Urgent Care Clinical Bulletin 7 April 2020

Update on Suffolk Covid triage protocol
An updated protocol is on page 3 which includes the St Nicholas' hospice details. We have been asked about the validity of using the Roth Score. Our view is there does not appear to be a validated tool to assess breathlessness over the telephone or by video and the Roth Score is all we have - however it is not fully validated.

Webinar – Wednesday 8 April at 1pm
After some technical issues, the webinar last Friday was joined by 58 clinicians and focused on the Suffolk Covid triage, end of life medication protocols and visiting service. The audio is available from David Pannell.

In preparation for the expected surge this weekend we have organised another clinical webinar this Wednesday. Practices and Out of Hours will be both open so we want to cover:

- What happens if a practice or Out of Hours clinician believes a home visit or base face to face appointment is needed?
- How we will communicate and support each other?

Click on the Zoom link below and it will take you to the meeting - passcode is 027715.

https://zoom.us/j/918931332?pwd=ZnFrZUw2VFhWYUpyQVRIdWVyNEp3dz09

We are recruiting for the Covid visiting service
We are now recruiting clinicians to work in the service which will focus on supporting high risk patients whilst also protecting clinicians. We want to develop a group of skilled clinicians able to don and doff PPE effectively, make difficult clinical decisions, are able to commit to a minimum of four sessions per week and are aware of the personal risks.

Individuals will be paid via the Fed (funded by the CCGs) and this funding can be used to back-fill the individual's time in their practices. Back-fill will preferably be arranged from within a PCN but the Fed may be able to help from our existing pool and the additional individuals who have come forward to help.

We have a short paper on how the service will work. If you are interested in helping please email David Pannell.

When booking a car Respiratory shift please be aware you will need to have been FFP3 fitted.

Plan for the next seven days

- From the morning of Wednesday, Riverside will become a 24/7 Clinical Hub staffed by at least one Clinical Shift Lead (senior clinician) with more on busy periods. They will be supported by a Co-ordinator ('Co-ord').
- A Covid pandemic home visiting service will also start. Initially it will focus on visits where the clinician may need to wear an FFP3 fit tested mask. After Easter it will expand to cover patients at less risk of aerosol transmission.
- From Thursday Riverside will manage patients with low-acuity who have called an ambulance and advice calls from crews. We will continue to stream cases from the Clinical Assessment Service during the out of hours period.
- Over Easter, member practices will be open alongside a full Out of Hours rota. The Fed will do visiting using the usual out of hours urgent care criteria.

- We will continue to work remotely. Last week you managed 1,167 cases and only 3% were seen/visited.
- Ipswich Hospital ED Streaming is now running 8am to midnight and may go 24/7 if demand dictates.

Home visits over Easter
Out of hours will be responsible for visits over Easter and we will continue to use our current criteria.

- Cannot be managed remotely.
- Clinically appropriate for a visit - confirmation of diagnosis, reassurance, emotional support are not reasons for visiting.
- Category 2b, 2c or 3 on the Suffolk Covid triage protocol.

We have agreed that the ultimate decision on whether to visit rests with the visiting clinician. Therefore, if you assess a patient over the telephone and conclude a visit may be necessary, please say to the patient the case will be passed to our Control Room and someone may call them back. Please do not confirm a visit will take place as expectations once set can be difficult to manage.

Practice based clinicians may want to discuss in advance a patient with the Fed's Clinical Shift Lead. This might help in situations where the visit does not meet the Out of Hours threshold but the practice clinician wants to personally visit anyway e.g. palliative. The Fed's Clinical Shift Lead will be aware of the bed availability and admission thresholds in the local hospitals.

Change to the Suffolk COVID medication algorithm
In light of the NICE guidance published at the end of last week this is the antibiotic guidance if you suspect pneumonia in a patient with Covid-19.

- Consider Doxycycline 200mg, then 100mg od (6) Amoxicillin 500mg tds (15) or NICE April 2020

Verification of death
We have tried to implement the government guidance that a doctor does not need to verify death. We still have some work to do to make sure Suffolk community nurses, paramedics, undertakers etc are aware of this.

EPS & Smartcard reminder
After 18 months of effort with TPP, EPS is now switched on and working. We are running the most up-to-date version of EPS so there is no need to change any pharmacy details. Even if the patient's nominated pharmacy is closed any pharmacy the patient chooses to attend will be able to access the prescription.
When sending a prescription via EPS please untick the 'print tokens' box and set this as your default.

Now we use EPS clinicians can only work if you bring your smartcard.

Covid testing of self-isolating clinicians
Sorry - no news on this.

Confirmation re indemnity
Just to confirm indemnity is in place covering wherever you work during Covid.
https://resolution.nhs.uk/2020/03/19/covid-19-and-business-continuity/

V13 6 April 2020 Rudland

Triage of Covid-19 patient at PCN or in OOH modified from Barnet CCC and NICE Use with medication algorithm

Category 1
Mild symptoms

Disposal– provide selfcare advice. Escalate via 111

No home visit

Category 2
Moderate to severe symptoms – **only requires face to face consultation if this will change clinical pathway**

Category 3
Severely unwell – dyspnoea, confusion and co-morbidity risk factors. Disposal – **Admit** via ambulance if resources permit or prioritise home visit via clinical shift lead for palliation (see palliation pathway)

Home visit only if effective PPE available

Category 2a
Cough, Fever may be a little SOB

Full sentences, able to selfcare and ambulant to usual standard.
If available Sats 95% or more, RR less 20.

Roth score: counting number 10 or more, or counting time of 7 seconds or more - Sats likely to greater or equal to 95%

Disposal – selfcare, consider antibiotics escalate via 111

Category 2b
Cough, Fever may be a SOB
May not manage full sentences at rest, still able to selfcare, SOB on exertion. If available Sats 93% or less, RR more 20 clinical concern.

Roth score: counting numbers 10 -7, or counting time between 7 - 5 seconds

Disposal – **active care**, **consider admission** if no advanced directive and bed availability
Home visit only if effective PPE available

Category 2 c
Cough, Fever and SOB
Breathless, not be completing long sentences, progressive SOB, struggling with selfcare, fatigue and lethargy
If available
Sats less than 90% and RR above 20- high level of clinical concern
Roth score: counting number 7 or less , counting time of 5 seconds or less
Disposal – **active care**, **consider admission** if no advanced directive and bed availability
Consider direct admission in view of hypoxia
Home visit only if effective PPE available

For patient with SOB consider preventing secondary bacterial infection:
Doxycycline 200mg then 100mg od (6)
Amoxicillin 500mg tds 5 days (15)
(NICE April 2020, also there is little pneumococcal penicillin resistance in Suffolk)

St Nicholas Hospice, Bury St Edmunds Community team, Mon-Fri 8am-5pm **01284 702525** Community team, Sat and Sun, 8am-4pm **07791 485101** Main reception (available 24-hours) **01284 766133**

St Elizabeth Hospice, Ipswich
Onecall patient support 0800 5670111
Professional advice 0800 5670111 – you will be directed to duty consultant 24/7

Roth Score: *There does not appear to be a validated tool to assess breathlessness over the telephone or by video – Roth Score is all we have however not fully validated*
Roth score index is measured by having the patient count from 1 to 30 in their native language, in a single breath, as rapidly as possible. The primary result of the Roth score is the duration of time and the highest number reached. Maximal counting number <10 or counting time <7 seconds identified patients with a room-air pulse oximetry <95% with sensitivity of 91% and 83%, respectively. Maximal counting number <7 or counting time <5 seconds identified patients with a room-air pulse oximetry <90% with sensitivity of 87% and 82%,

Guiding principals:
Most infectious at the beginning of illness
Illness is biphasic – Replication stage and adaptive immunity stage second peak at 8-10 days
Droplet spread and direct contact (2 m), don't self inoculate from hard surfaces
If asthmatic up SABA – don't add oral steroids, don't use nebuliser. Treat fever with paracetamol not NSAID
14% will be hypoxic and benefit from supplementary 0xygen (Martin Kiernan), Sats of 93% or less consider as threshold for admission
Clinical judgement, through careful history taking and questioning, may currently be the best available method for remote assessment
Auscultation is not predictive of chest pathology – leave your stethoscope in a clean area.
Co-Morbidities: Current cancer, Immunosuppression, LTC, Smoking, BMI > 40

PPE principals
Coughing and sneezing are known to release aerosols, however, it is thought that aerosols generated by medical procedures pose a more significant risk to infection transmission, rooms with few air changes an hour may add to risk (usually 6 per hour in hospital)
Suffolk GP Fed should be able to provide FFP3 fit tested mask with associated PPE including eye protection in community setting judged as high risk of Covid-19 infection.
The use of long sleeved gown gloves fluid resistant surgical mask and eye protection, over shoes, provides a high level of protection for clinicians visiting Covid-19 suspected patients where there is less risk of aerosol transmission.