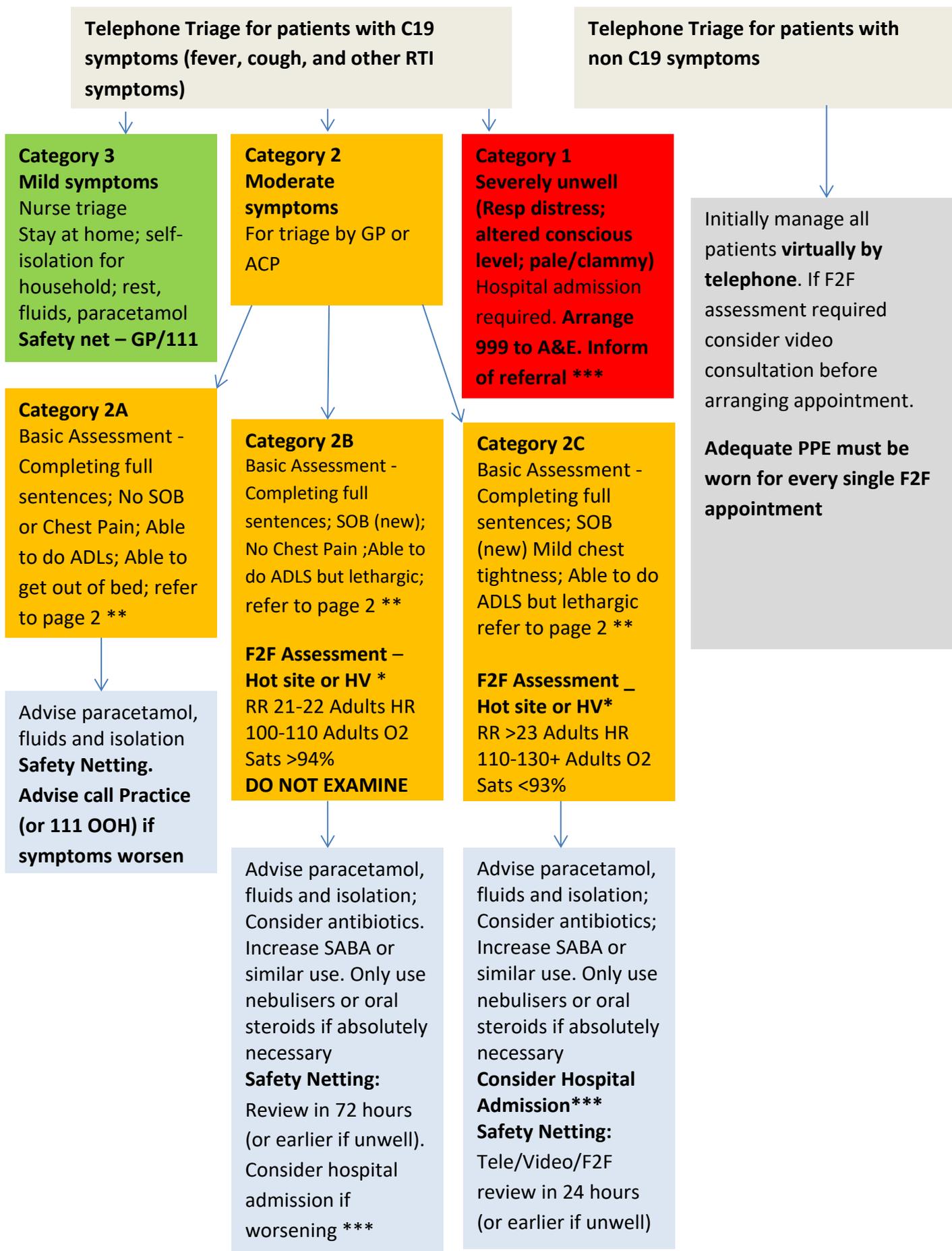


Assessment of patients aged 12 years or over during Covid19 pandemic

All patients contacting Urgent/Primary Care should be triaged by a Clinician prior to booking an appointment. It is anticipated that the majority of patients will not require a F2F appointment and should be assessed and managed remotely.



* For patients with Covid19 symptoms who are becoming worse but are NOT severely unwell, arrange FTF assessment by:

Video consultation

FTF assessment in Hot sites/UTC/MIUs with isolation process

FTF assessment at A&E (Respiratory Pathway if Lincoln or Boston Patients)

Home visit if housebound

Adequate PPE must be worn for every single F2F appointment

** Ask the patient to describe the problem with their breathing in their own words, and assess the ease and comfort of their speech. Ask open-ended questions and listen to whether the patient can complete their sentences.

“How is your breathing today?”

Align with NHS111 symptom checker, which asks three questions (developed through user testing but not evaluated in formal research):

“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. A clear story of deterioration is more important than whether the patient currently feels short of breath. Ask questions like:

“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. For example, a new, audible wheeze and a verbal report of blueness of the lips in a breathless patient are concerning.

In addition, as advised in the BMJ ‘Ten minute consultation’ on the remote assessment of a patient with possible COVID-19, we recommend that a video examination will add key detail such as whether the patient is blue, the extent of respiratory effort and the opportunity to count the respiratory rate.

*** Consideration of referral to A&E/acute hospital admission:

Covid19 should be suspected for any patient presenting with a history of flu type illness with an associated dry cough and worsening dyspnoea. Patients may appear relatively well on general assessment but the determining factor for severity of illness should be based on oxygen saturation. For patients with declining SpO₂, early intervention with CPAP can be very effective.

There are no specific criteria other than severe frailty that will help determine who will benefit most from clinical intervention. ULHT have been treating all patients regardless of age and co-morbidities. Even with critical care including ventilation, 50% of ICU patients will die regardless of age and co-morbidities. Need for critical care is a poor prognostic factor.

The mainstay of treatment is oxygen therapy – this can be very invasive and is required on an almost continuous basis. Before admitting patients, there needs to be consideration of whether the patient will want and/or tolerate continuous O₂ via cannulae, mask, CPAP. Experience has shown that patients with cognitive impairment may struggle to tolerate this. It is important to have this discussion with patient and family prior to admission.

Antibiotic therapy is given to patients with breathlessness on the basis that they may have a primary or co-existing bacterial infection. Therapy should be single agent for 5 days unless more severe in which case dual therapy should be considered.

Fluid therapy is not good for Covid patients and it is better for the patient to be slightly under-hydrated due to the effect of over hydration on ARDS. Encourage oral fluids to maintain hydration. Patients are currently being discharged from hospital with oxygen saturation above 92% when mobile and no longer requiring supplemental oxygen to maintain SpO₂ >92%. It would therefore be reasonable to keep patients in the community if their Spo₂ was 94% or above and being maintained at this level either in air or with their usual LTOT. Regular review is required with clear advice to the patient and their carers on how/when to get further advice.