote consultations.

As COVID-19 becomes more prevalent in the community, patients presenting with pneumonia symptoms are more likely to have a COVID-19 viral pneumonia than a community-acquired bacterial pneumonia.

COVID-19 viral pneumonia may be more likely if the patient:

- presents with a history of typical COVID-19 symptoms for about a week
- has severe muscle pain (myalgia)
- has loss of sense of smell (anosmia)
- is breathless but has no pleuritic pain
- has a history of exposure to known or suspected COVID-19, such as a household or workplace contact

A bacterial cause of pneumonia may be more likely if the patient:

- becomes rapidly unwell after only a few days of symptoms
- does not have a history of typical COVID-19 symptoms
- has pleuritic pain
- has purulent sputum

Beware increased incidence of PE in patients with COVID, which may present as pleuritic CP/shortness of breath/reduced saturations or be more occult

NICE COVID-19 rapid guideline: managing suspected or confirmed pneumonia in adults in the community

Deciding about hospital admission

Be aware that older people, or those with comorbidities, frailty, impaired immunity or a reduced ability to cough and clear secretions, are more likely to develop severe pneumonia. Because this can lead to respiratory failure and death, hospital admission would have been the usual recommendation for these people before the COVID-19 pandemic.

For support around decision making, click here (please note that at present accessing the ethics forum is via ethics@slam.nhs.uk)

When making decisions about hospital admission, take into account:

- severity of the pneumonia, including symptoms and signs of more severe illness
- benefits, risks and disadvantages of hospital admission
- care that can be offered in hospital compared with at home
- patient's wishes and care plans
- service delivery issues and local NHS resources during the COVID-19 pandemic

Explain that:

- benefits of hospital admission include improved diagnostic tests (chest X-ray, microbiological tests and blood tests) and respiratory support
- risks and disadvantages of hospital admission may include spreading or catching COVID-19 and loss of contact with families.

Assessing severity when suspected pneumonia

Assessing severity
Use the following symptoms and signs to help identify patients with more severe illness to help make decisions about hospital admission:

- 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

Management

Antibiotic treatment
COVID-19 pneumonia is caused by a virus, antibiotics are ineffective.
Do not offer an antibiotic for treatment or prevention of pneumonia if: COVID-19 is likely to be the cause **and** symptoms are mild.

Inappropriate antibiotic use may reduce availability if used indiscriminately, and broad-spectrum antibiotics in particular may lead to *C.difficile* infection and antimicrobial resistance.

Offer an oral antibiotic for treatment of pneumonia in people who can or wish to be treated in the community if:

- the likely cause is bacterial or
- unclear whether the cause is bacterial or viral and symptoms are more concerning or
- at high risk of complications because, e.g., elderly or frail, or have a pre-existing comorbidity such as immunosuppression or significant heart or lung disease (e.g. bronchiectasis or COPD), or have a history of severe illness following previous lung infection

See page 4 for guidance on antibiotic choice

Oral corticosteroids Do not routinely offer a corticosteroid unless the patient has other conditions for which these are indicated, such as asthma or COPD.

This guidance will change frequently
Publication date: 30/9/2020

Community Breathlessness Assessment- alternative option for assessing breathlessness

1. How much breathing discomfort (shortness of breath) do you have RIGHT NOW?

○	○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10	***Unable to respond***
None			**Mild**		**Moderate**			**Severe**		**Unbearable**	

2a. What was the WORST level of breathing discomfort (shortness of breath) that you experienced over the PAST 24 HOURS?

○	○	○	○	○	○	○	○	○	○	○	○
0	1	2	3	4	5	6	7	8	9	10	***Unable to respond***
None			**Mild**		**Moderate**			**Severe**		**Unbearable**	

Note: If the answer to 2a is "None", omit questions 2b & 3

2b. What were you doing when you experienced your worst breathing discomfort (shortness of breath)?

○ Heavier activity	(e.g. mowing the lawn, raking leaves, walking uphill)
○ Moderate activity	(e.g. walking, making the bed)
○ Light activity	(e.g. eating, dressing, speaking, preparing lunch)
○ Resting	(e.g. sitting in a chair or lying in bed)

3. Has your shortness of breath got worse over the PAST WEEK?

○	○	○
About the same	Worse	Much worse

Community Breathlessness Assessment(as advocated by KCL/Jolley); Adapted from Baker et al. BMC Nursing (2017) 16:3

Notes:

Before asking the patient to give their rating, **make sure that they understand the anchors on the scale, especially the bottom and the top end**. **This is essential.**

1) **Explain first that 0 (zero)** = **no breathlessness at all**, and **10 = unbearable breathlessness, the worst that they can imagine**. *(IMPORTANT - Note that this is not the same as "worst ever" – if you ask if "worst ever", the response will be confounded by the patient's previous experience of breathlessness).*
2) **Then explain that 5 (moderate)** is in the middle (**midway between nothing and unbearable),** and work from there.
   - **If a patient says that they are a 10,** ask if they can imagine being any more breathless than they are now. **If they can, then they are not a 10; negotiate down the scale accordingly.**

It is often easiest to start the conversation with an opener **"Are you short of breath right now".** However, if the patient says "no", **please still take them through the scales in Q1 & Q2a.** It is not uncommon for a patient to say that they are not short of breath at first, but when presented with the scale they choose 1 or 2 – in this case clarify that they were actually a little bit short of breath after all. This would be missed if you skip the scales in Q1 & Q2a entirely.

The very occasional patient finds it impossible to reliably use scales of any nature. If you suspect that this is the case, document "unable to respond" for Qs 1 & 2, and then move to Q3. However, the vast majority of people can say if breathlessness is the same or worse than before, even if they can't put a number on it, so please still use Q3 in this scenario.

Clinical Frailty Scale

CFS is best assessed when the person is stable. When used in the acute setting, the score should be based on the person's function 2 weeks prior. [See here for tips in using the CFS](#).

The CFS should not be used in younger people, people with stable long-term disabilities (for example cerebral palsy), learning disability or autism. An individual assessment is recommended in all cases where the CFS is not appropriate' Link for further guidance

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

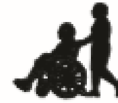
2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled**, but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.



7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

© 2007-2009. Version 1.2. All rights reserved. Geriatric Medicine Research, Dalhousie University, Halifax, Canada. Permission granted to copy for research and educational purposes only.

DALHOUSIE UNIVERSITY Inspiring Minds

NHS England Safety Netting Advice for Patient with suspected or confirmed COVID-19

Ring 999 if:

- You are **unable to complete short sentences at rest** due to breathlessness.
- Your **breathing suddenly worsens** within an hour.

OR if these more general signs of serious illness develop. You are:

- coughing up blood
- have blue lips or a blue face
- feel cold and sweaty with pale or blotchy skin
- have a rash that does not fade when you roll a glass over it
- collapse or faint
- become agitated, confused or very drowsy
- have stopped peeing or are peeing much less than usual.

Ring your GP/NHS 111 as soon as possible if:

- You slowly start feeling **more unwell or more breathless** for two or more hours.
- You are having difficulty breathing when getting up to go to the toilet or similar.
- You sense that something is wrong (general weakness, extreme tiredness, loss of appetite, reduced urine output, unable to care for yourself – simple tasks like washing and dressing or making food).

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0445-remote-monitoring-in-primary-care-v1.pdf

Changes from previous version (v16 – NB, V17 partially published only, V18 not published):

P1 – title amended to reflect no CCMS
P2 – EGPS appointments updated to reflect that telephone triage no longer necessary
P2 – update to facilities available at EGPS
P3 – clarification that monitoring is only required for those with moderate disease or using clinical judgement
P3 – added infection control to F2F assessment box
P3 – reminder to always code suspected COVID using the template; reminder to notify using form on DXS
P4 – amended error in low risk group oxygen saturations (only in v17), and updated to align fully with NHSE guidance and link to the guidance: (https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/06/C0445-remote-monitoring-in-primary-care-v1.pdf)
P4- updated desaturation test to align with London and NHSE guidance, and CEBM guidance https://www.cebm.net/covid-19/what-is-the-efficacy-and-safety-of-rapid-exercise-tests-for-exertional-desaturation-in-covid-19/
P4 – Removed IHL home visiting service
P6 – Added to final box – beware of PE
P5 – added updated criteria and updated symptoms
P7 – updated in line with NICE update 19th August 2020 to indicate that the disadvantages of hospital admission are uncertain.
P7 – Added ethics contact details
P10 – addition of safety netting advice from NHSE guidance