BTS Advice for Community Respiratory Services in relation to COVID19

Purpose:
This advice is designed to help clinicians working in community respiratory services with regard to COVID19 (updated 26 May 2020).

Principles and Scope:
This original guidance applied to the 'delay phase' of the pandemic plan. This continues to be a fast-evolving situation and we will update this as new information becomes available.
As the NHS moves into its 'recovery phase', this latest update should be read in conjunction with the BTS guidance on restoring and continuing respiratory services: https://brit-thoracic.org.uk/about-us/covid-19-resumption-and-continuation-of-respiratory-services/.

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. Some remaining pressure on acute services such that there has 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, stopped to reduce the risk to patients, and to enable staff redeployment to acute community settings. There is now the need to actively select and implement alternative methods of rehab such as online 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/. There is the separate need to consider how community respiratory services may be able to assist in the holistic rehabilitation of people following COVID-19 and BTS is working on a collection of resources (information will be provided when available). 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

2. Lung Function Testing. Routine testing was suspended as per ARTP guidance: https://www.artp.org.uk/News/artp-covid19-update-18th-march-2020. It is clear that re-introduction of routine lung function testing will be a particular challenge given that these tests are considered aerosol generating. See the BTS document on restarting services for further advice: https://brit-thoracic.org.uk/about-us/covid-19-resumption-and-continuation-of-respiratory-services/ but, in general, pressure on services will be such that a new approach to in who and how frequently lung function testing is necessary will need to be implemented,

with care to avoid duplication of investigations across primary, community and secondary care.

3. Reviewing In-Patients. Follow local Trust policies. The current NACAP programme remains suspended.

4. Routine Out-Patient Clinics and Oxygen Reviews. Continue to defer, or consider telephone or video clinics. For home oxygen safety visits, risk assess prior to attending as outlined below.

5. Breathe Easy Groups or other patient support groups – postpone to reduce risk to patients, and now actively explore alternatives such as video conferencing.

6. Community Acute Reviews including Admission Avoidance and Early Supported Discharge. This remains the most difficult area.

Risk assessment prior to essential home visits for admission avoidance:
Where possible, monitor progress by telephone/video consultation, only carry out home visits where deemed essential e.g where measurement of observations and clinical assessment for respiratory failure or sepsis are required or if the patient is so ill they have stopped carrying out their usual activities of daily living.

Triage over phone to assess risk:
FEVER and/or WORSENING or NEW COUGH – possible COVID19, treat as high-risk.

Public Health England advice for use of PPE in community settings is available here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/878750/T2_poster_Recommended_PPE_for_primary__outpatient__community_and_social_care_by_setting.pdf

Donning/doffing should be performed in keeping with PHE guidance.

Note that FFP3 masks (and eye protection) should be worn for aerosol generating processes e.g. home NIV. Nebulisation is currently **not** considered aerosol generating.

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

Early supported discharge:
Community Services will continue to need to liaise with acute services to develop pathways to support COVID19 +ve patients with chronic respiratory disease back home. It is envisaged that community respiratory teams will play a key role in these pathways.

Some hospital Trusts have developed pathways e.g. Virtual Ward to facilitate early rapid discharge of respiratory patients, with telephone follow-up of those considered higher risk. Consideration should be given to working across CCGs, Primary Care and community teams to ensure patients discharged home can have rapid clinical assessment if any cause for concern is raised on telephone follow-up. Some services have developed pathways for weaning oxygen in the community in patients recovering from COVID pneumonia/pneumonitis who have low oxygen requirements.

Local plans should be in place for discharge to care homes, those with home carers and the homeless.
The government has produced official guidance on COVID-19 hospital discharge service requirements available here:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874213/COVID-19_hospital_discharge_service_requirements.pdf

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 seven days after symptom onset according to PHE guidelines updated on 20/03/20 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 However some Trusts are recommending isolating for 7 days from the positive COVID-19 swab. Household contacts need to remain in self-isolation for longer, 14 days from onset of symptoms in the household index case.

COVID Recovery and rehabilitation:
Patients may face a long and protracted recovery from COVID. As the NHSE moves into 'recovery phase' there is a requirement to shift focus to rehabilitation. The Chartered Society of Physiotherapists have published a policy statement on COVID rehabilitation available here; https://www.csp.org.uk/professional-clinical/improvement-innovation/community-rehabilitation/rehab-covid-19-policy-statement.
Pulmonary rehabilitation service leaders are encouraged to link with local policy makers to establish their role in post-COVID rehabilitation.

An online resource to support COVID recovery has been developed by a multidisciplinary group in Lancashire Teaching hospitals available here;
https://covidpatientsupport.lthtr.nhs.uk/#/

Generic Considerations:
1. Have all applicable patients got an in-date appropriate rescue pack? Distribute now.
2. Advise people to make sure they have all have supplies of usual medications.
3. Review patients' usual oxygen saturations and risk of T2RF to guide need for admission if unwell.
4. Treating exacerbations. People with 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.
5. If any suspicion of COVID19 patients should self-isolate for 7 days, healthcare professionals can still visit if wearing basic PPE. Stay at home advice is available here: https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance
6. Review advanced care planning decisions and ceilings of care. Ensure these are shared across the system where this is possible.
7. Review local working with acute teams, oxygen teams if separate from the respiratory service and community palliative care.

8. If individuals have specific concerns about their own health, speak to Employee Health and Wellbeing (Occupational Health) and line manager. There are currently no official guidelines regarding change to working patterns.
9. Smoking cessation is important in reducing risk of infection.

The Future

It will be increasingly important to liaise with local acute services to understand local service capacity in relation to acute care for people with decompensated acute respiratory disease and thus the most appropriate location for care. This guidance will be updated accordingly.

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.