

Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of emergency department patients during the coronavirus pandemic

November 2020

As doctors we all have general responsibilities in relation to coronavirus and for these we should seek and act on national and local guidelines. These are constantly evolving and we should adhere to the latest advice available (which may change from the information contained in this document). Guidance from NHS England and NHS Improvement and Public Health England (PHE) is being frequently updated as the national caseload and required response is evolving.

Your trust will have an Incident Management Team in place and you will have plans on what activity continues in light of pressure on services and staffing. Please consult with your local management team. We must engage with those planning our local response. We may also need to work outside of our specific areas of training and expertise and the General Medical Council (GMC) [has already indicated its support for this](#) in the exceptional circumstances we may face.

Personal protective equipment (PPE)

As frontline clinicians, it is imperative that all members of your staff understand the importance of PPE and that all guidance is made clear to them. Any clinician assessing patients **suspected or confirmed to be infected with** coronavirus should wear appropriate PPE. Please check the [latest PHE guidance](#).

This is currently a fluid-resistant surgical mask, single-use disposable apron and gloves and eye protection if blood and/or body fluid contamination to the eyes or face is anticipated.

Currently, filtering facepiece respirators (FFP3) masks are only required for coronavirus positive patients and/or suspected positive patients requiring aerosol-generating procedures – this includes non-invasive ventilation (NIV), optiflow, intubation, open suctioning, tracheostomy, high speed drilling and bronchoscopy. Please see guidance from PHE and consult with your local infectious diseases team if in any doubt, and note that guidance on this may change.

Categories of acute patients to consider

1. Obligatory inpatient emergency admissions: Continue to require admission and may require emergency management.

It will be necessary for each admission area for medical patients (Acute Medical Unit [AMU], emergency department [ED]) to create parallel systems to separate patients with respiratory symptoms from those with other clinical presentations.

The management of the non-respiratory cohort should:

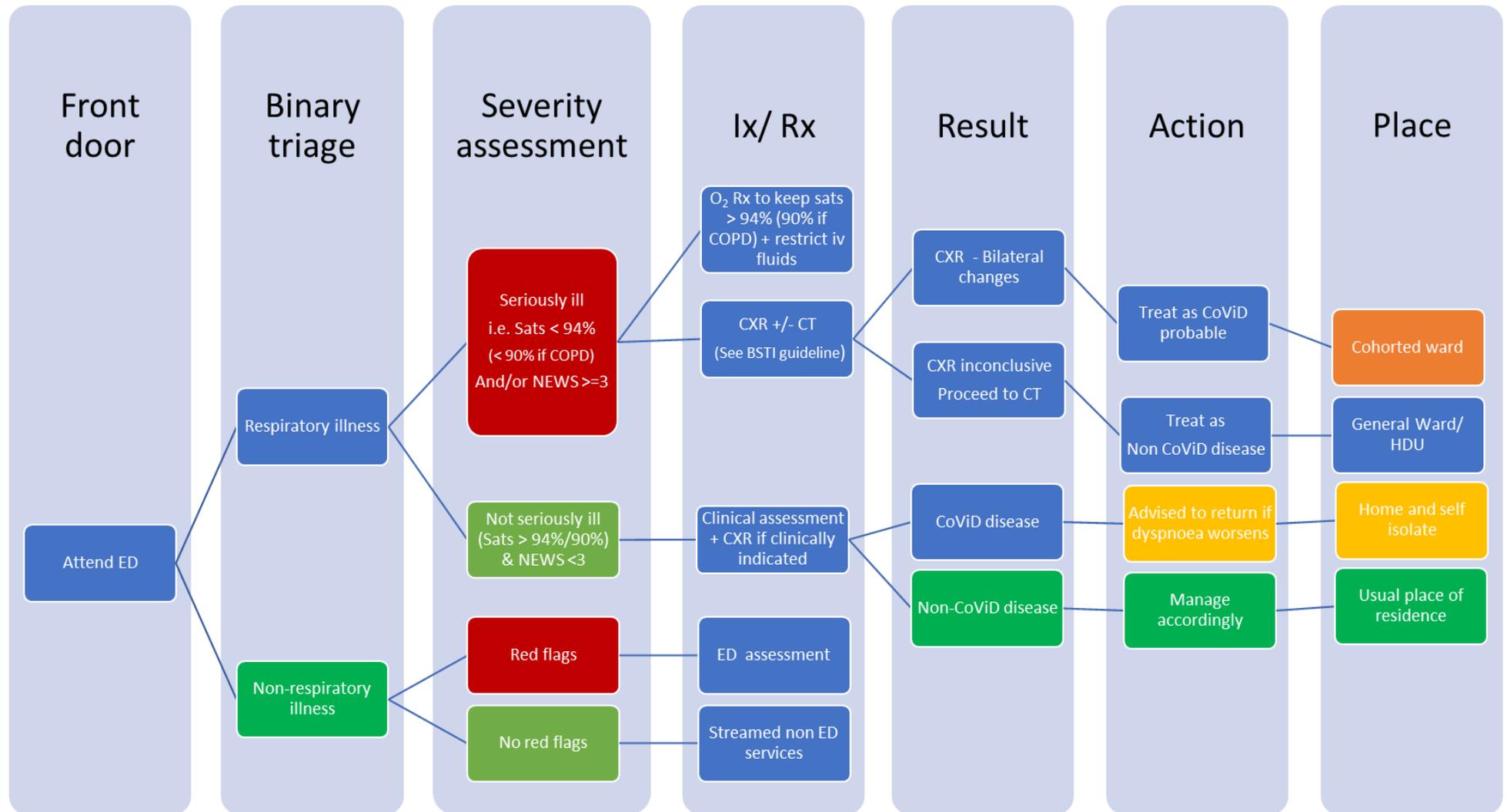
- aim to manage without admission
- use capacity from other specialties for whom elective work will be stepped down; especially Trauma and Orthopaedic (T&O), Obstetrics and Gynaecology (O&G), Ear, Nose and Throat (ENT), and ophthalmology, as these can be rapidly streamed at the front door
- make appropriate use of staff most at risk to their own health from coronavirus.

For the respiratory cohort, the priorities must be:

- an environment and equipment that best safeguard the health of the staff dealing with these patients
- severity assessment of the illness
- establishing a differential diagnosis based on history, examination, haematological, biochemical and chest X-ray (CXR) findings
- judicious use of CT where this will change decision making (see [British Society of Thoracic Imaging \[BSTI\] guidance on thoracic imaging in COVID-19 infection](#)):

See Figure 1 flowchart below outlining key steps in optimising the acute care pathways for all patient groups.

Figure 1: Possible flowchart for ED attendances



See also the [BSTI NHSE COVID-19 radiology decision support tool](#).

Patients discharged to home/usual place of residence will not be swab tested. Contact with these patients will be maintained by community home management teams. They must be advised to return to hospital if they become short of breath.

2. Clinical presentations not requiring admission:

(Taken from same-day emergency care guidelines, documents and expert advice from national clinical directors)

Expect **not** to admit overnight the following:

Clinical specialty	Emergencies that do not require admission
Respiratory	Pneumonia/chronic obstructive pulmonary disease (COPD) without oxygen/NIV requirement. May need initial antibiotics and assessment of response (yet may not require an overnight stay). Asthmatic with peak expiratory flow rate (PEFR) > 75% best or predicted. Pulmonary embolism without physiological compromise.
Central nervous system	Stroke with residual deficit not affecting activities of daily living. Transient ischemic attack. Cognitively impaired patient with minor head injury (GCS15) taking oral anticoagulation. Seizure patient who has recovered.
Gastrointestinal	Haemodynamically stable gastrointestinal bleed. Gastroenteritis taking oral fluids with normal/minimally changed urea and electrolytes.
Cardiovascular	New non-ventricular dysrhythmia adequately rate controlled. Acute coronary syndrome without high sensitivity troponin elevation at 6 hours. Syncope without electrocardiogram (ECG) conduction defect, rhythm disturbance or hypotension.
Musculoskeletal	Patients requiring physio/analgesia alone. Upper limb fracture. Fracture of the lower limb except femur, tibia, calcaneum. Dislocation following reduction. Minor stable vertebral fractures.

General surgery	Renal biliary colic in whom pain is controlled. Abdominal pain with normal CT and pain controlled. Abscess not showing signs of sepsis. Haematuria without clot retention, hypotension or anaemia.
Bacterial infection	National Early Warning Score (NEWS) ≤ 3 with clinical decision for oral antibiotic or same-day emergency care intravenous.
Toxicology	Overdose patients with non-toxic levels or asymptomatic 6-12 hours after ingestion (guided by ToxBase).
Other	Patients on an end of life pathway or for whom ceiling of care does not require hospitalisation.

All patients in the above groups who are not admitted must receive appropriate follow up, wherever possible by telephone/video call etc.

Advice for patients with flu-like symptoms who are not being admitted

PHE has published clear [guidelines on the first 7 days of illness](#).

- If at any point after discharge, a patient feels that:
 - they cannot cope with symptoms at home
 - their condition is getting worse after 7 days **or**
 - they feel that their symptoms (excluding cough) have not improved in 7 days

they should seek help via the NHS 111 online coronavirus service or call 111 if they cannot access help online. If their situation is an emergency, they will need to contact 999.

Please be aware [isolation guidelines](#) may be updated as we move from Contain to Delay to Mitigate phases.

Update information

November 2020: hyperlinks in this document were updated when the suite of guidance was moved from NHS England to NICE.

17 March 2020: version 1 published.