COVID-19: Standard operating procedures (SOPs) for primary care

Based on NHSE SOPS, written 15/4/2020

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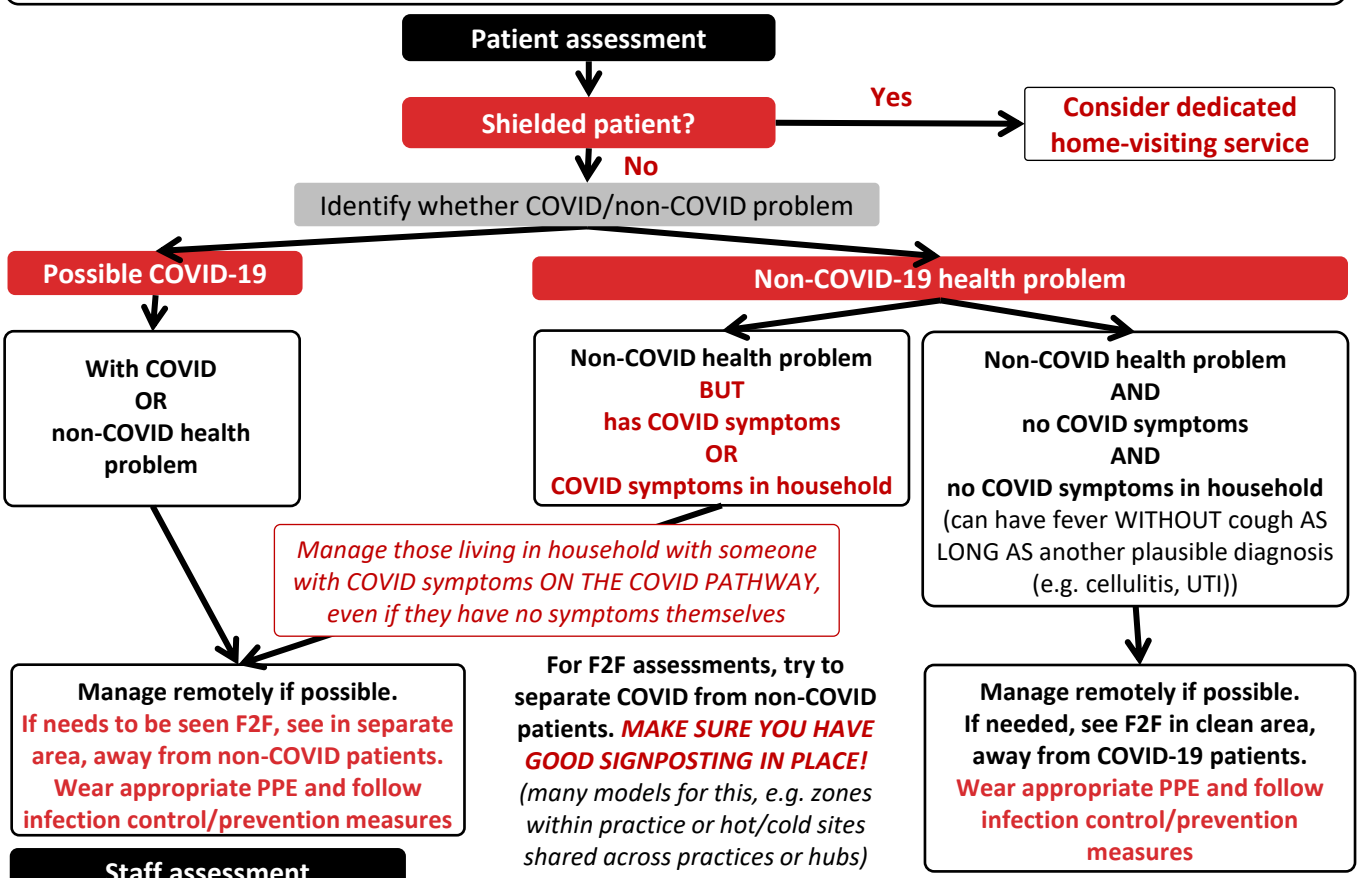
These are the updated Standard Operating Procedures for primary care that we should all be following. How does your practice compare? Is there anything you need to do differently?

REMOTE ASSESSMENT FIRST – for every primary care contact

See patients F2F only if examination is likely to add value and the benefits outweigh the risks of transmission.

COVID-19 typically presents with:

- **Fever (≥37.8ºC) and/or a dry and persistent cough.** In a Chinese cohort, AT PRESENTATION only 34% had sputum, 20% had dyspnoea, 15% had myalgia, 14% had headache and about 5% had GI symptoms (NEJM 2020, DOI: 10.1056/NEJMoa2002032). Anosmia/loss of taste reported. Day 5 and week 2 deterioration are being reported.
- **Remember: ALL THE OTHER CAUSES OF RESPIRATORY PATHOLOGY WILL STILL HAPPEN.** Other patterns of productive cough, dyspnoea without cough/fever, diurnal variation and wheeze should make us consider other diagnoses. Coryza or allergic symptoms make COVID *less* likely but not impossible. Bacterial and COVID-related viral pneumonia can complicate COVID-19 and can be difficult to distinguish (although the NICE guidance gives some indication; see our COVID article on *Clinical assessment and management*).
- **Think carefully about children:**
  - **Risk of missing COVID/not protecting self:** only 40–50% present with fever/cough. URTI symptoms more common, and most have a mild course of COVID-19.
  - **Risk of missing other pathology:** could this be sepsis, croup, bronchiolitis, bacterial pneumonia, etc…?
- **ANYONE LIVING IN THE SAME HOUSEHOLD AS SOMEONE WITH SYMPTOMS OF COVID SHOULD FOLLOW THE PATHWAY FOR PATIENTS WITH COVID-19.**



Staff assessment

- Where possible, staff should be allocated to either COVID or non-COVID patients.
- Staff should be risk assessed, identifying those at increased risk of COVID: the 'vulnerable' group and those who should be shielded ('extremely vulnerable' group). Staff in these groups MUST NOT see patients face to face (whether those patients have COVID symptoms or not). Remote working should be prioritised for these groups.
- Be prepared to work between practices because of staff sickness/need to self-isolate.

Care for the vulnerable & extremely vulnerable

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The 'extremely vulnerable'

The 'extremely vulnerable' (who should practice shielding):

- Solid-organ transplant recipients.
- People with specific cancers:
  - People with cancer who are undergoing active chemotherapy.
  - People undergoing radical radiotherapy for lung cancer.
  - Those with haematological cancers (at any stage of treatment).
  - Those having immunotherapy, other antibody treatments or targeted cancer treatments that affect the immune system (e.g. protein kinase or PARP inhibitors).
  - Those who have had bone marrow or stem cell transplants in the past 6 months, or who are still taking immunosuppression drugs.
- Those with severe respiratory conditions, including those with cystic fibrosis, severe asthma (4 or more courses of prednisolone in past 6m AND on LABA/LABA+ICS/leukotriene in past 6m) and severe COPD (on triple therapy inhalers – we assume this means LABA+LAMA+ICS) or roflumilast in the past 4m) (definition of severity from: https://digital.nhs.uk/coronavirus/shielded-patient-list/methodology/rule-logic).
- Those with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell (not sickle trait)).
- Those on immunosuppression therapies sufficient to significantly increase risk of infection.
- Pregnant women WITH significant heart disease.

The 'vulnerable'

The 'vulnerable' (who should practice careful social distancing):

- Those who are pregnant.
- Those over 70, regardless of any medical conditions.
- Those adults under 70 who qualify for a flu jab, which means:
  - Long-term respiratory conditions.
  - Chronic heart disease.
  - Chronic kidney disease.
  - Chronic liver disease.
  - Chronic neurological conditions.
  - Diabetes.
  - Splenectomy/sickle cell disease.
  - Weakened immune system: HIV/AIDS, on steroids, having chemo.
  - Severe obesity (BMI ≥40).

And if the vulnerable need to be seen?

ENSURE THEY ARE SEPARATED FROM COVID PATIENTS: manage remotely if possible. If need to be seen F2F, assess your best local option (ideally home visit by dedicated team, if capacity allows). However service organised, ensure no mixing with COVID patents.

What should we do for the extremely vulnerable?

- Ensure notes are clearly flagged.

Clinical care

- Manage urgent medical needs (with support from specialists if needed).
- Continue to do any essential follow-up.
- Review and update care plans.
- If a shielded patient develops COVID symptoms, they should be referred to the most appropriate service.

Protecting patients

- **All care should be done remotely or, if F2F appointment needed, they should be seen on a HOME VISIT and not brought to the practice UNLESS a designated site has been set up for this.**
- Strict infection measures should be followed at all times to protect shielded patients.
- Limit the number of people needing to visit the home. Any healthcare professional visiting must consider what else they can do during that visit to avoid multiple visits by other healthcare professionals.

Support: social prescribers can support in the following ways (the SOPs don't say what to do if you don't have a social prescriber, but perhaps another member of the team can do this):

- Make initial contact.
- Discuss needs, including help with shopping, medication, keeping physically active and emotional support.
- Work with the patient to develop a short plan covering their practical/physical/emotional needs, and identify organisations to help meet those needs (voluntary organisations, local authority).
- Arrange follow-up calls as needed.
- Patients can register with the Government here: https://www.gov.uk/coronavirus-extremely-vulnerable

Processes and logistics!

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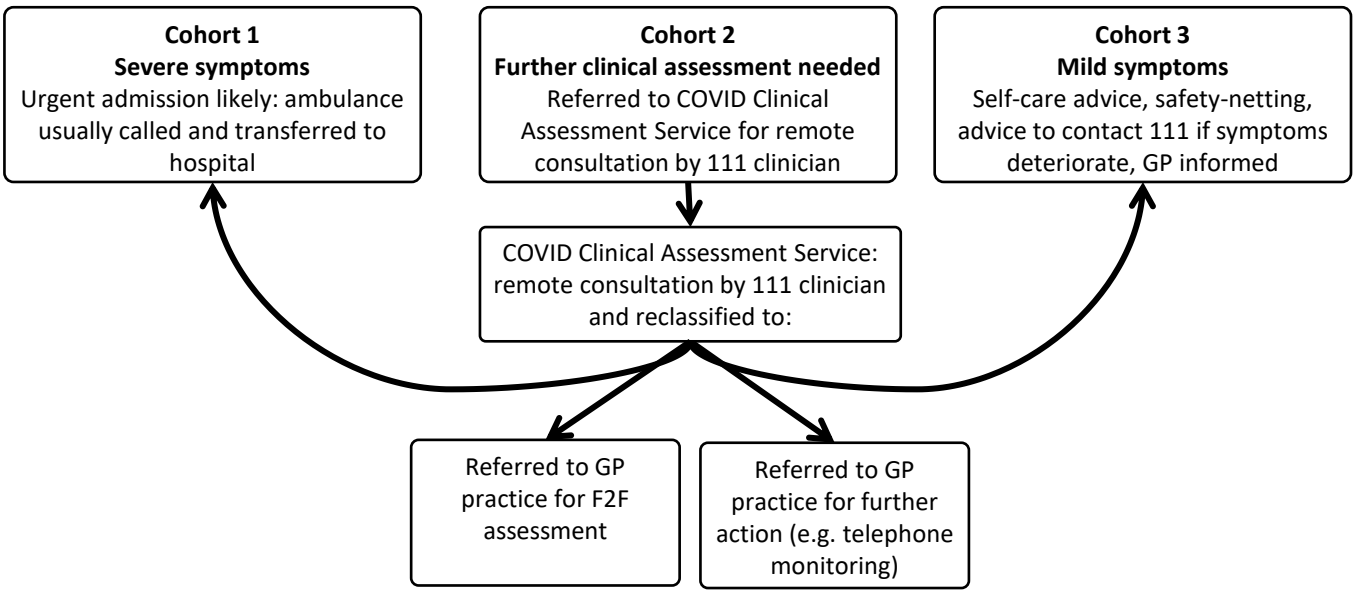
What happens when a patient accesses the 111 service?

Patents are triaged into 3 categories:



Transport to hospital

- **If ambulance care needed: inform call handler if patient has suspected COVID.**
- Relatives/friends can transport people (if patient is sufficiently stable), provided that they have already had significant exposure to the patient AND are aware of the risks of COVID -19.
- Public transport and taxis should NOT be used.

Case reporting

COVID is a notifiable disease but this applies only to TEST-CONFIRMED cases.
Local PHE Health Protection Teams should be informed of patients with SYMPTOMS of COVID-19 in any of the following settings:

- Long-term care facility.
- Prison/detention centre.
- Outbreak in hospital/healthcare setting.
- Schools.
- Other unusual scenarios.

Self-certification and MED3

Digital isolation notes can be downloaded by patients without contacting a doctor.
The notes can be accessed here: https://111.nhs.uk/isolation-note/ (the patient is asked a few questions, then the isolation note is generated and can be emailed to the person or to a friend/employer).

Repeat prescribing

- We are asked NOT to increase amounts of drugs issued (to ensure sufficient in the supply chain/stocks don't run out).
- Practices which do not accept repeat prescription requests from third parties (community pharmacies, digital apps) should review this policy urgently as it does not support those who are social distancing, isolated or shielding.