East of England Ambulance Service NHS Trust

COVID-19 Frequently Asked Questions – Clinical Assessment

Clinical Directorate

April 2020 V1.0

COVID-19 Frequently Asked Questions- Clinical Assessment

The situation regarding the COVID-19 pandemic is continually changing as more is learnt about the virus. This can cause problems with protecting ourselves and the public and affect the care which we deliver to our patients. We fully acknowledge the anxiety and stress that this pandemic may be having on our clinicians.

To support clinicians and empower them to make decisions which may deviate from normal best practice, we have developed this document to answer some frequently asked questions

Primarily, we must limit our exposure to patients to protect ourselves and the public. During this unprecedented time, our practise may deviate from the usual guidance which we follow.

General exposure and reducing risk to yourself

When someone calls 999, there are often concerned family members or bystanders in the room. Am I allowed to ask them to leave, as we are often in their house?

You must consider that everyone has a responsibility to socially distance themselves at this time. It is reasonable to ask any person to leave the room who is not directly involved in the patient's care, in a professional manner. There are of course circumstances when it would be beneficial to have a chaperone in the same room, such as when treating a child. In these situations, ask the parent/guardian to be in the room whilst maintaining a sensible distance.

What personal protective equipment should I use?

Check Need to Know regularly for the most up to date guidance on what the appropriate PPE is to use in specific circumstances.

What equipment should I take into the house?

At this time, the minimal equipment required should be taken into a property to reduce the risk of contamination. For every patient, the response bag and a defibrillator should be taken to the front door initially. Once the patient's needs are known, you can then identify exactly which equipment should be taken to their side. Further equipment can then be gathered based on the patient's needs.

If it is obvious from the patient's reported condition that further equipment will be needed i.e. a cardiac arrest, such equipment can be taken to the patient's side when it is known that the patient is viable for resuscitation.

There is a high chance that the patient I am attending, or one of the relatives in the house, has COVID-19. Are there any further precautions I should take to reduce the risk to myself?

If there is a high risk that somebody in the house is suffering from COVID-19 i.e. they have been suffering with a fever or have a new, continuous cough, it would be acceptable to ask the patient to either come to the front door or make their way to the ambulance (environmental and presenting condition permitting) to undertake your clinical assessment.

If the patient is unable to make their way to the ambulance, it may be beneficial for only one member of a double-staffed crew to enter a property, to confirm the treatment requirements of the patient, if it is safe to do so.

Clinical Assessment

We are taught to visualise the airway during a primary survey to identify blood, foreign bodies, swelling, and to observe the tongue. Will we need to modify how we do this?

In most cases, little will be achieved by closely inspecting the patient's airway. If the patient can hold a verbal conversation with you continuously, their airway can be assumed patent. Instead, spend a bit longer taking a history from a distance and document that a formal inspection of the airway has not been done. This is perfectly acceptable as we are going to have to rely more on the end of bed assessment and appearance. If the patient has a clear or developing airway obstruction, closer inspection will still be required; ensure adequate PPE is donned.

Can I still use airway adjuncts?

Yes. Please continue to manage a patient's airway as per the Clinical Practice Guidelines and airway cascade.

We are reminded about performing peak flow readings, as these form part of the care bundle for respiratory conditions. Does the risk of asking the patient to exhale forcefully need mitigating?

To minimise exposure to the virus, if the patient has their own device coach them to provide a reading, ensuring you are over 2 meters from the patient. You may provide the patient a peak flow if they do not have their, coach them through the process at a distance and then move over 2 meters whilst they provide a reading.

Do we continue to look, listen, and feel for a patient's breathing when assessing for a cardiac arrest?

No. Putting your cheek close to the patient's mouth is increasing your potential exposure and is not required. It is acceptable to look for signs of life, feel for a pulse and observe the absence of breathing.

We have always been taught to inspect, palpate, percuss, and auscultate (IPPA) when undertaken a full respiratory examination. Is it acceptable not to do this currently, even with COVID-19 being a respiratory condition?

It is recommended that a visual inspection of the patient's chest from a distance is continued, as a lot can be achieved by observation. If the patient's respiratory rate is normal and they are not using accessory muscles to breathe, they have no difficulty in breathing, are well perfused and their oxygen saturations are good further examination may not be required, If auscultation is required please consider undertaking whilst standing to the side of the patient ensuring appropriate PPE level 2 is worn.

Best practise is to take and record a minimum of two sets of observations for both patients we convey and those we do not. Can we reduce this to a single set whilst trying to keep adequate distance?

If the patient's first set of observations are within normal parameters, and there is no visible deterioration of the patient, it would be acceptable to just do one set to limit your proximity and exposure to the patient.

What do I do if the patient is actively coughing or sneezing?

Please provide the patient with a surgical mask at the earliest opportunity. Ensure appropriate PPE is donned for any contact with a patient.

Can I still assess a patient's circulation by palpating their pulse sites?

Yes, you can still take a patient's pulse, particularly if you have concerns over its efficacy, but this would involve being in closer proximity to the patient.

For all close proximity examinations and interventions please ensure these are not direct face to face, and that a "from the side" approach is used, explaining this process to the patient.

It is better to assess the patient visually and at distance initially. This would mean assessing for signs of poor perfusion indicating that they may have an issue with their circulation. This would include pallor, cyanosis, or reduced levels of consciousness for example. Utilising a pulse oximeter probe (when available) can assist assessing a patient's heart rate from an increased distance. Diaphoresis (sweating) can also be an indicator that the patient has got circulatory problems.

Should I continue to undertake ECGs?

Balanced against the risk of being in close proximity to the patient, there needs to be an indication to do an ECG.

Consider, if appropriate, to ask the patient or a relative to place the ECG electrodes and leads and monitor the patient's heart rhythm remotely by splitting the Corpuls modules.

Can I still undertake a GCS or AVPU score?

As with all other advice, if you can assess a patient's level of consciousness from a distance, please do so. However, if a patient is not responding as normal and may require airway, breathing, or circulatory assistance, please don appropriate PPE and manage your patient. A more detailed GCS can then be calculated.

Can I still measure a patient's blood glucose level?

Yes, this is unchanged. As per ECG advice though, only perform this test if it is clinically indicated. If the patient has a normal level of consciousness and is not displaying any signs of hypo- or hyperglycaemia, it is not necessary to undertake a blood glucose measurement.

Other Clinical Assessment

As with any of the guidance in this document, it is advised that a safe distance is maintained between yourself and patients when clinically safe to do so. Therefore, do not undertake any examinations or tests when they are not indicated.

If an examination is indicated i.e. a neurological exam, consider an abridged version with as little patient contact as possible. For example, a FAS test can be undertaken at distance by good explanation and observation of the patient's ability to perform the tasks.

Summary

The purpose of this document is to reduce the risk of you becoming infected with COVID-19 whilst still undertaking your role in the most effective manner. It is vitally important to remember that not every patient which we attend during this time is going to have COVID-19 – there will still be patients presenting with other pathologies.

It is about adjusting your assessment to what is reasonable for the patient and the current pandemic situation. It is about trying to maintain hands off and keeping your distance where you can. There will be circumstances where this is not possible, and the Trust has provided appropriate PPE and guidance on when to utilise this for your protection.

Modification of clinical assessment, such as the changes within this document, are recognised to be outside of normal practise but will need to be considered during this unprecedented time.

The Trust will support clearly rationalised decision-making, including those decisions made with remote clinical support. On occasion, this may be outside of normal guidance and will be based on the circumstances encountered. These decisions must always be documented on the (electronic) patient care record.

For any questions relating to this emergency guidance, please email the clinical lead team at clinical.leads@eastamb.nhs.uk

This FAQ document is likely to be updated regularly as new guidance is received.