

STANDARD OPERATING PROCEDURE

Care in the Community: Acute Respiratory Pathway

STANDARD

1. Equity of access to care is provided for patients with an acute respiratory condition in Taranaki
2. Patients who have severe or urgent medical needs are escalated appropriately
3. Acute respiratory care is provided safely as per best practice guidelines

CRITERIA

The following patients will be accepted on to the Care in the Community (CiTC) Acute Respiratory Pathway:

- Unenrolled patients with an acute respiratory illness
- Patients referred by GPs or other providers where capacity to provide immediate care is not available
- Patients with an acute respiratory illness not requiring hospital level care referred by the emergency departments outside of business hours
- Patients or whānau who contact the hub directly and have an acute respiratory illness

If following assessment, it is determined that the patient does not have an acute respiratory illness or cannot be safely managed by CiTC the hub team will facilitate referral to the appropriate service.

EQUIPMENT

1. Medications available on MPSO:
 - a. Paracetamol tablets and liquid.
 - b. Ibuprofen tab and liquid
 - c. Ondansetron
 - d. Salbutamol
 - e. Prednisolone tablets
 - f. Imodium tablets
 - g. Redipred
 - h. Amoxicillin – tablet and liquid
 - i. Trimethoprim tablets
 - j. Nitrofurantoin – slow release tablets
 - k. Roxithromycin – or other macrolide for penicillin allergic – liquid and tablet
 - l. Flucloxacillin – tablets
 - m. Cefalexin liquid for penicillin allergic children.
2. Medications available on Standing order via Robertsons Pharmacy:
 - a. Budesonide 200mcg inhaler (see Standing Order & Appendix 1)
3. Pulse Oximeter as required
4. Other equipment may be deployed on a case by case basis

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PROCEDURE

1. The Care in the Community Acute Respiratory Service will operate seven days a week:

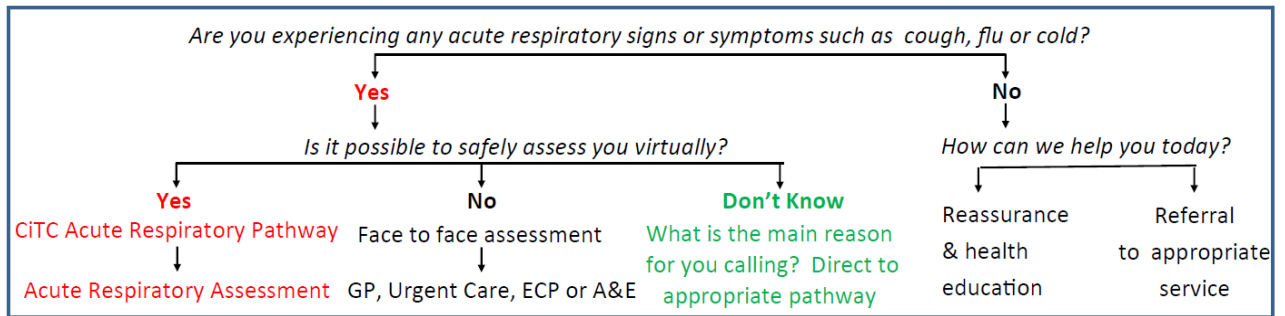
- Referrals will be accepted from patients or providers
- All referrals will be channelled via the Covid Hub/CITC Team
- Referrals can be submitted via:
 - Phone 0508 436 374
 - Email CovidHub@tdhb.org.nz
 - BPAC

2. Referrals from ED will be accepted as follows:

- 8am to 6pm 7 days a week:
 - patients with an acute respiratory illness
 - have been triaged and do not require ED admission
 - can be managed in the community
- 6pm to 10pm 7 days a week:
 - As above but patients must have any medications required to last overnight

3. Assessment process:

- On receipt of a referral the hub will determine the most appropriate location for assessment based on patient domicile and provider capacity:
 - North Taranaki – initial assessment to be conducted by Hub Assessors
 - South Taranaki - initial assessment to be conducted by:
 - Unenrolled patients: Ngati Ruanui who will enrol the patient if consent is provided to do this
 - Enrolled patients: Ngāruahine
- The assessor will complete an initial assessment using the *Care in the Community Assessment Form* (see Appendix 2) following the algorithm outlined below:



- An initial triage will be performed to identify any immediate or urgent issues that need rapid escalation:

RED FLAG QUESTIONS		
Are you experiencing severe shortness of breath currently?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Go to airway & breathing questions to further assess
Are you having difficulty breathing currently?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Go to airway & breathing questions to further assess
Do you have chest pain currently?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Go to circulation questions to further assess

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- Once established that it is safe to continue a full assessment will be completed, the outcome of which may be:
 - Escalate to Hub GP
 - Escalate to enrolled GP for face to face assessment
 - Refer to support or other services

NOTE: Referrals to ED or Specialist services will be made by the Hub GP

- Until the PMS go-live on 5th September 2022:
 - The assessment form will be completed and emailed to the Hub for safe storage
 - The assessment form will be used to keep a running record of subsequent contacts
 - The assessment form will be emailed to the enrolled GP on handover of the patient's care.

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Appendix 1:

Prescribing and dispensing of therapeutics by community teams within CiTC.

Purpose:

With respiratory illness, including but not limited to COVID-19 still affecting our community supports need access to medications to safely manage, monitor and treat patients in the community. At times this is limited due to pharmacy opening times, geographical barriers and whanau ability to collect medications.

Process for Budesonide

Patient accesses the CiTC team either via COVID pathway or other respiratory illness pathway.

Initially assess by nursing team in the hub or may be direct to Ngati Ruanui or Ngāruahine. This assessment may then trigger contact with the on-call hub doctor. This may be a referral for clinical review or discussion about a management plan this includes medications issued from the MPSO stock or prescription of medications on standing order.

If clinical review by prescriber:

The clinician with prescribing rights will document the assessment in CCCM or Indici (hub module). A prescription will be produced in the relevant system and ePS emailed to both the COVID hub and Robertson's pharmacy Hunter Street.

The suitable team will be notified in the community and the PDF prescription forwarded to them. They will dispense from stock they hold and make sure the correct regime if attached to the inhaler.

Dispensing will be documented in the relevant PMS including, who dispensed, how it was delivered/collected and confirming regime was included with the medication.

If not escalated for clinical review:

This may happen if the patient already normally takes this or similar medication but needs a supply out of hours. Also, if they have had an initial nurse review and it is felt they may benefit with prescription but don't need a doctor review at that time.

The consultation will be documented in CCCM or Indici. The nurse will either email or task the doctor on call or responsible person with prescribing rights with the details and plan. This will include the safety netting advice given, plan of escalation and follow up if things change.

The prescriber will then document in the notes happy to issue the prescription and produce a ePS. This will be sent to Robertson's and the COVID hub. The ePS does not have to be produced prior to dispensing if this will delay or complicate delivery/dispensing (i.e Patient already with community team, prescriber not able to document on PMS right away). Once agreed with the prescriber the medication can be dispensed and the prescriber must produce the ePS with in 48 hours.

As these prescriptions will be signed off by the prescriber within 1 week there is no requirement

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for an audit of the standing order monthly.

The supply of the Budesonide will be help with other MPSO stock at the community sites. This will be managed by Ngati Ruanui and Ngāruahine and medications supplied via Robertson’s Pharmacy in Hawera. Once the ePS is issued on the next working day via the pharmacy a restock of the supply can occur.

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Appendix 2: Acute Respiratory Assessment

	Name: _____ DOB: _____ NHI: _____	
Are you experiencing any acute respiratory signs or symptoms such as cough, flu or cold?		
Yes No		
Is it possible to safely assess you virtually?		
Yes CITC Acute Respiratory Pathway Acute Respiratory Assessment	No Face to face assessment GP, Urgent Care, ECP or A&E	Don't Know What is the main reason for you calling? Direct to appropriate pathway
		How can we help you today? Reassurance & health education Referral to appropriate service

RED FLAG QUESTIONS		
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Are you having difficulty breathing currently? <input type="checkbox"/> YES <input type="checkbox"/> NO		Go to airway & breathing questions to further assess
Do you have chest pain currently? <input type="checkbox"/> YES <input type="checkbox"/> NO		Go to circulation questions to further assess

Date		Acuity Score					
Assessment Time		1	2	3	4	5	6
Nurse		Self Management			Active Management		
Referral from							

Personal Information	
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Gender Diverse	Ethnicity: _____ Iwi and Hapu: _____
GP:	Pharmacy: _____
Address:	<input type="checkbox"/> verified
Primary Phone #:	Secondary Phone #:
Email:	Emergency contact:
Emergency contact phone #:	Relationship:

Medical History	Social History	Immunisation	Screening tool
Respiratory diseases <input type="checkbox"/> COPD <input type="checkbox"/> Asthma <input type="checkbox"/> Pulmonary embolism <input type="checkbox"/> Other respiratory diseases <hr/> <input type="checkbox"/> COVID-19 Recovered: Yes <input type="checkbox"/> No <input type="checkbox"/> Date positive: _____ <input type="checkbox"/> previous ICU admission for any of the above Cardiac Diseases <input type="checkbox"/> Heart attack <input type="checkbox"/> Heart failure <input type="checkbox"/> Heart surgery	Others <input type="checkbox"/> Hypertension <input type="checkbox"/> Diabetes <input type="checkbox"/> Previous stroke <input type="checkbox"/> Cancer <input type="checkbox"/> Pregnancy ___/40 AOG ___/52 post partum <input type="checkbox"/> Immunocompromised <input type="checkbox"/> Epilepsy <input type="checkbox"/> Mental health <input type="checkbox"/> Addiction <input type="checkbox"/> Kidney disease <input type="checkbox"/> OSA <input type="checkbox"/> CPAP <input type="checkbox"/> Others: _____	Currently Engaged Services <input type="checkbox"/> MSD <input type="checkbox"/> ART/ARTHA <input type="checkbox"/> Home support <input type="checkbox"/> Hospice <input type="checkbox"/> Mental Health <input type="checkbox"/> Alcohol & Drug <input type="checkbox"/> Others: _____	Smoking <input type="checkbox"/> Smoker <input type="checkbox"/> Ex >1 month <input type="checkbox"/> Never smoked <input type="checkbox"/> Brief advice given <input type="checkbox"/> Requires NRT <input type="checkbox"/> Declines NRT
		COVID-19 Vaccination <input type="checkbox"/> 1st primary dose <input type="checkbox"/> 2nd primary dose <input type="checkbox"/> 3rd primary dose Vaccine: _____ <input type="checkbox"/> Unvaccinated	Mental Health How is your overall mood and wellbeing? <input type="checkbox"/> Okay <input type="checkbox"/> Not Okay
		<input type="checkbox"/> 1st booster <input type="checkbox"/> 2nd booster Vaccine: _____ Flu Vaccination <input type="checkbox"/> Booster <input type="checkbox"/> Unvaccinated	Weight: _____ Height: _____

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Medications	Allergies	
<input type="checkbox"/> Anticoagulants:	Medications or Food	<input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> Immunosuppressant:		Reaction
<input type="checkbox"/> Inhalers:		
Assessment		
If you tick any of the red boxes, consider referring the patient to the on-call GP for review.		
How are you feeling today? <input type="checkbox"/> Better <input type="checkbox"/> Same <input type="checkbox"/> Worse		
Airway Do you have any of the following? <input type="checkbox"/> Runny nose <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Sore throat <input type="checkbox"/> Swallowing difficulties How does the patient talk over the phone? <input type="checkbox"/> Unable to speak <input type="checkbox"/> Speaking words <input type="checkbox"/> Speaking short phrases <input type="checkbox"/> Speaking full sentences	Notes	
Breathing Do you feel short of breath or have any difficulty breathing? <input type="checkbox"/> No <input type="checkbox"/> Yes Is your breathing harder than normal? <input type="checkbox"/> No <input type="checkbox"/> Yes Is your breathing faster than normal? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you feel SOB when doing any activities? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you feel SOB even when resting? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you feel SOB when lying down? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have a cough? <input type="checkbox"/> No <input type="checkbox"/> Yes Can you describe your cough? <input type="checkbox"/> Dry <input type="checkbox"/> Barking <input type="checkbox"/> Productive: _____ colour sputum <input type="checkbox"/> Blood-tinged Can you hear any abnormal sounds when the patient is talking or breathing? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Wheeze <input type="checkbox"/> Stridor Does the patient have a pulse oximeter? <input type="checkbox"/> NA <input type="checkbox"/> Yes SpO2: _____ % HR: _____ beats/minute Is the patient normally on home oxygen? <input type="checkbox"/> NA <input type="checkbox"/> Yes Home oxygen: _____ L/24H	Notes	
Circulation Does your chest hurt? <input type="checkbox"/> No <input type="checkbox"/> Yes On a scale of 1-10, how bad is the pain? ____/10 When did it start? _____ Where is the pain located? _____ How long does it last? _____ What is the pain like? <input type="checkbox"/> Burning <input type="checkbox"/> Crushing <input type="checkbox"/> Dull <input type="checkbox"/> Heaviness <input type="checkbox"/> Sharp <input type="checkbox"/> Tightness When do you get the pain? <input type="checkbox"/> When coughing <input type="checkbox"/> When breathing <input type="checkbox"/> During activities <input type="checkbox"/> All the time What makes it worse? _____ What makes it better? _____ Does the pain go anywhere else? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Have you taken anything for the pain? <input type="checkbox"/> No <input type="checkbox"/> Yes _____ Can you see any bluish discoloration: <input type="checkbox"/> Around your lips <input type="checkbox"/> On your fingertips Do you feel light headed when standing? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you feel cold or clammy? <input type="checkbox"/> No <input type="checkbox"/> Yes Does your urine look concentrated? <input type="checkbox"/> No <input type="checkbox"/> Yes Does the patient have a home BP apparatus? <input type="checkbox"/> NA <input type="checkbox"/> Yes BP: _____ mmHg Does the patient have a blood glucose machine? <input type="checkbox"/> NA <input type="checkbox"/> Yes BSL: _____	Notes	
Disability Is the patient: <input type="checkbox"/> Alert <input type="checkbox"/> Abnormally sleepy or difficult to rouse <input type="checkbox"/> Showing signs of new confusion	Notes	
Exposure / Others Are you eating or drinking ok? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have any abdominal pain? <input type="checkbox"/> No <input type="checkbox"/> Yes On a scale of 1-10, how bad is the pain? ____/10 Do you have any: Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhoea <input type="checkbox"/> How many times in the last 24 hours? ____ times/24 hours Are you sleeping ok? <input type="checkbox"/> No <input type="checkbox"/> Yes Do you have any headache? <input type="checkbox"/> No <input type="checkbox"/> Yes On a scale of 1-10, how bad is the pain? ____/10 Do you have any joint and/or muscular pain <input type="checkbox"/> No <input type="checkbox"/> Yes On a scale of 1-10, how bad is the pain? ____/10 Do you feel hot and cold? <input type="checkbox"/> No <input type="checkbox"/> Yes Are you shivering or shaking uncontrollably? <input type="checkbox"/> No <input type="checkbox"/> Yes	Notes	

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