

Remote Consultations Guidance Under COVID-19 Restrictions

Introduction

The Royal College of Nursing (RCN) recognise that the coronavirus (COVID-19) pandemic has led to unprecedented demand on health and social care services.

It has also meant there is a need for increased use of remote consultations in order to reduce the face-to-face contact time with patients as far as possible to minimise the risk of transmitting infection. It will also further protect patients/clients and staff from exposure to the virus by reducing the footfall in clinical areas.

The need for remote consultations will continue for some time (NHS, 2020) and beyond the pandemic as a useful mechanism for maximising on the capacity as well as the accessibility of services, as identified in the NHS England toolkit for Primary care on online consultations September 2019.

Scope of Guidance

This guidance has been developed to support nursing staff including health visitors, midwives and nursing support workers, practising in any area where they are being asked to see and/or treat patients via a telephone or video or through other remote consultation processes. The guidance is particularly relevant to areas such as general practice, community services, extended hours services and out of hours.

Remote consultations - best practice principles

This guidance is intended to provide additional principles around working remotely.

The principles of good practice in relation to consent, confidentiality, and good record keeping will apply; see the [RCN record keeping guidance](#) and the NI recording guidelines from [NIPEC](#).

It links to other RCN resources on working remotely:

- [Guidance to support 'Having courageous conversations by telephone or video during the COVID-19 pandemic'](#), developed as part of a suite of resources to support end of life care.
- ['Prescribing safely under COVID-19'](#), using the existing mechanisms for remote independent prescribing.

All registrants must adhere to the [NMC code](#).

Additional supervision and support requirements

To support remote and video consultations, all service providers must ensure staff have support and supervision and access to colleagues to discuss issues and concerns.

There needs to be a process for ensuring staff have the resources available and opportunities via supervision to help them develop their skills. See the, [QNI resources for COVID](#) and the [GPNI information for primary care](#) Staff also need to have access to reliable internet and remote tools, for example Zoom or Microsoft Teams etc.

Triage process

The decision for offering a remote consultation as opposed to a face-to-face consultation will be based on the initial triage process. It will broadly assess:

- the need for review or assess the severity of symptoms both physical and psychological
- previous knowledge of the patient/client as well as the family and wider situation as appropriate and access to their clinical records
- a need to physically examine the patient/client
- previous medical history for example, seeing a patient for a follow up or review of a pre-existing condition; a history of safeguarding concerns; or an infant who has been failing to thrive may trigger a need to see the person/child face-to-face.

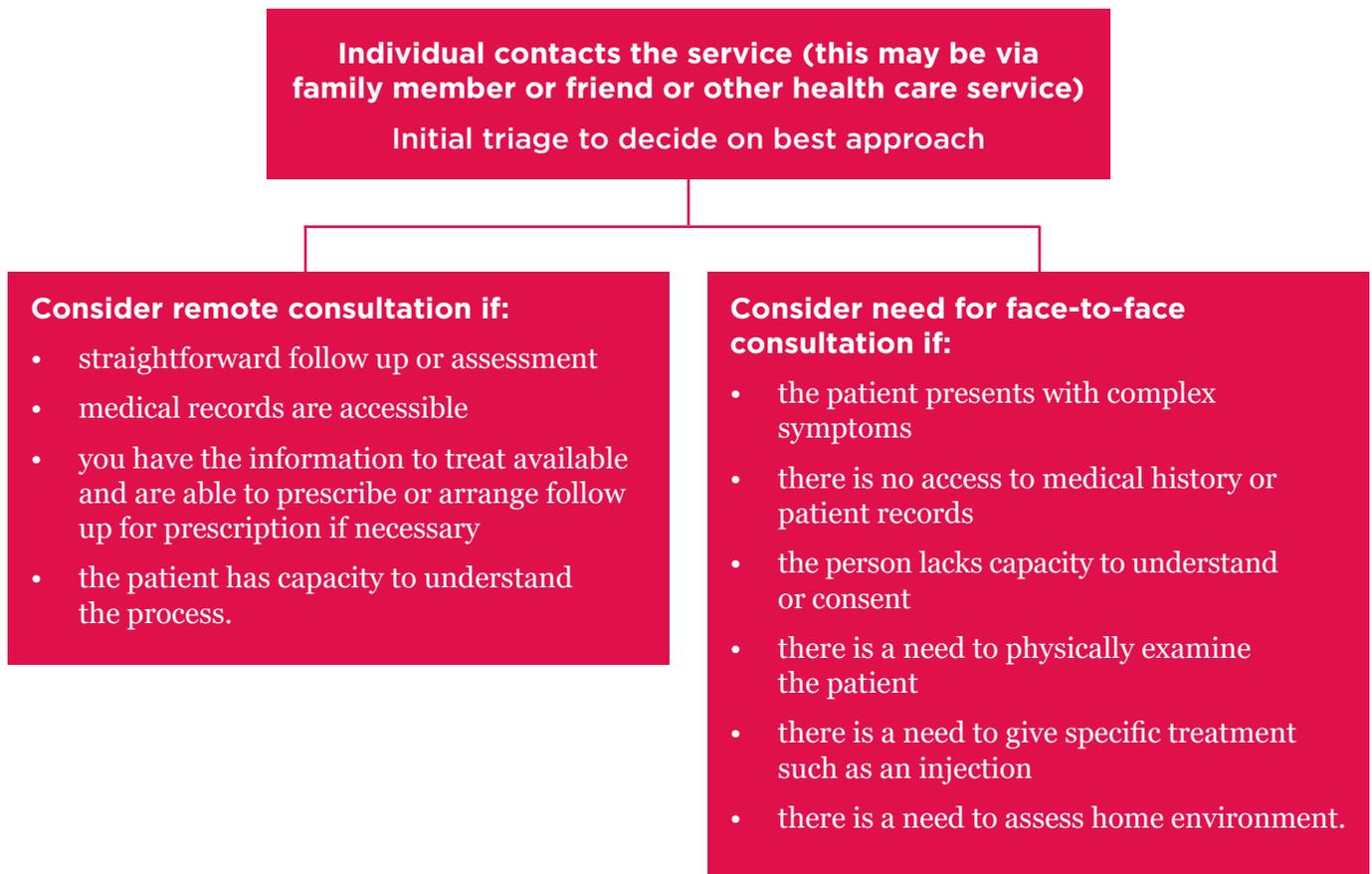
The GMC [information to support remote consultations](#) includes a simple algorithm adapted in figure 1 below to help assess the best

approach. Ultimately it is a clinical decision to be taken with the information available. It may be appropriate for some of the consultation to take place remotely and bring the person in for a short time to administer treatment, for example for a childhood vaccination or a contraception injection. There may be other situations where the clinical or social background would make the clinician want to see the patient/client, for example a clinical assessment to determine prescribing of antibiotics.

There are additional tools to support which services should remain a priority for people to be able to access during the pandemic to support the decision-making process. See the case studies at the end of the guidance.

The RCN have information on the coronavirus [clinical pages](#) to support decisions around health and care support. See also, the [NHS COVID-19 prioritisation within community health services](#).

Figure 1: GMC Algorithm to support the triage process



Chaperones

The NHS and GMC have clear guidelines for having a chaperone present when undertaking intimate physical examinations. The RCN would also support and recommend this. The RCN document; [Genital examination in women](#), includes some useful information, but the need for chaperoning is applicable regardless of gender.

The [GMC guidance: Intimate examinations and chaperones](#) and the CQC information about chaperones provide a good framework for all health care professionals including nursing staff.

It is good practice to make sure that organisations including general practice have a chaperone policy in place and that this is clearly visible to the public, alongside information about why this is important. All patients and parents with children should routinely be offered a chaperone during any consultation or procedure. In practical terms this should be offered before any procedure, ideally at the time of booking the appointment.

Where a patient is offered but does not want a chaperone, it is important that the practice has recorded that the offer was made and declined. If a chaperone is requested and none is available at that time, then there should be an opportunity to reschedule the appointment within a reasonable timeframe. If this is not possible because of the urgency of the situation, then again this would need to be fully explained to the patient and recorded in their notes. A decision to continue or otherwise should be reached jointly.

Staff acting as chaperones must be given appropriate training about the role and what it means. They should also have a risk assessment and may need further checks through the Disclosure and Barring Service (DBS), [access NI](#) or [Disclosure Scotland](#) if there isn't already one in place.

A remote or video consultation does not negate the need to offer a chaperone and the same principles would apply. The likelihood is however that the chaperone will be remote and as such all parties need to agree and be

assured that the links and remote connections are working appropriately.

Information described in the *Key Principles for intimate clinical assessments undertaken remotely in response to COVID-19* (NHS England & NHSI, 2020) gives further guidance to support clinicians provide care in a way that is in the best interests of their patients, whilst protecting both patients and clinicians from the risks associated with remote intimate assessments.

The guide is applicable across all health care settings. Focusing on how to safely manage the receipt, storage and use of intimate images taken by patients for clinical purposes, it reiterates the principles that remote consulting should be approached in the same way that it would be for face-to-face interactions.

Interpreting services

Many services have access to telephone interpreting services such as language line. The use of interpreting services can be done through a three-way telephone conversation and will mean that more time needs to be allowed for the remote consultation. Ensure that you document the use of any interpreting services. This is good practice to ensure the patient understands what is being advised. It is also good practice to avoid the use of family/friends as interpreters, because of the risk of misinterpretation or lack of understanding and you cannot be confident the translation is exactly as you are saying.

Other consideration regarding the consultation

It is also important to note that during a remote consultation there may be other people present. Ask and check if there are others listening to the conversation, be aware however, that you cannot know for certain and that the patient may record the conversation, this is ultimately up to them.

Top tips guidance on initiating and concluding the conversation

1	<p>Introduction:</p> <p>Establish who you are speaking to and that it is the correct person and introduce yourself. Check that the patient can hear and understand you and is in a suitable place to talk. Consider any reasonable adjustments that may be required ie - hard of hearing/learning disability/cognitive impairment/English as a second language and if interpreting services are needed.</p> <p>Environment:</p> <p>Wherever possible, make sure you have a quiet private space to have the telephone/video conversation.</p> <p>Refusals:</p> <p>If the person says at any time during this conversation that they do not wish to discuss these issues, respect their choice. Assure them that they can reconsider at any time. Advise how to contact you – or in your absence who to contact, and how. If appropriate arrange a date and time to call back.</p> <p>Documentation:</p> <p>Record details of this conversation clearly, either immediately or as soon as is possible (recording time and date). Be specific about how information was obtained. Make sure that you document clearly that this was a remote consultation during the COVID-19 pandemic.</p> <p>Chaperone:</p> <p>In discussion with the patient/client/family, consider if a chaperone is required. If so the consultation should be organised to facilitate this.</p>
2	<p>Introduction:</p> <p>‘Hello. My name is..... I am (describe your role)’</p> <p>within the principles of mental capacity legislation, check that the person is the person you want to talk to, ‘Who am I speaking to please?’. Ask, as an extra security check, ‘Could you confirm your address/telephone number please?’. Can they hear and understand you, and are they in a suitable place to talk?</p> <p>If you have reason to suspect that they are having any difficulty with understanding or communication, ask if there is someone with them who could join the conversation and help them. If a friend or relative joins the call at any stage, say ‘Hello. My name is’ again and reiterate the reason for your call. Establish and document the name of the friend or relative and their relationship to the person.</p>
3	<p>Establish the reason why this is a remote consultation instead of face-to-face:</p> <p>‘Unfortunately, during the COVID-19 crisis, we can’t visit people at home or get them to come into the surgery for their review, so I have had to contact you by phone/ video call. I am calling today to...’</p>
<p>Main part of the conversation which will be led by the reason for the call, for example, to carry out an asthma review or a contraception check. (See scenarios for examples)</p>	
8	<p>Concluding the conversation and agreeing further actions:</p> <p>‘Are you able to summarise what we have discussed today?’</p> <p>Document what the patient says and reinforce any actions that you have agreed.</p>
9	<p>Follow up:</p> <p>Consider whether follow-up is needed and, if so, what achievable follow-up can be arranged. Explain when and how the person will be followed up. Make appropriate arrangements for this to happen and document these.</p>
10	<p>Documentation:</p> <p>Ensure documentation reflects that this is a remote consultation and be specific about how information was obtained.</p>

Case studies/scenario situations:

The following scenarios are designed to give people an idea of how remote consultations might work and the decision-making triage process.

They are not intended to provide detail or guidance on the specific clinical needs that might present.

Links to useful and relevant guidance to support practice and information specific to managing coronavirus for particular conditions or situations are included within the case studies.

Case Study – Mental Health

Josie who has psychotic depression, lives in a shared house. Her family live in Scotland, so she is used to using Facetime to keep them updated on her wellbeing. In the past Josie has participated in Skype family meetings which were set up by her community psychiatric nurse (CPN) who until recently has been meeting Josie in a local café to work on her self-esteem and rebuild her social skills.

Josie has worked very hard to maintain her part-time job and go to the gym. None of these coping strategies are now available to her. One of Josie's housemates is showing COVID-19 symptoms and the house is self-isolating. Josie has not told them about her mental health problems, she has always worried they will ridicule her.

Josie's family have contacted the mental health team to let them know, they are worried Josie's mental health is deteriorating; she isn't sleeping and is increasingly expressing grave concerns that she is responsible for making her housemate ill. Josie has agreed to have a teleconference with her CPN.

Using the top tips to determine whether the consultation can take place remotely.

- Review Josie's mental wellbeing and her current experiences
- Determine what Josie's concerns are about – normalise her worries 'lots of people are sharing these anxieties at the moment'
- How they are affecting her relationships with her housemates?
- Identify what strategies she has used to overcome her anxieties - what has worked and what hasn't?
- Are there ways Josie could be kinder and more forgiving towards herself?
- Who or what are her main sources of support? Is there a housemate she could confide in? What would be the advantages and disadvantages of doing this?
- Gain her consent to update her family – what could can mental health team and Josie do to alleviate their concerns?
- Generate ideas to maintain wellbeing and set a timeframe to test out the shared solutions.
- Set a date for the next consultation – this will be based on Josie's response to this meeting.

The Royal College of Psychiatry (RCPsych) have [further advice for clinicians](#) on facilitating safe digital consultations.

Case Study – Childhood vaccination

The Joint Committee for vaccination and Immunisation (JCVI) have advised that childhood vaccinations up to and including the preschool booster should continue and immunisation services for these be maintained to reduce the serious risk of vaccine-preventable disease, see [here](#).

The RCN have produced guidance to support maintaining the National Immunisation schedule during COVID-19 see [here](#).

The vaccines themselves require a visit to the surgery or potentially a home visit but the guidance advises that a telephone call in advance will help to minimise the time spent in the surgery.

Jamie is now 13 months of age and due his one year vaccines. His previous vaccines were all given on time. His parents have not responded to text reminders.

Using the principles in the top tips you call to check with the family. The mother acknowledges she is anxious about coming into the surgery when they have been advised to stay at home, as far as possible.

Acknowledge her concerns about taking a young baby out. Explain that the vaccines are however, important and any delay will put them at greater risk of vaccine preventable diseases such as measles, meningitis and whooping cough. Advise the mother that the primary care team is taking all possible steps to protect them and their child whilst they are in the practice. Physical distancing will be maintained except when the nurse gives the injections. Other children/parents will be well separated.

The mother agrees to coming in but still take the opportunity to discuss as much as you can about the schedule, what Jamie is due, and give post-immunisation advice so that you minimise the time they need to be in the surgery.

Explain that the nurse will be wearing personal protective equipment such as a mask and eye protection and apron and that this is routine for all patient contact. Explain that Jamie is now due to have a booster of the pneumococcal vaccine, meningococcal c and Hib, meningococcal B and the MMR vaccine. Explain that these are given in 4 separate injections and that you will give them as quickly as possible. Ask the mother if she has any particular questions or concerns about the vaccines and take the time to discuss these.

Remind the mother to bring Jamie's red book but say you may ask them to complete the detail, possibly, once they are at home.

Check the mother understands and is happy to proceed and again give her a chance to ask questions.

Case Study – With safeguarding in mind

It is recognised that social distancing can put additional pressure on household were people living with dementia reside. There is [guidance from Dementia UK](#) to help support the person, families and others to help manage this situation.

People might be seeking appointments for a wide range of issues including COVID-19 symptoms, rash, pain, sleeplessness, other infections and minor injury.

Masks and gowns can be very off putting for someone living with dementia if they are unable to comprehend or retain why this occurring and a remote consultation may be desirable. It is often helpful to have a family member who resides in the household to support them through the process. However, person-centred dementia care encourages us to engage with the person directly only drawing on other people where necessary. You may need additional time to illicit a response and this should be done in a calm unhurried manner and if possible watching body language. It is helpful to repeat your summary and decision making, encouraging the person/family to write it down so it can be returned to later.

Dorothy and Frank Epstein are well known to the practice. Dorothy has dementia and Frank is her main care giver with support of family. They have been coping reasonably well but there is obvious concern about how they are coping given the social distancing from family. Frank also has a history of angina. A request for a repeat prescription may elicit a prompt to contact the couple.

Regardless of the clinical need for the consultation there is an opportunity for health care professionals to engage in good safeguarding practice. Discussing any stressors and difficulties for both the person living with dementia and others in the household is important, restlessness, sleeplessness, distress, medicines use and pain may be present. The Alzheimer's organisation have some useful [guidance](#).

Good safeguarding practice is not only being professionally curious about interactions, language and presentations it is also about preventing the in situations which abuse, harm and neglect occur. Recognising and acting on circumstances that are increasingly demanding is particularly necessary as you might be the only person they have contact with. There are some useful [Guidance for the public on the mental health and wellbeing aspects of coronavirus \(COVID-19\)](#).

As part of the safety netting of any remote appointment, follow up should be arranged where you feel households are experiencing increased stress and further referral to other agencies for support or safeguarding opportunities should be considered.

This stress may take many forms, and all health care professionals need to be aware, as they would be in normal consultations about the need to assess for signs of domestic abuse, modern slavery and any other form of abuse, which may be taking place. Guidance can be found at [rcn.org.uk/clinical-topics/infection-prevention-and-control/novel-coronavirus](https://www.rcn.org.uk/clinical-topics/infection-prevention-and-control/novel-coronavirus) (under the Safeguarding banner), also at domestic violence and abuse and modern slavery. [rcn.org.uk/clinical-topics/modern-slavery](https://www.rcn.org.uk/clinical-topics/modern-slavery)

Case Study – Health Care Assistant providing support for stroke patient

Mary is a health care assistant who works on the stroke rehabilitation unit at her local community trust. She supports stroke patients who have recently been discharged and assists in the emotional and wellbeing of stroke management. This involves working closely with family members to support them in day-to-day life.

One of the patients, Mr Khan, is 79 and was recently discharged from hospital following a lengthy stay after having a stroke. He lives with his wife Amal, also 79, who is generally fit and well and has no underlying health conditions. They have two daughters who live 50 miles away.

Mr Khan has dysarthria and has been having speech and language support to help him, which he is still getting remotely. He is still finding it difficult to speak.

Using the principles in the top tips you call to check in on Mr Khan and his wife and talk through some of the challenges they may be experiencing and what additional support they might need. Coronavirus can make anyone seriously unwell, but some people are at higher risk and need to take extra steps to avoid becoming unwell, see [here](#).

We know that for stroke patients and carers coming to terms with the after-effects of stroke can be very difficult and this could be an especially lonely time. Whether the stroke was recent or some time ago, the current situation could have a big impact on people's emotional wellbeing. It is important to recognise this and think about ways to get support and added pressures of social distancing can put additional pressures on households. The Stroke Association have some [useful information for stroke survivors](#) tools to [support stroke survivors to manage loneliness and isolation](#), the RCN also has [information on stroke](#) and see the Royal College of Physicians' [Clinical guide for the management of stroke patients during the coronavirus pandemic](#).

Safeguarding is everyone's responsibility and each health care practitioner plays a part including care assistants like Mary. Recognising and acting on circumstances that are increasingly demanding is particularly necessary to protect and safeguard at-risk adults, see the RCN [first steps for health care assistants](#). A telephone consultation will provide an opportunity for Mary to discuss the current stressors and what is most important to Mr Khan and his wife at this current time.

As part of the safety netting of any remote consultation, follow up should be arranged further and referral to relevant agencies for support or safeguarding should be considered and or escalated as appropriate to the registered nurse.

Case Study – Failure to thrive

Johnny's weight had been significantly below that expected for his age prior to the Pandemic.

As the child's named health visitor using the principles in the top tips you call to check with the family as previously arranged. The mother advises that Johnny has not been eating and drinking as well lately and seems to be paler than usual. Given the history and previous concerns it would be appropriate to advise that the mother needs to bring Johnny to the surgery so that he can be assessed properly. Johnny's mother is anxious about coming into the surgery when they have been advised to stay at home, as far as possible.

There are two options here – the health visitor could visit the family home using the correct PPE having explained the need to wear PPE or providing the family are not self-isolating then the health visitor could ask the mum to bring the child to the surgery at a specified time where she/he or the child's GP could see the child – if the latter the health visitor provides reassurance about the measures being taken at the surgery to prevent the spread of infection.

It is vital that you feel confident and that you have the right PPE protection if a home visit is needed, having completed the necessary risk assessment and acquiring the correct PPE, there is some useful guidance [here](#).

Supporting guidance from the Institute of Health Visiting on [virtual contact](#) and [vulnerable families](#) is also available.

Case Study – Chronic obstructive pulmonary disease (COPD)

James is a 78 year-old gentleman who has COPD. He is an ex-smoker and is currently being shielded during the COVID-19 pandemic. He is overdue his annual COPD review so you have booked a remote consultation with him for today.

As per the [NICE COVID-19 rapid guideline: community-based care of patients with chronic obstructive pulmonary disease \(COPD\)](#) an annual review is recommended via telephone or remote consultation.

Using the consultation guidelines you have established the patient's identity and that he is happy to continue with a video consultation. During the consultation your aim is to complete as much of the Quality Outcome Framework (QOF) review as you can remotely. You also want to check that James is shielding, well in himself and has support from family, friends or a local COVID-19 support group to get his medicines and shopping. Also see the [British Lung Foundation resources around coronavirus](#).

James is on regular steroid and bronchodilator inhalers including a salbutamol nebuliser that he uses when he needs it. During the review you notice that he is ordering his salbutamol inhaler more frequently than normal and ask him about this. James tells you that he knows COVID-19 can affect your breathing so he has ordered extra inhalers in case he needs them. He also admits that his friend told him there was a shortage of salbutamol inhalers so he didn't want to run out. You discuss his concerns, establishing that his symptoms have not deteriorated and that he is well in himself. You reassure him that pharmacies are able to get the inhalers and that he should be ordering his normal amounts.

James has previously had rescue packs so knows how to order these and you confirm when he would need to contact the practice for further support. Once you have completed as much of the COPD review as you can, you advise James that you will need to complete the rest of the examination face-to-face once the restrictions are lifted because James is stable. If you were concerned about James' COPD then you would need to consider if a face-to-face review is needed. If you feel that this is needed, then you would need to organise a home visit.

Some key things that you can establish on a video call include:

- patient can speak in sentences
- respiratory rate
- colour – are there any signs of cyanosis?
- patient's understanding of their medication and when to take it
- inhaler technique
- patient's general well-being- do they look well kempt, any signs of weight loss etc?

As part of the consultation you also establish that James is struggling to get his food shopping. He has tried to get a delivery slot for a local supermarket but can't get one for three weeks and he is low on some essential supplies so you signpost him to a local support group who are shopping for shielded and vulnerable patients.

James needs his repeat prescription, so you order this from the local chemist who normally deliver to him.

You conclude the consultation as per the consultation guidelines, advising James that he can contact the surgery if he is concerned or needs any help or support. As James lives alone you organise a regular weekly well-being check from the social prescriber in your team. The [British Thoracic Society](#) have some [COVID-19: information for the respiratory community](#).

Case Study – Contraception review

There are a number of different models for the provision of contraceptive and sexual health services in primary care. Wherever you are working you should ensure that there is clear, up-to-date signposting for patients to what local contraceptive services and national online services are currently available and how these can be accessed.

Where necessary seek advice from local sexual health services who may be continuing to offer face-to-face appointments and/or remote advice. Further advice can be accessed via the [RCN Sexual Health Clinical](#) pages.

Natalie is 28 years-old and is on the progesterone only pill (POP) following the birth of her son nine months ago. She has requested a repeat prescription so needs a contraceptive review prior to this being issued so you book a telephone consultation.

Using the consultation guidelines, you establish that you are speaking to the correct patient and that she is happy to have a telephone consultation with you.

Prior to the consultation you review her medical records, you can see her last POP review was carried out 6 months ago 3 months after commencing POP. She had her blood pressure and weight checked which were within normal range. She was not experiencing any irregular menstrual bleeding and she was remembering to take her pill daily and had no other side effects to report at the time.

Following the contraceptive template on your clinical system you chat to Natalie about her contraception, her general wellbeing and if she is happy with her current contraception. If there are no new problems and Natalie wishes to continue with POP then as the progestogen only pill has very few contraindications it can be prescribed following the remote consultation. Prior to prescribing ensure there are no changes to medical history, including new medication, which may reduce the efficacy of the POP. The POP can be prescribed 12 months at a time if required. See the guidance from the Primary Care Women's Health Forum on [How to manage contraceptive provision without face-to-face consultations](#).

On this occasion however, Natalie asks to change to a long acting form of contraception. The decision to commence POP was made when she was breast feeding her son, but she advises you that she has returned to work and has stopped breast feeding.

You discuss any risk factors and the contraception that Natalie used prior to her pregnancy. Natalie is keen to use a non- hormonal contraception for her future contraceptive needs and following a review of the methods available to her she decides that she would like the coil (IUCD). If your local sexual health service is not offering IUCD fittings then you would explain that due to the Covid-19 pandemic an assessment for a coil would need to be delayed until the restrictions are lifted to comply with the guidance to keep footfall within health care services to a minimum to protect both staff and patients. Natalie is happy with this and you agree to continue progesterone only pill until she can book in to have an assessment for her coil.

As part of the consultation you also check on Natalie's well-being and how she is doing since returning to work. You advise of local support groups and check that she has access to her local health visitor.

You conclude the consultation as per the consultation guidelines.

Case Study – Palliative Care

Harjit Kaur is a 34-year-old lady who has been diagnosed with lung cancer with bowel metastasis she has lived with the disease for 4 years, having had surgery to remove some of the bowel tumours and had chemotherapy. Harjit lives with her husband, three children and her mother-in-law.

Harjit and her husband were recently informed that her cancer had now spread to her liver and her bones and she is moving into the palliative phase of her disease. Using the consultation guidelines, you have established the identity of the lady, how she would like you to address her, and gained consent to talk with her in the company of her husband, you also request if there are any other family members she would like to include.

Explore Harjit's understanding of her disease progression and what does she feel is likely to happen now? What are her hopes and fears for her future? Listen with kindness and give her and her husband time to reflect.

Explore and assess Harjit's symptoms holistically does she have:

- increased pain
- breathlessness- respiratory symptoms, cough etc
- nausea – vomiting – other gastrointestinal symptoms, fullness, constipation
- fatigue - could we arrange a blood test if fatigue is becoming debilitating?

Think about how we may be able to relieve symptoms using pharmacological and non-pharmacological intervention.

Would a referral to specialist palliative care services help at this time? If declined advise that should she change her mind at any time this referral can be made. (Recognise that she may be frightened and therefore not accept these referrals now but at a later date.)

- Explore Harjit's social circumstances – consider introduction to hospice support for family support. Does she receive support from anywhere else, community groups/ faith groups etc.
- Are there any spiritual cultural issues that she would like to discuss?
- Explore how she is feeling mentally, it's expected and understandable that she will be feeling sad and fearful. She may feel she needs help to discuss her disease progression with her children, or not, follow her cues. Do not presume you know best. Respect her choices but offer support and onward referral for support as needed. Support her maintain control over her choices and decisions. Sue Ryder have produced a [useful leaflet](#) to support parents discuss dying with their child/children.
- Does she have any financial concerns/[Macmillan welfare benefits advice line](#) is accessible and will support.
- Explore any future planning as appropriate to do so (see [courageous conversations/ 10 top tips](#)).

Conclude conversation as per the consultation guidelines. Always leave contact details for any follow up.

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