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.

Principles and Scope:
This guidance applies to the current 'delay phase' of the pandemic plan. This is a fast-evolving situation and we will 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. The pressure on acute services such that there will be a shift in staff resource from chronic to acute care, and the potential for intense pressure on acute medical services.

Common Components of Community Services:

1. Pulmonary Rehabilitation. Stop classes to reduce the risk to patients, and to enable staff redeployment to acute community settings. Consider 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/. The BTS PR advisory group are also working on a collection of resources.

2. Lung Function Testing. Routine testing suspended as per ARTP guidance: https://www.artp.org.uk/News/artp-covid19-update-18th-march-2020

3. Reviewing In-Patients. Follow local Trust policies. Advice from NACAP on discharge bundles and the Best Practice Tariff is imminent following discussion with HQIP.

4. Routine Out-Patient Clinics and Oxygen Reviews. 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.

6. Community Acute Reviews including Admission Avoidance and Early Supported Discharge. This is 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.

Basic PPE should be worn for all **high-risk** patients; gloves, apron, surgical mask and eye protection following risk assessment. See Table 1 in:
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/872745/Infection_prevention_and_control_guidance_for_pandemic_coronavirus.pdf

Donning/doffing should be performed in keeping with PHE guidance

The ambulance service has produced this guide on use of PPE for staff working in the community setting:
https://www.gov.uk/government/publications/covid-19-guidance-for-ambulance-trusts/covid-19-guidance-for-ambulance-trusts#personal-protective-equipment-ppe

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

If suspicion of COVID19, a surgical mask should be placed on the patient (if possible) during the visit.

Early supported discharge:
Community Services will 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 are developing 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 are considering discharging patients with low oxygen requirements and weaning in the community, protocols are in development.
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
Household contact need to remain in self-isolation for longer, 14 days from onset of symptoms in the household index case.

After 7 days from symptom onset, staff visiting the confirmed case at home do not need to wear PPE. If there are other people in the same household that are symptomatic and have been unwell for less than 7 days, the visiting staff should avoid any contact with them.

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.