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Specialty guides for patient management during the Coronavirus pandemic

Clinical guide for the management of non-coronavirus patients requiring acute treatment: general and internal medicine during the coronavirus pandemic

20 March Version 2

"…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 COVID-19, and for these we should seek and act upon national and local guidelines. We also have a specific responsibility to ensure that essential care continues with the minimum burden on the NHS. We must engage with those planning our local response. We may also need to work outside our specific areas of training and expertise and the General Medical Council has already indicated its support for this in the exceptional circumstances we may face.[1] General and internal medicine (GIM) covers a wide range of specialties with a different balance of outpatient, elective and non-elective inpatients, a role in diagnostic services and the management of long-term conditions that require ongoing therapy.

Many of the services are in the front line, with responsibilities that involve direct and indirect support to emergency departments (ED) and admissions units, but some services may need to consider how they extend their roles to release other clinicians to support emergency care. In response to pressures on the NHS, the elective component of our work will need to be reduced to support emergency activity. However, the non-elective patient will continue to

[1] https://www.gmc-uk.org/news/news-archive/how-we-will-continue-to-regulate-in-light-of-novel-coronavirus

need care. We should seek the best local solutions to continue the proper management while developing and protecting resources for the response to COVID-19.

In addition, overall factors such as staff sickness, supply chain and the use of some facilities to develop additional inpatient capacity, including HDU and ITU resources, may impact on normal pathways of care.

Patients served by GIM can be considered in a few categories:

1. **Non-elective inpatients:** Continue to require admission and ongoing management, eg myocardial infarction, other infection, issues related to frailty. *We must expedite treatment to avoid delays and expedite rehab to minimise length of stay.*

2. **Diagnostic work:** This includes elective procedures such as angiography, endoscopy and biopsies. *The requirement for such procedures should be risk-assessed and deferred or delayed if possible.*

3. **Other elective admissions:** These include day-case procedures for infusions, interventional procedures or stabilisation. This includes both day-case and longer-stay episodes. *Consider whether the admission can be delayed, should be risk-assessed and deferred or delayed if possible.*

4. **Outpatients:** Outpatients cover a wide range of services. The principles should consider the balance of need for face-to-face contact, the interval of observation and the purpose of the visit. Review current lists to determine who can be discharged, those who can be delayed and those that still require some form of follow-up. They may also require a variety of diagnostic tests to support that visit. *Consider whether the visit can be delayed, cancelled, distance-managed (eg via primary care or telephone consultation) or remains necessary.*

5. **Other pathways:** Within GIM there are pathways of patient care that either confer additional risk through therapy or the underlying condition or have complex and multiple interactions with the health system. Examples include complex home ventilation, patients on biologics or other immunosuppressive regimes, cystic fibrosis, dialysis and solid organ transplantation*. These pathways need to be identified and risk-assessed to mitigate harm. These pathways often have small teams and are therefore fragile. Individual specialties are providing guidance via the royal colleges, specialist societies and the commissioning bodies*
   https://www.rcplondon.ac.uk/news/covid-19-expert-update-doctors

Leadership

- **A consultant must be designated as 'medical specialty lead consultant'.** Services can designate the scope of the role – it can cover a single specialty or be broader. This duty can be for one day, a few days or even five days in small units. This is an *essential* role during crisis management. It cannot be performed by the consultant 'on-call' or the consultant in endoscopy or Cardiac Catheter Suite lab. They must be free of clinical duties, and the role involves co-ordinating the whole service from ED throughout discharge or admission and liaison with other specialties and managers.
- **A leadership team should support the lead and include relevant members of the MDT**
- Establish a daily sitrep and dashboard with critical data to share across the workforce. That should include patient flows, workforce issue, stock levels and other key messages (eg state of COVID response, PPE requirements).
- It can be very stressful during a crisis. Support each other and share the workload. Do not expect the clinical director to do all the co-ordination. Short-notice sick leave rotas need to be developed. It helps no-one to be at work with COVID-19, and appropriate isolation and reporting applies to all. Support the juniors. This is potentially going to be a long process, so leave must still be allocated for down time.
- Identify pathways that require actions outside normal provider pathways, including contingency plans for supply chain issues.

Outpatients

- Routine follow-up outpatients can be managed by cancellation, delay, remote management or still require face-to-face attendance. Principles should be to reduce travel to provider organisations while maintaining continuity of care. Where patients do need to attend, consider the estate issues such as route to clinic, waiting areas and crowding.
- As the system comes under more pressure, these risk assessments will need updating.
- Consider the issues of provision of supporting diagnostics – eg phlebotomy, imaging or medications to minimise risk.
- Appropriate outpatient care may reduce the burden on the non-elective NHS. Rapid access clinics may prevent admissions or support discharge.

Inpatients including elective and non-elective

- Establish discharge planning at the start of an admission process.
- Consider preadmission triage with senior staff taking calls from primary care and nursing home facilities.

- Identify services across an organisation to support rehabilitation and discharge to maintain capacity.
- During the COVID-19 crisis, triage elective admissions to:
  - avoid unnecessary admission
  - reduce exposure of the individual to a hospital environment
  - free beds for more urgent cases.
- Increase use of same-day or day-case procedures where elective activity is still required.

Specialist pathways

Individual departments should consider other specialist pathways that need additional work to maintain activity as safely as possible.

EDs will change their system and will use triage at the front door and stream patients directly to inpatient areas before examination or diagnostics. Consider in-reach services that are consultant-led to pull patients needing admission to inpatient areas or facilitate rapid discharge to the community.

Identify and upskill staff to support other areas to release staff to manage COVID-19 cases. While not every clinician will feel they have the skills to manage every situation, they have important roles in supporting the system. That should be recognised and supported as clinical teams move into unfamiliar areas. Consider simple training refresher courses to reinforce skills.

Principles

- We should avoid unproductive attendances at hospital.
- Senior decision-making at the first point of contact should reduce or even prevent the need for further attendances.
- A decrease in elective work will allow for a greater senior presence at the front door and cross-cover in other areas
- Clinicians may need to work in unfamiliar environments or outside their subspecialist areas. They will need to be supported.
- Provide simple clear communication within your teams.
- Plan for the next stage and consider potential scenarios ahead of time.
- The risk benefit analysis of everything we do will change and evolve during this epidemic.
- We must support each other.

Covid-19 GIM escalation policy.

Prevalence of COVID-19	Low	Medium	High	Very high
Impact on organisation	Normal winter pressures Business as normal	Limited ITU Limited bed capacity	No ITU, emergency ITU in operation	Escalation to ITU restricted
Phase	Prepare to respond, reducing elective activity	Reduce/stop elective and routine activity	Redirect resource to emergency activity	Major incident
Elective inpatient activity	Identify activity	Reduce activity to critical time-dependent episodes of care	Stop activity	
Non-elective inpatient activity	Upskill staff Plan reallocation of staff to support emergency activity	Twice-daily consultant-led ward reviews Enhance rapid discharge planning Establish discharge and emergency access clinics Establish senior-led triage of referrals from GPs and nursing homes 24/7	In-reach to ED/ MAU to pull emergency activity away from front door Escalate discharge processes	Consider triage criteria
Outpatients	Identify activity and develop standard operating procedure (SOP) for remote access clinic	Delay follow-ups Identify diagnostic support services Begin remote access clinics	Increase discharge and emergency access clinic capacity to support discharge planning	Consider staff step-down options while maintaining activity to maintain staff resilience

Specific pathways	Plan	Phase 1	Phase 2	
Discharge planning and admission avoidance	Identify support and pathways for discharge planning. SOP for MDT-led discharge	Consider consultant receipt of referral calls from GP and nursing home/ community sources Specialty support to same-day emergency care services		