Tameside & Glossop CCG/LMC GP Guidance

Vs 30 07/01/2022

No C19 Symptoms

Telephone / Video Consult

Offer a F2F appointment if clinically indicated

Tips to deliver good primary care

If your practice has specific reasons why care (eg. blood tests, smears) cannot be delivered due to specific C-19 related risks/capacity issues then consider making good use of the PCAS service or talk to your PCN CD to explore alternatives.

RCGP/BMA Guidance on workload prioritisation

Staff risk assessment: Ensure the risk/benefit has been considered including a risk assessment of the person carrying out the assessment or procedure using a recognised health risk assessment tool.

Preventative/LTC Care: See LINK for CCG Guidance

Care Home Visits Checklist https://www.tamesideandglossopccg.org/clinical

Caring for vulnerable groups (LCS Bundle):

SMI healthchecks: See LINK for guidance on CCG expectations.

LD healthchecks: See LINK for guidance on CCG expectations.

Encouraging optimum self-care

Signposting patients to self-care resources for optimising health and managing long term conditions.

COVID Vaccination incl complications

Information about local vaccination availability: tameside.gov.uk/covidvaccine

NICE guidance on VITT post-AZ vaccine: LINK

If patients present following symptoms more than 4 days and within 28 days of AZ vaccine:

- new onset of severe headache, which is getting worse and does not respond to simple painkillers
- an unusual headache which seems worse when lying down or bending over, or may be accompanied by blurred vision, nausea and vomiting, difficulty with speech, weakness, drowsiness or seizures
- new unexplained pinprick bruising or bleeding
- shortness of breath, chest pain, leg swelling or persistent abdominal pain

Direct them to A&E **unless** the person is not acutely unwell, and same day FBCresults can be obtained, and if they show thrombocytopenia, the person can be referred to the emergency department immediately.

COVID 19 Testing

Symptomatic staff or patients: www.gov.uk/get-coronavirus-test or 119

Symptomatic staff: Either the same route as symptomatic patients (above) or practice-provided PCR test

Local testing information: tameside.gov.uk/coronavirus/testing

Asymptomatic patient-facing practice staff: Practice-provided lateral flow test (LFT) twice a week and report to https://www.gov.uk/report-covid19-result

Asymptomatic members of the public: https://www.gov.uk/find-covid-19-lateral-flow-test-site

C19 Symptoms — Cough or fever

(Pts may have myalgia, fatigue, anosmia, sore throat, diarrhoea, congestion or delirium/unexplained deterioration/falls in older people)

Triage Assessment: Phone/Video

This will be done in the first instance by 111/CCAS. However if patients phone their GP surgery then they should be dealt with by the practice and not redirected to 111. CCAS may book directly into GP system via GP Connect.

Alternative diagnosis to C19 more likely (but C19 possible).

Usually no resp symptoms
eg. fever due to pyelonephritis, Endocarditis etc

OR

Resp Sx with no fever more likely due to asthma, HF etc

In these circumstances the clinician may decide to risk a brief F2F consultation due to their knowledge of the patient. If this is the case TAKE PRECAUTIONS and use PPE in line with PHE guidance.

C19 is the *most likely* cause of symptoms

Mild

Stay at home, self-care advice, contact NHS 111 if symptoms get worse.

Consider increased VTE risk in any **pregnant or post-partum woman** with a positive COVID test. **All pregnant women with COVID should be assessed by maternity service unless they are very well and satn>94%**

Rest, Paracetamol, Fluids
Safety Netting. Advised to call Practice (or 111 OOH) if symptoms are worse.
Note: patients can become unwell on day 6-8 and rapidly deteriorate. Consider home O2 monitoring if they fall into a high risk category for serious disease

Moderate

New SOB, Mild chest tightness
Completing full sentences
Struggling to do ADLS

Adults RR 20-24 Adults HR 91-130
(measured by Pt/over video)

If patient has a monitor
Adults O2 Sats 93-94% or 3-4% less than normal

CONSIDER HOSPITAL ASSESSMENT

If not yet for hospital assessment:
Home O2 monitoring

Severe

Check if pt already has a care plan stating they prefer not to be admitted.
No urine output in 12 hours
New confusion

Adults RR ≥25
Adults HR ≥131

If patient has a monitor
Adults O2 Sats ≤92% or >4% less than usual

Assess pre-COVID
Clinical Frailty Score (CFS)

CFS≤4

999

CFS≥5

Phone Digital Health 0161 922 4460

Digital health Team will assess

Admission arranged by Digital health

Digital health may request further care including EoLC to be provided by GP/ Community Services

REMEMBER -all non-COVID acute medical admissions also go via Digital health as before 0161 922 4460.

Consider Home O2 monitoring
All patients either: age >50, BMI>40, Extremely clinically vulnerable, high risk ethnic group, pregnant, learning disability.

CHECK THE PROCESS FOR THIS IN YOUR PCN

Recommended terms/codes

'Acute Covid-19 infection': signs and symptoms of COVID-19: ≤4 weeks.

'Ongoing symptomatic COVID-19': signs and symptoms of COVID-19: 4-12 weeks.

'Post-COVID-19 syndrome': signs and symptoms that develop during or after COVID-19, lasting >12 weeks and not explained by another diagnosis.

Consider phone/Video review to reassess in 24 - 48 hours by practice or PCAS if feasible.

Consider Secondary bacterial pneumonia if there is pleuritic chest pain or purulent sputum
Doxycycline 200mg stat, 100mg od 5/7
OR Amoxicillin 500mg tds 5/7

Patients with COVID pneumonia have an increased risk of VTE, esp in the post-partum period. Consider admission if concerned.

Principles for seeing Pts with possible COVID

Consider double triage with colleague.

Person triaging sees the patient.

Restrict building access eg. by entryphone, or allowing 2 people at a time with adequate social distancing.

Consider assessing patients outside.

Clinician wears at least gloves, mask, apron and eye protection. PPE Guidance.

Patient comes in to surgery alone if possible and not to touch anything.

Use the shortest possible path to consulting room and dedicate one room (Red room) in the practice for face to face assessment.

Patient washes hands, and to wear a surgical mask.

Patient brought in for brief exam.

Clean the room surfaces, and equipment with alcohol wipes. Open window(s) to air the room. Remove PPE, wash hands.

Phone patient afterwards to discuss plan and safetynet.

Support for GPs, APs and GPNs

Palliative care advice: 24 hour advice line at Willow Wood Hospice, staffed by experienced nurses. 0161 330 5080

Peer GP/PN support phone call from tgccg.gppeersupport@nhs.net Mon-Fri 9-6pm

Check with your PCN resilience lead re. remote O2 satn Full NHSE Guidance LINK

Videos to help patients to measure their pulse rate and respiratory rate remotely: Pulse Rate Respiratory Rate

Supporting patients with post-C19 Symptoms

GM Support for patients

This link from the BMJ guides GPs/APs in how to assess patients with possible Post-COVID symptoms.

Guidance from BLS/Asthma UK on post-COVID Symptoms HERE.

Info for patients on symptom management from TGICFT/CCG

On line recovery support https://www.yourcovidrecovery.nhs.uk/

T&G OPTIONS: Patients with persistent Sx beyond 12 weeks following COVID or probable COVID can be referred to **TGICFT Post-COVID Syndrome Assessment Clinic**. Referral proforma templates have been sent to Practice Managers to be uploaded into your medical record system.

Updates and Feedback: Please check you are using the most up to date version of this guidance. If any part of the pathway has not worked for you in the way you expect we need to know so that we can sort out problems. If you have any problem or feedback please email **tgccg.primarycarereporting@nhs.net**

Bronchiolitis Pathway

Clinical Assessment / Management Tool for Children Younger than 1 year old with suspected Bronchiolitis

Healthier Together

NHS

Management - Primary Care and Community Settings

Patient Presents

Suspected Bronchiolitis?

- Snuffly Nose
- Poor feeding
- Pyrexia
- Head bobbing
- Bronchiolitis Season
- Chesty Cough
- Vomiting
- Increased work of breathing
- Cyanosis
- Inspiratory crackles +/- wheeze

Risk factors for severe disease

- Pre-existing lung condition • Immunocompromised • Congenital Heart Disease
- Age <6 weeks (corrected) • Re-attendance • Prematurity <35 weeks • Neuromuscular weakness

Do the symptoms and/or signs suggest **an immediately life threatening (high risk) illness?**

Yes

- **Refer immediately** to emergency care by **999**
- Alert Paediatrician
- Stay with child whilst waiting and give **High-Flow Oxygen** support

Consider differential diagnosis if - temp ≥38°C (sepsis) or sweaty (cardiac) or unusual features of illness

Table 1

Clinical Findings	Green - low risk	Amber - intermediate risk	Red - high risk
Behaviour	• Alert • Normal	• Irritable • Decreased activity • Reduced response to social cues • No smile	• Unable to rouse • No response to social cues • Appears ill to a healthcare professional • Wakes only with prolonged stimulation • Weak or continuous cry
Skin	• CRT < 2 secs • Normal colour skin, lips and tongue • Moist mucous membranes	• CRT 2-3 secs • Pallor colour reported by parent/carer • Pale/mottled • Cool peripheries	• CRT > 3 secs • Cyanotic lips and tongue • Pale/Mottled/Ashen blue
Respiratory Rate	• Under 12mths <50 breaths/minute • Mild respiratory distress	• Increased work of breathing • All ages > 60 breaths /minute	• All ages > 70 breaths/minute • Respiratory distress
O_2 Sats in air**	• 95% or above	• 92-94%	• <92%
Chest Recession	• Mild	• Moderate	• Severe
Nasal Flaring	• Absent	• May be present	• Present
Grunting	• Absent	• Absent	• Present
Feeding Hydration	• Normal - Tolerating 75% of fluid • Occasional cough induced vomiting	• 50-75% fluid intake over 3-4 feeds • Reduced urine output	• <50% fluid intake over 2-3 feeds / 12 hours or appears dehydrated • Significantly reduced urine output
Apnoeas	• Absent	• Absent	• Yes
Other		• Pre-existing lung condition • Immunocompromised • Congenital Heart Disease • Age <6 weeks (corrected) • Re-attendance • Prematurity <35 weeks • Neuromuscular weakness • Additional parent/carer support required	

Table 2 Normal Paediatric Values:

(APLS†)	Respiratory Rate at rest: [b/min]	Heart Rate [bpm]	Systolic Blood Pressure [mmHg]
< 1 year	30 - 40	110 - 160	70 - 90
1-2 years	25 - 35	100 - 150	80 - 95

Also think about...

Babies with bronchiolitis often deteriorate up to Day 3. This needs to be considered in those patients with risk factors for severe disease

Green Action

Provide appropriate and clear guidance to the parent / carer and refer them to the patient advice sheet.

Confirm they are comfortable with the decisions / advice given and then think "Safeguarding" before sending home.

Amber Action

Advice from Paediatrician should be sought and/or a clear management plan agreed with parents.

Refer

Manage

Management Plan

- Provide the parent/carer with a safety net: use the advice sheet and advise on signs and symptoms and changes and signpost as to where to go should things change
- Consider referral to acute paediatric community nursing team if available
- Arrange any required follow up or review and send any relevant documentation to the provider of follow-up or review

Urgent Action

Consider commencing high flow oxygen support

Refer immediately to emergency care – consider 999

Alert Paediatrician

Commence relevant treatment to stabilise child for transfer

Send relevant documentation

999

Hospital Emergency Department / Paediatric Unit

GMC Best Practice recommends: Record your findings (See "Good Medical Practice" http://bit.ly/1DPXl2b)

**NB: Oximetry is an important part of the assessment and should be measured with an oximeter appropriately designed for infants if available.

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