Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of respiratory patients during the coronavirus pandemic

26 March 2020 Version 1

“…and there are no more surgeons, urologists, orthopaedists, we are only doctors who suddenly become part of a single team to face this tsunami that has overwhelmed us…”
Dr Daniele Macchine, Bergamo, Italy. 9 March 2020

As doctors we all have general responsibilities in relation to coronavirus and for these we should seek and act upon national and local guidelines. As respiratory physicians we will have a key role to play in treating people with coronavirus. We must engage with those planning our local response. We may also need to work outside of our specific areas of training and expertise and the GMC has already indicated its support for this in the exceptional circumstances we may face.

This document will focus on the delivery of respiratory medicine during the coronavirus outbreak and should be used in conjunction with the adult respiratory medicine escalation policy. The vast majority of respiratory physicians are also accredited in general internal medicine and will have a key role to play in supporting on the on call general medical take and inpatients. We expect that all respiratory staff will be focussing on managing patients with acute respiratory failure. Other staff may backfill other respiratory roles with guidance from respiratory specialists. Please work in teams and support your colleagues through this challenging period.

Where possible provision should be made for respiratory physicians to come off the acute wards to be available for specific advice out of hours. Other medical colleagues need to pick up all the non-respiratory patients and manage them on their or an extended medical ward bed base so as to free up respiratory physicians.

Respiratory medicine can be considered in a few categories:

1. Obligatory in-patients
2. Ambulatory care and management of pleural disease
3. Outpatient clinics
4. Investigations: including lung function tests, bronchoscopy and imaging
5. **Community respiratory services**: including pulmonary rehabilitation, home oxygen services and community OPD and CNS clinics

When planning your local response, please consider the following:

**Obligatory in-patients**
- Some patients with respiratory disease will still require admission
- Length of stay (LOS) must be minimised, with the community team enhancing their supportive discharge support (or enacting where not available) to facilitate this; including working both weekends and extended days where demand requires it. The palliative approach to some patients could be enhanced by this community role who will need appropriate equipment and virtual respiratory consultant support to deliver it. Some capacity may be freed up by a reduction in community clinics and pulmonary rehabilitation.
- **A consultant must be designated as ‘lead consultant’** This duty can be for 1 day, a few days or even 5 days at a time in small units. This is an essential role during crisis management. It cannot be performed by the consultant “on-call” or the consultant in clinic or on the ward. They must be free of clinical duties and the role involves coordination of the whole service from ED, OPD and liaison with other specialties and managers.
- It can be very stressful during a crisis. Support each other, discuss activities and plans daily and consider methods to communicate this to ward staff. Lead clinicians should delegate and ensure the workload is shared. Do not expect the Clinical Director / respiratory lead to do all the coordination!
- Establish a daily sitrep and dashboard with key data. That should include patient flows, workforce issues, stock levels and other key messages (eg state of coronavirus response, personal protective equipment (PPE) requirements).
- Plan for daily consultant ward rounds on inpatients to minimise length of stay.
- As demand increases plan for a senior respiratory decision maker to be in A&E/MAU to triage all respiratory admissions.
- The document ‘Clinical guide for the management of emergency department patients during the coronavirus pandemic’ explains the separation of the patients with respiratory symptoms who require admission.
- Ensure non-respiratory physicians have support and training in helping deliver some routine respiratory care. This could be facilitated by deploying hospital-based nurses to support colleagues.

**Ambulatory care and management of pleural disease**
- Maximise ambulatory care options to allow safe discharge from A&E/MAU of appropriate cases
- Use home intravenous antibiotic services where available
- Move to a day case, ambulatory care model for pleural disease
- Agree local pathways for pleural disease that can be used for urgent admission avoidance
- There should be a clean day case area for patients to attend for pleural procedures, administration of biologics for asthma, insertion of lines and test dose of antibiotics for CF
Outpatient clinics

GIRFT has produced a virtual working guide as part of this series of Specialty guides: www.england.nhs.uk/coronavirus/secondary-care/other-resources/specialty-guides/

- The majority of outpatient consultations should be switched to either telephone or virtual
- Delay any routine annual reviews for the time being
- We need a specific comment about ILD and provision of their drugs
- Have a system in place to record these consultations and to make sure that appropriate follow up is booked
- Initially continue to see urgent new referrals including suspected lung cancer cases
- As demand increases only see cases that need a time critical decision for which a treatment will be available, and the decision cannot be made virtually
- Agree the point at which you will pause all outpatient activity
- **During the coronavirus epidemic it is vital that other patients and staff are protected. This involves appropriate appointment scheduling to prevent crowding in waiting rooms, ability to isolate patients and use of personal protection.**

Investigations

- Both bronchoscopy and most pulmonary function tests have the potential to aerosolise coronavirus and therefore these investigations should only be performed where absolutely necessary and after consultation with the bronchoscopist / physiologist. Patients should be screened prior to either procedure taking place
- For routine pulmonary function testing the ARTP advice should be followed www.artp.org.uk/News/artp-covid19-update-18th-march-2020
- Agree within your department when to only perform investigations for urgent cases where the results will have a direct impact on patient care and/or are part of a cancer pathway.
- Agree within your department when to only perform investigations if they have a critical impact on patient care and the result will impact on a treatment that can be delivered in a timely fashion.
- Agree within your department the criteria of imaging and performing bronchoscopy on critical inpatients.

Community respiratory Services

- The majority of community respiratory services should be switched to telephone or virtual consultation.
- Routine annual reviews should continue virtually to reassure patients and ensure they are happy with their management plans to avoid hospital attendance.
- Have a system in place to record these consultations and to make sure that appropriate follow up is booked.
• Postpone pulmonary rehabilitation courses and offer telephone advice where required. Consider how staff released from rehabilitation programs (ie physiotherapists) can support acute providers given their experience.

• Resources for patients from the British Lung Foundation [www.blf.org.uk/exercise-video](http://www.blf.org.uk/exercise-video)