CLINICAL INSTRUCTION

To: All clinical staff

Date: 5th February 2021

Document number: CI105

Following feedback nationally the COVID-19 Clinical Decision Tool has been further revised and updated for clinicians ('face to face' or 'hear and treat'), with a view of supporting safe disposition decisions.

Throughout the COVID-19 pandemic, our understanding of the virus as a disease process has continued to develop both in identifying transmission and severity. This has resulted in opportunities to review previous guidance issued to ambulance clinicians.

This updated tool to the one introduced in January 2021 has been revised and now **approved by the National Ambulance Medical Directors (NASMeD) group on behalf of the Association of Ambulance Chief Executives (AACE) and also NHSE/I.** The updated and revised tool will soon be added to JRCALC Clinical Practice Guidelines and available to all UK ambulance Trusts to use.

With **immediate effect**, ambulance clinicians are to **use this tool** to support decisions surrounding disposition in patients where the **most likely working impression is COVID-19**. **Please can all previous versions be destroyed including the one introduced on 21st January 2021.**

Applying the tool:

A clinician **must** undertake a **thorough clinical examination**, then consider the likely differential diagnosis based upon patient presentation, clinical findings and history. Once other pathologies have been excluded**, if the best working impression is COVID-19 then this tool should be utilised**.

Patients with severe or moderate symptoms will be conveyed to hospital unless an advanced care/treatment plan is in place.

If a patient is presenting with mild symptoms, they **may** be suitable for non-conveyance with appropriate safety netting, worsening advice and referral. It is important that if non-conveyance is being considered an **exertion test** is performed. Experience of COVID-19 has shown exertion tests are an effective predictor at identifying those at most risk of deterioration. Two different exertion tests are recommended, ambulance clinicians should **select the most appropriate test for their patient**. Where it is felt that neither can be safely undertaken for their patient, then please discuss with the Clinical Advice Line (CAL) in the first instance.

The sit-to-stand test:

- Using a standard height chair (ideally without armrests) positioned against a wall
- The patient needs to be seated upright on the chair with knees and hips flexed at 90^0
- Ask patients to put hands on hips (or folded across their chest) and arms are kept stationary
- Record heart rate and oxygen saturations on air

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COVID-19 Clinical Decision Tool - continued

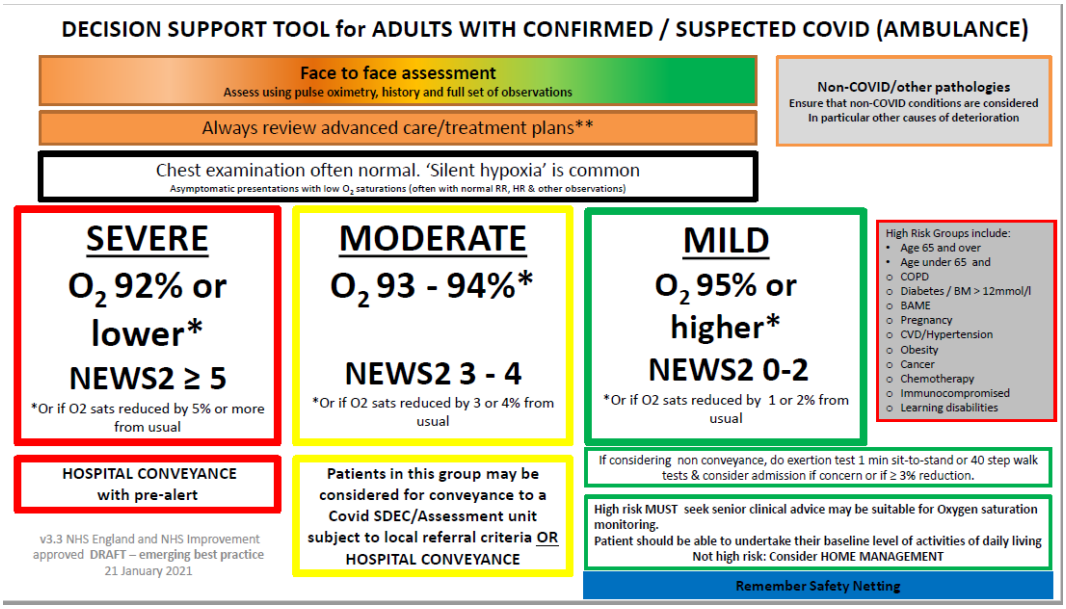
- Check that the patient's oxygen saturations are above 94% before proceeding.
- Ask patient to stand straight upright and then sit down again, repeating this for 1 minute. Their bottom must contact the chair on each repetition
- Record the number of times they can do this in 1 minute. There must be a minimum of 5 cycles for the test to be diagnostically significant
- Re-measure the patients pulse oximetry levels after exercise

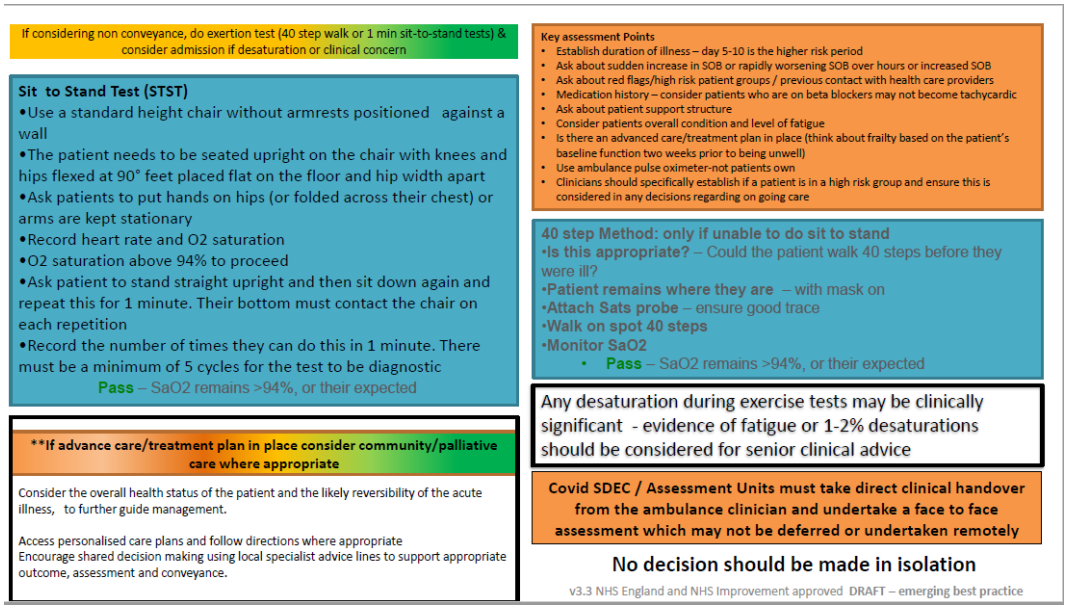
40-step test:

- The patient is instructed to remain where they are – with a suitable face mask on
- Attach an oxygen saturation probe and ensure a good pleth trace
- Check that the patients oxygen saturations are above 94% on air
- Ask the patient to walk on the spot for 40 steps
- Re-measure the pulse oximetry levels after exercise

In either test, a reduction in oxygen saturations of 3% or more is significant and admission should be considered, though any reduction in oxygen saturations may be clinically important.

For patients with normally low oxygen saturations (i.e. those with COPD) please follow the asterixed guidance in the flow chart.





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