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Guidance for practices

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Please be aware that this is a rapidly evolving situation.

Guide to Support Nurses in General Practice to Care for Patients During the Covid-19 Era

The aim of this guide is to support nurses working in general practice with caring for and monitoring the health of patients with long-term conditions, during Covid-19 and potentially beyond. As nurses working in general practice it is important to recognise that we come from a wide range of career backgrounds, we each bring our own knowledge, skills and experience to our role, and that we practice within our competences. With the full QOF scheme in abeyance this year, this guide endeavours to identify the key areas that are familiar to most general practice nurses – reflecting the templates on our systems - whilst acknowledging the range of practice and expertise that exists among us and in our practices. We hope you find this resource helpful and are interested in your feedback.

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Note: Please prioritise your patient lists once recall registers can be restarted (based on blood pressure control, blood test control, when last seen face-to-face (F2F) etc.). Those that did not meet the target last year should be a particular priority for follow up once normal service resumes.

LTC	Remote/online assessment (telephone if patient does not have IT access/ability)	Video assessment	Essential F2F assessment	Defer until safer to do F2F assessment	Notes
Atrial fibrillation	Review notes: • Calculation CHA2DS2-Vasc and HAS-BLED scores and check medication concordance. • Highlight those that are not taking anticoagulation and refer to GP/independent prescriber if CHA2DS”-VASc ≥2.		Essential to monitor INR. For those practices that provide in-house INR monitoring see: Medicines management: drug monitoring during the Covid-19 pandemic.		• Consider the practice/CCG criteria for switching patients to a DOAC and refer to GP those that may be suitable, this should reduce the requirement for INR monitoring. • Not all practices offer INR monitoring it will depend on local agreements.

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People with chronic heart disease (CHD). Secondary prevention of CHD	• To enable remote monitoring encourage patients to have their own blood pressure (BP) machine and agree process for providing and reviewing readings. • Review can be performed remotely. • Medication review including lifestyle advice flu/pneumo advice where appropriate.	Consider video assessment when review due – check concordance with meds and general observations.	• Annual Influenza vaccination and pneumococcal if appropriate. • Subject to the individuals last blood test date and the practice protocol, may need to do a monitor blood test if these were abnormal prior to Covid-19 or if >1 year since lat normal test. • If doing a blood test ensure all the annual blood tests are done at the same time	Measurement of cholesterol, renal function if previously satisfactory.	• Consider looking at the list and prioritising those that did not meet the target last year and arrange follow up once normal service resumes. • Some patients have home BP monitors. • Consider medication review: check if bloods required, renal function, lipids, defer. • Identify those that are not taking antiplatelet or anticoagulant and pass list to GP/independent prescriber to prioritise for early review. • Consider a phone call remind and encourage them to have flu vaccine in the autumn and lifestyle discussions with nurse, only defer BP check if no access to home monitoring.

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Heart failure	Home monitoring to include: • Check of symptoms including shortness of air/breath. • Blood pressure. • Weight. • If appropriate check Coordinate My Care (CMC) plan in place. • Medication review including lifestyle advice flu/pneumo advice where appropriate.	Consider video assessment when review due – check compliance with medication and can check for oedema, weight and general observations.	May need to do blood monitoring if was abnormal prior to Covid-19 – depends on stability and degree of heart failure.		• If locally available, check if patient is in contact with heart failure community nurses and that they have their protocols. • Review coding of when heart failure was diagnosed (coding ECHO is often missed). • Review notes and identify patients to contact once normal services are resumed. • ACE/ARB can only be started/up titrated if it is possible to monitor renal function.

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Hypertension	• To enable remote monitoring encourage patients to have their own BP machine and agree process for providing and reviewing readings. • Review can be performed remotely. • Can access home BP chart and instructions from BIHS. • Medication review including lifestyle advice flu/pneumo advice where appropriate.		Continue essential blood monitoring. See: Medicines management: drug monitoring during the Covid-19 pandemic		• Depending on practice capacity, stratify patients based on either last or average BP to prioritise those for review. • If patient does not have or is not able to be provided with a BP monitor for home monitoring, may need to be brought in to have BP.

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Peripheral arterial disease	• Establish if they have their own or can purchase BP machine and send in details via email. • Can access home BP chart and instructions from BIHS. • Check medication concordance. • Lifestyle advice. • Using the features defined by nice, grade into asymptomatic, intermittent claudicaton or critical ischaemia. • Smoking cessation advice where required.	Depending on severity consider a video assessment – check for overall limb perfusion, pain, oedema and capillary refill time.	If following video assessment concern regarding critical ischaemia will need F2F assessment by GP/ANP for pulse checks and further management.	If on video assessment no evidence of poor perfusion to limbs, pulse checks can be delayed.	

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Stroke and transient ischaemic attack	• Establish if they have their own or can purchase BP machine and are able to send in details via email. • Can access home BP chart and instructions from BIHS. • Check taking medications including antiplatelet/anticoagulant and no side effects (eg gastro and taking PPI). Warn re: red flags. • Maybe on warfarin so see AF for monitoring requirements. • Consider how any long term neurological deficit impacts on ADLs. • Enquire if any change in neurological symptoms. • Discuss lifestyle changes including diet, exercise and smoking.		• Continue essential blood monitoring. • See: Medicines management: drug monitoring during the Covid-19 pandemic. • Annual influenza vaccination and pneumococcal if appropriate. • For blood pressure monitor need to risk stratify patients See BP strat advice.		Review notes and pass list to GP/independent prescriber

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Diabetes	• Screen notes to help prioritise and risk assess patients. • Can measure own blood glucose where indicated. • Consider the use of ketone monitoring in high risk patients. • Can buy own BP machine and send in details via email. • Can access home BP chart and instructions from British and Irish Hypertension Society (BIHS). • Medication review including concordance and that taking all appropriate preventative medications. • Discuss lifestyle modifications and health promotion.	Consider if the patient would benefit from a video assessment especially if there are concerns including blood glucose control.	• May need urgent bloods if HbA1C was higher than 75 pre Covid-19. • Consider frequency of other required blood tests including eGFR, according to clinical need. • Sign post to BP advice above. • Active diabetic foot problem. • Annual Influenza vaccination and pneumococcal if appropriate.	Foot check for those without an active diabetic foot problem, retinopathy, etc	• Priority for review to those with high/very HbA1c and/or high BP see NICE T2DM guidelines for treatment targets. • Only initiate/titrate ACEi/ARB if able to monitor renal function. • Could be contacting and reviewing lifestyle factors especially as exercise levels may have changed due to current situation and anxieties high. • May also need to prioritise poorest IFCCs as capacity allows. • Referral to clinical pharmacist as appropriate.

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Asthma	• Measure peak flow at home – prescribe one on FP10 if they do not have. • Download peak flow diary with symptom diary from Asthma UK. • Send up-to-date asthma action plan. • Signpost to UK / Rightbreathe for Inhaler technique videos. • Either remotely or by telephone complete a full symptom review including exacerbations, SABA use. • Review medication and concordance. • Discuss lifestyle modifications.	To assess inhaler technique.	Annual Influenza vaccination and pneumococcal if appropriate.		• Prioritise patients for review based on risk stratification (SABA use, emergency admissions, oral steroid use). • Inhaler technique can be done via video call and/or link sent to "right breathe". -Could put note on scripts about pharmacy checking when patient collect scripts. • AccuRx has an option ("florey") to offer the RCGP questions to be sent out by text, it would be important to offer follow up by video/phone call those that are not RCGP controlled. • For those patients with asthma aged 14 or over who have not attained the age of 20, on the register, in whom there is a record of smoking status in the notes they could be assessed via phone call - caution needed as mobile numbers may be their parents.

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Chronic obstructive pulmonary disease	• Either remotely of via telephone complete a full symptom review including current Symptoms, MRC Score, Medications, Concordance, Triggers, Exacerbations, Treatment plan, new symptoms, rescue packs, safety netting and C19 management Use MyCOPD. • Use Rightbreathe for IT. • Check has rescue pack if appropriate. • For severe COPD and If appropriate check CMC in place. • Discuss lifestyle including smoking cessation advice.	• Consider a video consultation if you need to assess respiratory rate, effort of breathing or general appearance. • SATs if possible.	• If symptoms are worsening, need to make sure it is not Covid-19. • Annual Influenza vaccination and pneumococcal if appropriate.		• AccuRx have a text system ("florey") that could be used to ask MRC score or CATScore. • These scores must be reviewed and follow up arrange either telephone or video. • For those percentage of patients with COPD and MRC score >3 at any time in the preceding 12 months with a subsequent record of an offer of referral to a pulmonary rehabilitation programme. • This could be done by notes review and then followed by telephone/video call to offer pulmonary rehab.

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Dementia	• Dementia reviews would normally be undertaken by a GP or specialist team. • Establish that there is appropriate support for carer – via phone call, video. • Tel call- patients are often frail, elderly with dementia so there is a need to speak to carers and care home staff in care homes. • If severe dementia, consider need for CMC plan.	If severe dementia and end of life care consider regular video view of patient with careers every 28 days.			• Consider other co-morbidities. • Are there any new symptoms – do they need new medications? Are they taking current medication? • Notes review - to check plan in place. • **Carers**: Ask if they are connected to local authority carer network and young carer network. • Needs GP/clinical pharmacist review to consider rationalisation of medication using STOPP-START decision aid.

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Depression	• Depression reviews would normally be undertaken by a GP or specialist team. • Signpost patient to utilise online support and apps. • Make sure patients know the 24hr contact number for urgent help and support including Samaritans. • Check in notes for any safeguarding concerns. • Consider utilising PHQ-9 and GAD-7 questionnaires. • Medication review.	Consider if it is appropriate and beneficial to assess via video consultation in order to establish a sense of eye contact, body language and overall mental state.	Patients exhibiting significant suicidal ideation.		• Notes review to identify those that are coming up for a review. • Check that they are taking their medication and discuss lifestyle factors and what social support networks they have in place. • Consider referral to SPLW as appropriate. • Liaise with local community mental health teams as appropriate. • The frequency of follow up / review will depend on a number of factors including severity of the condition and should be determined in discussion with the patient.

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Mental health	• Signpost patient to utilise online support and apps. • Make sure patients know the 24hr contact number for urgent help and support including Samaritans. • Check in notes for any safeguarding concerns. • Consider utilising PHQ-9 and GAD-7 questionnaires if appropriate and refer to GP if not improving despite treatment or is deteriorating.	It would be appropriate and important to assess via video consultation in order to establish a sense of eye contact, body language and overall mental state. If there are any issues regards non-contact/have refused contact, they will require more regular contact as they may be deteriorating.	• Depot injections (if administered by the practice). • If on lithium ensure appropriate blood monitoring		• Ensure blood monitoring is up to date, arrange if overdue. • All care plans will need reviewing in 2020.

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Cancer	• Cancer reviews would normally be undertaken by a GP or specialist team. • Consider making contact to provide support either telephone or video. • Discuss shielding if patient is considered very high risk • May need to discuss ACP issues if this has not been carried out previously. • Check CMC plan set up.				Review register and patient notes to identify those patients that are coming up for review, pass list to GP for clinical review.
Chronic kidney disease	• Remote BP monitoring. • Discussion with patient regarding blood results and urine ACR (when available) and BP control. • Home monitoring of weight. • Medication review. • Lifestyle advice including smoking cessation advice.		• May need to have bloods done if needs close monitoring of renal function. • Annual Influenza vaccination and pneumococcal if appropriate.		Access renal service as needed – remote service is set up in many places. Would need renal function and Albumin: creatinine.

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Epilepsy	• Epilepsy reviews would normally be undertaken by a GP or specialist team. • Annual review including fit frequency, medication review etc can be done remotely.				If increasing fit frequency would need discussion with epilepsy specialists to determine if needs a titration of medication or neurological assessment
Liver disease	Carers may need supportive contact call.			Maintain contact but otherwise defer until safer to do F2F assessment unless problems occur.	

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Osteoporosis	• Check that patients are taking their medication especially if patients are not as active due to reduced activity. • May need warning to reduce risk of falling as Covid-19 risk if they have a fracture. • Medication review. • Lifestyle advice including smoking cessation advice			Planned follow up DEXA scanning.	• For those patients aged 75 or over with fragility fracture and osteoporosis. • Phone call if the patient is extremely frail or has dementia speak to carers or care home staff in they are in a care home. • Reviews are done as part of medication reviews.
Rheumatoid arthritis	• Some patients are on shielding list - consider a phone call contact. • Remote assessment of joint activity, using the DAS score (leaflet and app available) • Medication reviews.	To assess any acutely inflamed joints.	DMARD blood monitoring.	Maintain contact but otherwise defer until safer to do F2F assessment unless problems occur.	

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Palliative care	• Need regular scheduled contact for support. • Refer to palliative care team. • Check CMC record set up. • Medication review including need for EoL medications.	• Advisable to aid emotional support of patient/family. • Enable further assessment of symptoms including pain control.	Based on need and safety (consider risk to both patient, family and clinician).		Maintain a list for regular review of these patients.
Cardiovascular disease primary prevention				Maintain contact but otherwise defer until safer to do F2F assessment unless problems occur.	
Blood pressure					See hypertension
Obesity	• Encourage exercise/follow diet plans etc. • Maintain weight diary/chart. • Shielding as appropriate.			Maintain contact but otherwise defer until safer to do F2F assessment unless problems occur.	

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Useful resources

- Long-term condition management resources for practice nurse teams
- HEE webinar on management of long-term conditions during Covid-19
- Information & support for nurses working within general practice during Covid-19
- Post Covid-19 recovery: primary care support for long term condition management
- RCGP Learning: Remote consultation and triaging