Remote consulting: a survival guide

Primary care has done the most AMAZING pivot in the past few weeks, dealing with a new and novel clinical condition and, for many of us, completely changing the way we are working. We are (*mostly!)* triaging ALL patients by telephone and consulting with many by telephone or video.

For some of us, this is business as usual. For many, it is either new or of a volume we have never encountered before. Many of us are worried about quality of care, and this creates anxiety. The GMC, CQC and information commission have all said they will take account of these exceptional circumstances when judging medical care over this period.

This *may* also become the new normal: as patients and clinicians try it, they may prefer it. So, it could be here to stay.

This article has been developed from numerous sources including 'Video consultations: a guide for practice' by Prof Trisha Greenhalgh, web-based learning resources by Dr Hussain Gandhi (Dr Gandalf of eGPlearning) and others as referenced.

What is the evidence for video/telephone consulting?

- Large body of evidence that these methods of consulting are broadly safe and acceptable for low-risk patients, generally with long-term conditions.
- Very limited research on their use in an acute epidemic setting or in primary care (this is absence of evidence rather than evidence of absence).
- In order to be effective, good, dependable technical connections are important. If these are not achievable, video offers no benefit over telephone consulting. Major breakdowns in technology disrupt the quality of the remote consultation.

Hierarchy of consultations

Patients are getting used to a different kind of primary care consultation. The primary care standard operating procedure (as updated 19/3/2020) states that ALL patients requesting an appointment in primary care should be triaged by telephone. What type of information or appointment they are offered will depend on their need, and could be seen as a hierarchy.

Consultation type	Who for?
Self-care with reference to resources	Worried well or mildly symptomatic patients may not need any clinical input at all. Sources of support include: • NHS 111 online resource. • Practice website. • PHE information DIRECT to patients. • Sympathetic, well-trained receptionists – they make a big difference and may divert up to 25% of patients! The media, government and PHE will also be signposting to self-care.
Telephone consultations	Useful both **to triage** and **assess** in the current situation. **There is no need to use video if telephone will do**. Can be done if: • You are self-isolating (but not if you are ill!). • There is a risk of transmission from patients (so that would be almost anyone at the moment!). • There is a need to provide remote support to a different town with high sickness levels. • Technologically easier than video for patients and some clinicians.
Video consultations	In addition to the reasons for considering telephone consultations, we may pick video if: • Patient prefers to see a clinician's face! • You need to eye-ball the patient (to use your GP-jedi skills, to look at a rash or tonsils, etc.). • The consultation sounds 'higher risk' or 'more serious' on a telephone call. • The patient is anxious – there is a more 'therapeutic presence' with video, and therefore potentially a more effective consultation.
Face to face	Who needs to be seen? A rough guide includes those who: • Are unable to access or use the technology. • Are complex, unwell, comorbid and there is uncertainty about the need for admission. • Are homeless. • Have a learning disability.

When should we NOT use remote consulting?

Our first contact with patients will be remote triage or consultation. As a general principle, these scenarios will need to be seen face to face:

- Assessing patients with serious high-risk conditions who are likely to need physical examination (**including high-risk groups for poor outcomes of COVID who are unwell)**. *Guidance for home visiting is expected imminently and will require significant thought about service design, PPE and the need to avoid cross-contamination.*
- Any examination that cannot be deferred, e.g. acute abdominal pain, gynaecological assessment where serious pathology is suspected.
- Patient cannot use or does not have the technology to participate, e.g. dementia, some learning disabilities, homelessness, some mental health problems.
- Some deaf or hard-of-hearing patients may find it difficult to participate (video may be better than phone for lip reading or use of chat function).

How to do remote consulting: good practice

These are general points important for all types of remote consulting.

Set the context	Copy and paste 'Remote triage during COVID-19 epidemic 2020' or use an embedded template with this information already contained, e.g. Primary Care Pathways.
Confidentiality and demographics	• *"Hello, please may I speak to (the patient's forename)?"* Now confirm FULL name, date of birth and first line of address. • Use an auto-consultation or macro, or copy and paste 'Patient identity checked and confirmed'. • AFTER you have confirmed you are speaking to the patient or the patient has given permission to speak to a relative, start your consultation: "*My name is Dr Red Whale, calling from Sunnyside practice. How can I help you today?".*
Make use of the golden minute	• It is tempting to forget this on telephone consultations, but allowing the patient or relative to speak for a full minute (if needed) uninterrupted will save time in the long run. • It is also important for another reason: in that first minute, try to make the best assessment you can as to whether this can be dealt with by phone/video consulting. • If it cannot and is definitely going to need to be seen/home visit, gently stop the consultation and arrange the next step – otherwise you will duplicate effort.
Start with open questions	• Often when we consult on the phone, we revert to closed questions much sooner. • Open questions will offer a more satisfying consultation for you and the patient, EVEN when we are under immense time pressure.
How to interrupt	• If you need to interrupt to clarify or ask some additional questions, wait for a natural pause or the end of the sentence (it is harder by telephone because neither you nor the patient have visual cues).
Safety-netting	• Be specific. Tell them what you would expect to happen if all goes well, when you would be worried (e.g. too breathless to talk, unable to keep down fluids) and what to do in that situation. • Offer written back up if possible, e.g. you can use AccuRx to send text message links to information, e.g. the 'When do I need to worry?' leaflet for children, below.
Housekeeping	• Take breaks (yes, REALLY) – as with any consultation type, decision fatigue can be a problem. • Particularly at this time, we need to connect (even if briefly) with our colleagues several times a day, eat, drink and go to the loo.
Technical stuff	• If at all possible, use a headset (ideally blue tooth) as the sound quality is likely to be better, and it means that your hands are free to do other administrative tasks if needed.
Practicalities	• Avoid interruptions – remote consultations should have the SAME status as face-to-face consultations, and the same measures should be put in place to protect the interaction from interruption.

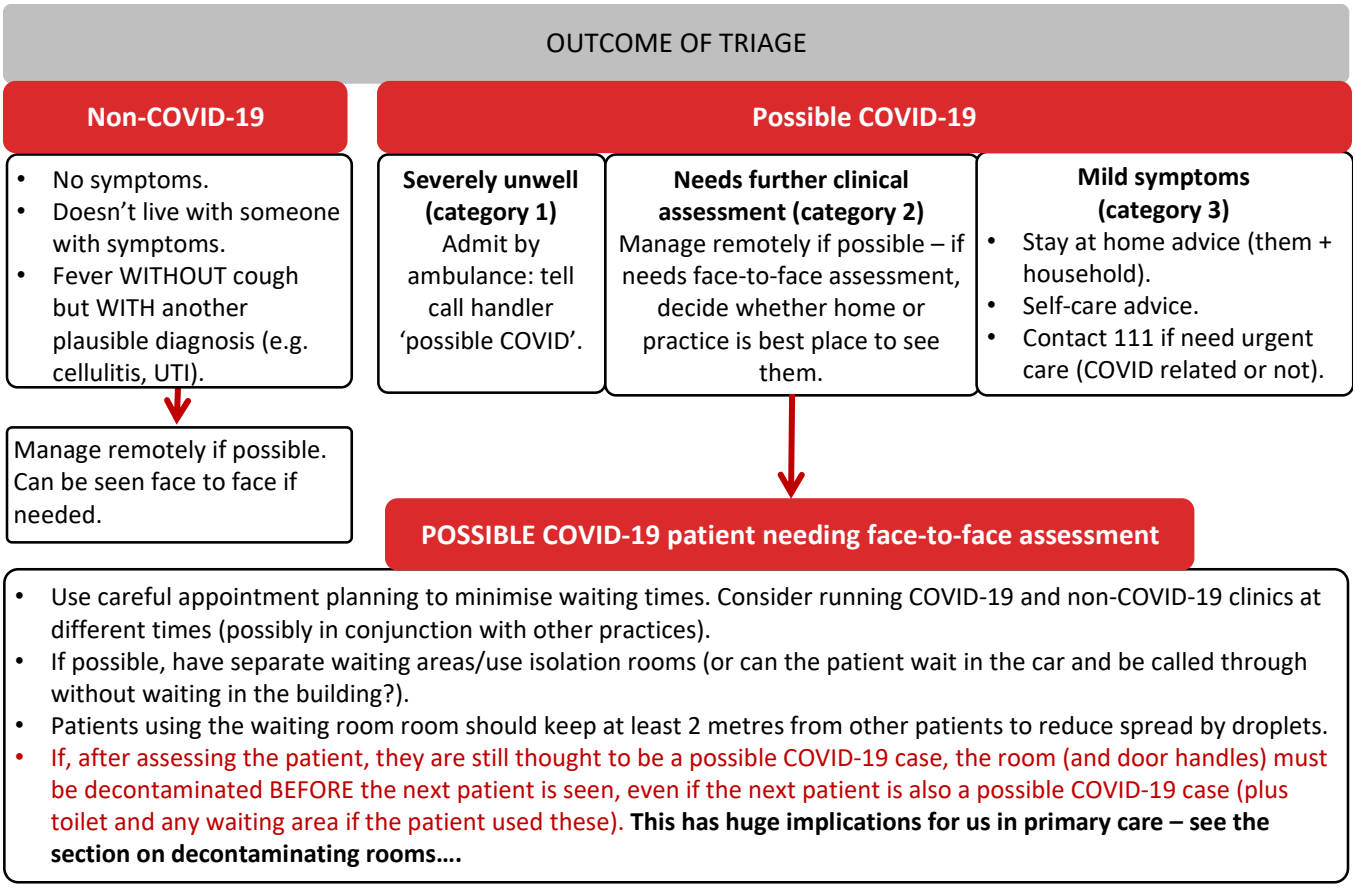
Specifics for video consultations

Before	• Is this problem suitable for a video consultation? • Are you in a private, well-lit room? • Make sure you have the patient's phone number in case the connection fails. • Do you have access to the medical record on a separate screen?	
Starting the consultation	• Check technical set up: "*Can you hear me? Can you see me?".* • If you can, look at your camera, not the screen. It creates the feeling of making eye contact. If you look at the screen, you may find it harder to build rapport. • Record verbal consent for the video consultation. • Introduce everyone in the room and ask the patient to do the same.	

	• Reassure the patient that the consultation will be very similar to what they are used to. • Then formally start: "*How can I help you today?*".	
Closing the consultation	• Summarise the key points carefully as it is easier for the patient to miss things on a video consultation, particularly if there has been interference. • Ask if any clarification is needed. • At the end: "*If there is nothing further, I am going to close the call now. Goodbye*".	

Triage flow in primary care

This was correct as of 23/3/2020:



Remote assessment of respiratory status

The Oxford Centre for Evidence-Based Medicine did a rapid review of the evidence to determine if there are any evidence-based ways to assess dyspnoea by telephone or video. The quick answer is that there are not. So, we are going to be doing a LOT of this in a void of evidence.

Instead, it made 4 recommendations on the basis of expert consensus (the best we have!) of 50 clinicians who regularly assess patients by phone. These are incorporated into the tips below.

Here are some tips to help us to make these decisions:

Could this be COVID-19?	• COVID-19 typically dry and persistent cough. • Phenomenon of 'day 5 deterioration' being reported. • Other patterns of productive cough, dyspnoea without fever or cough, diurnal variation and wheeze, etc. may make us consider other possible diagnoses. • Coryza or allergic symptoms make COVID *less* likely but not impossible. • Also remember: ALL THE OTHER CAUSES OF RESPIRATORY PATHOLOGY WILL STILL HAPPEN. • **Think carefully about children,** remembering that most have a mild course of COVID-19: could this be sepsis, croup, bronchiolitis, bacterial pneumonia, etc…?
History and functional assessment	• Ask the patient to describe their breathing in their own words, and assess how easily they can speak. • What is the patient doing now? *(Lying down vs. able to do usual activities.)* • How much are they able to do in comparison with normal? • If speaking to a relative: "*How would you describe their breathing? Can I listen?".*
Align with NHS 111 symptom checker	• *"Are you so breathless that you are unable to speak more than a few words?"* • *"Are you breathing harder or faster than usual when doing nothing at all?"* • *"Are you so ill that you've stopped doing all your usual daily activities?"*
Is there evidence of deterioration?	A clear story of a deteriorating picture is important: • *"Is your breathing faster, slower or the same as normal today?"* • *"What could you do yesterday that you cannot do today?"* • *"What makes you breathless now that did not yesterday?"*
Speech	• Able to complete sentences? Speaking with ease?
Medication use	• Frequency of use of reliever medications in comparison with normal. • What impact are these having?
Observations/tests	• Some patients have instruments at home: BP machine, oxygen sats probe, peak flow, etc. If they do, make use of these. • If necessary, show your device and how to use it if the patient is unfamiliar. • Try to count respirations over the telephone or video screen. • You could use the Roth Score as a proxy measure of dyspnoea and oxygen saturations – see below.

The Roth Score: a proxy measure for hypoxia

The Roth Score can be used as a quick and reasonably accurate proxy measurement for hypoxia. As pragmatists, many of us will use this over the coming months, but we should remember that it has NOT been validated in primary care in this context so should be taken as part of the whole clinical picture (Clinical Cardiology 2016;39(11)636).

Doing the Roth Score

To get your patient to do the Roth Score, you need a stopwatch (or second hand), and you need to ask them to:

- Take a deep breath in and count from 1 to 30 out loud (in their native language) as quickly as possible.
- Measure the number they get up to and the total time they are able to count for.

Roughly speaking:

Highest number they are able to count up to without taking a breath (sensitivity):	Total duration of time they are able to count for without taking a breath (sensitivity):	Roughly correlates with pulse oximetry of:
<10 (91%)	**<7 seconds (83%)**	**<95%**
<7 (87%)	**<5 seconds (82%)**	**<90%**

So, if your patient cannot count above 10 or cannot count for >7 seconds without taking a breath, they are probably hypoxic.

Limitations include that it is effort dependent. It is also just one study in one hospital, and NOT done remotely. However, in the imperfect circumstances we are working in, this may be helpful. It could also be administered by non-medical professionals, e.g. in nursing/residential home settings, and may be useful to help risk stratify cases over the coming weeks.

Management options

If we are not admitting patients, we will need to decide between a number of options:

- Self-management and good safety-netting: for those who are unwell but can manage at home with monitoring (remote if possible) and safety-netting.
- Trial of treatment for equally likely diagnoses: e.g. for those with presumed COPD/asthma exacerbation(steroids) or for possible bacterial pneumonia (antibiotics), again with rigorous safety-netting.
- And, in time, offer palliative care at home: for those who are very sick but do not want/are not suitable/eligible for admission.

Keeping this framework in our heads will help us.

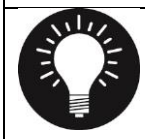
Tips for other minor illnesses

We will continue to have a lower threshold for face-to-face review of the very young and the complex!

If you find yourself triaging these conditions and this is relatively new, you may find the associated articles in www.GPCPD.com helpful.

	Sore throat	**Urinary tract infection**	**Sinusitis**	**Earache**
What do we not want to miss?	85% will be better by day 7. 1% will get a complication:. • Quinsy. • Sepsis.	• Pyelonephritis. • Acute prostatitis. • Urinary sepsis. • Bladder/renal cancer.	Most get better but can take a while! If sick, think about: • Periorbital infection. • Cerebral abscess (!). • Rarer causes of facial pain, e.g. GCA/ophthalmic shingles.	Most children will get better within 3d. Watch out for adults. If atypical or sick, consider rare things: • Mastoiditis. • Tumour.
Assessment	Use FeverPAIN score: 1 point for each of: **Fever** in previous 24h. **P**urulence of tonsils. **A**ttended rapidly (within 3d of symptoms). **I**nflamed tonsils. **N**o cough/coryza. Ask what tonsils look like (and look if you are video consulting). Red flags: • Can't manage fluids. • Can't swallow saliva. • Increasingly unwell, e.g. feeling faint, confusion.	We are likely to treat without urine dip at present (unless have home sticks). Ask: • Frank haematuria? • Systemic symptoms?: o Fever/rigors. o Postural dizziness (low BP). o Loin pain/tenderness. o Vomiting and unable to manage oral fluids/medication.	Typical history: • Nasal blockage/congestion/discharge. • Facial pain/pressure. • Reduced sense of smell. Red flags: • Systemically unwell. • Swelling of face/periorbital area.	Facial weakness. Numbness or tingling in face? Pain in bone behind the ear? Discharge or itching from ear.
Pragmatic management	Analgesia, fluids. Use FeverPAIN score: • 0 or 1: simple measures. • 2 or 3: back-up prescription – use if no improvement within 3–5d. • 4 or more: offer antibiotics immediately if severe symptoms or a back-up prescription if less severe	Treat based on symptoms. • Uncomplicated: first-line antibiotics. • Complicated: as per NICE (see GPCPD). Careful safety-netting and, if deteriorating, to call for help and admission.	As per NICE: 10 days or less: • Do not offer antibiotics. • Simple analgesia. • Review if symptoms worsen rapidly/significantly or systemically unwell. >10 days:	Simple analgesia most important. *Consider* antibiotics if: • Age <2 with bilateral infection. • Otorrhea. • Systemically unwell (will probably need face-to-face assessment).

	(60% of these patients will have a strep sore throat). Safety-net.	If unable to keep fluids/ antibiotics down, possible sepsis. May need assessment and admission.	• *Consider* high-dose nasal steroids. • *Consider* back-up antibiotic script if not resolved in further 10 days. • Safety-net.	
Typical duration	7 days. If prolonged, consider: • EBV – self-limiting. • Rarer things, particularly if aged >45, e.g. head and neck carcinoma.	Symptoms usually start to improve within 48–72 hours of starting antibiotics.	18 days.	4 days.

	**Remote consulting: a survival guide** • Remote consulting is essential at present, and probably here to stay. • All patients wishing to be seen in primary care should be triaged remotely. • We can try to assess respiratory status remotely using history, function, patient equipment. • We can also try out the Roth Score. • Document 'Remote triage during COVID epidemic'. Safety-net carefully.
	Join us for our FREE webinar on *Remote consulting: a survival guide*. Click on this link to register: https://www.gp-update.co.uk/webinars/OWREM250320 Use GPCPD to print out PDFs of all the common minor illness conditions to support your team in triage over the next 3 months.
	To watch a video interview between Dr Gandalf and Prof Trish Greenhalgh, click here: https://www.youtube.com/watch?v=XlNtWaA6FZs For worried parents of children with simple URTIs (this could be emailed), available in multiple languages and with appropriate contact details for England, Scotland and Wales: http://www.whenshouldiworry.com New to using AccuRx? A demo by Red Whale presenter, Dr Osman Bhatti, for his CEPN can be seen here: https://www.youtube.com/watch?v=lUusnj4w3xI&feature=youtu.be