

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

16 March 2020

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

General and internal medicine (GIM) covers a wide range of specialties with a different balance of outpatient, elective and non-elective in patients, 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 may need be curtailed. However, the non-elective patient will continue to need care. We should seek the

best local solutions to continue the proper management while developing and protecting resources for the response to coronavirus.

In addition, overall factors such as staff sickness, supply chain shortages and the use of some facilities to develop additional in-patient capacity including high dependency unit and Intensive Treatment Unit resources may impact on normal pathways of care.

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

- **Non elective in-patients:** Continue to require admission and ongoing management, eg myocardial infarction, other infection, issues related to frailty. We must expedite treatment to avoid delay and expedite rehabilitation to minimise length of stay.
- **Diagnostic work:** This includes elective procedures such as angiography, endoscopy, biopsies. The requirement for such procedures should be risk assessed and deferred or delayed if possible.
- **Other elective admissions:** These include day-case procedures for infusions, interventional procedures or stabilisation. This includes both day-case and longer stay episodes.
- **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. 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.
- **Specialist 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.

When planning your local response, by service area, please consider the following:

Leadership.

- **A consultant must be designated as ‘lead consultant’.** 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 clinic or the consultant in theatre. They must be free of clinical duties and the role involves co-ordination of the whole service from emergency department (ED) through to theatre scheduling 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 coronavirus response, personal protective equipment (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!
- 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 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.

In patients including elective and non-elective

- Establish discharge planning at the start of an admission process.
- Across an organisation identify services to support rehabilitation and discharge to maintain capacity.
- During the coronavirus crisis, triage elective admissions to:
 - avoid unnecessary admission
 - reduce exposure of the individual to a hospital environment.
 - free-up beds for more urgent cases
- Increase use of same day or day cases 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 in patient areas before examination or diagnostics.**
Consider inreach 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 coronavirus 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.
 - Clinicians may need to work in unfamiliar environments or outside of their sub-specialist 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.

Prevalence of coronavirus	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	Reduce/stop routine activity	Redirect resource to emergency activity	Major incident
Elective in patient activity	Identify activity	Reduce activity	Stop activity	
Non elective in patient activity	Upskill staff Plan reallocation of staff to	Twice daily consultant led ward reviews	In reach to ED/MAU to pull emergency	Consider triage criteria

	support emergency activity	Enhance rapid discharge planning Establish discharge clinics to facilitate	activity away from front door Escalate discharge processed	
Outpatients	Identify activity	Delay follow ups Identify diagnostic support services Commence remote access clinics	Increase discharge clinic capacity to support discharge planning	Consider staff step-down options while maintaining activity to maintain staff resilience Deploy medical students and physician aides to support OP activity
Specific pathways	Plan	Phase 1	Phase 2	