**Guidance for community respiratory services in NCL relating to the Covid19 pandemic**

**- where and how to assess patients and appropriate management pathways.**

Principles/ important points

1. As the pandemic progresses it will be difficult to exclude patients with chronic respiratory disease from being Covid +ve therefore home visits should only be delivered in PPE and should only be if perceived of value in triaging need for admission.
2. Given anticipated workforce constraints it may be more appropriate that all care is delivered remotely and that staff are redeployed to ED/ community hub to support admission avoidance there (depending on requirements/ organisational structures)
3. Inpatient evironments will become increasingly high risk for patients due to risk of cross infection/ system pressure. If possible aim to manage at home (remotely)
4. Keep up to date with latest public health guidance as it evolves ( [www.gov.uk](http://www.gov.uk))
5. If face to face contact required avoid aerosol generating procedures such as chest physio, spirometry, PEFR or measurement of CO or FeNO. These would require full PPE which is in short supply. Nebulisers are not aerosol generating procedures.
6. Document treatment escalation plans (complete CMC record if possible). It is anticipated that respiratory failure in inpatients will be treated with oxygen and CPAP if needed. If invasive ventilation is required, weaning is typically very slow and older patients with co-morbidity may have a poor outcome. Discuss with integrated respiratory consultant if needed.
7. Identify patient cohort at risk and advise that these patients have a rescue pack available in their home and obtain a home thermometer and home pulse oximeter if possible.
8. Avoid use of prednisolone for AECOPD unless severe wheeze/concomitant asthma, eosinophilia on FBC previously >0.3. Use antibiotics as per current guidance.
9. Patients with comorbidity and >70 years old may decompensate with Covid+ve pneumonia. Evidence of RR >21 and/ or saturations <95% should trigger need for assessment in ED (if appropriate for agreed ceiling of care and considering patients usual baseline oxygen saturations).
10. Patients with Covid+ve pneumonitis can have severe hypoxia without severe breathlessness
11. The course of a Covid19 illness can last 3-4 days with a flare in symptoms and fever at day 7 or it can be more prolonged to 10-12 days
12. There can be a peak in symptoms (fever) in the afternoons and patients should be encouraged to maintain oral fluids and use paracetamol (in preference to ibuprofen).

**Actions following clinician or patient self-referral to community respiratory services**

**Triage by telephone** to assess need for admission or remote home management or face to face assessment in appropriate location/ home. Speak to carer if appropriate.

1: Screen for symptoms of Covid19 infection:

* Do they have a fever >37.8
* If no thermometer: have they felt shivery, achy or are they hot to the touch?
* Do they have a new continuous cough, different to their usual symptoms

2. Screen for severity of illness

* Ask re level of breathlessness and assess ease of speech (are you breathless even sitting still)
* Assess rate of worsening (today compared to yesterday) and compared to usual symptoms
* Have you stopped doing all usual daily activities
* Ask re oxygen saturations if home oximeter, or whether any blue discoloration of lips suggesting cyanosis
* Other symptoms of severity (collase/ chest pain/ signs of sepsis)

3. Assess whether increased risk of severe illness with Covid19

* Review co-morbidity (heart failure, chronic kidney disease, hepatic failure, HIV+ve, BMI >40, pregnancy, chronic neurological disease all have an increased risk of severe illness with Covid19)
* Use of immune supression/ chemotherapy

4. Decide whether for home management (Green), needs face to face review (Amber) or 999 call for admission.

5. Clinical judgement is crucial and overrides the pathway

6. If has advance care plan for home or hospice based care follow current palliative care guidance.

**Amber**

**Arrange face to face review with PPE (clinic/ ED/ home)- see box1**

* If breathlessness significantly increased from baseline
* Reduced fluid intake
* Deteriorating trend

**Assess**

Observations stable?

- saturations >94%

- HR<100

- RR<20

Consider Age/ comorbidities

**Advise**

* Return home if reassuring obs/ no clinician concern: manage as per green pathway
* ED assessment if sats <94% (consider usual baseline), RR>20, HR>100 or clinician concern or rapid deterioration
* Follow red pathway if severe features
* Advise contacts self isolate for 14 days

**Red**

**LAS 999 call if severe illness**

* severe breathlessness
* sats <92% or drop of 4% from usual baseline
* RR>21
* Severe chest pain
* Collapse
* Signs of sepsis

**Action**

* Alert ED to Covid19 suspected admission
* Hand over any TEP/ CMC record
* Don’t visit at home
* Advise contacts self-isolate for 14 days.

**Green**

**Manage at home (without visit):**

* If symptoms mild (with/ without fever)
* If not deteriorating trend
* Able to self care/ eat and drink normally
* If oxygen saturations at their usual baseline or >95% (if has home oximeter)

**Advise**

* Use paracetamol (not ibuprofen) for fever
* Start rescue pack if features of AECOPD & call GP to replenish RP
* Avoid prednisolone unless history of asthma, FBC eosinophils >0.3 previously
* Advise to self-isolate for 7 days from symptom start day or for the duration of the illness
* Confirm adequate social support.
* Arrange telephone follow up & clear safety netting for escalation with rapid response team
* Add to Covid risk register to ensure contact by phone (d7/d10)

**Box 1. Management of home/ face to face contact in suspected Covid19 +ve patients**

* Only visit at home if this is felt important to avoid a potential admission and if workforce constraints permit
* Ask the patient to wear a mask during the consultation to protect them and the case worker- dispose at visit end
* Wear PPE with gloves, gown, mask and shoe covers – visit in pairs
* Minimise physical contact with the patient and keep 2m distance if possible
* Avoid aerosol generating procedures such as chest physiotherapy (unless in full PPE with visor/ FFP3 mask and double gloves)
* Don’t perform spirometry, CO monitoring or FeNO
* Sputum samples should be collected by the patient in a separate room and double bagged-biohazard clearly written on lab-form & brought to lab direct
* Don’t perform viral swabs as these are only indicated if due to be admitted (but check latest guidance)

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Chartered Society Physiotherapy

<https://www.csp.org.uk/news/coronavirus/frequently-asked-questions-about-coronavirus>

Some respiratory physiotherapy interventions will also be classed as ‘aerosol generating’ procedures. These include:

* Manual techniques (eg expiratory vibrations, percussion, manual assisted cough) that generate a cough and the expectoration of sputum.
* Use of positive pressure breathing devices (eg IPPB), mechanical insufflation-exsufflation devices, intra/extra pulmonary high frequency oscillation devices (eg The Vest/MetaNeb/Percussionaire etc).
* Any mobilisation or therapy that may result in coughing and expectoration of mucus.

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