BTS Advice for Community Respiratory Services in relation to caring for patients with chronic respiratory disease during the COVID19 pandemic

Purpose:
This advice is designed to help clinicians working in community respiratory services with regard to the care of people with chronic respiratory disease during the COVID19 pandemic and in the recovery phase (updated 25/03/2021 at a time when the majority of those living with clinically significant disease had been offered at least one dose of coronavirus vaccine). It is not about the community care of people with COVID19.

History, Principles and Scope:
This was originally developed during the 'delay phase' of Wave 1, in Spring 2020, with updates since. This continues to be a fast-evolving situation and we will continue to update this as new information becomes available.

Community Respiratory Services are diverse and provide many different aspects of care to people with respiratory disease. Use this guidance as appropriate to your local situation.

This advice does not supersede local policies and infection control guidance, it is here to help support that.

We are working on the following principles:
1. Excellent, equitable care for people with chronic respiratory disease.
2. The need to protect high-risk patients from acquiring COVID19.
3. The need to minimise the risk to staff working in community services.
4. Consideration of intermittent pressures on acute services such that there may have been a shift in staff resource from chronic to acute care, and the potential for further periods of intense pressure on acute medical services.

Common Components of Community Services:

1. **Pulmonary Rehabilitation**. Face-to-face classes were, in general, initially stopped to reduce the risk to patients, and to enable staff redeployment to acute community settings. There was then the need to actively select and implement alternative methods of rehab such as apps, and web-based resources, e.g. BLF https://www.blf.org.uk/exercise-video and the University Hospitals of Leicester team at http://www.spaceforcopd.co.uk/. Updated guidance on restarting quality-assured Pulmonary Rehabilitation is in preparation by the BTS. For the moment, consider local infection control requirements.
2. **Post-COVID rehabilitation.** There has been the separate need to consider how community respiratory services are assisting in the holistic rehabilitation of people following COVID-19. Current resources on components of a rehabilitation programme for this indication can be found here: https://www.brit-thoracic.org.uk/about-us/covid-19-information-for-the-respiratory-community/#pulmonary-rehabilitation-resource-pack
3. **Lung Function Testing.** Routine testing was initially suspended as per ARTP guidance: https://www.artp.org.uk/News/artp-covid19-update-18th-march-2020. Re-introduction of routine lung function testing has been a particular challenge given that these tests are considered aerosol generating. The ARTP have introduced guidance on COVID19 infection control for lung function testing available here;

https://www.artp.org.uk/write/MediaUploads/Standards/COVID19/ARTP_COVID19_Infection_Control_Issues_for_Lung_Function.pdf .
See also the BTS document on restarting services for further advice:
https://brit-thoracic.org.uk/about-us/covid-19-resumption-and-continuation-of-respiratory-services/ .
In general, pressure on services remains such that new approaches to deciding in who and how frequently lung function testing is necessary continue to be implemented, with care to avoid duplication of investigations across primary, community and secondary care. Priority is given to situations where management decisions are directly impacted by results from the test (e.g. new diagnosis, selection of intervention) rather than situations which might be considered 'nice-to-know' routine monitoring. Some areas have developed innovative ways to deliver spirometry such as drive-through services and digital home monitoring software. The Primary Care Respiratory Society (PCRS) have produced a number of position statements, including use of spirometry in Primary Care and diagnosis of airways disease during the COVID19 pandemic, available here: https://www.pcrs-uk.org/coronavirus
For patients in whom asthma is a likely diagnosis, a trial of treatment whilst monitoring PEFR or a validated symptom questionnaire is recommended.

4. **Reviewing In-Patients,** for example at MDT Meetings or for delivery of care bundles. Follow local Trust policies. The NACAP secondary care audit programme remains active to support local QI. MDT meetings can be run virtually to ensure continuity of care across primary, community and secondary care settings.

5. **Routine Out-Patient Clinics and Oxygen Reviews**. Continue to consider a blend of face-to-face, telephone and video clinics as necessary to the patient and intervention. For home oxygen safety visits, risk assess prior to attending as outlined below.

6. **Breathe Easy Groups or other peer support groups** – current advice from the AUK-BLF partnership is that groups remain suspended at the moment, with no date on when they will resume. Re-opening is being supported on a case-by-case basis, and some groups have moved online.

7. **Acute Reviews in the Community** including Admission Avoidance and Early Supported Discharge home visits:

   Risk assessment prior to essential home visits for admission avoidance:
   If necessary, monitor progress by telephone/video consultation, only carry out home visits where measurement of observations and clinical assessment are required. Appropriate PPE should be worn in patients' homes.

   Public Health England advice for use of PPE and infection prevention and control in low, medium and high risk settings is available here:
   https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

Nebulisation is currently **not** considered aerosol generating for bronchodilators but nebulised saline is considered an AGP because of increased cough

Some respiratory physiotherapy interventions are classed as 'aerosol generating' procedures and require full PPE. See CSP guidance:
https://www.csp.org.uk/news/coronavirus/clinical-practice-faqs

Early supported discharge:
Community Services will continue to need to review with acute services ,the pathways they have developed to support COVID19 positive patients with (and, in some areas without) chronic respiratory disease. Community respiratory teams and virtual wards have played a key role in these pathways.

COVID19 Virtual Wards
In the initial COVID19 wave, a number of 'COVID virtual wards' (CVW) were set up to support certain at risk groups, by making pulse oximeters available for home testing of oxygen saturation levels and linking the individual up to a clinical team. Some were secondary care based, some primary care based and other spanned both.

A rapid systematic review carried out by the Nuffield Trust of the existing CWVs in England (accessible here: https://www.nuffieldtrust.org.uk/files/vw-evaluation-final-slideset-for-dissemination-12th-oct-2020.pdf) found that the wards were safe and effective, ensuring patients were being treated in the optimal setting. This model has now been successfully rolled out across many parts of England via the AHSN networks (across all settings). National guidance has been produced to support and standardise care across CVWs. This video (between minutes 7-19) gives an overview of the rational and evidence base for this approach: https://www.youtube.com/watch?v=oM6BXvWbA8c

Lifting of self-isolation and use of PPE in confirmed COVID cases discharged home:
For confirmed COVID cases that are discharged from hospital, self-isolation can be lifted 10 days after a positive COVID19 swab according to PHE guidelines updated on 15/2/21 link:
https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

Generic Considerations for those with COPD and other pre-existing long term conditions:

1. Ensure all eligible patients have got an in-date appropriate rescue pack. (We emphasise the need for patient education to ensure correct use of rescue packs).
2. Review patients' usual oxygen saturations and risk of T2RF to guide need for admission if unwell.
3. Treating exacerbations. People should continue to be treated with inhaled or oral corticosteroids according to NICE guidance. Note that the standard course recommended for AECOPD is 5 days only. There is no evidence to use or not to use oral or inhaled corticosteroids outside usual guidelines in COPD patients with COVID19. Antibiotics should be issued only if suspicion of secondary bacterial infection.
4. Review advanced care planning decisions and ceilings of care. Ensure these are shared across the system where this is possible.

5. Review local working with acute teams, oxygen teams if separate from the respiratory service and community palliative care.
6. If individuals have specific concerns about their own health, a formal risk assessment should be carried out by their line manager. There are no official guidelines regarding change to working patterns.
7. Smoking cessation is important in reducing risk of infection.
8. Support patients in accepting a coronavirus vaccine.

Please contact bts@brit-thoracic.org.uk for queries.
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Disclaimer: Advice has been based on PHE advice where available and expert opinion where not available. Variations to this advice may be required depending on clinical setting and individual patients. This guidance is issued to specialist respiratory teams working in the community setting. It is not designed to cover secondary care or primary care settings, where guidance is being issued by PHE.