NHS Lanarkshire

COVID Hub
Acute Respiratory Illness Centre (ARIC)

Induction Pack including clinical pathways

Version 12

09.03.2021

Review date: 20th April 2021

Acute Respiratory Illness Centre
Update to Clinical Pathways

Version History	Date	Summary of changes
Version 12	09.03.2021	**Removal of Appendix** Appendix 9 has been removed (Patient Information Leaflet - COVID – 19 Advice for Your Recovery)
Version 11	23.02.2021	**Case Discussion** This item in the document has been removed
Version 11	23.02.2021	**Professional Leads.** Professional Leads:- Dr Mike Coates, Dr Richard Watson, Dr Sharon Russell & Dr Iain Hathorn
Version 11	23.02.2021	**Background** Community Assessment Centre (CAC) has been renamed Acute Respiratory Illness Centres (ARIC) to reflect the breadth of respiratory presentations during the winter period.
Version 11	23.02.2021	**Medication List** Updated – Appendix 3.
Version 11	23.02.2021 Addition	**Definition - WHO** “Clinicians should be alert to the possibility of atypical and non-specific presentations in older people with frailty, those with pre-existing conditions and patients who are immunocompromised. Inpatients must be assessed for bacterial sepsis or other causes of symptoms as appropriate. A wide variety of clinical symptoms have been associated with COVID-19: headache, loss of smell, nasal obstruction, lethargy, myalgia (aching muscles), rhinorrhea (runny nose), taste dysfunction, sore throat, diarrhoea, vomiting and confusion; fever may not be reported in all symptomatic individuals1. Patients may also be asymptomatic2. Possible COVID-19 case A person presenting recent onset of any of the following cardinal COVID-19 symptoms: new continuous cough OR fever /temperature >=37.8 OR Loss of or change in sense of smell (anosmia) or taste(ageusia)”
Version 11	23.02.2021 Addition	**Pregnancy** Information from Clinical Lead E Ferguson - "Pregnant or recently pregnant women seem to be less likely to be symptomatic or exhibit the common symptoms of fever and shortness of breath than non-pregnant women. Pregnant or recently pregnant women are at a higher risk of ICU admission, especially if they have underlying risk factors, such as obesity, diabetes, hypertension or BAME. Spontaneous preterm birth rates are higher in pregnant women infected with Covid-19 compared with non-infected pregnant women and so women who experience worrying obstetric symptoms such as premature contractions, rupture of membranes, antepartum haemorrhage or reduced foetal movements, should seek attention promptly".
Version 11	23.02.2021	**On-going monitoring and self-care** **Sentences added regarding Oxygen Self-Monitoring**

	Addition	○ In January NHSL agreed to pilot the provision of oximeters for home monitor of covid in patients who have been seen in ARIC and meet the inclusion criteria. Clinicians wishing to take part in this pilot must attend a training session initially. Please contact Jane McDonald or Pamela Buddy. WHO recently supportive of this approach stating *"Potential benefits outweigh potential harms especially if patients are symptomatic and at risk of severe disease but only as part of a larger package of care including patient and practitioner education and Follow up "* **Pilot and Patient Positioning for optimal oxygenation** ○ Evidence in relation to improved oxygen saturation in seated position was accepted by The Clinical reference group and adoption of this where possible within the ARIC while patients await ambulance transfer is to be encouraged. **Safety Netting** ○ WHO states Patients with risk factors for severe illness should be monitored closely, should be given the possible risk of deterioration. If they and their care givers notice that they develop any worsening symptoms (such as light headedness, difficulty breathing, chest pain, dehydration, etc.), they should seek urgent care through the established COVID-19 care pathway. Caregivers of children with mild COVID-19 should monitor for signs and symptoms of clinical deterioration requiring urgent re-evaluation. These include difficulty breathing/fast or shallow breathing (for infants: grunting, inability to breastfeed), blue lips or face, chest pain or pressure, new confusion, inability to awaken/not interacting when awake, inability to drink or keep down any liquids. An aid memoire will be developed for use in the ARIC and distributed to all staff and available in the service to give and email to patients **Health Protection team (HPT)** ○ Clinicians are reminded that the Health Protection Team (Public Health) must be contacted if a positive result from a patient in Care home, Prison, School, etc. to allow public health to identify any potential clusters. If you come across such cases please, if possible, check this has been done by the manager of the unit /service concerned.
Version 10	19.01.2021	**PPE –** removal of paragraph and updated NHS Lanarkshire position
Version 9	18.12.2020	**PPE –** Updated NHS Lanarkshire position
Version 9	11.12.2020	**Appendix 4 –** Care home
Version 8	24.11.2020	**Page 9 – Professional Leads.** Professional Leads: - Dr Mark Russell, Dr Sharon Russell & Dr Iain Hathorn
Version 8	24.11.2020	**Page 9 – face to Face Assessment: Changing Masks** "Any individual visiting or attending an acute adult hospital (including mental health, maternity, neonatal and paediatrics) community hospitals, primary care premises (GP practices, dentists, opticians & pharmacies) or an adult care home should wear a face mask/covering of the same kind the Scottish Government has recommended be worn on public transport. If a patient arrives already wearing an appropriate face cover, Infection Prevention Control advised it is better not to change their mask while in the Centre and to leave their existing mask intact."

Version 8	24.11.2020	**Page 9 – Face to Face Assessment: Oxygen Saturation** "If saturation drops by 3 or more percent but remains above admission levels the patient should be advised that it is likely COVID is affecting their lung capacity on exercising, however this is not sufficient to require them to be admitted at this stage".
Version 8	24.11.2020	**Page 10 – ENT Examination:** "Throat or nose examination should only be undertaken if it will change management significantly. Ear examination is low risk and may be needed, especially in children with pyrexia. Full PPE including eye protection should be worn. Throat examination is not considered an Aerosol Generating Procedure so a FFP3 mask is not needed. However, it is important to avoid making the patient cough so when examining the throat, I would advise against using a tongue depressor when possible. If a quinsy is present the patient will usually have trismus and a deviation of the uvula, and this can be diagnosed without using a tongue depressor. Patients should be asked to avoid talking or coughing during the examination. Examining the throat should present no more risk to the healthcare worker than taking a COVID 19 swab.
Version 8	24.11.2020	Update and change references of Seasonal COVID Centre/COVID Assessment Centre (CAC) and to Acute Respiratory Illness Centre
Version 8		**Page 14 – Patient Pathway:** "It was our aspiration that the service has defined and agreed inclusion criteria. In particular, the symptoms should be acute, and not chronic. The Clinical Reference Group has debated extensively around developing guidance for potential dual diagnosis situations, and for those that do not follow specific timelines. The consensus is that definition of "clear alternative source of infection" in reality can be quite difficult. Balancing the need to protect General Practice, Emergency Departments, our own staff and other patients from potential COVID exposure needs weighed against our ability to deliver this operationally and not overwhelming this one particular aspect of the service. High degree of professionalism is therefore called upon and individual clinical judgements"

Background

Following Scottish Government National directive NHS Lanarkshire established a Pan-Lanarkshire COVID-19 Triage Hub (based in Airdrie CHC) the Community Assessment Centre (CAC) - based in Douglas St, Hamilton. The centres opened on the 23rd March 2020. Community Assessment Centre (CAC) has been renamed Acute Respiratory Illness Centres (ARIC) to reflect the breadth of respiratory presentations during the winter period.

The purpose of the Triage Hub and ARIC was and remains to provide a clinical pathway for patients who may potentially have COVID-19 away from the front door of our GP practices and A & E departments. Increasing the resilience of both the primary and secondary services as a result. The guiding principles around this service are:

- Patients should be managed in the community where clinically possible.
- Secondary care should only be for clinically significantly unwell needing inpatient assessment and management.
- Patients presenting with Cardinal Symptoms of Covid 19 **(box1)** should be regarded as possible cases and should be managed in separate healthcare settings to those without.
- Risk of healthcare associated COVID-19 needs to be recognise and should be minimised as much as possible.

Subsequently SG communicated the following relevant **recommendations:**

- The current case definition will be used to triage patients to the Covid pathway but it is recognised that many winter illnesses will present with similar symptoms.
- The Acute Respiratory Illness Centres need to be resourced with an appropriate whole system MDT to meet any increase in demand, particularly seasonal flu presentations that meet the case definition and are potentially Covid until proven otherwise
- The pathway should enable timely and safe assessment and reduce Covid-related demand on frontline general practice and emergency departments.
- Primary Care Directorate should continue to oversee the implementation and delivery of the Covid pathway for continuity and report on performance to the Strategic Advisory Group.

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9. **Appendixes**
    - Appendix 1: SIGN telephone triage
    - Appendix 2: Frailty Scale
    - Appendix 3: Medication available within the ARIC
    - Appendix 4: Home Visiting Processes in Relation to Covid 19 Pandemic
    - Appendix 5 & 6: Clinical Support Tool for remote clinical assessment
    - Appendix 7: Novel coronavirus (COVID-19) Guidance for primary care Management of patients in primary care
    - Appendix 8: Guidance for CPR in Lanarkshire

1. RESPONSIBILITIES

PRE-SHIFT

Preparation for what may be an unusual working environment is strongly recommended. Please ensure you are familiar with the HPs guidance from primary care – currently at:

- https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2930/documents/1_covid-19-guidance-for-primary-care.pdf

There may be other, very relevant, guidance recently published and monitoring the compendium of guide prior to each shift and familiarization is expected.

- https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2999/documents/1_covid-19-compendium.pdf

Please read this induction document and raise any concerns with the clinical leadership team.
Prior to your first shift or if returning after a while, we would strongly encourage a shadowing session and these can be arranged by calling the Hub on 01698 753349.

CLINICIANS AT HIGH RISK OF COVID 19 COMPLICATIONS

If you are concerned that you belong to the currently acknowledged higher risk categories for Covid and /or have a medical condition which may put you at additional risk when working in this environment it is important that you undergo an Occupational Health assessment. NHSL has contracted with SALUS to provide this service. Please self-refer advising them you are a GP planning to work front line in red zones. It will be expected you have taken this into consideration prior to committing to work in the red zones of the ARICs. Many shielding doctors have continued to work for the service over this period as triage clinicians both in the hub and remotely – please speak to the lead clinicians if you have any concerns or clarifications.

DURING SHIFT

MDT and roles

The future will see general practitioners in Scotland fulfilling roles supporting a wide range of clinical professionals, working as an expert medical generalist and the senior clinical decision maker within multidisciplinary community teams.

This is the model we aspire to within the ARIC

Advanced Nurse practitioners (ANP)'s are broad spectrum generalists who practice autonomously once they are qualified. The trainee ANPs practice at varying levels whilst they are going through their academic pathway which can take up to 2 years and will require to seek supervision and support in their decision making.

Clinical support workers are able to provide clinical assistance as required. They operate under the direction of a registered practitioner and are able to assist in clinical observations (if trained and deemed competent), patient care duties and administrative support as required. They are not registered practitioners and as such cannot administer medication, or supply it to patients.

POST SHIFT

Post shift feedback questionnaire.

We are very grateful of your commitment to the service and your feedback to continued improvement is essential. Please take the time to complete within 12 hours of each shift ending so we have timeous warning of any issues arising and can investigate and remediate where possible. Please find link to staff survey below:

https://forms.office.com/Pages/ResponsePage.aspx?id=veDvEDCgykuAnLXmdF5JmqwATcdR7IFHrYlkgcW-

1. Is this your first session in the ARAC
2. Did you receive the induction material?
3. Did you receive and orientation to your working environment?
4. Were you included in the shift handover?
5. Did you experience any unresolved difficulties in relation to?
    - Admin /hub support
    - IT or telephony equipment
    - Workload on shift
    - PPE or other equipment availability
    - Assessment /management of any patient
    - Situation that required you to escalated to the shift leader

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Self-care
There are a wide range of supports available to GPs. Try the *How are you feeling today* toolkit:

- https://www.nhsemployers.org/retention-and-staff-experience/health-and-wellbeing/taking-a-targeted-approach/taking-a-targeted-approach/how-are-you-feeling-today-nhs-toolkit

NHSL contracts SALUS to provide physical and mental health services to if contracted staff and GPs and their practice staff which includes a **24-hour telephone psychological help line -01698 752000**

- http://firstport2/staff-support/salus-occupational-health-and-safety/default.aspx
- BMA *https://www.bma.org.uk/advice-and-support/your-wellbeing/wellbeing-support-services/sources-of-support-for-your-wellbeing*

Professional leads for this service are; Dr Mike Coates, Dr Richard Watson, Dr Sharon Russell, and Dr Iain Hathorn and should be contacted by email (or mobile as per global address book if urgent)

2. CASE DEFINITION

Symptoms in Covid 19 from HPS Primary care guidance 9.2.21
"Clinicians should be alert to the possibility of atypical and non-specific presentations in older people with frailty, those with pre-existing conditions and patients who are immunocompromised. Inpatients must be assessed for bacterial sepsis or other causes of symptoms as appropriate.
A wide variety of clinical symptoms have been associated with COVID-19: headache, loss of smell, nasal obstruction, lethargy, myalgia (aching muscles), rhinorrhea (runny nose), taste dysfunction, sore throat, diarrhoea, vomiting and confusion; fever may not be reported in all symptomatic individuals. Patients may also be asymptomatic.

A person presenting recent onset of any of the following **cardinal COVID-19 symptoms**:
New continuous cough
OR

Fever /temperature >=37.8
OR
Loss of or change in sense of smell (anosmia) or taste (ageusia)"

REMOTE TRIAGE

Telephone and NEAR ME are available as remote triage options within the HUB – see working remotely for support on use of these technologies.

The BMJ article by Trisha Greenhalgh et al "Covid-19: a remote assessment in primary care" is a useful primer.

RCGP and BMJ have the following useful flow charts. The one we are currently recommending is The Scottish primary care cell in conjunction with SIGN

https://www.signdecisionsupport.uk/media/1153/infographic-scottish-primary-care-hub-triage-guide-v4-200723.pdf - (Appendix 1)

- Many hypoxic patients however do not complain of significant breathlessness, but of exhaustion. Any patient in the second week of a potential COVID illness who reports significantly worsening exhaustion should be reviewed face to face.
- Increasing age and co-morbidity are risk factors for progression to more severe disease. Initial UK data for patients admitted to critical care shows a 70:30 Male: Female ratio.
- Confusion, especially in younger adults (who are less likely to report exhaustion or breathlessness) should be regarded as a significant symptom as this may be associated with hypoxia.

NICE advises it is difficult in primary care to determine whether pneumonia has a COVID-19 viral cause or a bacterial cause (either primary or secondary to COVID-19). Particularly during remote consultations. However, as COVID-19 becomes more prevalent in the community, patients presenting with pneumonia symptoms are more likely to have a COVID-19 viral pneumonia than a community-acquired bacterial pneumonia. NICE suggest: COVID-19 viral pneumonia may be more likely if the patient:

- presents with a history of typical COVID-19 symptoms for about a week
- has severe muscle pain (myalgia)
- has loss of sense of smell (anosmia)
- is breathless but has no pleuritic pain
- Has a history of exposure to known or suspected COVID-19, such as a household or workplace contact?

Bacterial cause of pneumonia may be more likely if the patient:

- becomes rapidly unwell after only a few days of symptoms
- does not have a history of typical COVID-19 symptoms
- has pleuritic pain
- has purulent sputum

NICE advice that that significantly early dyspnoea (before day 5), particularly accompanied by a productive cough, is less likely to be COVID induced and may represent a bacterial pneumonia. It is suggested that it would be appropriate to consider antibiotics in this group. For bacterial pneumonia NICE recommends doxycycline 200 mg on the first day, then 100 mg once a day for 5 days in total. A suitable alternative in pregnancy is amoxicillin 500 mg 3 times a day for 5 days. Doxycycline is preferred because it has a broader spectrum of cover than amoxicillin, particularly against *Mycoplasma pneumoniae* and *Staphylococcus aureus*, which are more likely to be secondary bacterial causes of pneumonia during the COVID-19 pandemic. (Issue a digital Rx where possible where not TTO packs are within the centre for 7 days as that's how they are supplied – please adv. a 5-day course is the recommended)

Patients who are significantly frail (CFS >7) are likely to need to be assessed at home rather than in the assessment centres. This is not a formal cut off but suggested consideration as part of the clinical decision making process. During telephone triage is likely you will gather the information needed to make this call. https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf.(Appendix 2)

While clinicians will require to use their clinical judgment in who should be seen face to face, the section below describes those who are unlikely to be suitable for self-care.

- Day 7+, not improving and co morbidity placing them in high risk group
- general worsening, particularly worsening exhaustion or breathlessness
- SOB at rest or causing significant impact on usual ability to perform activities of daily living
- Second or subsequent contacts after day 7
- New confusion, difficult to rouse, mottled, blue lips, little or no urine output
- Neck stiffness, non-blanching rashes.

Consider immediate ambulance transfer to hospital

- Significant SOB at rest – unable to complete sentences
- Day 7+ and rapid and significant deterioration over preceding hours
- Day 7+, no prior frailty, expressing significant doubt about ability to come to ARIC due to exhaustion/SOB
- Widespread non-blanching rash or other significant clinical concern regarding sepsis

REFERRAL TO THE FACE TO FACE RESPIRATORY ASSESSMENT CENTER

Those who cannot be safely advised and managed remotely and are not for immediate admission should be considered for face to face assessment.

Any proposed examination needs to be likely to advance the diagnosis and management plan.
At the ARIC it is very unlikely that the same clinician triaging the call will be seeing the patient in the red zone. The clinicians in the F2F centre are therefore very dependent on a well taken and clearly documented initial assessment. Have you asked questions to explore differential diagnosis? Further history taking at the F2F end should be limited where possible to questions needed to clarify there has been no further deterioration. This not only protects our workforce but reassures the patient that there is a seamless well communicated process.

Patients can be transported 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 surgical 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 their destination to minimise risk of exposure to others. https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2930/documents/1_covid-19-guidance-for-primary-care.pdf

There may be availability of access to volunteer patient transport via the Hub for those unable to be brought to the centre in any other way.

FACE TO FACE ASSESSMENT

Approximately 15% of patients present with the symptom triad of fever, cough, and dyspnoea, and 90% present with more than one symptom. Some patients may be minimally symptomatic or asymptomatic, while others may present with severe pneumonia or complications such as acute respiratory syndrome, septic shock, acute myocardial infarction, venous thromboembolism, or multi-organ failure. (https://bestpractice.bmj.com/topics/en-gb/3000201/diagnosis-recommendations)

Patients will arrive at the ARIC as directed by admin staff in the hub. Clinician assessment team will be advised of their arrival and given a number to phone. Please use this number to contact the patient:

Confirm the history in Adastra, and establish that there is no new deterioration since initial contact. When satisfied with this the patient should be advised again on the purpose and likely format of their examination and how to access the centres assessment area. Wheelchair can be provided if necessary.

If older than 3 years, and can tolerate it, the patient should be asked to wear a fluid-resistant (Type IIR) surgical face mask (FRSM) this is to minimise the dispersal of respiratory secretions and reduce both direct transmission risk and environmental contamination. A FRSM should not be worn by patients if there is potential for their clinical care to be compromised (for example, when receiving oxygen therapy via a mask). A FRSM can be worn until damp or uncomfortable. (https://www.gov.uk/government/publications/wuhan-novel-coronavirus-initial-investigation-of-possible-cases/investigation-and-initial-clinical-management-of-possible-cases-of-wuhan-novel-coronavirus-wn-cov-infection). Any individual visiting or attending an acute adult hospital (including mental health, maternity, neonatal and paediatrics) community hospitals, primary care premises (GP practices, dentists, opticians & pharmacies) or an adult care home should wear a face mask/covering of the same kind the Scottish Government has recommended be worn on public transport. If a patient arrives already wearing an appropriate face cover, Infection Prevention Control advised it is better not to change their mask while in the Centre but to leave their existing mask intact.

The clinician who will be entering the red zone should now don PPE. (See link to video in PPE section below) They should then enter the room with the patient. If not already performed by HCSW please check the patient's observations and examine the patient to the extent required. Minimize where possible the time spent in the room with the patient.

The default position is that BP, pulse, RR, oxygen saturation, conscious level should be taken and recorded in order to inform the wider assessment and provide context for changes over time.

Oxygen saturation measurement:
Reduced oxygen saturation has been one of the main physical markers for severity of covid 19.
We advise therefore that saturation should be taken immediately on arrival this would usually have involved a degree of physical exercise –walking from the car to the assessment room. If initial reading was taken at rest and >96% the patient should also be asked undertake the 1 min sit to stand test while their oxygen saturations are checked. This process should also be undertaken if O2 saturations are seen to fluctuate at rest.

Suggested narrative:
"I am going to ask you to perform a brief exercise test to make your heart beat faster and to look at your oxygen levels. It only lasts 1 minute and it's important that you try your hardest will however stop the test if you are struggling want you to stand up and sit down as quickly as you can without using your hands to push yourself up off the chair. I'm going to give you a count down and will let you know when you are half way. "

Sitting upright on a 90-degree chair, the patient is then timed for 1 minute. An oxygen saturation probe remains attached for the duration of the test.

The test is stopped if the patient is unable to tolerate it, or the saturations drop below 92% or by 3% from starting point (pre-existing hypoxic lung disease).

Regarding sats levels: Consider admission in the following circumstances:

- O2 Saturations < 92% (or <88% in known COPD)
- "Swinging" saturations during monitoring (normal saturations but dip periodically on exercise testing)
- 3% drop in sats during the sit stand test.
- Saturations borderline, passes exercise test but raised respiratory rate at rest (>25)
- Saturations borderline but sudden symptomatic deterioration over preceding hours

If saturation drops by 3 or more percent but remains above admission levels the patient should be advised that it is likely COVID is affecting their lung capacity on exercising, however this is not sufficient to require them to be

admitted at this stage. If appropriate, the clinician may want to suggest enrolling in the remote oxygen self-monitoring pilot as below.

Nursing staff /HCSWs are generally available to help with patient observations and initiate any treatment required.

Centre for evidenced based medicine wrote in April **"***Enthusiasm for NEWS2 in the primary care management of COVID-19 may be premature. If used at all, this score should be used alongside a wider clinical assessment of the patient and in the context of changes over time.***"** that currently there is no research on the value of NEWS score for COVID-19 outside hospital. It does not include age or comorbidities, which are known to be strong independent predictors of survival in COVID-19. https://www.cebm.net/covid-19/should-we-use-the-news-or-news2-score-when-assessing-patients-with-possible-covid-19-in-primary-care/ However until a better alternative, clinicians may find this a useful tool in the assessment and monitoring of their patients

Chest examination;
BMJ best practice suggests that where possible **a**void use of a stethoscope due to risk of viral contamination. However, when Auscultation of the chest is indicated it may reveal inspiratory crackles, rales, and/or bronchial breathing in patients with pneumonia or respiratory distress. Chest examination is often normal even in severe COVID; it should only be undertaken if it helps in distinguishing other suspected pathology.

Patients with respiratory distress may have other observable signs of respiratory distress: tachycardia, tachypnoea, or cyanosis accompanying hypoxia. Bradycardia has been noted in a small cohort of patients with mild to moderate disease. Respiratory rate is the most useful and admission should be considered when > 22 /min.

ENT examination:
Given the necessity to remove a patient's mask to conduct ENT examination, it should only be undertaken if it will make a significant change to patient management i.e. exclude local pharyngeal pathology. (For PCR throat and nasal swab see "swabbing")

Throat or nose examination should only be undertaken if it will change management significantly. Ear examination is low risk and may be needed, especially in children with pyrexia.

Full PPE including eye protection should be worn. Throat examination is not considered an Aerosol Generating Procedure so a FFP3 mask is not needed. However, it is important to avoid making the patient cough so when examining the throat, I would advise against using a tongue depressor when possible. If a quinsy is present the patient will usually have trismus and a deviation of the uvula, and this can be diagnosed without using a tongue depressor.

Patients should be asked to avoid talking or coughing during the examination.
Examining the throat should present no more risk to the healthcare worker than taking a COVID 19 swab.

The patient needs to be advised of the outcome of your assessment, likely diagnosis and agree a treatment and monitoring plan /safety net advice before withdrawing from the room. It is good practice to confirm understanding using *talk back* or similar tools.

On leaving the red zone PPE should be removed according to the recommended order (check video) and retire to a clean room to complete the patient's record.

ISSUING MEDICATION

For Medication available within the ARIC refer to Appendix 3.

All medications commonly required are stocked in the ARIC and should be dispensed as required. Due to current uncertainties regarding stock of individual treatment packs (TTO packs). **If a medication is to be advised it is currently preferable that a prescription is issued.** Please do the prescription in Adastra, make a free text note in the case notes asking the hub to issue, and forward to "Advice" as unfortunately "Prescription Request" is not currently available in the ARIC Adastra screens. Please also note which pharmacy you have agreed with the patient that a friend/relative from outside their household will collect the prescription from. Local voluntary services may be available to help. NO paper prescriptions will be issued.

If this is not possible medication can be dispensed from TTO packs maintained at the centres. In this situation a RX should still be generated and signed. Medication can be dispensed by a variety of the MDT members.

SWABBING FOR SURVEILLANCE:

- CMO letter issued on 7 October www.sehd.scot.nhs.uk/cmo/CMO(2020)26.pdf which supports the continuation of the surveillance programme to May 2021.
- An updated protocol (version 8) https://hpspubsrepo.blob.core.windows.net/hps-website/nss/3018/documents/1_covid-19-esocis-community-programme-protocol.pdf was published on Friday 9 October. Data will now be collected through the newly developed digital form.

Of note:

- "The Scottish Government has asked that NHS Boards test all patients attending ARIC, GP red pathways or receiving home visits for face-to-face assessment of COVID-19 symptoms. These should be 'diagnostic' tests for SARS-CoV-2 infection, processed in local NHS Board labs with results quickly returned to patients and clinicians for the purposes of informing care and self-isolation decisions."

And:

- To facilitate ongoing community surveillance, PHS asks that patients or supporting staff in NHS Boards complete an online enhanced surveillance form (ESF) for all patients receiving a diagnostic test, either via a home visit, in a ARIC /GP red pathway or uk.gov testing site. "
- Priority for completion enhanced surveillance forms should be given to those patients that are **within 5 days from onset of symptoms**. Therefore, it is very important to complete both date of sample collected and date of onset of symptoms.
- A form is requested for patients of all ages being swabbed including those under 5 years old.
- As centres will be testing all patients that attend, as clinically appropriate, 7 days a week, as well as out of hours and home visits.

From national data self-swab appears to be as reliable as physician swabbing.
Where possible swabs should therefore be performed by the patient / or in children by the parent with appropriate advice. Videos on how to self-swab are readily available.
Consideration must be given in cases where self-swabbing will not be appropriate include those with physical conditions that will impact on their dexterity – i.e. rheumatoid arthritis.

HOME VISIT

All home visits should be appropriately triaged as per SIGN telephone triage Appendix 1. Please also see Appendix 4 Home visiting.

If carrying out a home visit, follow infection prevention and control advice as appropriate to the task. Where possible, 2m physical distancing should be maintained. For further guidance on PPE procedures and home visiting see Appendix 4. This should be disposed of by the patient in accordance with guidance on NHS Inform. If the visit is in a nursing or residential home, please also consult HPS COVID-19 - information and guidance for care home settings. For more information regarding providing care to people in their home please consult COVID19 - guidance

for domiciliary care. (https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2930/documents/1_covid-19-guidance-for-primary-care.pdf)

Visiting patients who are on CPAP or BiPAP at home.

Consider phone/digital consultations in the first instance to assess whether the patient requires a home visit.
If a home visit cannot be avoided find out what time the patient is on CPAP/BiPAP and plan visit for at least an hour or more after the CPAP or BiPAP has been switched off.
Ask the patient to move to another room in the property and close the door to the room where the CPAP or BiPAP is undertaken.

If the visit must take place when the patient is on the CPAP/BiPAP or if the above measures cannot be followed, the practitioner must wear AGP PPE in line with table 2: performing an AGP.

If the practitioner is not fit tested for an FFP mask, the patient will require admission to hospital for assessment.
Alert the ambulance that the patient is a suspected/confirmed COVID-19 requiring CPAP/BiPAP.

Deciding about hospital admission

(https://www.nice.org.uk/guidance/ng165/chapter/4-Managing-suspected-or-confirmed-pneumonia)

Be aware that older people, or those with comorbidities, frailty, impaired immunity or a reduced ability to cough and clear secretions, are more likely to develop severe pneumonia. Because this can lead to respiratory failure and death, hospital admission would have been the usual recommendation for these people before the COVID-19 pandemic.

When making decisions about hospital admission, take into account:

- the severity of the pneumonia, including symptoms and signs of more severe illness
- the benefits, risks and disadvantages of hospital admission
- the care that can be offered in hospital compared with at home
- the patient's wishes and care plans
- Service delivery issues and local NHS resources during the COVID-19 pandemic.
- Explain that the benefits of hospital admission include improved diagnostic tests (chest X-ray, microbiological tests and blood tests) and respiratory support
- the risks and disadvantages of hospital admission may include spreading or catching COVID-19 and loss of contact with families

Given that any patient being admitted is likely to be hypoxic, they should in most circumstances be transferred to hospital by ambulance.
Ensure regular monitoring is performed, HCSW can usually do this as long as they are given clear instructions from the assessing clinician when medical escalation must be made. “if oxygen sats drop, respiration or pule rate increase, BP falls or consciously level changes, - escalate immediately to clinician “
Ensure Oxygenation is maximised while awaiting.
Patient Transport is not available for the transfer of patients between ARICs and hospital

ONGOING MONITORING AND SELF-CARE ADVICE

For those not requiring immediate admission.

Remote Oxygen Self-monitoring
In January NHSL agreed to pilot the provision of oximeters for home monitor of covid in patients who have been seen in ARIC and meet the inclusion criteria. Clinicians wishing to take part in this pilot must attend a training session initially. Please contact Jane McDonald or Pamela Buddy.

WHO recently supportive of this approach stating *"Potential benefits outweigh potential harms especially if patients are symptomatic and at risk of severe disease but only as part of a larger package of care including patient and practitioner education and Follow up "*

Patient positioning for optimal oxygenation
Evidence in relation to improved oxygen saturation in seated position was accepted by The Clinical reference group and adoption of this where possible within the ARIC while patients await ambulance transfer is to be encouraged.

Safety Netting.
WHO states Patients with risk factors for severe illness should be monitored closely, should be advised of the possible risk of deterioration. If they and their care givers notice that they develop any worsening symptoms (such as light headedness, difficulty breathing, chest pain, dehydration, etc.), they should seek urgent care through the established COVID-19 care pathway.
Caregivers of children with mild COVID-19 should monitor for signs and symptoms of clinical deterioration requiring urgent re-evaluation. These include difficulty breathing/fast or shallow breathing (for infants: grunting, inability to breastfeed), blue lips or face, chest pain or pressure, new confusion, inability to awaken/not interacting when awake, inability to drink or keep down any liquids.
An aid memoire will be developed for use in the ARIC and distributed to all staff and available in the service to give and email to patients.

Health Protection Team
Clinicians are reminded that the Health Protection Team (Public Health) must be contacted if a positive result from a patient in Care home, Prison, School, etc. to allow public health to identify any potential clusters. If you come across such cases please, if possible, check this has been done by the manager of the unit /service concerned.

PAEDIATRICS CASES.

Remote initial assessment: Tables of Amber and Red flag symptoms for remote assessment (based on NICE guidance on fever in under 5s) are available here – (and reproduced at appendix 5&6)

- <1yr -https://what0-18.nhs.uk/application/files/8915/8685/4572/CS50218_NHS_Cough_in_child_under_1_year_pathway_for_remote_assessment_Oct_19_v4.pdf
- >1yr - https://what0-18.nhs.uk/application/files/7615/8685/4607/CS50218_NHS_Cough_in_child_over_1_year_pathway_for_remote_assessment_Oct_19_v4.pdf

RCPCH guidance on assessment of children with bronchiolitis and other lower respiratory tract infections during Covid 19 is available below. They advise that "*The potential COVID-19 status of an infant or child should not affect the initial assessment and management of the infant or child when they present to a healthcare setting. Key features of assessment are oxygenation, hydration and nutrition."*
- https://www.rcpch.ac.uk/resources/national-guidance-management-children-bronchiolitis-during-covid-19.

Risk factors for severe respiratory disease in children include:

- Pre-existing lung condition
- Immunocompromised
- Congenital Heart Disease
- Age <6 weeks (corrected)
- Re-attendance

- Pre maturity <35 weeks
- Neuromuscular weakness

Don't forget to consider undiagnosed Urinary tract infection as cause of fever in children.

Note that **prolonged fever** (>= 5 days) may indicate **paediatric multisystem inflammatory syndrome associated with coronavirus (**PIMS-TS, or MIS-C), respiratory symptoms are often absent. Non-white ethnicities appear to be particularly at risk.

In children, there are no reliable clinical signs that help predict bacterial pneumonia, other than severity of illness (increased work of breathing, tachypnoea, persistent fever). Amoxicillin is the first line choice of antibiotic; erythromycin/clarithromycin are suitable alternatives [SIGN/BTS guidance from pre-COVID era].

Sats <=95% is an amber flag in NICE fever guideline.
Sats <=94% is referral to hospital prompt in SIGN bronchiolitis guideline.

Normal paediatric values:

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

Throat examination in children - even if tonsillitis suspected, do not examine the throat unless absolutely necessary. If using a scoring system (e.g. FeverPAIN) to decide on whether to give antibiotics for tonsillitis, a pragmatic approach is to just start with score of 2, not examine the throat and accept a slight increase in antibiotic prescribing.

FeverPAIN: -

- Fever in past 24hrs
- Absence of cough/coryza
- Symptoms <=3 days
- Purulent tonsils
- Severe tonsil inflammation

3 points (40-50% risk of streptococcal infection), consider delayed antibiotics. Above 3 points, immediate antibiotic prescribing is justified.

Note that antibiotics rarely confer a benefit in children under 3 years with tonsillitis and so this scoring system should not be used - only prescribed antibiotics to young children under 3 years in exceptional circumstances or if a diagnosis of scarlet fever is strongly considered.

If it is considered essential to examine the throat, it can be done safely: use droplet PPE (apron, gloves, mask, visor/goggles). Do it after doing nose/throat swab for COVID-19. It is inappropriate to refer to secondary care simply for tonsillar examination.– https://www.rcpch.ac.uk/resources/covid-19-guidance-paediatric-services]
Self-care advice and safety netting in children

You may consider the following useful links for sharing with families and to base your advice
https://what0-18.nhs.uk/application/files/4115/9109/6760/NHS_Bronchiolitis_Advice_Sheet.pdf

PREGNANCY

"Pregnant or recently pregnant women seem to be less likely to be symptomatic or exhibit the common symptoms of fever and shortness of breath than non-pregnant women. Pregnant or recently pregnant women are at a higher risk of ICU admission, especially if they have underlying risk factors, such as obesity, diabetes, hypertension or BAME. Spontaneous preterm birth rates are higher in pregnant women infected with Covid-19 compared with non-infected pregnant women and so women who experience worrying obstetric symptoms such as premature contractions, rupture of membranes, antepartum haemorrhage or reduced foetal movements, should seek attention promptly".

---

3. PATIENT PATHWAY

From the patient's point of view, an initial screening of patients is usually carried out by NHS 24; currently a majority of patients calling do require further clinical assessment. The patient will then be called by a GP or other HCP from the hub.

Some patients will have presented to their GP. Should a GP working in practice triage a patient, and in the course of that call, determine that the patient meets the above criteria and makes a judgment that the patient needs to be seen, they can directly book a F2f appointment by calling the Airdrie Hub – 01698 753349*. It was our aspiration that the service has defined and agreed inclusion criteria. In particular, the symptoms should be acute, and not chronic.* The Clinical Reference Group has debated extensively around developing guidance for potential dual diagnosis situations, and for those that do not follow specific timelines. The consensus is that definition of "clear alternative source of infection" in reality can be quite difficult. Balancing the need to protect General Practice, Emergency Departments, our own staff and other patients from potential COVID exposure needs weighed against our ability to deliver this operationally and not overwhelming this one particular aspect of the service. High degree of professionalism is therefore called upon and individual clinical judgements

All patients not via the direct GP to hub route will require a **remote clinical assessment,** and a decision made as to whether a face to face assessment is required. If not, they will be given management, monitoring and self-care advice. If a prescription is required, this should be faxed/emailed from the hub to a local pharmacy, the hardcopy posted to the pharmacy, and the medication collected by someone who is **not** a member of the patient's household (as the whole household should be self-isolating).

If further assessment is required and the patient is able to travel they should be seen in the ARIC, utilising patient transport if necessary. They can only be brought by car by a member of their own household. Consideration (and documentation of this assessment of transport) of the circumstances where a patient may be being unwell enough to require to be seen, they will not be well enough to safely drive themselves.

If a HCP thinks that further assessment is required and patient is, according to the assessment above, housebound, there are further considerations; (see Home Visit above)

4. SAFETY

SIGNIFICANT MEASURES HAVE BEEN TAKEN TO ENSURE THE SAFETY OF ALL STAFF WORKING IN THE SERVICE.

RESPONSIBILITIES REGARDING WELLNESS

All face to face staff are offered LF testing facilities. Please speak to Service manager Pamela Buddy or Jane MacDonald if you wish this.

If you develop a positive LFT or any possible COVID symptoms, specifically new onset cough, breathlessness or pyrexia, **do not come to work.** We appreciate as much notice as possible in these circumstances, but little notice may be possible and it is understood in the current environment that staff absence rates are likely to be significantly higher than usual. Please do not put colleagues and patients at risk by coming to work if you are unwell. Please phone the hub on 01698 753 349 before midnight, and 0300 303 0109 for OOH Hub between midnight and 8am and let admin staff know you won't be able to work. Isolate and arrange a test and feedback to the unit. Further action may be necessary if you have been in the unit in the preceding 48 hours Please advise as soon as possible if this is the case. Arrange a PCR test via SALUS portal.

COVID HUB

In the hub, all computers have been set up with Adastra. It is likely that only a few clinicians will be working there at any time, so you are asked to take advantage of the space and ensure that you appropriately socially distance at all times. Wear face coverings Fluid resistant surgical masks when within the building.
Please use hand sanitiser provided on arrival and departure, and please use the Green Clinell Disinfectant Wipes to clean your work area, including phone, keyboard, and mouse both before and after use.

ACUTE RESPIRATORY ILLNESS CENTRE'S

Staff break facilities are available, observe appropriate social distancing. Site staff will clean the Red area in use after each patient but if you are using a computer in a Green area, please ensure each area is sanitised before and after use as above.

CLOTHING

If working in the red zone, please wear comfortable clothing that can be washed at 60 C.

PPE

Staff who have not working in the ARICs before are asked to watch this video before their first shift which gives advice on the correct doffing and donning procedure.

NHSL policy in relation to PPE. Recent decision from Gold strategic command states that "given supply of PPE is now more secure we should be adopting consistent PPE in line with National policy. All should be wearing the same PPE that which is provided nationally. "At the time of writing this is the same PPE used in secondary care in the same circumstances and consists of;

- Fluid Resistant Surgical Facemask
- Nitrile Gloves (single gloves only)
- Plastic Apron

- Eye protection – single use glasses are available. Visors suitable for sessional use can also be supplied

In general, Aerosol Generating Procedures (as defined by HPS) will not be undertaken within the ARICs. Contrary to HPS primary care guidance https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2930/documents/1_covid-19-guidance-for-primary-care.pdf, NHS Lanarkshire has decided that CPR is a potential AGP in keeping with Resus Council guidance. FFP3 masks, full length gowns and visors are available on the Resus Trolley and should be donned before CPR is commenced. Face-fit testing for FFP3 masks will be arranged for all clinicians working in the ARIC and supplied for this circumstance only. However, see appendix 7 for the full current NHSL guidance.

We are aware of the anxiety and debates regarding levels of PPE. A number of national professional groups continue to review the evidence and so will the Clinical Reference Group of the ARICs should new reports be issued.

5. Clinical Computer Systems

Adastra

Adastra is used to record all clinical consultations. Three short videos have been made to illustrate who to use Adastra.

- Handling a triage case in the Hub
- Handling a triage case when working remotely
- Handling a face to face assessment in the ARIC

For clinicians how prefer to have a guide next to them while they work, we have prepared a guide in PowerPoint format which you can either view on screen or print.
As the setup of Adastra for the Covid service has been rapid, there are currently some user interface quirks which are not intuitive:

- When selecting a patient, please use the ECD (Enter Case Details) screen from left menu-bar, not the Covid Triage/Covid Assessment Screens
- When forwarding a patient from triage to be seen in the Acute Respiratory Illness Centre, please
    - Use the Forward button and select Covid Assessment
    - Close the Case Screen using the X in the top right corner, directly above consultation finish time
    - Right click on the patient in the ECD screen and select Pass to Dispatch

If you need to do a prescription in the ARIC, please do the prescription in Adastra, make a free text note in the case notes asking the hub to issue, and forward to “Advice” as unfortunately “Prescription Request” is not currently available in the ARIC Adastra screens.

Clinical Portal

Clinical Portal Access can be arranged for all staff working within the service. As well as allowing access to previous Investigations and communications between primary and secondary care, the GP Summary tab allows access to high priority Read Codes from Vision/EMIS.

STAFF SAFETY BRIEF is held twice a day at 08:00 and 18:00 if you are on shift at this time please try to attend for important information relevant to your shift. After the live briefing the information should be accessible on the Microsoft teams link shortly afterwards and you are again encouraged to access. If you need advice on this, please speak to the senior ANP on shift.

6. WORKING IN THE ACUTE RESPIRATORY ILLNESS CENTRE'S (ARICS)

The Covid telephone Hub is located on the second floor of Airdrie Community Health Centre. Nearby parking is available in the Hallcraig Street, multi-storey car park. In the Out of Hours period, you can also park in the Health Centre car park on the Gartlea Road side of the building.
Please enter via the Gartlea entrance and go to the second floor. In the out of hours' period, please press 9 on the buzzer at the side door and you will be admitted by the hub. Once on the second floor you can enter via Tinto Medical Practice. Go to the end of the corridor and turn left. The hub is on your left half way along the corridor you have just turned into. Please make yourself know to the hub admin staff on arrival. If you have not been before and not known to the service, you will be asked to show **photographic ID**

Your responsibilities when working in the hub are:

- To take patient calls which have been passed to the hub by NHS 24, to clinically assess and arrange ongoing management as described elsewhere in this guide
- To take calls from other professionals (including paramedics from SAS, community nursing and pharmacists) who need advice in relation to specific patients.
- Arrange further assessment if appropriate in either the face to face unit(s) or via domically assessment.
- To review, print and sign prescriptions generated by clinicians working remotely in the ARICs or undertaking remote triage. If you have a concern about the safety of any prescription, please discuss it with the clinician concerned and if you remain concerned, with one of the clinical leads.
- To provide clinical advice to the hub admin staff when requested.

Prescriptions are faxed or emailed depending on pharmacy preference by Hub admin staff. Please make a note on the prescription of where it should be sent but also within the treatment field in Adastra for future reference.

Seeing patients in the ARIC or on a home visit involves a use of a (sometimes pressurised) resource. There should therefore be a clear benefit, in terms of an expected change in the management of the patient which can be gained from this. Sometimes precise diagnosis is not clear over the telephone, but both options have the same clinical management outcome. In most of these cases, there is little to be gained from face to face assessment, so please think carefully about this particularly around (resource intensive) home visits.

We try to staff the service to be able to manage expected demand. While you should prioritise each patient appropriately if their clinical need demands it, please help us to do this by selecting default (4 hour) timescales for visits and ARICs attendance where possible. There should be a clear reason for more urgent attendance, particularly around home visits. Given the geography of Lanarkshire, urgent visits can sometimes necessitate an immediate lengthy journey and impact on the care that can be provided to other patients.

The admin staff in the hub are a useful resource with regards to any issues you may have with Adastra. However, it is easy for questions about process to essentially become clinical questions, so if peers in the hub are unable to help you, please phone the shift Lead for advice.

7. WORKING IN THE CLINICAL ASSESSMENT CENTER'S

Please make yourself known to the shift lead on arrival. If you are new to the service, you will be asked to show photo ID. You will be shown the changing and rest facilities that are available, familiarized with your clinical space and where the resuscitation equipment. Oxygen supplies and onsite medication stocks are.

You should be made aware who is working alongside you by name and role. As part of the MDT there will be colleagues from a spread of professions, experience and confidence. Understanding the skill base of each team on session will be essential.

Your principal role in the ARIC will be to see patients who are sent to the ARIC by triage colleagues in the hub. You may also be asked to visit patients at home. A driver, car and equipment will be provided.

All patients whose care is transferred to you will already have been triaged by a colleague. **Please do not re-triage calls unless you feel that the patient's immediate safety is at risk to the extent that they require immediate conveyance to hospital**. Any such instance must be discussed with the shift clinical lead immediately thereafter.

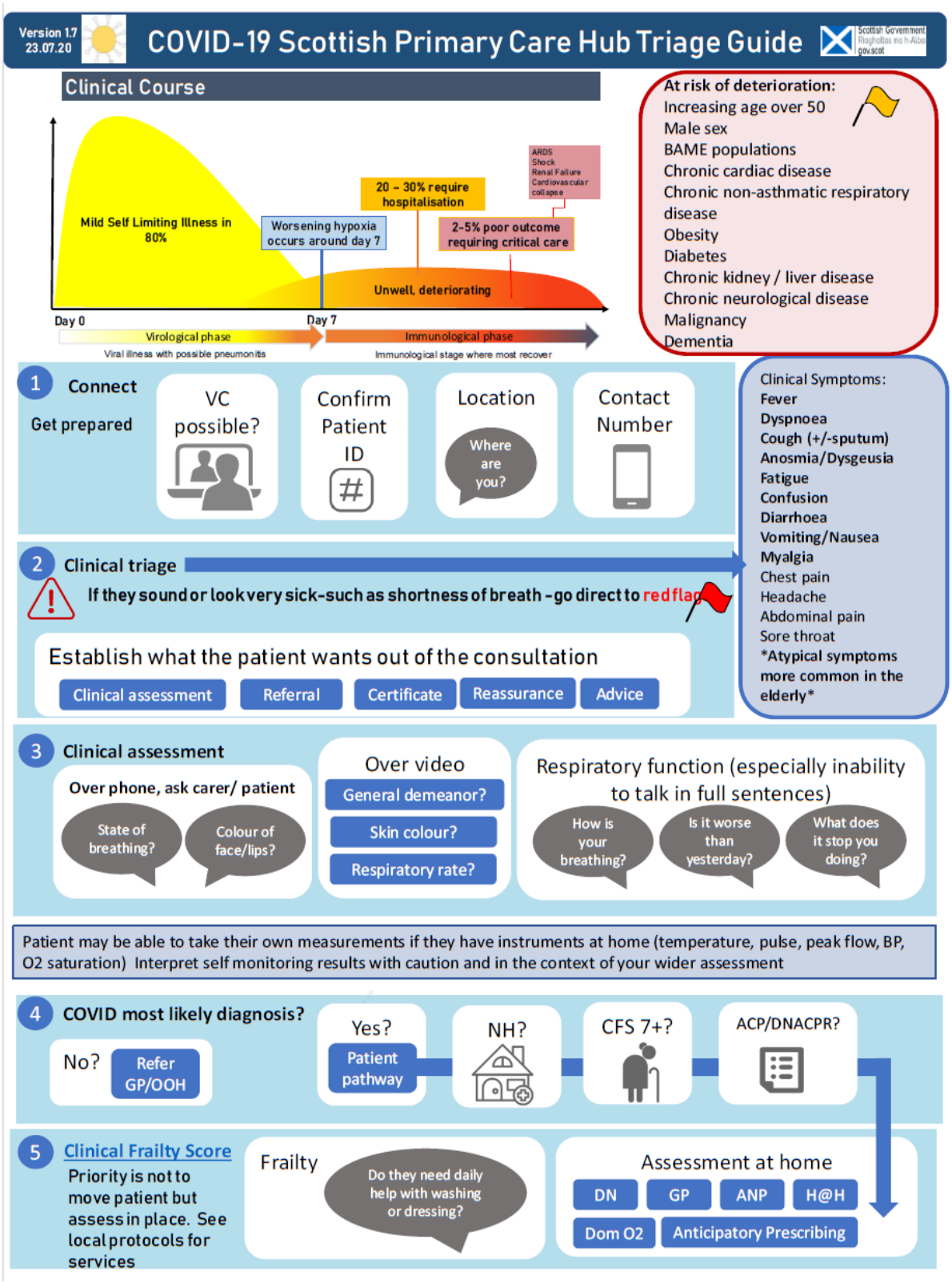
8. CPR

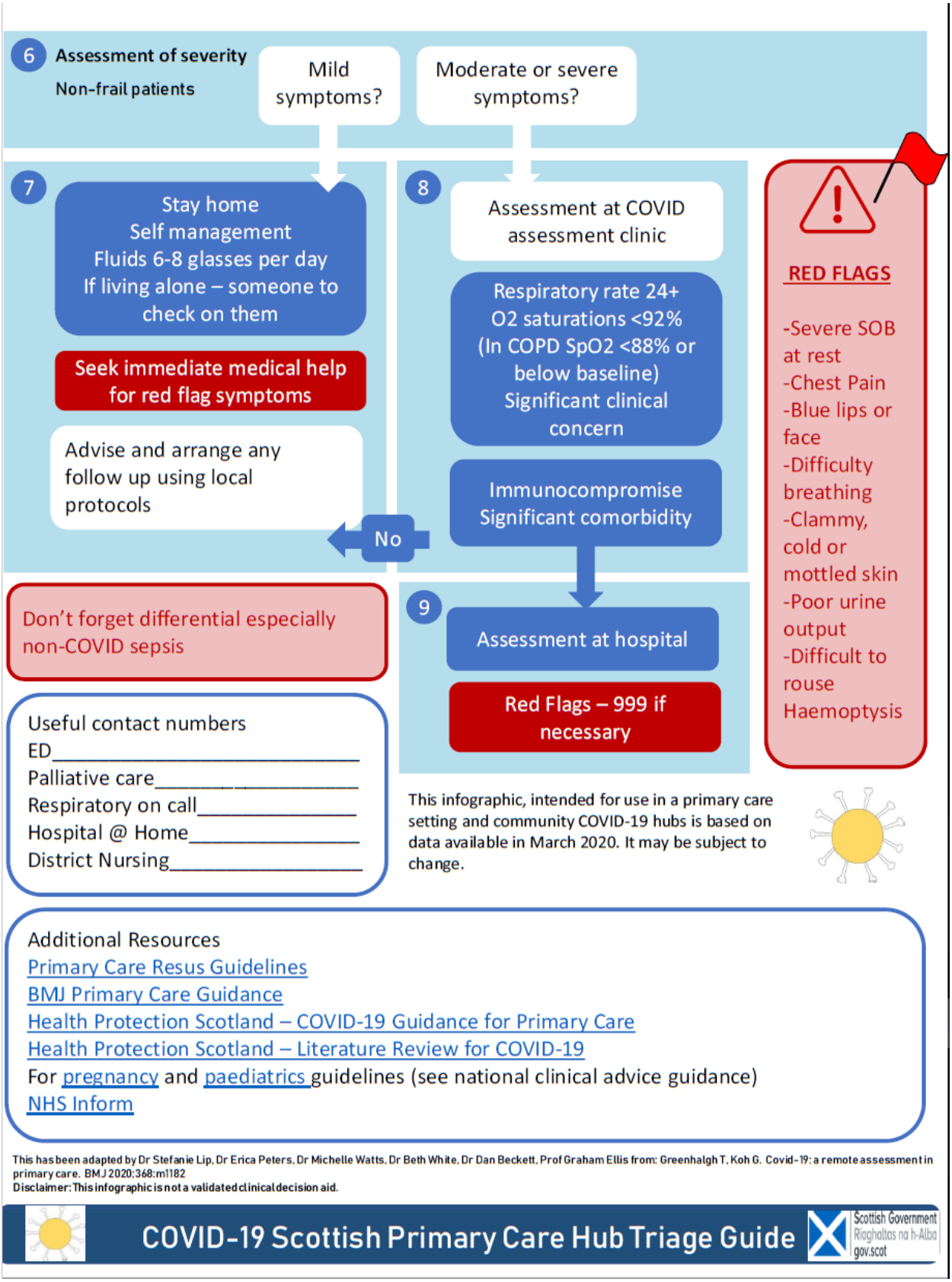
All GPs working within the Assessment centres will be offered the option to be Face fit tested on the understanding that this will enable the service to provide a CPR response in concordance with the UK Resuscitation guidance policy. FFP3 masks are only to be used for situations in accordance with HPS guidance. If you wish this and have not been offered, please contact Pamela Buddy.

Appendix 8 referencing NHSL CPR guidance.

9. APPENDICES

APPENDIX 1


Version 1.7
23.07.20
COVID-19 Scottish Primary Care Hub Triage Guide
Clinical Course
Mild Self Limiting Illness in 80%
Worsening hypoxia occurs around day 7
20 – 30% require hospitalisation
2-5% poor outcome requiring critical care
ARDS
Shock
Renal Failure
Cardiovascular collapse
Unwell, deteriorating
Day 0
Day 7
Virological phase
Viral illness with possible pneumonitis
Immunological phase
Immunological stage where most recover
At risk of deterioration:
Increasing age over 50
Male sex
BAME populations
Chronic cardiac disease
Chronic non-asthmatic respiratory disease
Obesity
Diabetes
Chronic kidney / liver disease
Chronic neurological disease
Malignancy
Dementia
1 Connect
Get prepared
VC possible?
Confirm Patient ID
Location
Where are you?
Contact Number
Clinical Symptoms:
Fever
Dyspnoea
Cough (+/-sputum)
Anosmia/Dysgeusia
Fatigue
Confusion
Diarrhoea
Vomiting/Nausea
Myalgia
Chest pain
Headache
Abdominal pain
Sore throat
Atypical symptoms more common in the elderly
2 Clinical triage
If they sound or look very sick-such as shortness of breath - go direct to red flag
Establish what the patient wants out of the consultation
Clinical assessment
Referral
Certificate
Reassurance
Advice
3 Clinical assessment
Over phone, ask carer/ patient
State of breathing?
Colour of face/lips?
Over video
General demeanor?
Skin colour?
Respiratory rate?
Respiratory function (especially inability to talk in full sentences)
How is your breathing?
Is it worse than yesterday?
What does it stop you doing?
Patient may be able to take their own measurements if they have instruments at home (temperature, pulse, peak flow, BP, O2 saturation) Interpret self monitoring results with caution and in the context of your wider assessment
4 COVID most likely diagnosis?
No?
Refer GP/OOH
Yes?
Patient pathway
NH?
CFS 7+?
ACP/DNACPR?
5 Clinical Frailty Score
Priority is not to move patient but assess in place. See local protocols for services
Frailty
Do they need daily help with washing or dressing?
Assessment at home
DN
GP
ANP
H@H
Dom O2
Anticipatory Prescribing


6 Assessment of severity
Non-frail patients
Mild symptoms?
Moderate or severe symptoms?
7
Stay home
Self management
Fluids 6-8 glasses per day
If living alone – someone to check on them
Seek immediate medical help for red flag symptoms
Advise and arrange any follow up using local protocols
No
8
Assessment at COVID assessment clinic
Respiratory rate 24+
O2 saturations <92%
(In COPD SpO2 <88% or below baseline)
Significant clinical concern
Immunocompromise
Significant comorbidity
9
Assessment at hospital
Red Flags – 999 if necessary
RED FLAGS
-Severe SOB at rest
-Chest Pain
-Blue lips or face
-Difficulty breathing
-Clammy, cold or mottled skin
-Poor urine output
-Difficult to rouse
Haemoptysis
Don't forget differential especially non-COVID sepsis
Useful contact numbers
ED_____
Palliative care_____
Respiratory on call_____
Hospital @ Home_____
District Nursing_____
This infographic, intended for use in a primary care setting and community COVID-19 hubs is based on data available in March 2020. It may be subject to change.
Additional Resources
Primary Care Resus Guidelines
BMJ Primary Care Guidance
Health Protection Scotland – COVID-19 Guidance for Primary Care
Health Protection Scotland – Literature Review for COVID-19
For pregnancy and paediatrics guidelines (see national clinical advice guidance)
NHS Inform
This has been adapted by Dr Stefanie Lip, Dr Erica Peters, Dr Michelle Watts, Dr Beth White, Dr Dan Beckett, Prof Graham Ellis from: Greenhalgh T, Koh G. Covid-19: a remote assessment in primary care. BMJ 2020;368:m1182
Disclaimer: This infographic is not a validated clinical decision aid.
COVID-19 Scottish Primary Care Hub Triage Guide
Scottish Government
Riaghaltas na h-Alba
gov.scot

APPENDIX 2

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY *Inspiring Minds*

APPENDIX 3

JAC

17-Feb-2021 Page 1 of 5

BLIST for HAIRMYRES HOSPITAL PHARMACY STORE

Selected Profiles **All Sections** **All groups**

compiled on 17-Feb-2021 at 10:07 by LEK **LEK1710736**

HM CAC DOUGLAS STREET

week commencing:

ORAL TABLETS/CAPSULES/POWDERS	1	2	3	4	5	6	7	8	9	10	11	12	13
CO-CODAMOL 8/500mg Tablets 100 Tablet Pack (max 1)													
CO-CODAMOL 30/500 mg Tablets 100 Tablet Pack (max 1)													
FUROSEMIDE 20 mg Tablets 28 Tablet Pack (max 1)													
GLUCOSE 3.7 g Tablets 20 Tablet Pack (max 1)													
LORAZEPAM (SCORED) 1 mg Tablets 28 Tablet Pack (max 1)													
METOCLOPRAMIDE 10 mg Tablets 28 Tablet Pack (max 1)													
PARACETAMOL 500 mg Tablets 100 Tablet Pack (max 1)													
PREDNISOLONE 5 mg Tablets 28 Tablet Pack (max 4)													
ORAL LIQUIDS	1	2	3	4	5	6	7	8	9	10	11	12	13
DEXAMETHASONE 2 mg in 5ml Sugar Free Oral Solution 150 mL Pack (max 1)													
GLUCOSE 15 g in 60ml Oral Solution 1 x 60ml Pack (max 2)													
GLUCOSE 40 % Oral Gel 3 x 25G Pack (max 1)													
IBUPROFEN 100 mg in 5ml Sugar-Free Suspension 100 mL Pack (max 1)													
INJECTIONS	1	2	3	4	5	6	7	8	9	10	11	12	13
ADRENALINE (EPINEPHRINE) 10ml 1 in 10,000 Ampoules 10 x 10mL Ampoule Pack													
ADRENALINE (EPINEPHRINE) 1ml 1 in 1000 Ampoules 10 x 1mL Ampoule Pack (max 1)													
ATROPINE SULFATE 600 micrograms in 1mL Injection 10 x 1mL Ampoule Pack (max 1)													
BENZYLPENICILLIN 600 mg Injection 25 x 600mg Vial Pack (max 1)													
CEFOTAXIME 1 g Vial d.u's of 1 x 1g Vial from 10 x 1g Vial Pack (max 1)													
CHLORPHENAMINE 10 mg in 1ml Injection 5 x 1mL Ampoule Pack (max 1)													
DIAZEPAM 10 mg in 2ml Injection 10 x 2mL Ampoule Pack (max 1)													
DICLOFENAC SODIUM 75 mg in 3mL Injection 10 x 3mL Ampoule Pack (max 1)													

Highlighted Drugs are not set in BIDWD as Advance Order Assembly Items

JAC

BLIST for HAIRMYRES HOSPITAL PHARMACY STORE

Selected Profiles **All Sections** **All groups**

compiled on **17-Feb-2021** at **10:07** by **LEK** **LEK1710736**

HM CAC DOUGLAS STREET

	1	2	3	4	5	6	7	8	9	10	11	12	13
INJECTIONS													
FUROSEMIDE 50 mg in 5ml Ampoules 10 x 5mL Ampoule Pack													
GLUCAGON (RYS) 1 mg Injection 1 x 1mg Vial Pack (max 3)													
HYDROCORTISONE SODIUM SUCCINATE (WITH DILUENT) 100 mg Injection 1 x 100mg Vial Pack (max 3)													
HYOSCINE N-BUTYLBROMIDE 20 mg in 1ml Ampoules 10 x 1mL Ampoule Pack (max 1)													
LEVOMEPROMAZINE 25 mg in 1ml Ampoules 10 x 1mL Ampoule Pack (max 1)													
NALOXONE 400 micrograms in 1mL Injection 10 x 1mL Ampoule Pack (max 1)													
PROCHLORPERAZINE 12.5 mg in 1ml Injection 10 x 1mL Ampoule Pack (max 1)													
WATER FOR INJECTION (10ML) PLASTIC Ampoules 20 x 10mL Ampoule Pack (max 2)													
RESPIRATORY PRODUCTS	1	2	3	4	5	6	7	8	9	10	11	12	13
IPRATROPIUM BROMIDE 250 micrograms in 1mL Nebules 20 Nebule Pack (max 2)													
SALBUTAMOL 2.5 mg in 2.5ml Nebules 20 x 2.5mL Nebule Pack (max 6)													
SALBUTAMOL 5 mg in 2.5ml Nebules 20 x 2.5mL Nebule Pack (max 6)													
RECTAL AND VAGINAL PRODUCTS	1	2	3	4	5	6	7	8	9	10	11	12	13
DIAZEPAM RECTAL TUBE 5 mg Enema 5 Enema Pack (max 1)													
DIAZEPAM RECTAL TUBE 2.5 mg Enema 5 Enema Pack (max 1)													
PARACETAMOL 125 mg Suppositories 10 Suppository Pack (max 1)													
OTHER PRODUCTS	1	2	3	4	5	6	7	8	9	10	11	12	13
PREGNANCY TESTING KIT (ALERE HCG) 20 Unit Pack (max 1)													
SODIUM CHLORIDE (FKE1323) x 500ml 0.9 % Intravenous Infusion 20 x 500ml Pack (max 1)													
VOLUMATIC Spacer 1 Device Pack (max 20)													
VOLUMATIC PAEDIATRIC Spacer 1 Device Pack (max 20)													
WATER FOR IRRIGATION POURBOTTLE (UKF7114) x litre Irrigation 6 x 1 Litre Pack (max 1)													

Highlighted Drugs are not set in BIDWD as Advance Order Assembly Items

JAC

BLIST for HAIRMYRES HOSPITAL PHARMACY STORE

Selected Profiles **All Sections** **All groups**

compiled on **17-Feb-2021** at **10:07** by **LEK** **LEK1710736**

HM CAC DOUGLAS STREET

TTO	1	2	3	4	5	6	7	8	9	10	11	12	13
ACICLOVIR 800 mg Dispersible Tablets 35 Tablet TTO Pack (max 3)													
AMOXICILLIN 250 mg Capsules 21 Capsule TTO Pack (max 10)													
AMOXICILLIN 250 mg in 5ml Sugar-Free Syrup 100 mL TTO Pack													
AMOXICILLIN 125 mg in 5ml Sugar-Free Syrup 100 mL Tayside Pack (max 10)													
BENZYDAMINE 0.15% Oral Spray 30 mL TTO Pack (max 3)													
CEFALEXIN 500 mg Capsules 21 Capsule TTO Pack (max 6)													
CHLORPHENAMINE 4 mg Tablets 28 Tablet TTO Pack (max 4)													
CIPROFLOXACIN 500 mg Tablets 14 Tablet TTO Pack (max 3)													
CLARITHROMYCIN 125 mg in 5ml Suspension 70 mL TTO Pack (max 10)													
CO-AMOXICLAV 250mg + 62mg / 5mL Suspension 100 mL Tayside Pack (max 3)													
CO-AMOXICLAV 500/125mg Tablets 21 Tablet Tayside Pack (max 6)													
CO-CODAMOL 8/500mg Tablets 32 Tablet TTO Pack (max 10)													
CO-CODAMOL 30/500 mg Tablets 30 Tablet TTO Pack (max 3)													
ERYTHROMYCIN 250 mg Enteric Coated Tablets 28 Tablet Tayside Pack (max 3)													
FLUCLOXACILLIN 500 mg Capsules 28 Capsule TTO Pack (max 4)													
GLYCERYL TRINITRATE 400 micrograms per metered dose Spray 75 Dose TTO Pack (max 2)													
IBUPROFEN 400 mg Tablets 24 Tablet TTO Pack (max 10)													
IBUPROFEN 100 mg in 5ml Sugar-Free Suspension 100 mL TTO Pack (max 6)													
NITROFURANTOIN 100 mg Modified-Release Capsules 14 Capsule TTO Pack (min 5, max 10)													
NYSTATIN 100000 units in 1 ml Suspension 30 mL TTO Pack (max 2)													
OMEPRAZOLE 20 mg Capsules 7 Capsule TTO Pack (max 4)													

Highlighted Drugs are not set in BIDWD as Advance Order Assembly Items

JAC

BLIST for HAIRMYRES HOSPITAL PHARMACY STORE

Selected Profiles **All Sections** **All groups**

compiled on **17-Feb-2021** at **10:07** by **LEK** **LEK1710736**

HM CAC DOUGLAS STREET

TTO	1	2	3	4	5	6	7	8	9	10	11	12	13
PARACETAMOL 250 mg in 5ml Sugar-Free Suspension 100 mL TTO Pack (max 6)													
PARACETAMOL 120 mg in 5ml Sugar-Free Suspension 100 mL Tayside Pack (max 6)													
PHENOXYMETHYLPENICILLIN 250 mg Tablets 80 Tablet TTO Pack (max 10)													
PHENOXYMETHYLPENICILLIN 250 mg in 5ml Sugar Free Oral Solution 100 mL TTO Pack (max 10)													
PHENOXYMETHYLPENICILLIN 125 mg in 5ml Sugar Free Oral Solution 100 mL Tayside Pack (max 10)													
PROCHLORPERAZINE 5 mg Tablets 28 Tablet TTO Pack (max 10)													
TRIMETHOPRIM 200 mg Tablets 6 Tablet TTO Pack (min 5, max 10)													
14 Tablet Tayside Pack (max 6)													
TRIMETHOPRIM 50 mg in 5ml Suspension 100 mL TTO Pack (max 6)													

Miscellaneous	1	2	3	4	5	6	7	8	9	10	11	12	13
AMOXICILLIN 500 mg Capsules 21 Capsule CAC Pack (max 50)													
CLARITHROMYCIN 500 mg Tablets 14 Tablet TTO Pack (max 50)													
CO-CODAMOL 30/500 mg Tablets 30 Tablet TTO Pack (max 50)													
DOXYCYCLINE 100 mg Capsules 8 Capsule TTO Pack (max 50)													
LORAZEPAM 1 mg Tablets 10 Tablet TTO COVID Pack													
MORPHINE SULFATE 10 mg in 5ml Solution 100 mL TTO COVID Pack													
PARACETAMOL 500 mg Tablets 32 Tablet TTO Pack (max 50)													
PARACETAMOL 500 mg Soluble Tablets 24 Tablet TTO COVID Pack													
PREDNISOLONE 5 mg Tablets 40 Tablet TTO Pack (max 50)													
SALBUTAMOL 100 micrograms Inhaler CFC Free 200 Dose TTO Pack (max 50)													

Highlighted Drugs are not set in BIDWD as Advance Order Assembly Items

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APPENDIX 4

Home Visiting Processes in Relation to Covid 19 Pandemic

This short paper describes the process to be followed for home visiting patients during the Covid 19 pandemic in the Out of Hours Service or the Covid Community Assessment Centre. The guidance is based on HPS guidance for community care and follows the same processes as are followed by district nursing colleagues.

Clinicians are expected to follow this guidance, not only for the safety of the patient and visiting clinician, but also for the safety and reassurance of the drivers and following clinicians

Preparation

In addition to the usual equipment for Out of Hours visiting, ensure that the boot of the vehicle is adequately stocked with the following: -

Personal Protective Equipment (PPE)

- Roll of aprons
- Box of fluid resistant surgical face mask (FRSM) Type IIR
- Box of nitrile gloves
- Small stock of eye protection goggles or full face visors

NB – level 3 AGP PPE is required if visiting a patient who is using CPAP/BiPAP or within 1 hour of using CPAP/BiPAP

Clinical Equipment

- Stethoscope
- Thermometer with single use covers
- Oxygen saturation probe
- Otoscope with single use ear-pieces
- Sphygmomanometer

Additional clinical equipment may be taken from the red visiting bag as indicated by the clinical scenario

Cleaning and Waste Sundries

Clear waste bags
Alcohol based hand rub
Pack of 70% alcohol (red) wipes
2 boxes with lids, one of carrying equipment into house and one to receive clean equipment on cleaning after visit

While Travelling

In keeping with Scottish Government advice, the driver and the doctor should wear a face covering or mask while travelling together in the car and a window should be open for ventilation. The driver and clinician should sit diagonally opposite, i.e. driver front right and clinical rear left.

Arrival at Home Visit

On arrival at the patient's home, the clinician should bring the following equipment to the threshold of the patient's home: -

1. For managing the patient
    a. Box with clinical equipment as listed above
    b. Fluid resistant surgical face mask (FRSM) Type IIR to give to patient
2. For leaving at the threshold in preparation for doffing PPE and cleaning equipment
    a. 2 clear waste bags and 1 clinical waste bag
    b. Plastic bag or washable bag for outdoor wear.
    c. Pair of nitrile gloves

d. Hand sanitiser
e. Pack of 70% alcohol (red) wipes
f. Box for receiving clean equipment

House with porch or vestibule

- Remove outdoor wear if applicable and place in washable/plastic bag
- Apply alcohol based hand rub
- Don apron, face mask, face/eye protection (if applicable) and gloves in this order
- Approach patient and carry out clinical task

House without porch or vestibule

- At door entrance apply Alcohol Based Hand Rub (ABHR) then face mask and face/eye protection (if applicable)
- Enter house and immediately inside remove outdoor wear if applicable and place in washable/plastic bag
- Apply alcohol based hand rub
- Apply apron and gloves in this order and approach patient to carry out clinical assessment

NB - If visiting a patient who is using CPAP/BiPAP or within 1 hour of using CPAP/BiPAP, level 3 AGP PPE should be donned

Completion of Visit

When the clinical assessment has been carried out, the clinician should doff PPE and clean equipment before leaving the patient's home, keeping at least 2 metres away from the patient or family. This is necessary so that the clinician is clean before touching any door handles or door release buttons or lift buttons.

Doffing Personal Protective Equipment

PPE should be doffed in the following order: -

1. Gloves
2. Apron
3. Eye or face protection (if applicable)
4. Fluid resistant surgical face mask (FRSM) Type IIR

The doffed PPE should be placed in one of the clear waste bags and the clinician's hands should be cleaned with alcohol based hand rub.

Cleaning Equipment

Once PPE has been doffed and placed in the clear waste bag and the clinician's hands cleaned, the clinician should don the additional pair of nitrile gloves and should then clean each item of equipment with the 70% alcohol (red) wipes. The box which has been used to carry equipment into the home should also be cleaned. The cleaned equipment and box should be placed in the clean box which has been left at the threshold. Once all equipment has been cleaned, the wipes and gloves should be discarded in the first waste bag. The waste bag should be tied up and then placed in the second clinical waste bag which should in turn be tied up. The clinician's hands should again be cleaned with alcohol based hand rub.

Disposal of Waste

If visiting a patient with suspected or confirmed Covid-19, the double bagged waste will be left in the patient's home for 72 hours after which it can be disposed of in the household waste. The bag should be marked for storage for 72 hours and marked with the date and time, e.g. with adhesive labels. If visiting a patient with cognitive impairment, the waste should be left in a safe place in the patient's home and a note should be left in the carers' diary regarding disposal in house-hold waste after 72 hours.

If visiting a patient with no suspicion of Covid, the waste can be bagged and disposed of as normal.

In the event that it is not possible to leave waste in the home, this can be placed in a clinical waste bag and placed in car boot to be taken and disposed of in clinical waste stream on return to clinical environment.

Outdoor Wear

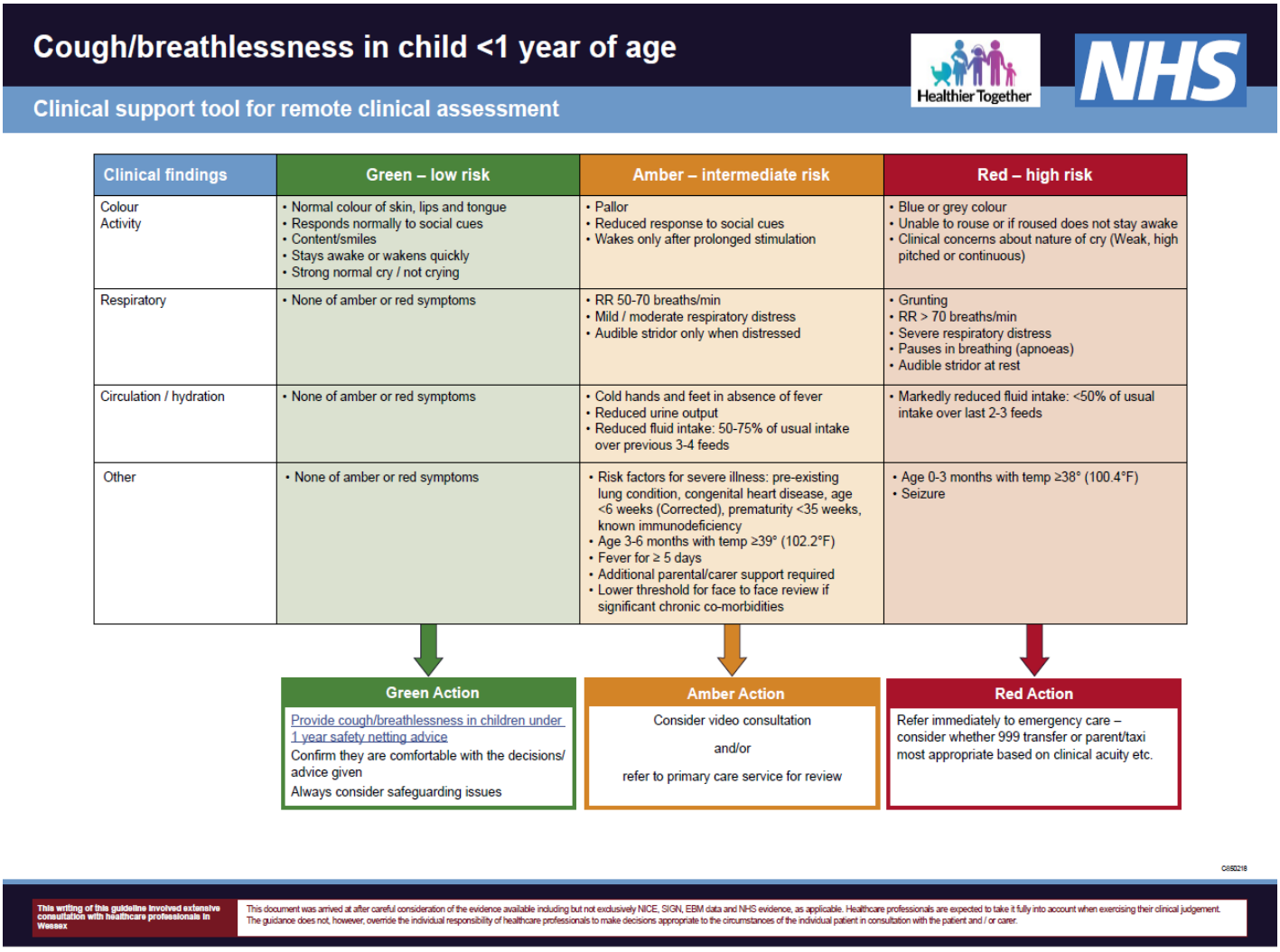
Once waste has been bagged and hand hygiene performed with alcohol based hand rub, outdoor wear can be put on at the threshold of the house and then alcohol based hand rub applied.

Clean Equipment

The clean equipment should be allowed to air dry in the clean box before closing the lid and returning to the boot of the car in readiness for the next visit

Dr Iain A Hathorn
Clinical Director in Primary Care
24th November 2020

APPENDIX 5



Cough/breathlessness in child <1 year of age

Clinical support tool for remote clinical assessment

Healthier Together

NHS

Clinical findings	Green – low risk	Amber – intermediate risk	Red – high risk
Colour Activity	• Normal colour of skin, lips and tongue • Responds normally to social cues • Content/smiles • Stays awake or wakens quickly • Strong normal cry / not crying	• Pallor • Reduced response to social cues • Wakes only after prolonged stimulation	• Blue or grey colour • Unable to rouse or if roused does not stay awake • Clinical concerns about nature of cry (Weak, high pitched or continuous)
Respiratory	• None of amber or red symptoms	• RR 50-70 breaths/min • Mild / moderate respiratory distress • Audible stridor only when distressed	• Grunting • RR > 70 breaths/min • Severe respiratory distress • Pauses in breathing (apnoeas) • Audible stridor at rest
Circulation / hydration	• None of amber or red symptoms	• Cold hands and feet in absence of fever • Reduced urine output • Reduced fluid intake: 50-75% of usual intake over previous 3-4 feeds	• Markedly reduced fluid intake: <50% of usual intake over last 2-3 feeds
Other	• None of amber or red symptoms	• Risk factors for severe illness: pre-existing lung condition, congenital heart disease, age <6 weeks (Corrected), prematurity <35 weeks, known immunodeficiency • Age 3-6 months with temp ≥39° (102.2°F) • Fever for ≥ 5 days • Additional parental/carer support required • Lower threshold for face to face review if significant chronic co-morbidities	• Age 0-3 months with temp ≥38° (100.4°F) • Seizure

Green Action

Provide cough/breathlessness in children under 1 year safety netting advice

Confirm they are comfortable with the decisions/ advice given

Always consider safeguarding issues

Amber Action

Consider video consultation

and/or

refer to primary care service for review

Red Action

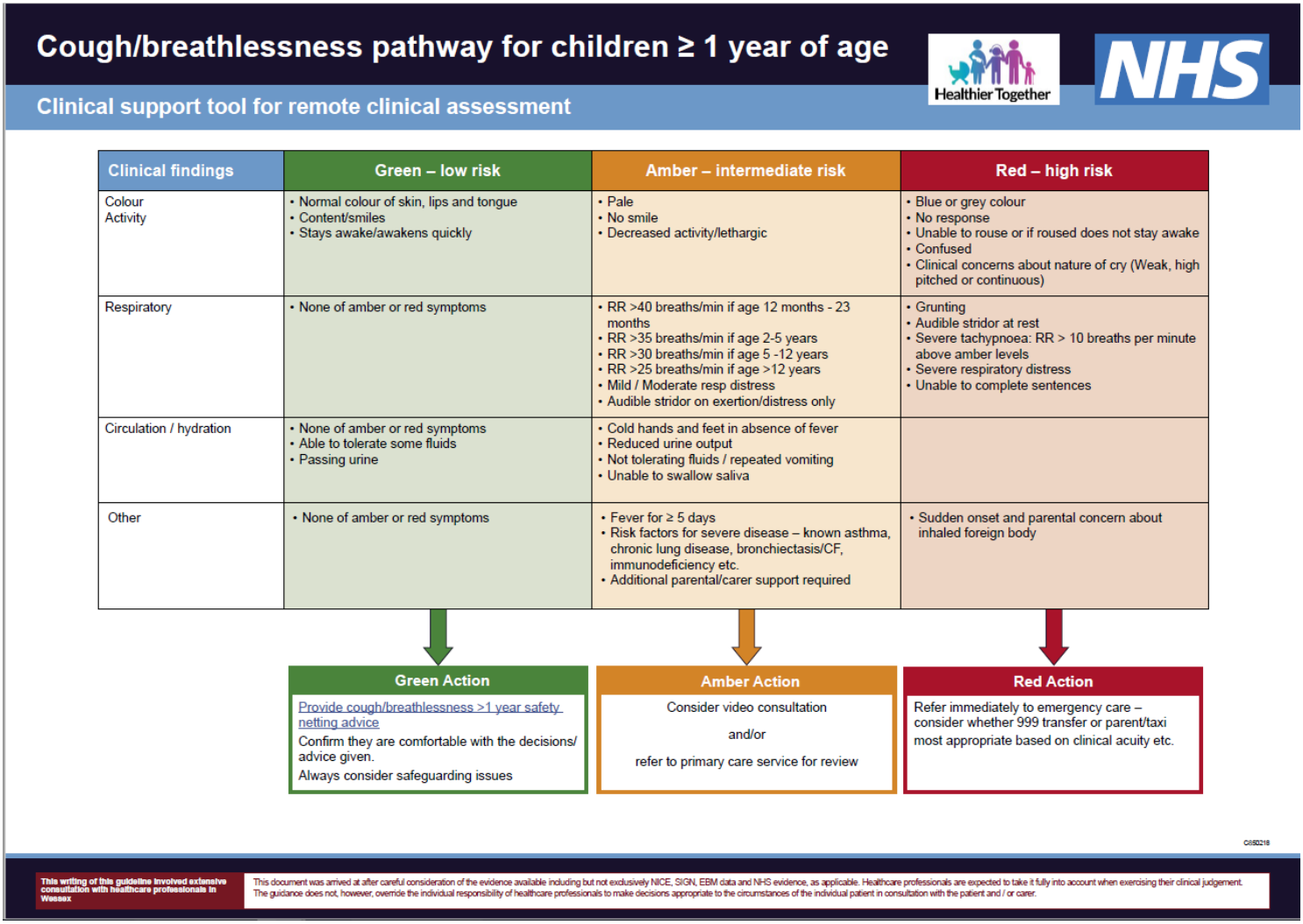
Refer immediately to emergency care – consider whether 999 transfer or parent/taxi most appropriate based on clinical acuity etc.

C652218

This writing of this guideline involved extensive consultation with healthcare professionals in Wessex

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.

APPENDIX 6



Cough/breathlessness pathway for children ≥ 1 year of age

Clinical support tool for remote clinical assessment

Healthier Together

NHS

Clinical findings	Green – low risk	Amber – intermediate risk	Red – high risk
Colour Activity	• Normal colour of skin, lips and tongue • Content/smiles • Stays awake/awakens quickly	• Pale • No smile • Decreased activity/lethargic	• Blue or grey colour • No response • Unable to rouse or if roused does not stay awake • Confused • Clinical concerns about nature of cry (Weak, high pitched or continuous)
Respiratory	• None of amber or red symptoms	• RR >40 breaths/min if age 12 months - 23 months • RR >35 breaths/min if age 2-5 years • RR >30 breaths/min if age 5 -12 years • RR >25 breaths/min if age >12 years • Mild / Moderate resp distress • Audible stridor on exertion/distress only	• Grunting • Audible stridor at rest • Severe tachypnoea: RR > 10 breaths per minute above amber levels • Severe respiratory distress • Unable to complete sentences
Circulation / hydration	• None of amber or red symptoms • Able to tolerate some fluids • Passing urine	• Cold hands and feet in absence of fever • Reduced urine output • Not tolerating fluids / repeated vomiting • Unable to swallow saliva	
Other	• None of amber or red symptoms	• Fever for ≥ 5 days • Risk factors for severe disease – known asthma, chronic lung disease, bronchiectasis/CF, immunodeficiency etc. • Additional parental/carer support required	• Sudden onset and parental concern about inhaled foreign body

Green Action

Provide cough/breathlessness >1 year safety netting advice

Confirm they are comfortable with the decisions/ advice given.

Always consider safeguarding issues

Amber Action

Consider video consultation

and/or

refer to primary care service for review

Red Action

Refer immediately to emergency care – consider whether 999 transfer or parent/taxi most appropriate based on clinical acuity etc.

C650218

This writing of this guideline involved extensive consultation with healthcare professionals in Wessex

This document was arrived at after careful consideration of the evidence available including but not exclusively NICE, SIGN, EBM data and NHS evidence, as applicable. Healthcare professionals are expected to take it fully into account when exercising their clinical judgement. The guidance does not, however, override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient in consultation with the patient and / or carer.

APPENDIX 7

Appendix 5 - 1_covid-19-guidanc

APPENDIX 8

Guidance for CPR in Lanarkshire

The issue of the treatment of Cardiac Arrest in the context of the Covid 19 Pandemic has been considered by the Bronze Clinical Reference group in April, re-examined in September in view of an updated statement from the UK Resuscitation Council and has also been discussed by the NHSL Resuscitation Committee.
The following is NHS Lanarkshire's guidance

Hospital Settings including MH/LD and Community Hospitals
For all patients who suffer a Cardiac Arrest, rapid defibrillation of a shockable rhythm is the most important intervention and should be initiated in all appropriate patients.

COVID -19 Positive or Suspected Patients
NHSL have recommended that staff follow the guidance on PPE issued by Resuscitation Council UK regarding the resuscitation of COVID-19 suspected or confirmed patients.

This states that Chest Compressions and all Airway interventions are Aerosol Generating Procedures (AGP) and hence Health Care Workers should not carry these out without the appropriate PPE which includes an FFP3 mask.

Patients not suspected of having COVID-19
Patients who have been risk assessed and are believed to be at low risk of having COVID-19 should receive full resuscitation in line with RCUK guidelines.

Nursing staff on in-patient wards should ensure that every patient's status is updated on a daily basis and in the event of a Cardiac Arrest the patient's status needs to be clearly communicated to the Resuscitation team.

Patients with unknown COVID-19 status
Patient who are of unknown status e.g. a patient attending a clinic or X-Ray should be treated as a possible case and full PPE must be worn before attempting any AGP.

Community Settings
Patients who suffer a Cardiac Arrest out of hospital are less likely to have immediate access to defibrillation and no CPR would reduce the likelihood of successful defibrillation. These patients are more likely to have unknown COVID 19 status.

In view of this, The Resuscitation Council UK recommends Chest Compression only CPR with the patient's face covered with a lint free cloth to reduce any aerosol in these settings where the COVID status is unknown. In some community healthcare settings there may be access to defibrillators and PPE which includes an FFP3 mask, where either of these are available should be utilised in patients with unknown or confirmed COVID positive status.

Patients who have been risk assessed as being of low risk of COVID 19 can have normal CPR as per guidelines.

Resuscitation in Children
Children who have Cardiac Arrest are very likely to have a respiratory cause of this. Without ventilation, the likelihood of survival is remote. Also the incidence of COVID 19 transmission from children is substantially less. For these reasons the Resuscitation Council recommends rescue breaths and ventilator support for children, acknowledging that there is a small risk to the rescuer of transmitting COVID 19.

10. CONTRIBUTORS

Table below highlights all professional who contributed to the creation this clinical pathway

Dr Sharon Russell	Associate Medical Director South HSCP
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Kelly Mackay	Respiratory Nurse
David Watson	Senior Nurse
Dr Kirk Russell	General Pracitioner and GP Sub Representative
Dr Lynn Duff	General Pracitioner and GP Sub Representative
Dr Lana O'Hara	Pediatrician
George Lindsay	Chief Pharmacist, Primary Care
Jacqueline Kelland	Medicine Management Pharmacist
Carol Lamb	Senior Advanced Nurse Pracitioner
Elaine Ferguson	Consultant Obstetrician and Gynecologist
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