

## Coronavirus – Top 10 tips on what to do in primary care

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**Consider your balance between remote and face to face care – have you got it right and how might it need to change in the months to come?**

All public restrictions have now been eased and there is significant pressure in the press for GPs to return to seeing all patients face to face, with little understanding of the pressures that GPs are under. The RCGP is vigorously defending GPs against the allegations that we are hiding<sup>1</sup>. Consider what is right for your practice – many practices operated a triage model even before COVID-19 and others may consider that phone triage is a useful future model to deal with the pressures on general practice and to make best use of the widening of the primary care workforce to include staff such as clinical pharmacists.

Whilst face masks have become optional in many public areas, they should still be worn by patients and staff in healthcare settings such as GP surgeries<sup>2</sup>.

The decision as to whether a face-to-face appointment is needed is a clinical one which should ideally be made using the principles of shared decision making. The GP will also have to take into account the resources available to them and how important it is to reduce footfall (this may vary depending on local COVID-19 prevalence).

When deciding on remote versus face-to-face, consider the following:

- Does the patient need an examination that cannot be done by phone or video?
- Has the patient had several phone or video appointments for the same problem, which has not resolved? If so then they probably need to be seen in person.
- Is there something you are missing? Could they be in a situation of domestic abuse or coercion and not able to speak freely on the phone? Listen to your instincts and if you have any inkling that they may not be speaking freely, or if there is a past history of domestic abuse, then consider a face-to-face review alone.
- Does the patient have a condition for which a face-to-face appointment is preferable, even if not essential? For example managing patients with mental health difficulties remotely may miss non-verbal cues. Consider whether these patients should be seen in person for some appointments, with others being done remotely. Broadly speaking, remote consultations work best for more straightforward conditions, those which are more complex or sensitive are more likely to benefit from a face-to-face assessment. Remember though that for some patients with underlying complex problems but with a simple question, such as a repeat prescription or issuing a fit note, it may be appropriate to deal with their problem remotely.
- Remember that medico-legally clinical staff need to be able demonstrate that satisfactory assessment and decision making has taken place. If you aren't sure, it would be better to see the patient face-to-face.

As always, communication is important. Listen to what your receptionists are saying – are they explaining how remote assessment can work and benefit both patient and GP? Practices who implemented phone triage before COVID-19 often spent many weeks training reception staff, but the pandemic has meant that many haven't had the luxury of such training. Is now the time to think about reception training to ensure that staff are conveying the possible options to patients correctly? If you are a commissioner, consider whether your CCG should provide staff training resources at scale.



**Think about ongoing management of respiratory symptoms and be aware of the issues with COVID-19 in children and what to do if resuscitation is needed.**

Know what the 'hot hub' arrangements are locally for patients with symptoms that could be COVID-19 – they may include a physical hot hub, a visiting service, a saturations monitoring service or 'hot rooms' within individual practices. The initial contact should always be with the patient's own GP who should assess by phone and video, referring on to a 'hot hub' or similar only if a face-to-face appointment is necessary.

Remote management using home pulse oximetry has been shown to be safe, as long as there is clinical support available using a 'virtual ward' model<sup>3</sup>; in some areas, saturation monitors have been bought in bulk and distributed to patients for whom this will help the decision making process. Concern was initially raised that these devices may be less accurate in those with black or brown skin, however this issue is mainly for those with saturations of below 90%, who should hopefully be in hospital rather than being managed in primary care. As always, patient assessment should be holistic, rather than relying solely on a number from a saturation monitor, and the patient's usual baseline should be taken into account.

Guidelines have been published regarding resuscitation in primary care<sup>4,5</sup>. An arrest should be checked for by the absence of signs of life and normal breathing or the lack of a carotid pulse; do not put your face close to the patient's mouth to establish this. In the first few minutes after a non-asphyxial arrest, compression only CPR may be as effective as combined ventilation and compression. Ventilation is considered to be an aerosol generating procedure (AGP) by some authorities and should only be carried out if appropriate protective equipment is available. This includes a filtering face piece (FFP3) mask, often not available in primary care. If all you have is non AGP protective equipment (e.g. an apron, surgical mask, gloves and eye protection) then you should attach a defibrillator as soon as possible and shock if appropriate. If chest compressions are carried out then the patient's nose and mouth should be covered with a cloth. If a situation arises where mouth to mouth ventilation is carried out then a face shield should be used when available. No self-isolation is needed afterwards unless the patient has been confirmed positive for COVID-19.

Concerns have been raised that some children with COVID-19 will develop a multi-system inflammatory reaction which can require intensive care. This syndrome has been named paediatric inflammatory multisystem syndrome (PIMS)<sup>6</sup>; clinical features are similar to Kawasaki's syndrome. Most children with COVID-19 will only have minor illness but we should be on the alert for a small number of children who may become critically ill.



### Shielding has ended but QCovid is available for GPs who find it useful

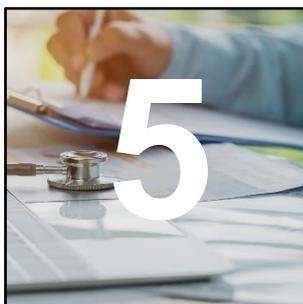
The shielding programme has now been closed down in all four countries of the UK<sup>7,8,9,10</sup>. More information about this is in [our eLearning resource, which is being regularly updated](#).

The QCovid calculator<sup>11</sup> has been developed by Oxford University and uses data from the first wave of the pandemic to calculate the absolute and relative risk of catching COVID-19 and being admitted, or catching COVID-19 and dying from it. GPs have access to QCovid if they wish to use it. It can sometimes be useful in a consultation, for example to reassure a patient who is nervous about attending hospital for an essential appointment.



### Think about which groups of patients may find it hard to access primary care with our current ways of working

With the move to full triage, we must be careful not to exacerbate health inequalities for some groups of patients, particularly those who are digitally excluded. More information about this can be found in the [recently published RCGP module](#) on health inequalities<sup>12</sup>. Don't forget those with mental health issues – there are NHSE resources to do with dementia<sup>13</sup>, learning difficulties<sup>14</sup> and autism<sup>14</sup> which may be useful. Consider how deaf patients will access your surgery if the main access point is on the phone<sup>15,16</sup>.



### Appraisal is restarting in a very light-touch way and the CQC have restarted inspections

- We are now half-way through the new appraisal year, with a new format involving significantly less need for documentation; preparation should only take around 30 minutes<sup>17</sup>.
- Changes to appraisal are summarised in [this useful video](#)<sup>18</sup>.
- Those who have missed an appraisal will not need to catch it up and will revalidate with one less appraisal in this revalidation cycle
- If you are due to revalidate after April 2021 and before your next appraisal, but have not yet been able to carry out your surveys then talk to your appraiser or appraisal office – in this situation revalidation will usually be deferred. Similarly, if appraisals are still happening in your area but you feel unable to take part in the appraisal process due to personal circumstances please talk to your appraiser or local appraisal office – there is understanding of

the recent difficulties and you are likely to receive a helpful and empathetic response.

- CQC inspections have restarted<sup>19</sup> – the BMA have expressed concern about the timing of this and called for a complete overhaul of the inspection process<sup>20</sup>.
- You do not need to do a med3 for anyone who is self-isolating, unless they need to be off work for more than two weeks. Those self-isolating for 7 days can use a self-certificate and if it extends for longer than that they can get a certificate online from 111<sup>21</sup>.
- Patients who ask their GP about problems at work, such as concerns that their place of employment is not COVID-19 secure, should be encouraged to talk to their union or ACAS<sup>22</sup> – there is no obligation on GPs to write letters to employers in this situation.
- If you are working somewhere different from usual, or working in a different way due to COVID-19, the government's indemnity scheme will still cover you. It will also cover new activity due to COVID-19 for which there is no existing indemnity in place. It is still good practice to act only within your level of competence<sup>23</sup>. It is always sensible to have your own indemnity cover and all of the major defence organisations have information about COVID-19 on their websites.
- Fit notes can be e-mailed or texted to patients – patients do not need to have the original with a 'wet' signature, but this can be posted if requested.



### Keep up to date with COVID-19 vaccination changes

As of 27.9.21, over 93 million COVID-19 vaccination doses have now been administered to UK citizens. All adults aged 18 or over have now been offered a vaccine and those in the original groups 1-9 (including healthcare professionals) are being offered a booster; preferred is the Pfizer/BioNTech or Moderna brand. A Pfizer/BioNTech booster is the same dose as given in the primary course but a Moderna booster is half the dose (0.25mls) that is given in the primary course. At the same time, many citizens continue to be offered either a first dose (if they have not come forward already) or alternatively a second dose of vaccine. The second dose is routinely being given at eight weeks, earlier for those who are due to start immunosuppressive therapy.

Patients with severe immunosuppression such as undergoing chemotherapy or having received a solid organ transplant, should be offered a third dose of their primary course of vaccination. This would be from 8 weeks after their second dose. This would be separate from and potentially in addition to any booster vaccine. Further information on this is available on these links for [England](#), [Scotland](#), [Wales](#), and [Northern Ireland](#).

The timing of second doses varies from area to area, with surge vaccination, including early second doses, taking place in some areas of high COVID-19 prevalence. The second dose is

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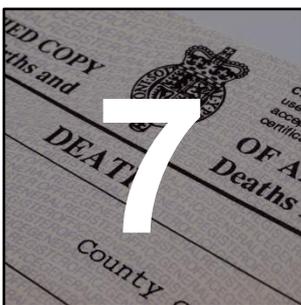
Vaccination has now also been offered to everyone aged 12 or over, with the 12-15 cohort largely being vaccinated in school<sup>24,25</sup>, though for those aged 12-15 who were offered the vaccine earlier due to co-morbidities it may also be done in GP or mass vaccination centres. At the time of writing, those aged from 12 to 17 and 9 months are being offered a single dose of the Pfizer/BioNTech vaccination only. This brand is being offered in preference to the Moderna vaccine as there is a smaller risk of myocarditis as an adverse effect<sup>26</sup>.

There is now less publicity about thrombosis after COVID-19 vaccination; this was a rare side-effect of the OAZ vaccine and should therefore be less of an issue as we use more Pfizer/BioNTech and Moderna for boosters.

Those with a history of anaphylaxis (to any allergen) had previously been told that they couldn't have the Pfizer/BioNTech vaccination but this has now been changed and the contraindication is only for those with allergies to a constituent of the vaccine<sup>27</sup>. For both Moderna and Pfizer vaccination, there remains a requirement for 15 minutes observation after vaccination due to the risk of anaphylaxis. It does not apply to Astra Zeneca vaccine, though patients should not drive within 15 minutes of receiving the OAZ vaccine. Pregnancy, breastfeeding and being on an anticoagulant are not a contraindication to either vaccine and women who are pregnant are recommended to have vaccination with either Pfizer/BioNTech or Moderna.

At the start of the vaccination programme there were significant restrictions on how the Pfizer/BioNTech vaccination could be moved once it had been defrosted; these have now been relaxed somewhat, which makes it easier to give in community clinics. It can now be stored in a fridge after defrosting for 31 days (increased from five)<sup>40</sup> and can be moved for up to two journeys of six hours each, or one journey of twelve hours (including initial delivery to the main site). Once reconstituted, the vaccine should be carried by hand when possible and drawn up next to the patient<sup>41</sup>.

The RCGP has a short eLearning module on the [COVID-19 vaccination](#) as well as a new reference on [anaphylaxis and the COVID-19 vaccination](#). Any other queries are likely to be answered with reference to the relevant chapter of the [Green Book](#).



**Death certification requirements are relaxed for as long as the Coronavirus Act is in force**

You can put COVID-19 on a death certificate if the patient was diagnosed clinically but did not have a swab<sup>28</sup>.

Significant changes have been made to death certification and cremation paperwork. These include the fact that paperwork can be emailed, the doctor filling out the death certificate and cremation paperwork does not need to have seen the patient in life and there is no longer a need to see the body after death. For more detail on this, [see our short module](#) on death certification.



### Look after yourself and your staff

Anyone who actually listens to the security briefings on a plane will know that you should put your own oxygen mask on before helping others. The same principle applies here; if you get ill, you won't be able to care for your patients or help your colleagues. As well as using PPE if you see patients with possible coronavirus, look after your mental health by taking the time to debrief and by taking breaks when needed. An occupational health opinion could be sensible for some GPs with chronic conditions for whom a practice based risk assessment is not enough. If your mental health is affected, consider using some of the services available for GPs, such as practitioner health<sup>29</sup>, and the NHS wellbeing support line<sup>30</sup>.



### Continue to plan ahead; this will be a marathon, not a sprint

Schools are open, although colleagues may be affected by children being sent home with COVID-19. There may also be an absence of wrap around care, so check if any of your staff are affected by this and need to change their hours. Could they switch to doing core clinical work in the surgery and admin from home after the kids are in bed?

Contacts of COVID-19 who are double vaccinated no longer need to self-isolate, but some healthcare settings have their own rules and ask staff who are contacts to work from home for a period of time. Consider how you would manage a patient-facing member of staff with a household contact who is positive for COVID-19.

Much routine care has now restarted, including smears, with priority for those with a previous abnormal smear or those with severe mental health problems or who are otherwise vulnerable. Remember that all women with HIV should have annual smears<sup>31</sup> and consider prioritising them. Make sure that what you are doing is sustainable for you and your practice. Childhood immunisations must continue. Guidance has been issued<sup>32</sup> as to which patients on warfarin can be safely switched to a DOAC which will help to reduce attendances at anticoagulation clinics. Guidance on spacing out DMARD monitoring<sup>33</sup> has now been retired and normal monitoring was resumed in August, however this may need to be reconsidered depending on pressures on phlebotomy and other services. Consider restarting the fitting of long-active contraceptive methods if this is something that you or your practice normally provide. The Primary Care Women's Health forum<sup>34</sup> has produced a series of webinars on the practicalities of doing this as well as other information on women's health during lockdown and the Faculty of Sexual and Reproductive Health also has information on their website about restoration of services<sup>35</sup>.



### Your core clinical skills are still important

Not every ill patient will have coronavirus and remember that “normal” things still occur. Even under pressure allow space for patients to tell you what’s wrong with them. Keep an open mind, think laterally, and suspend your judgement as it saves time in the end. Consider which are the relevant questions to ask; your core clinical skills are your most reliable tools. If ‘pattern recognition’ is not working, re-frame your ideas using first principles and using probability and an analytical approach. Learn to tolerate uncertainty and share this with the patient. Most of us have long been aware of the importance of recognising when a patient ‘makes your antennae twitch’ and this has been validated in a study<sup>36</sup> showing the importance of GP gut feelings, so don’t underestimate the importance of listening to your inner voice. Make sure that you document that your triage decisions are made due to COVID-19 so that if your decisions are called into question in years to come you remember the surrounding circumstances. NICE have brought out a guideline about the management of COVID-19, including end of life symptoms<sup>37</sup>. If your patient needs referring to secondary care then you should still make the referral rather than holding onto them in primary care. You may be starting to see patients who are affected by long covid – find out if there is a multidisciplinary long covid clinic in your area and read the NICE guidelines<sup>38</sup> and RCGP eLearning resources<sup>39</sup> on long covid.

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DOI – Dr Hazell is on the executive committee of the PCWHF, a role which involves both paid and unpaid work. The quoted BMJ paper on remote oxygen saturations monitoring was co-authored by Dr. Jonathan Leach, RCGP Honorary Secretary.