Scenarios representing management of patients where there is concern regarding COVID 19 / SAR-CoV-2 virus infection presenting to general practice. Version 1.0 09/03/2020

Introduction

It is recommended that patients who have a concern regarding possible infection with COVID 19 /SARS-CoV-2 infection should contact their doctor by telephone. Attendance at the GP practice should be avoided however it is necessary to consider and plan for unplanned attendance at the GP practice. The following scenarios are intended to provide a guide to factors to consider when planning for such an attendance and dealing with such an attendance.

This is a rapidly evolving situation. This document is likely to require review and improvement on and regular basis. GPs with questions or suggestions for improvement may contact Nuala O'Connor (Nuala.OConnor@ICGP.ie) or Martin Cormican (martin.cormican@hse.ie) by email and please copy to Donna.McNena@hse.ie

Scenario 1 (Best outcome – Patient does not enter the surgery)

JD comes to a GP surgery with a fever for a day and a cough and shortness of breath. He does not have an appointment. He sees the sign on the door of the surgery and asking him to phone first if he has been affected area. He goes back to his car and phones the receptionist. The receptionist puts the call to the GP. GP checks the algorithm at www.hpsc.ie talks to patient confirms returned from Beijing 10 days ago and has cough and feels feverish but is not in any distress. GP advises wait in the car and that GP will (a) telephone JD from their office while JD is seated in the car or (b) walk to the car to do quick visual check while talking to JD on the phone. If GP walks to car JD should be advised to keep the window closed when GP approaches the car. GP calls from their office or walks to the car park (bringing surgical mask and alcohol hand gel in case of unforeseen requirement) to clarify details and assess if distressed. GP asks JD to wait in the car, to call the practice number again if he feels unwell and that someone from the practice will check with him by phone from time to time that he is OK.

OUTCOME: GP calls public health. Following discussion with public health it is agreed that JD may self-transport to a receiving hospital by for testing at an agreed time and location or public health contacts the NAS and arranges testing at home or transfer to a receiving hospital. GP will NOT be involved in taking tests.

Scenario 2 (Patient enters the surgery but is immediately identified)

JD comes to a GP surgery with a fever for a day and a cough and shortness of breath. He does not have an appointment. He sees the sign on the door of the surgery and asking him to phone first if he has been in an affected area. A taxi dropped him off at the surgery and he left his phone at home. He approaches the receptionist and tells them that he saw the sign on the door, he came back from an affected area 10 days ago but has no phone to call and in it is raining and freezing outside [See Note 1]. Receptionist asks him to clean his hands with gel and gives him a surgical mask or tissues to cover his face. There is an empty room available. The receptionist directs him to the empty room and closes the door. The receptionist performs hand hygiene and then alerts the GP. The GP finishes with the patient he is seeing.

If the circumstances allow for the GP to speak to JD without entering the room this may avoid the risk of exposure.

If the GP needs to enter the room, the GP cleans their hands with alcohol hand rub puts on PPE as per video and enters room to speak to patient bringing the healthcare risk waste bag into the room [See Note 2]. JD confirms he returned from northern Italy 10 days ago and has cough and feels feverish. GP can see he has flu like illness but is not in any distress. GP checks that he has tissues /mask and advises to wait in the room. GP tells him someone will check on him through the door every 10 minutes or so but asks the patient to answer through the door not to open the door. GP removes PPE except surgical mask and puts into the healthcare risk-waste bag. GP leaves the room bringing the healthcare risk waste bag with them. GP closes the door, removes surgical mask and puts into the healthcare risk waste bag. GP closes the bag and then places the bag inside another bag for disposal as healthcare risk waste. GP performs hand hygiene.

OUTCOME: GP calls public health who link with NAS and arrange transfer to a receiving hospital or may arrange testing at home if there is someone who can come to take JD home.

GP goes back to seeing patients in his usual room [Note 3]. NAS arrive or own transport arrives. Patient with face covered (with mask or tissues) walks out of the surgery. The door of the room where patient waited is closed, locked if possible and signage do not enter is placed on the door.

It is good to leave the room for at least an hour to make sure droplets are settled and may be starting to dry. If the room is not needed it can be left for longer – the amount of viable virus on any surface in the room will decline with time so if the room is not required nothing is lost and safety of whoever cleans the room is likely to be increased somewhat by leaving it overnight. Note also if planning ahead is it a good idea to have the designated room you might use with a minimum of clutter and stuff. In so far as possible the room should not have any books, papers, decorative items or toys and the minimum of furniture and no soft furniture. The extent to which this is possible will depend very much on the individual GP surgery however; the less stuff there is the room the easier the clean-up.

Making the room safe to use – decontamination:
After an interval (of an hour or more if possible) a member of staff wearing a disposable apron and gloves enters the room with a pack of combined detergent/disinfectant wipes such as those issued to GPs in the PPE pack. There is no requirement for mask or goggles because there is no one there to generate droplets by coughing or sneezing and any droplets that were there will have settled. The member of staff checks that all horizontal surfaces are visually clean. The staff member then wipes all horizontal surfaces (table tops, seats of chairs, shelfs) and the backs of chairs and other contact surfaces including door handles and the area of the door around the door handles with combined detergent/disinfectant wipes. The staff member disposes of used wipes as healthcare risk waste. The walls and floor do not require any particular attention unless contaminated with blood or body fluids. The healthcare worker removes the apron and gloves and disposes of them as healthcare risk waste and then performs hand hygiene. After the surfaces are dry the room is available for re use. If gloves become damaged at any stage during cleaning the gloves should be removed, hand hygiene performed and fresh gloves used.

Scenario 3 (Patient enters the surgery and is identified after a brief delay).
JD comes to a GP surgery with a fever for a day and a cough and shortness of breath. He does not have an appointment. He does not notice the sign on the door of the surgery asking him to phone first if he has been in China. The receptionist is busy so he has to wait his turn to speak with them (waits 10 minutes in line and coughs a couple of times). He tells the receptionist that he has a cough and a temperature and feels a bit short of breath. He does not mention that he has been in China and the receptionist forgets to ask but remembers that all patients with a flu-like illness should be asked to clean their hands and be given a mask or tissues to cover their face if they have to sit in the waiting area. There are 10 other people waiting.

After 40 minutes wait one of the doctors has a slot free and the patient enters the doctor's examination room. The doctor asks about recent travel and finds out that JD came back from Beijing 10 days ago. The doctor cleans their hands immediately and is careful to keep their hands away from their face.

Depending on the clinical circumstances and practicality the GP

a) explains that they need to leave the room and that the will speak to the patient from a distance (for example by phone if the patient has a phone with them)
   OR
b) explains that they will need to leave the room for a few minutes to put on gloves and a mask and that they will be back. GP cleans their hands with alcohol hand rub puts on PPE as per video and enters room to speak to patient bringing the healthcare risk waste bag into the room.

JD confirms he returned from Beijing 10 days ago and has cough and feels feverish. GP establishes that JD has flu like illness but is not in any distress. GP checks that he has tissues /mask and advises him to wait in the room. GP tells him someone will check on him through the door every 10 minutes or so but asks the patient to answer through the door not to open the door.

If GP has used PPE they remove PPE except surgical mask and puts into the healthcare risk-waste bag. GP leaves the room bringing the healthcare risk waste bag with them. GP closes the door and removes surgical mask and puts into the healthcare risk waste bag. GP closes the bag and then places the bag inside another bag for disposal as healthcare risk waste. GP performs hand hygiene.

OUTCOME: GP calls public health who link with NAS and arrange for testing at home or transfer to a receiving hospital. NAS arrive or own transport arrives. (Note 3] Patient with face covered (with mask or tissues) walks out of the surgery. The door of the room where patient waited is closed, locked if possible and signage do not enter is placed on the door.

GP goes back to seeing patients in another room if there is a room that they can use. [see A member of staff records the name of all the patients who were in the waiting area. A visual signal to patients to avoid the area where the patient was sitting is improvised – the goal is to avoid anyone sitting within 1 m (3 Ft.) of where the patient was sitting. NAS or someone who can drive JD home arrives. Patient with face covered (with mask or tissues) walks out of the surgery. The door of the room where patient waited remains closed, locked if possible and signage do not enter is placed on the door.

Note if the practice has a single consultation room it will is generally preferable not to see further patients until the JD has been transferred and an hour has elapsed and the room has been cleaned and surfaces allowed to dry.

It is good to leave the room for at least an hour to make sure droplets are settled and may be starting to dry. If the room is not needed it can be left for longer – the amount of viable virus on any surface in the room will decline with time so if the room is not required nothing is lost and safety of whoever cleans the room is likely to be increased somewhat by leaving it overnight. Note also if planning ahead is it a good idea to have the designated room you might use with a minimum of clutter and stuff. In so far as possible the room should not have any books, papers, decorative items or toys and the minimum of furniture and no soft furniture – this will make clean up much easier).

After an interval (an hour or more if possible) a member of staff wearing a disposable apron and gloves enters the marked off area in the waiting room with combined detergent/disinfectant wipes. There is no requirement for mask or goggles because there is no one there to generate droplets by coughing and sneezing and droplets generated by JD will have settled and be partially dried at this point. The staff member disposes of any disposable materials (papers and similar) into healthcare risk waste. The member of staff checks that all horizontal surfaces are visually clean. The staff member then wipes all horizontal surfaces (table tops, seats of chairs, shelfs) and the backs of chairs and other contact surfaces including door handles and the area of the door around the door handles with combined detergent/disinfectant wipes such as those provided in the PPE pack. The staff member disposes of used wipes as healthcare risk waste. The walls and floor do not require any particular attention unless contaminated with blood or body fluids. The healthcare worker removes the apron and gloves and disposes of them as healthcare risk waste and then performs hand hygiene. After the surfaces are dry the area is available for re use. If gloves become damaged at any stage during cleaning the gloves should be removed, hand hygiene performed and fresh gloves used. The staff member enters the examination room and follows a similar process. The room is now available for normal use.

Scenario 4 (Patient enters surgery and moves around freely in the waiting area for an extended period)

JD comes to a GP surgery with a fever for a day and a cough and shortness of breath. He does not have an appointment. He does not notice the sign on the door of the surgery asking him to phone first if he has been in China. The receptionist is busy so he has to wait his turn to speak with them (waits 10 minutes in line and coughs a couple of times). He tells the receptionist that he has aches and pains all over and has no energy. He does not refer to respiratory symptoms. He does not mention that he has been in China. The receptionist asks JD to take a seat. The practice is busy. He is sitting in the middle of the reception area for an hour and a half standing up and moving around from time to time and coughing and sneezing from time to time. When the doctor is free the patient goes into the examination room and the GP establishes that JD has a flu-like illness. GP asks about recent travel and finds out that JD came back from Beijing 10 days ago. GP can see he has flu like illness but is not in any distress. GP immediately performs hand hygiene. GP checks that he has a tissues /mask and advises to wait in the room and explains that he will now leave the room. GP tells him someone will check on him through the door every 10 minutes or so but asks the patient

to answer through the door not to open the door. GP leaves the room, closes the door and performs hand hygiene.

GP calls public health and NAS and arranges transfer to a receiving hospital or home testing if someone is available to drive patient home. GP goes back to seeing patients in his usual room [see Note 3 above]. NAS arrive or own transport arrives. Patient with face covered (with mask or tissues) walks out of the surgery. The door of the room where patient waited is closed, locked if possible and signage do not enter is placed on the door.

GP goes back to seeing those patients who were waiting in another room if there is a room that they can use. A member of staff records the name of all the patients who were in the waiting area while JD was there. A sign is placed on the entrance door indicating that the surgery has had to close temporarily and the door is locked. Note there is unlikely to be any value in asking patients who are already in the waiting room to leave before they are seen if there is a room available in which they can be seen. NAS arrive or own transport arrives. Patient with face covered (with mask or tissues) walks out of the surgery. The door of the room where patient waited remains closed locked if possible and signage do not enter is placed on the door.

GP will discusses with public health re communication/debriefing of others working in the practice and communication with patients who may have been exposed. Staff debriefing to include importance of respecting patient confidentiality.

When all the patients who were waiting to be seen have been seen and have left the surgery it should be left for an hour. If practical it can be left for longer – the amount of viable virus on any surface in the room will decline with time so if the room is not required nothing is lost and safety of whoever cleans the room is likely to be increased a bit by leaving it overnight.

After an interval (an hour or more if possible) a member of staff wearing a disposable apron and gloves enters the waiting room with combined detergent/disinfectant wipes. There is no requirement for mask or goggles because JD is not there to generate droplets by coughing or sneezing and any droplets will have settled at this point and be starting to dry. The staff member disposes of any disposable materials (papers and similar) into healthcare risk waste. The staff member then wipes all horizontal surfaces (table tops, seats of chairs, shelfs) and the backs of chairs and other contact surfaces including door handles and the area of the door around the door handles with combined detergent/disinfectant wipes. The staff member disposes of used wipes as healthcare risk waste. The walls and floor do not require any particular attention unless contaminated with blood or body fluids. The healthcare worker removes the apron and gloves and disposes of them as healthcare risk waste and then performs hand hygiene. After the surfaces are dry the area is available for re use. If gloves become damaged at any stage during cleaning the gloves should be removed, hand hygiene performed and fresh gloves used. The staff member enters the examination room and follows a similar process. The room is now available for normal use.

Note 1. In some circumstances it may be practical and preferable for the patient to wait outside the practice if there is a place that affords adequate shelter and away from other people.

Note 2. There is not an absolute requirement for PPE if the GP is confident that they can retain a safe distance (at least more than 1 m) from the patient while in the same room as the patient performing a brief assessment however there is risk that if something unforeseen happens there will not be an opportunity to put on PPE quickly. If in any circumstance a GP considers that donning PPE is not required while in the room assessing the patient at a minimum they should be scrupulous about hand hygiene, avoid putting their hand to their face and have surgical mask and gloves to hand which can be put on quickly.

Note 3. In this scenario, the patient has no car and no phone but if the patient has had close contact, where they live with a person who can be contacted and is willing to transport them to the receiving hospital JD may self-transport to a receiving hospital by for testing at an agreed time and location. JD should not use public transport.

Note rationale for scenario

The staff including the doctor can continue to see patients while awaiting test results after they have performed hand hygiene. Even if the healthcare workers were exposed, because of lapses in hand hygiene or PPE use and may have become infected they are unlikely to shed virus during the period of waiting for the test result. Note if they develop symptoms of respiratory virus infection at any time they should immediately cease work– healthcare workers with flu like symptoms should never see patients regardless of which virus is the cause of infection.

There is also then a second order question which arises in the context of that person subsequently been proven positive and whether any further steps would be advised in that context (after horse has bolted really but needs to be asked)

If the result is positive and the doctor did not adhere to good hand hygiene practice and appropriate use of PPE they would most likely be managed as a close contact and may be advised to avoid patient contact until at least 14 days after exposure at least in this high containment phase. If we have to move to mitigation this would perhaps need to be reconsidered.

It is important to remember that pathways might change as the pattern of COVID 19 in Ireland evolves. However, basic principles of how you, your practice team and patients stay safe will not.

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