NHS National Services Scotland

# Novel coronavirus (COVID-19) Guidance for Primary Care

## Management of patients presenting to primary care

**Version 10.2**

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**Before use check the HPS COVID-19 page to verify this is the current version**

Health Protection Scotland

## Version History

| Version | Date | Summary of changes |
|---|---|---|
| V1.0 | 23/01/20 | First publication |
| V2.0 | 24/01/20 | Added:<br>- Algorithm for suspect case of WN-Cov in primary care |
| V3.0 | 28/01/20 | Added:<br>- Section 4 – environmental cleaning following possible case in primary care<br>- Appendix 3 – putting on and removing PPE in primary care<br>Amended:<br>- Appendix 1 updated to include NHS24 |
| V4.0 | 31/01/20 | Amended clinical and epidemiological case definition and updated appendix 1 (algorithm for management of suspected case of novel coronavirus in Primary Care),<br>Reference to Wuhan Coronavirus (WN-Cov) changed to coronavirus (2019n-CoV) |
| V5.0 | 02/02/2020 | Refined definition of contacts with a case (page 3). |
| V6.0 | 05/02/2020 | Appendix 3 (pages 10 and 11): Advice amended for putting on and removing PPE (appendix 3 in version 5 was incorrect). |
| V7.0 | 07/02/2020 | Amended to align with updated case definition and contact definition issued by PHE on 06/02/20 |
| V7.1 | 07/02/2020 | Small amendment to contact definition |
| V8.0 | 12/02/2020 | Text and algorithm amended to include action re symptomatic contact of possible case<br>Algorithm amended to clarify that travel includes transit through a risk area<br>Addition of:<br>- section on test results<br>- section on further information<br>Waste guidance amended to reflect management as Category B<br>Appendix 3: Removed reference to double glove.<br>Version history has been moved to page 1. |
| V8.1 | 24/02/2020 | Reference to coronavirus (2019n-CoV) changed to COVID-19 |
| V8.2 | 26/02/2020 | Included links to PPE instructional videos |
| V8.3. | 28/02/2020 | Phone numbers corrected in appendix 2 |
| V8.4 | 05/03/2020 | Phone numbers corrected in appendix 2 |
| V8.5 | 12/03/2020 | Update to<br>• Case definition<br>• Management section (including PPE)<br>• Test result section |
| V 9.0 | 13/03/20 | Updated to reflect move from containment to delay |

| Version | Date | Summary of changes |
|---|---|---|
| V 9.1 | 14/03/20 | Update to: Reporting to HPT<br>Addition of AGPS and advice |
| V10 | 16/03/20 | Update: stay at home advice<br>Handling deceased |
| V 10.1 | 19/03/20 | Update: Removal of avian influenza reference<br>CPR IPC information added |
| V 10.2 | 20/03/20 | Clarification: statement on triage of patients |

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## Introduction

Novel coronavirus (COVID-19) is a new is a new strain of coronavirus first identified in Wuhan, China. Clinical presentation may range from mild-to-moderate illness to pneumonia or severe acute respiratory infection. Because of this, patients with COVID-19 could present to primary care either via telephone or in person.

It has been announced by the UK/Scottish Government that as of 16 March anyone developing symptoms consistent with COVID-19, however mild, should stay at home for 7 days from the onset of symptoms as per existing advice. In addition, it is now recommended that anyone living in the same household as a symptomatic person should self-isolate for 14 days.

Information on COVID-19, including stay at home advice for people who are self-isolating and their households, can be found on **NHS Inform**.

Further, people are advised to take social distancing measures to help reduce the transmission of COVID-19. In particular, this is strongly advised for people aged 70 or over, people with underlying medical conditions and pregnant women. Further advice on these measures will be available on NHS Inform.

Please note that this is an evolving situation and the most up to date guidance and risk areas should always be checked online at **HPS COVID-19 page.**

## Case definition

As of 13 March 2020 the possible case definition for COVID-19 is based purely on clinical criteria. For most people COVID-19 will be a mild, self-limiting infection and will not require testing. The case definition differs depending on whether the patient requires admission to hospital or not.

### 1. Case definition for individuals in the community

People with the following symptoms are advised to self-isolate for seven days and COVID-19 testing is not recommended

Recent onset (within the last 7 days):

- New continuous cough

**and/or**

- High temperature

### 2. Case definition for individuals requiring hospital admission

Patients requiring hospital admission **and** meeting the clinical criteria below should be tested for COVID-19.

- Clinical or radiological evidence of pneumonia

**or**

- Acute respiratory distress syndrome

**or**

- Influenza like illness (fever ≥37.8°C and at least one of the following respiratory symptoms, which must be of acute onset: persistent cough (with or without sputum), hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing, sneezing)

Clinicians should be alert to the possibility of atypical presentations in patients who are immunocompromised.

## Actions in primary care

Staff who are pregnant or otherwise immunosuppressed should not provide direct care for a patient with possible or confirmed COVID-19, this includes obtaining samples. Any deviation from this should be a local decision. Pregnant staff or staff who are immunosuppressed should seek advice from the local Occupational Health Department.

### 1. Triage of Patients

Primary Care should make every effort to triage patients by telephone to avoid the patient presenting at the practice unnecessarily and minimising any contact with patients with respiratory symptoms.

### 2. Management of patients identified through telephone consultation who do not require clinical assessment and meet the possible case definition for COVID-19

Advise the patient to self-isolate at home. Direct the patient to "stay at home" advice which can be found on **NHS Inform**. "Stay at home" advice differs depending on whether the patient lives alone or in a household with other people.

Provide the patient with worsening advice and direct them to phone the practice (or **NHS24** if out of hours) if their symptoms deteriorate. They should not attend the practice in person or go to A&E. If it is an emergency they should phone 999 and inform the call handler of their symptoms.

### 3. Management of patients requiring clinical assessment

#### 3.1. Infection Prevention and Control

**For all consultations for acute respiratory infection or influenza like illness** wear PPE in line with National Infection Prevention and Control Manual **Appendix 16: Level 2 – Droplet Precautions:**

- Gloves
- Disposable plastic apron
- Fluid-resistant (Type IIR) surgical face mask (FRSM)
- Eye protection (e.g. goggles or a visor) if blood/body fluid contamination to the eyes/face is anticipated.

Try to keep exposure to the minimum. Guidance for putting on and removing PPE can be found in Appendix 2 of this document. The evidence underpinning it can be found in the **National Infection Prevention and Control Manual (NICPM).**

FFP3 is only required if undertaking an Aerosol Generating Procedure (AGP) which should be avoided in the Primary Care setting for this group of patients. The following procedures are considered AGPs:

- Intubation, extubation and related procedures e.g. manual ventilation and open suctioning *
- Tracheotomy/tracheostomy procedures (insertion/open suctioning/removal)
- Bronchoscopy
- Surgery and post mortem procedures involving high-speed devices
- Some dental procedures (e.g. high-speed drilling)
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure Ventilation (BiPAP) and Continuous Positive Airway Pressure Ventilation (CPAP) **
- High Frequency Oscillatory Ventilation (HFOV)
- Induction of sputum
- High flow nasal oxygen (HFNO) ***

* Chest compressions and defibrillation can be performed whilst wearing fluid resistant surgical face mask, apron and gloves (you should also wear goggles or a visor if risk of splashing/spray). However, an FFP3 mask, fluid resistant surgical gown, eye protection and gloves are required for airway manoeuvres or bag and mask manual ventilation. Further information can be found at **Resuscitation Council (UK)** .

** CPAP and BiPAP are considered Aerosol Generating Procedures (AGPs). Long Term Oxygen Therapy is not. The current recommended advice is as follows:

- Primary care staff should avoid visiting patients who have respiratory symptoms and are on CPAP/BiPAP at home.
- Consider phone consultations in the first instance to assess whether the patient requires a home visit. If it is safe to postpone the visit until symptoms have resolved, then do so.
- If you must carry out a home visit, phone ahead and establish what times of the day the patient is on their CPAP/BiPAP. Primary care staff should ensure they visit at least 1 hour after the CPAP/Bi PAP was switched off which will provide adequate time for the aerosols to dissipate (based on 3 Air Changes per Hour (ACH) in an average domestic property). On visiting they should wear PPE in line with droplet precautions.
- If the clinical condition is such that the CPAP/BiPAP cannot be turned off for a full hour before the visit then the patient should, if possible, move to another room before the practitioner enters their home and the door of the room where the CPAP/BiPAP takes place should be closed. The practitioner can then enter the patient's home to assess their condition.
- If the patients clinical condition is such that neither of these is possible *and* there are no appropriate primary care practitioners available who have been face fit tested or there no access to FFP3 masks then the patient will require transfer to hospital for clinical assessment.
- Alert the ambulance that the patient is a suspected COVID-19 requiring CPCP/BiPAP

***Note: High Flow Nasal Oxygen, sometimes referred to as High Flow Nasal Cannula Therapy, is the process by which warmed and humidified respiratory gases are delivered to a patient through a nasal cannula via a specifically designed nasal cannula interface. These devices can be set to deliver oxygen at specific concentrations and flow rates (typically 40-60L/min-1 for adults). **This is different from standard home oxygen delivered through a nasal cannula which is not an AGP.**

### 3.2. Face to face clinical assessment

Where possible consider practical approaches to facilitate infection prevention and control measures for this group of patients. This could include:

- designated area of practice / rooms for seeing patient with respiratory symptoms
- seeing such patients at a specific time of day (e.g. end of a list or separate clinic)
- rooms used for assessment of these patients should be kept clutter free with equipment kept in closed cupboards to minimise potential for contamination. Soft furnishings should be avoided where possible. Tie back examination curtains to avoid contamination. The practice should have a regular laundering regime in place for curtains
- segregation of patients with respiratory symptoms from other patients e.g. using separate entrances, separate waiting areas, dedicated staff for respiratory patients.
- all non-essential items including toys, books and magazines should be removed receptions, waiting areas, consulting and treatment rooms

### 3.3. Clinical assessment at home visit

If carrying out a home visit, follow infection prevention and control advice as per 3.1 above. Practitioners should carry a waste bag do dispose of PPE following the visit.

Following the patient consultation, PPE should be removed as per appendix 2. This should be placed in a clinical waste bag and then hands washed with soap and water. On return to the surgery waste should be disposed as per normal practice for clinical waste.

### 3.4. Management of patients following clinical assessment

If the patient does not require referral to secondary care and they meet the case definition for a possible case of COVID-19 they and their household members should be advised to self-isolate. Direct the patient to “stay at home” advice which can be found at **NHS Inform**. Provide the patient with worsening advice and direct them to phone the practice (or NHS24 if out of hours) if their symptoms deteriorate. They should not attend the practice in person or go to A&E. If it is an emergency they should phone 999 and inform the call handler of their symptoms.

If the patient **does** require referral to secondary care this should be done via existing mechanisms for hospital referral – phone ahead, do not advise the patient to self-present at A&E or minor injury unit.

### 3.5. Transport to hospital

Patients must not use public transport or taxis to get to hospital. Transport options include:

- Patients can be taken to hospital 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 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 the hospital to minimise risk of exposure to staff, patients and visitors

  OR

- If the patient clinically well enough to drive themselves to the hospital then they can do so. They should be given clear instructions on what to do when they get to the hospital to minimise risk of exposure to staff, patients and visitors

  OR

- Arrange transfer by Scottish Ambulance Service (ensuring that you inform the ambulance call handler of the concerns about COVID-19) and proceed with management as follows:
  - Staff should withdraw from the room if the patient is clinically well enough to be left unattended.
  - Close the door to the room.
  - Wash your hands with soap and water.
  - If required, identify suitable toilet facilities that only the patient will use.
  - If required to re-enter the room, don PPE as per appendix 2.

## 4. Self-isolation

Patients self-isolating should be advised to follow the “stay at home” advice on **NHS Inform**.

Stay at home advice differs depending on whether the patient lives alone or in a household with other people.

## 5. Reporting to Local Health Protection Team

The local Health Protection Team (HPT) should be informed of any confirmed case in:

- a long-term care facility
- a prison or place of detention or other close setting
- in a healthcare worker.

## 6. Environmental cleaning following a suspected case

Once a suspected case has left premises, the room where the patient was placed/isolated should not be used until adequately decontaminated. The room door should remain shut until it has been cleaned with detergent and disinfectant. Once this process has been completed, the room can be put back into use immediately.

### 6.1. Preparation

The person responsible for undertaking the cleaning with detergent and disinfectant should be familiar with these processes and procedures:

- collect any cleaning equipment and waste bags required before entering the room
- any cloths and mop heads used must be disposed of as single use items
- before entering the room, perform hand hygiene then put on a disposable plastic apron and gloves

### 6.2. On entering the room

- Keep the door closed with windows open to improve airflow and ventilation whilst using detergent and disinfection products.
- Bag any disposable items that have been used for the care of the patient as clinical waste,
- Provided curtains have been tied back during the examination and no contamination is evident, these can be left in situ. Otherwise, remove any fabric curtains or screens and bag as infectious linen.
- Close any sharps containers, wipe the outer surfaces with either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.) or a neutral purpose detergent followed by disinfection (1000 ppm av.cl.).

### 6.3. Cleaning process

Use disposable cloths/paper roll/disposable mop heads, to clean and disinfect all hard surfaces/floor/chairs/door handles/reusable non-invasive care equipment/sanitary fittings in the room, following one of the 2 options below:

1. Use either a combined detergent disinfectant solution at a dilution of 1000 parts per million (ppm) available chlorine (av.cl.)

or

2. A neutral purpose detergent followed by disinfection (1000 ppm av.cl.):

- follow manufacturer's instructions for dilution, application and contact times for all detergents and disinfectants;
- any cloths and mop heads used must be disposed of as single use items.

### 6.4. Cleaning and disinfection of reusable equipment

- clean and disinfect any reusable non-invasive care equipment, such as blood pressure monitors, digital thermometers, glucometers, that are in the room prior to their removal
- clean all reusable equipment systematically from the top or furthest away point

### 6.5. Carpeted flooring and soft furnishings

Ideally the use of examination rooms that are carpeted should be avoided. For carpeted floors/items that cannot withstand chlorine-releasing agents, consult the manufacturer's instructions for a suitable alternative to use following, or combined with, detergent cleaning.

### 6.6. On leaving the room

- discard detergent/disinfectant solutions safely at disposal point
- dispose of all waste as clinical waste
- clean, dry and store re-usable parts of cleaning equipment, such as mop handles
- remove and discard PPE as clinical waste as per local policy
- perform hand hygiene

### 6.7. Cleaning of communal areas

If a possible case spent time in a communal area used for non-respiratory patients, for example, a waiting area or toilet facilities, then these areas should be cleaned with detergent and disinfectant (as above) unless there has been a blood/body fluid spill which should be dealt with immediately (guidance is available at **Appendix 9** of the National Infection Prevention and Control Manual). Once cleaning and disinfection have been completed, these areas can be put back into use immediately.

### 6.8. Attending deaths

The principles of Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs) continue to apply whilst deceased individuals remain in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients. Where the deceased was known or suspected to have been infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

## Further information

Further Information for health professionals can be found on the **HPS COVID-19 page**

Information for the general public **NHS Inform.**

# Appendix 1: Contact details for local Health Protection Teams

| Organisation | Office Hours Telephone Number | Out of Hours Telephone Number Ask for Public Health On Call |
|---|---|---|
| Ayrshire and Arran | 01292 885858 | 01563 521 133<br>Crosshouse Hospital switchboard |
| Borders | 01896 825560 | 01896 826 000<br>Borders General switchboard |
| Dumfries and Galloway | 01387 272 724 | 01387 246 246 |
| Fife | 01592 226435 | 01592 643355<br>Victoria Hospital switchboard |
| Forth Valley | 01786 457 283<br>Ask for CPHM on call | 01324 566000<br>Ask for CPHM on call |
| Grampian | 01224 558520 | 0345 456 6000 |
| Greater Glasgow & Clyde | 0141 201 4917 | 0141 211 3600<br>Gartnavel switchboard |
| Highland | 01463 704886 | 01463 704 000<br>Raigmore switchboard |
| Lanarkshire | 01698 858232 / 858228 | 01236 748 748<br>Monklands switchboard |
| Lothian | 0131 465 5420/5422 | 0131 242 1000<br>Edinburgh Royal switchboard |
| Orkney | 01856 888034 | 01856 888 000<br>Balfour Hospital switchboard |
| Shetland | 01595 743340 | 01595 743000<br>Gilbert Bain switchboard |
| Tayside | 01382 596 976/987 | 01382 660111<br>Ninewells switchboard |
| Western Isles | 01851 708 033 | 01851 704 704 |

# Appendix 2: Putting on and removing Personal Protective Equipment (PPE)

**Putting on PPE**
PPE should be put on before entering the room where the patient is. Put PPE on in the following order:

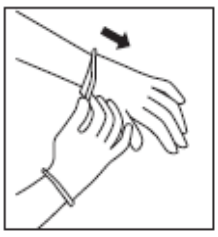
1. Disposable plastic apron
2. A Type IIR (Fluid Resistant Surgical Facemask) FRSM. This should be close fitting and fully cover the nose and mouth. Do not touch the front of the mask when being worn
3. Disposable non-sterile nitrile, latex or neoprene gloves. There is no requirement for double-gloving

The order given above is a practical one; the order for putting on is less critical than the order of removal given below.

**Removal of PPE**
PPE should be removed in an order that minimises the potential for cross-contamination. Before leaving the room where the patient is, gloves, apron and FRSM should be removed (in that order, where worn) and disposed of as clinical waste. Guidance on the order of removal of PPE is as follows:

**1. Gloves**

- Grasp the outside of glove with the opposite gloved hand; peel off.
- Hold the removed glove in the remaining gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Discard as clinical waste.



**2. Apron**

- Unfasten or break apron ties.
- Pull the apron away from the neck and shoulders, touching the inside of the apron only.
- Turn the apron inside out, fold or roll into a bundle and discard as clinical waste.

**3. Fluid Resistant Surgical Facemask (FRSM)**

- Untie or break bottom ties, followed by top ties or elastic, and remove by handling the ties only and discard as clinical waste.

Perform hand hygiene immediately after removing all PPE.

## Instructional video

An instructional video for the correct order for donning, doffing and disposal of PPE for healthcare workers in a primary care setting has been produced.

You can access this in the following locations:

- **YouTube**
- **Vimeo**