

(COVID-19) INTERIM Guidance for Primary Care

**Management of patients presenting to
primary care**

Version 1.2 PHW

**Acknowledgement: With thanks to Health Protection Scotland
This document is uncontrolled when printed.**

Version History

Version	Date	Summary of changes
V1.1	17/03/20	First draft
V1.2	18/03/20	Final amendments for publication

Introduction

Novel coronavirus (COVID-19) is a new strain of coronavirus first identified in Wuhan, China. Clinical presentation may range from mild-to-moderate illness to pneumonia or severe acute respiratory infection. Because of this, patients with COVID-19 could present to primary care either via telephone or in person.

As of 12 March 2020 the UK has moved into the “delay phase” of management. This includes significant changes to the identification and management of possible cases.

Please note that this is an evolving situation and the most up to date guidance and advice should always be checked online at : <https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/> and <https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response>

Case definition

As of 13 March 2020 the possible case definition for COVID-19 is based purely on clinical criteria. For most people COVID-19 will be a mild, self-limiting infection and will not require testing. The case definition differs depending on whether the patient requires admission to hospital or not.

1. Case definition for individuals in the community

Individuals with the following symptoms are advised to self-isolate for 7 days and COVID-19 testing is not currently required.

Recent onset (within the last 7 days):

- New continuous cough

and/or

- High temperature

New guidance issued on 16th March extended the requirement for self-isolation to whole households for 14 days when one member of the household has symptoms see detailed guidance below:

<https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance>

2. Case definition for individuals requiring hospital admission

Patients requiring hospital admission (overnight stay) **and** meeting the clinical criteria below will be tested for COVID-19 in the hospital.

- Clinical or radiological evidence of pneumonia

or

- Acute respiratory distress syndrome

or

- Influenza like illness (fever $\geq 37.8^{\circ}\text{C}$ and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing)

Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.

Actions in primary care

Staff who are pregnant or otherwise immunosuppressed should not provide direct care for a patient with possible or confirmed COVID-19. Any deviation from this should be a local decision.

1. Triage of Patients

Primary Care practices are advised to make every effort to triage patients by telephone to avoid the patient presenting at the practice unnecessarily or staff being sent unnecessarily to the home, so as to minimise any contact with patients who have respiratory symptoms.

2. Management of patients identified through telephone consultation who do not require clinical assessment and meet the possible case definition for COVID-19

Advise the patient to self-isolate at home. Direct the patient to “[stay at home](https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response)” advice, which can be found at <https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response>

Provide the patient with worsening symptom information and advise them to phone the practice back or NHS 111 if this occurs. They should not attend the practice in person or go to A&E. If it is an emergency they should phone 999 and inform the call handler of their symptoms.

Alternative strategies need to be considered where there is no need for direct clinical contact with the patient such as digital solutions skype/FaceTime, or telemedicine where a consultation can be done remotely e.g. CPN, dietician, and health visitor.

3. Management of patients requiring clinical assessment

3.1. Infection Prevention and Control

For all consultations for acute respiratory infection or influenza like illness (fever $\geq 37.8^{\circ}\text{C}$ and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing) wear PPE in line with National Infection Prevention and Control Manual, Public Health Wales

<http://www.wales.nhs.uk/sitesplus/888/page/95007>

This PPE MUST ONLY BE USED for consultations for acute respiratory infection or influenza like illness (unless AGP's performed see below)

- **Fluid Resistant Surgical Mask (FRSM)**
- **Disposable gloves**
- **Disposable plastic apron**
- **Appropriate eye protection, after risk assessment of need, if splashing or spraying of body fluids likely.***

PPE must be used in conjunction with effective Hand Hygiene

****Reusable eye protection must be decontaminated after every use)***

Try to keep exposure to the minimum. Guidance for putting on and removing PPE can be found in Appendix 1 of this document.

Any Aerosol Generating Procedures (AGP) should be avoided in the Primary Care setting for this group of patients.

The following procedures are considered AGPs:

- Intubation, extubation and related procedures e.g. manual ventilation and open suctioning
- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)
- Bronchoscopy
- Surgery and post mortem procedures involving high-speed devices
- Some dental procedures (e.g. high-speed drilling)
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP) *
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum
- High flow nasal oxygen (HFNO) **

* CPAP and BiPAP are considered Aerosol Generating Procedures (AGPs). Long Term Oxygen Therapy is not. I would advise as follows;

- Primary care staff should avoid visiting patients who have respiratory symptoms and are on CPAP/BiPAP at home.
- Consider phone consultations in the first instance to assess whether the patient requires a home visit. If it is safe to postpone the visit until symptoms have resolved, then do so.
- If you must carry out a home visit, phone ahead and establish what times of the day the patient is on their CPAP/BiPAP. Primary care staff should ensure they visit at least 1 hour after the CPAP/Bi P AP was switched off which will provide adequate time for the aerosols to dissipate (based on 3 Air Changes per Hour (ACH) in an average domestic property). On visiting they should wear PPE in line with droplet precautions.
- If the clinical condition is such that the CPAP/BiPAP cannot be turned off for a full hour before the visit then the patient should, if possible, move to another room before the practitioner enters their home and the door of the room where the CPAP/BiPAP takes place should be closed. The practitioner can then enter the patient's home to assess their condition.
- If the patients clinical condition is such that neither of these is possible *and* there are no appropriate primary care practitioners available who have been face fit tested or there no access to FFP3 masks then the patient will require transfer to hospital for clinical assessment.
- Alert the ambulance that the patient is a suspected COVID-19 requiring CPCP/BiPAP

Note: High Flow Nasal Oxygen, sometimes referred to as High Flow Nasal Cannula Therapy, is the process by which warmed and humidified respiratory gases are delivered to a patient through a nasal cannula via a specifically designed nasal cannula interface. These devices can be set to deliver oxygen at specific concentrations and flow rates (typically 40-60L/min-1 for adults). **This is different from standard home oxygen delivered through a nasal cannula which is not an AGP.

3.2. Clinical assessment in the surgery

Where possible consider practical approaches to facilitate infection prevention and control measures for this group of patients. This could include:

- designated area of practice / rooms for seeing patient with respiratory symptoms
- seeing such patients at a specific time of day (e.g. end of a list or separate clinic)
- rooms used for assessment of these patients should be kept clutter free with equipment kept in closed cupboards to minimise potential for contamination. Soft furnishings should be avoided where possible. Tie back examination curtains to avoid contamination. The practice should have a regular laundering regime in place for curtains.
- segregation of patients with respiratory symptoms from other patients e.g. using separate entrances, separate waiting areas, dedicated staff for respiratory patients.
- all non-essential items including toys, books and magazines should be removed receptions, waiting areas, consulting and treatment rooms.
- Consider cohorting staff who have likely recovered from COVID-19 to care for those patients who are symptomatic . They would still use same level of PPE .

The supply of PPE is intended for HCW's who are within 1m of a patient to clinically assess and provide direct care to a symptomatic patient in the practice or in the patient home by nurses or doctor etc. It is not intended for circulating staff e.g. receptionists, admin staff. Social distancing of 2m should be used in other areas of the practice such as demarked zone at reception for booking in.

3.3. Clinical assessment at home visit

If carrying out a home visit (including nursing or shared living home) follow infection prevention and control advice as per 3.1 above. Practitioners should carry a waste bag do dispose of PPE following the visit.

Following the patient consultation, PPE should be removed as per appendix 1. This should be placed in a clinical waste bag and then hands washed with soap and water. On return to the surgery waste should be disposed as per normal practice for clinical waste.

At home the patient should be asked to secure pets in another room during the visit and ask all other family (unless supporting the patient) to also ensure no direct contact with the HCW.

Avoid taking any unnecessary equipment into the patient room or home. This should be planned before the visit so only essential items are taken into the area.

Re-useable equipment should be avoided if possible; if used, it should be decontaminated according to the manufacturer's instructions before removal from the room/home.

Within a care home / nursing home / shared living centre, where possible designate key reusable equipment to the care of the patient while they are infectious e.g. BP cuffs, stethoscope, walking aids.

3.4. Management of patients following clinical assessment

If the patient does not require referral to secondary care and they meet the case definition for a possible case of COVID-19 they should be advised to self-isolate at home until 7 days after the onset of their symptoms. If the individual lives with others, the whole household must self-isolate for 14 days. Direct the patient to “[stay at home](https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response)” advice, which can be found at <https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response> Provide the patient with worsening symptom information and advise them to phone the surgery or NHS 111 if their symptoms are worsening. They should not attend the practice in person or go to A&E. If it is an emergency they should phone 999 and inform the call handler of their symptoms.

If the patient **does** require referral to secondary care this should be done via existing mechanisms for hospital referral – phone ahead, do not advise the patient to self-present at A&E or minor injury unit.

3.5 Transport to hospital

Patients must not use public transport or taxis to get to hospital. Transport options include:

- Patients can be taken to hospital by an accompanying friend or family member if they have already had significant exposure to the patient and are aware of the possible COVID-19 diagnosis.
The patient should sit in the rear of the car and wear a face mask if available. The car should be well ventilated with an open window. They should be given clear instructions on what to do when they get to the hospital to minimise risk of exposure to staff, patients and visitors

OR

- If the patient is clinically well enough to drive themselves to the hospital then they can do so. They should be given clear instructions on what to do when they get to the hospital to minimise risk of exposure to staff, patients and visitors

-

OR

- Arrange transfer by Welsh Ambulance Service (ensuring that you inform the ambulance call handler of the concerns about COVID-19) and proceed with management as follows:
 - Staff should withdraw from the room if the patient is clinically well enough to be left unattended.
 - Close the door to the room
 - Wash your hands with soap and water.
 - If required, identify suitable toilet facilities that only the patient will use.
 - If required to re-enter the room, don PPE as per appendix 1.

4. Self-isolation

Patients self-isolating should be advised to follow the “[stay at home](https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response)” advice, which can be found at <https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response>.

If symptoms worsen during self-isolation or have not improved after seven days, then they should be reassessed.

From 16th March the whole household **needs to self-isolate for 14 days when one member of the household has symptoms.**

5. Reporting to Local Health Protection Team

The local Health Protection Team (HPT) should be informed of any confirmed case in:

- a long-term care facility
- a prison or place of detention
- a healthcare worker (also advise the healthcare worker to inform their employer)

6. Environmental cleaning following a suspected case

Once a suspected case has left premises, the room where the patient was placed/isolated should not be used until adequately decontaminated. The room door should remain shut until it has been cleaned with detergent and disinfectant. Once this process has been completed, the room can be put back into use immediately.

6.1. Preparation

The person responsible for undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures:

- collect any cleaning equipment and waste bags required before entering the room
- any cloths and mop heads used must be disposed of as single use items
- before entering the room, perform hand hygiene then put on a disposable plastic apron and gloves

6.2. On entering the room

- Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
- Bag any disposable items that have been used for the care of the patient as clinical waste,
- Provided curtains have been tied back during the examination and no contamination is evident, these can be left in situ. Otherwise, remove any fabric curtains or screens and bag as infectious linen.
- Close any sharps containers, wipe the outer surfaces with either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine or a neutral purpose detergent followed by disinfection (1000 ppm av.cl.).

6.3. Cleaning process

Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the 2 options below:

1. Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl)

or

2. a neutral purpose detergent followed by disinfection (1000 ppm av.cl):

- follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants;
- any cloths and mop heads used must be disposed of as single use items.

6.4. Cleaning and disinfection of reusable equipment

- clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal
- clean all reusable equipment systematically from the top or furthest away point

6.5. Carpeted flooring and soft furnishings

Ideally the use of examination rooms that are carpeted should be avoided. For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use following, or combined with, detergent cleaning.

6.6. On leaving the room

- discard detergent/disinfectant solutions safely at disposal point
- dispose of all waste as clinical waste
- clean, dry and store re-usable parts of cleaning equipment, such as mop handles
- remove and discard PPE as clinical waste as per local policy
- perform hand hygiene

6.7. Cleaning of communal areas

If a possible case spent time in a communal area used for non-respiratory patients, for example, a waiting area or toilet facilities, then these areas should be cleaned with detergent and disinfectant (as above) unless there has been a blood/body fluid spill which should be dealt with immediately (guidance is in the National Infection Prevention and Control Manual available via Public Health Wales website). Once cleaning and disinfection have been completed, these areas can be put back into use immediately.

Further information

Further Information for health professionals can be found at:

<https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response>

Contact Details for Health Protection Wales

0300 00 300 32.

Appendix 1: Putting on and removing Personal Protective Equipment (PPE)

Putting on PPE

PPE should be put on before entering the room where the patient is. Perform Hand Hygiene before putting on PPE, the PPE should be put on in the following order:

1. Disposable plastic apron
2. A Type IIR (Fluid Resistant Surgical Facemask) FRSM. This should be close fitting and fully cover the nose and mouth. Do not touch the front of the mask when being worn
3. Disposable non-sterile nitrile, latex or neoprene gloves. There is no requirement for double-gloving

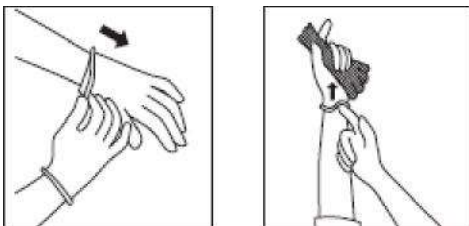
The order given above is a practical one; the order for putting on is less critical than the order of removal given below.

Removal of PPE

PPE should be removed in an order that minimises the potential for cross-contamination. Before leaving the room where the patient is, gloves, apron and FRSM should be removed (in that order, where worn) and disposed of as clinical waste. Guidance on the order of removal of PPE is as follows:

1. Gloves

- Grasp the outside of glove with the opposite gloved hand; peel off.
- Hold the removed glove in the remaining gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Discard as clinical waste.



Perform Hand Hygiene.

2. Apron

- Unfasten or break apron ties.
- Pull the apron away from the neck and shoulders, touching the inside of the apron only.
- Turn the apron inside out, fold or roll into a bundle and discard as clinical waste.

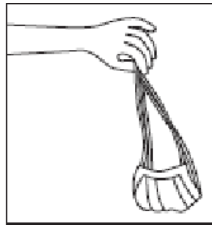
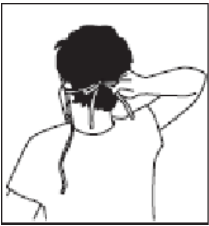


3. Eye Protection if used

Use both hands to remove the eye protection by the side arms avoiding contact with the eyes – discard to clinical waste or decontaminate re-usable eye protection thoroughly..

4. Fluid Resistant Surgical Facemask (FRSM)

Untie or break bottom ties, followed by top ties or elastic, and remove by handling the ties only and discard as clinical waste.



Perform Hand Hygiene after removal of all PPE.