TELEPHONE TRIAGE TIPS

Acute Sore throat	Do FeverPAIN score to aid antibiotic prescribing – can be done over the **phone**. Ask patients if they can see their tonsils/pus/exudate. Consider delayed abx prescribing. https://viewer.microguide.global/guide/1000000198#content,dcb3abf2-5957-412a-b1b0-2c5550ce4779
Acute Otitis Media	If < 3 days, no need to treat unless discharge symptoms or < 2y with bilateral symptoms. Consider prescribing abx over the **phone** in these cases or if systemically very unwell – see NICE guidance below. https://www.nice.org.uk/guidance.ng91/resources/visual-summary-pdf-4787282702
Acute Otis Extrena	If well and has itching/soreness/history of recurrent OE, prescribe topical drops after 3 days as delayed script.
Sinusitis	If < 10 days – NO antibiotics unless significant systematic upset. If > 10 days – delayed or immediate abx + consider nasal steroid drops/spray. https://viewer.microguide.global/guide/1000000198#content,2b7a2073-6b32-4ae0-a65a-d9a8c53849dc
Acute Exacerbation of COPD	Low threshold for oral steroids if any SOB above baseline. Ensure rescue packs are replenished. Remember if COVID+COPD – caution re steroids. Use functional baseline of mobility to assess sats as Roth score will not work. https://viewer.microguide.global/guide/1000000198#content,50092025-1ceb-46fc-be28-ce029042fb7a
Infective Exacerbation of Bronchiectasis	Consider antibiotics based on previous sputum samples if available – 14 day courses
Community Acquired Pneumonia	Do rough CURB-65 over the **phone**: 1. Confusion 2. Cannot talk full sentences 3. Reduced UO 4. Dizzy on standing up (low BP) Low threshold to treat with abx – use BCCG pathway for prescribing.

Urinary Tract

Lower UTI	No need to send urine for culture routinely. Nitrofurantoin 1st line but check eGFR and ensure no signs of pyelonephritis! Review previous cultures if recurrent infections to help prescribing. https://viewer.microguide.global/guide/1000000198#content,462335ae-4c22-44fc-adac-fddad638b149
Acute Pyelonephritis	If loin pain/tenderness and NO vomiting/dizziness on mobilising/high temp then consider prescribing antibiotics over the **phone** – risk of Covid-19 by coming into surgery more than prescribing high dose abx, note use next day review and safety net is a must. Can you get obs done – devices the patient has, bp machine access. Escalation to a&e if vomiting and dizziness. https://viewer.microguide.global/guide/1000000198#content,b3e7d0cc-e4c2-4f11-8cc6-59dac25ac656

TELEPHONE TRIAGE TIPS

Gastroenteritis	Mild, self-limiting in majority. Can take 10-14 days for bowels to settle in some cases. Emphasise importance of rehydration – Fluids++, Oral Rehydration Salts, foods rich in water for children (watermelon/ice lollies). Abdominal Pain and diarrhoea (often) green may be a symptom of COVID. Note elderly/HTN meds/AKI – **consider next day telephone review** for PU output in all age groups.
Cellulitis	**Video Consultation/**Photo via Email may be helpful. If prescribing antibiotics, advise patients to mark area with a pen and arrange **telephone follow-up 24-48 hours.** Dizziness – must have obs check, consider if RR team needed for obs but remember their service is limited. https://viewer.microguide.global/guide/1000000198#content,6b97d12b-fef9-428e-b801-a30f84f1f6cd
Conjunctivitis	Self-limiting 7-14 days. Poor evidence base for topical antibiotics. Consider video consultation to reassure. Delayed abx. Note risk of preseptal cellulitis – video if swelling reported.

Gynae

IMB/PCB	Assess by **telephone** – may need **face to face** to assess cervix/take swabs
Serious Gynae pathology: ?ectopic ?cancer	If this is possible will need to **refer**
Miscarriage	**Telephone** – can usually be managed at home (as long as safety net re ectopic)

Endocrine

Diabetes & complications/unwell with fever	**Video/visit** – need to remember could be Covid but equally sending unwell diabetic to hot site could have dire consequences
Thyroid	**Video**
Other	**Telephone**

Cardiovascular

Chest pain	**Telephone/Video** – detailed history and risk assessment. If concerned re cardiac cause/haemodynamic instability for **hospital** referral. Assess breathless, including Roth score. Consider Wells score.
Vascular	Any rash/skin changes → **video** consultation. If concerned re pulses/ischaemia, consider **F2F** assessment or **hospital** referral.
Calf pain	**Telephone/video** – assess as much of Well's score as possible. If concerned re DVT for referral to **ambulatory care.**
Palpitations	Would suggest only significant if persistent with symptoms (breathlessness/chest pain) and if this the case need **A&E.**

TELEPHONE TRIAGE TIPS

Gastrointestinal

General	**Video**/**Telephone** consultation – can try and self-examine. Ask about associated symptoms/fever – video and **may need face 2 face** **Strongly consider urine dip and pregnancy test.**
Dyspepsia	Test and treat, consider if vomiting and severe pain – pancreatitis → **A&E**
RUQ Pain	No fever – biliary colic – order USS but note delays – diet and analgesia: Fever but no vomiting – Rx for cholecystitis – next day review. Consider how to get obs checked. Fever + vomiting – A&E May need to consider examination if lacking diagnostic clarity – discuss with 2nd doctor.
Lower GI pain	Review hx – diverticular symptoms/hx/constipation, DDx if diverticulitis – broad-spectrum abx and next day review call. Women – think pelvic pathology – severity may dictate investigation – remember delay in USS. May need to consider examination if lacking diagnostic clarity – discuss with gynae doctor in surgery. Consider UTI → urine can be left for MSU or dip depending on your clinical concern. Think access to obs
RIF pain	**Video** consult always – jump test. Might need **examination** or escalate to **A&E.** Always discuss with 2nd doctor.
LIF pain	Pelvic/bowel symptoms – as for lower GI pain.
Hernia	Difficult to assess – may need examination – note routine hernias can't wait. Ask for symptoms or strangulation/reducibility.
Rectal symptoms	Consider treating and follow up call for piles/haemorrhoids – always set up review.
Bloating	Consider ovaries – test first if concerns. Rv if ongoing. Most other symptoms without red flags can wait.
PR Bleeding	If heavy/dizzy → consider **A&E;** If risk significant pathology, consider **2ww/F2F cold clinic** (assuming not in association couch/fever/Covid symptoms)
Diarrhoea/Vomiting	Hx to assess hydration status/PMHx/medications. ?unwell, altered responsiveness, e.g. irritable/lethargic, decreased urine output, pale/mottled skin, cold extremities. May benefit from **video** to eyeball patient. If persistent/unwell, need to consider **F2F/2ww/A&E**

Neurology

General	Consider neuro advice line if concerns
Headache: Tension	**Telephone** only

TELEPHONE TRIAGE TIPS

Headache: Migraine	**Telephone** only
Headache: Meningitis	**Telephone**/**video**-> Refer to hospital if suspected
Headache: Subarachnoid	**Telephone**/**video**-> Refer to hospital
Headache: Suspected Tumour	**Telephone**/**video**-> Refer to hospital
Headache: Temporal arteritis	**Telephone**/**video**-> Refer to hospital
Dementia (Alzheimer's) deterioration/new	**Telephone**
Parkinson's Disease deterioration	**Telephone**
Stroke/TIA	**Telephone**/**Video**-> refer to **hospital**
Faints, Fits, Blackouts	**Telephone** + **Video** -> will need **F2F**
Multiple sclerosis flare ups	**Telephone**
Numbness & Tingling	**Telephone** + **Video** – will need to be **F2F** (not urgent but will eventually have to be dealt with) for examination.
Back Pain	**Telephone** – red flags will need **F2F**
Neurological symptoms in disease of other systems, including cancer	**Telephone** – Realistically will probably need advice from a specialist.

Musculoskeletal (MSK) conditions

General	Always ask about trauma/injury/fall Ask the patient if the can weight bare when assessing foot/knee injuries and/or pain. X-rays often do not change management plans. **Avoid** unless suspected bony injury/diagnostic uncertainty. The majority of MSK conditions can be managed through self-help measures and adequate analgesia – ask specifically what they are taking, doses, timings etc. Encourage self-help exercises and signpost patients accordingly ○ https://www.circlehealth.co.uk/integratedcare/msk - good website with videos of each condition ○ https://www.hasantahir.com/exercise.php - basic exercise sheets Consider **video** consultations to access 'active' movements.
Hot Joints	Septic arthritis rare but mustn't be missed; history and **video** will help

Dermatology

General	Hx may help e.g. recurrent cellulitis, tender/hot to touch, doesn't blanch, mole that is weeping/itchy/bleeding Consider telephone review in 24-48hrs to assess if improving
Petechial rash	**A&E**
Other rash /eczema/psoriasis	Manage with **video** consultation (if elderly patients that do not have a mobile – ask if can use a family members mobile)

TELEPHONE TRIAGE TIPS

Opthalmology

All routine General Ophthalmic Services have been suspended due to the current COVID – 19 pandemic. This means routine sight tests and eye examinations are no longer being provided by optometry practices.

All domiciliary eyecare services are also similarly suspended.

HSC Board is working with primary eyecare providers to continue to provide NI PEARS urgent eyecare, individually or within locality "clusters". If a patient has an urgent eyecare problem, ask them to contact their own optometrist via phone for advice.

For the current list of NIPEARS provider practices click on link
http://www.hscboard.hscni.net/eyes/

In addition, the regional eye casualty service is still currently available for emergencies or urgent sight threatening conditions:

- BHSCT Eye Casualty: **RVH tel: 028 9615 5872 or** RVH main **switchboard 028 9024 0503 ask for Eye Casualty.**

- WHSCT Eye Casualty: **Altnagelvin Hospital tel: 028 7134 5171 ask for ophthalmologist on call.**

Given the nature of the current situation things are changing rapidly so if you have any additional queries do not hesitate to contact ophthalmic services at HSCB via
Ophthalmic.Services@hscni.net

Blepharitis and infection of eye lid	**Telephone/Video** only
Meibomian Cysts	**Telephone/Video** only
Entropion/Ectropion	**Video** only (Non-urgent so really can wait a few months)
Ptosis/Proptosis	**Telephone/Video** only
Squint	**Telephone/Video** only
Conjunctivitis	**Telephone/Video** only

TELEPHONE TRIAGE TIPS

Dry Eye	**Telephone**
FB in the eye	**Telephone**/**Video** and advice If not successful may need **F2F** for removal. High risk due to aerosol of eye fluids so will need full FFP3 Refer to A/E
Corneal abrasions, ulcers/ minor trauma	**Telephone**/**Video** – will need close up examination **F2F** with **FFP3** due to contact with eye fluids Refer to A/E or Contact Local Eye Casualty for advice before referral
Herpes Zoster and the eye	**Telephone**/**Video** – will need close up examination **F2F** with (especially as elderly without video facilities) with **FFP3** due to contact with eye fluids Contact Local Eye Casualty for advice before referral
Iritis	**Telephone**/**Video** – will need close up examination **F2F** with (especially as elderly without video facilities) with **FFP3** due to contact with eye fluids Contact Local Eye Casualty for advice before referral
Acute loss of vision Optic Atrophy, Retinal Detachment, Flashing Lights, Retinal Vein Thrombosis, Senile Macular degeneration- acute on chronic	**Telephone**/**Video** – Realistically GP will not be able to manage this so will need to go to **hospital** for proper assessment Contact Local Eye Casualty for advice before referral
Double vision	**Telephone** only. Realistically many GP's will not have the skills to manage this so no point F2F. Rarely an acute problem so probably needs A&G for safety and onward referral at some point.
Cataracts	**Telephone** advice – can wait a few months for review
Retinopathy-diabetic	**Telephone** consultation. IF sudden loss of vision as per acute loss of vision advice --> refer to **hospital.** Contact Local Eye Casualty for advice before referral
Medication	**Telephone** only.
Eye Malignancies	**Telephone**/**Video** (rare so unlikely to present without visual difficulties acutely. Will need a proper examination with a slit lamp so will need a referral to **hospital** so F2F not needed Contact Local Eye Casualty for advice before referral
Contact Lens Problems.	**Telephone**. Will we have access to local optician to ask advice?