COVID-19
Clinical Advice

Supporting people with COVID-19 related illness in the community setting: Clinical management of those with moderate to severe illness

Version 2.1
Updated 18 November 2020
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1 Purpose of this guidance

This guidance has been developed to support the GP-led clinical management, (including appropriate use of oxygen), of people with COVID-19 related symptoms in the community setting during usual practice hours and out of hours.

2 Who is covered by this guidance?

This guidance relates to people with moderate to severe COVID-19 related symptoms who, after a person-centred care planning conversation and careful weighing up of harms and benefits, are assessed as being more likely to benefit from being cared for in a community setting rather than in a hospital setting.

This may include people who:

- do not wish to be admitted to hospital
- are unlikely to respond to medical procedures such as non-invasive positive pressure ventilation or mechanical ventilation.

Such care planning conversations should take account of:

- the person's current wishes, if known
- previous care planning multidisciplinary team (MDT) discussions or advance directives
- family and carer/s' views and knowledge of the individual's previously expressed wishes
- the person's clinical condition (consider clinical frailty scale score – see Figure 1) and likely benefit of specific hospital interventions (note - the frailty score should not be used in those under age 65).
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Figure 1: Clinical Frailty Scale

| CLINICAL FRAILTY SCALE | 6 | LIVING WITH MODERATE FRAILTY | People who need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standing) with dressing. |
| 7 | LIVING WITH SEVERE FRAILTY | Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within -6 months). |
| 8 | LIVING WITH VERY SEVERE FRAILTY | Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness. |
| 9 | TERMINALLY ILL | Approaching the end of life. This category applies to people with a life expectancy <6 months, who are not otherwise living with severe frailty. (Many terminally ill people can still exercise until very close to death.) |

**SCORING FRAILTY IN PEOPLE WITH DEMENTIA**

The degree of frailty generally corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal. In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting. In severe dementia, they cannot do personal care without help. In very severe dementia they are often bedfast. Many are virtually mute.

Clinical Frailty Scale ©2006–2020 Rockwood. Version 2.0 (Dec). All rights reserved. For permissions: www.geriatricresearch.ca

3 | Who is not covered by this guidance?

This guidance does not relate to any person who is unwell, and who, in your clinical opinion would be likely to gain additional benefit from more intensive hospital based care which cannot be provided in the community. People in this group should be admitted in accordance with their care plan and wishes, following the national clinical guidance.

Shared decision making, taking the person’s own wishes and concerns into account, alongside the availability of local resource and support are key factors in agreeing person-centred management plans.
4  Context

Our current understanding (from learned experience and emerging international evidence) is that 80% of people who are affected by COVID-19 will have mild symptoms. However a small number (estimated at around 5%) will become seriously ill and require intensive care management. Increased risks are associated with age, ethnicity and obesity alongside underlying long-term conditions.

COVID-19 can more severely affect people with frailty, in particular our care home population.

Research from the European Respiratory Journal suggests that approximately 15-22% of people with COVID-19 symptoms with frailty and/or other comorbidities who are managed in the community will die. This means most will recover. It is important to ensure that those people who remain in the community have access to life-sustaining care, including oxygen where this is appropriate, as well as good palliative care where that is needed. As with any potentially life-limiting illness these are not mutually exclusive, and should be considered as part of the anticipatory care planning process.

Support from frailty in-reach, respiratory and palliative care teams should all be available to primary care community teams, with clear plans in place for managing a person in the community 24 hours per day.

Wherever possible, direct professional to professional communication lines and use of videoconsulting should support all staff working in settings such as care homes, and out-of-hours, to provide holistic care whilst minimising risk of infection.

All staff providing care to people with COVID-19 symptoms, being managed in the community, should follow HPS infection and control guidance at all times.

It is essential to note that community pathways are not mutually exclusive from acute hospital care and the clinical situation may change very rapidly. Clinical decision making and care plan review should reflect this.

There will be times when some treatments will cease to provide benefit, and palliative care should become the primary approach. It will be important to prepare families and care givers about that possibility and keep them informed and consulted.
5 Supportive treatments with hope of recovery

The most common symptoms of acute COVID-19 illness are cough, fever and loss of taste/smell. Patients at any age can present with varying degrees of symptoms, from mild flu-like symptoms, to becoming rapidly unwell in a matter of hours. More information can be found in the national guidance on community assessment of acute COVID-19 & referral to secondary care.

As we learn more about the progress of this disease, it is recognised that:

• people with milder symptoms may begin to deteriorate after the first week
• older people may present with less typical symptoms, including confusion, bladder and bowel problems.

Treatment options include:

• good hydration
• medication review if appropriate
• breathing techniques
• proning (see Figure 2)
  (It has been found that some patients in hospital may benefit from changing positions. This may be considered in the community setting, but only where it is felt clinically appropriate to do so, recognising evidence to support this approach in the community has yet to be established).
• cooling using wet wipes (discarded in clinical waste after single use) - **DO NOT USE FANS**
• psychological support
  - importance of an explanation regarding personal protective equipment (PPE)
  - connections with the family and carers through information sharing and technology.
• consideration of:
  - delirium
  - bladder and bowel function
  - anxiety
• treatment of fever with paracetamol
• pain/breathlessness, consider oral dose morphine, or benzodiazepines if tolerated.
• where there are clinical symptoms suggestive of COVID-19, and where there is a new oxygen requirement consider starting Dexamathasone 6 mg once daily for 10 days (see section 7).

Thromboprophylaxis is used to support care in the acute hospital setting. There is currently no evidence to support this approach in the community, and advice should be sought from specialist teams before prescribing.

*Figure 2: Proning*

**Lying ‘Prone’ on the ward**

What is lying ‘Prone’? This is when the clinical team judge that lying on your front for a period of time will help your breathing and your oxygen levels.

Try adding pillows under your pelvis and upper chest to make this position more comfortable

*Why do we ask patients to lie in the prone position?*

• Some patients who have pneumonia or similar problems have areas at the bottom of the lungs which are partly deflated. This means that air and oxygen isn’t getting into them very well.

• Lying a patient prone on their front can improve ‘ventilation’ and opens up these partially deflated areas.

• Lying prone can improve breathlessness and help get some more oxygen into the body.

• Lying prone can also help cough be more effective. This helps with clearing out any secretions that are in your chest.

*Available evidence suggests that lying prone must be considered early in acute lung conditions for best outcomes. This is why it might be suggested as part of your treatment on the ward, even if you’re feeling better.*

*Stephanie Milroy, Lisa Morrison, Kimbereley Barton, Chris Carlin. April 2020*
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6 Use of oxygen
See Appendix A for flow chart

Key points to consider

The primary role of oxygen in the management of COVID-19 is to correct hypoxaemia in order to try to improve outcome for the person.

- Is this clinically appropriate? Is the patient acutely breathless? (SpO₂ <94% and RR>20). Patients with suspected COVID-19 related breathlessness, and SpO₂ >94% in room air do not require oxygen.
  - oxygen may be used on a “trial for benefit” basis - does the person’s breathlessness improve, do oxygen saturation levels improve?
- This must be a shared decision
- Does the clinical situation merit reconsideration of hospital admission?
- Is it safe to administer? (e.g. smoker in household, other risks)
- Is an oxygen supply easily available?
  - follow national guidance and contact local Health Board lead for supply (see Appendix B for information and Appendix C for list of local contacts)
- How will this be monitored and how will you know if the person is getting benefit, e.g. reduction in breathlessness symptoms, oxygen saturations are improved?
- SpO₂ levels should be checked at least four times daily - are staff available and clinically competent? Is there a supply of pulse oximeters?
- Monitoring will support clinical decision making, which may include:
  - reconsideration for admission
  - titration of oxygen levels
  - consider withdrawal if not helping.
- Are there non-COVID-19 related issues, e.g. COPD or other risks for hypercapnoeic respiratory failure? This will need to be taken into account when assessing for target SpO₂
- How long will it take to source sufficient supply?

Anecdotal evidence from Scottish clinicians suggests that the majority of people with COVID-19 related breathlessness, if they are going to respond to oxygen therapy, are likely to do so within approximately 30 minutes of starting oxygen. This might be helpful to consider when using emergency bag or other locally available supplies.
Administration of Oxygen

Start oxygen, via nasal cannula, (simple masks should not be used for flow rates below 5 L/min) starting at 2 L/min, titrating up to a maximum of 4 L/min, aiming for the following:

in patients who are NOT at risk of hypercapnoeic respiratory failure
  • aim for target SpO₂ 94–96%

in patients who are at risk of hypercapnoeic respiratory failure (e.g. existing COPD, severe frailty)
  • aim for target SpO₂ 88–92%

Sources of support
  • local oxygen lead (see Appendix B for list of contacts)
  • respiratory liaison team
  • COVID-19 lead consultant

ASK FOR HELP IF UNSURE ABOUT USING OXYGEN – SUPPORT IS ALWAYS AVAILABLE

7 | Use of steroids

As the pandemic has progressed, new learning is emerging around treatment options.

A randomised controlled trial into use of dexamethasone in hospitalised patients with COVID-19, and subsequent meta-analysis, suggest that 6 mg dexamethasone daily for up to 10 days reduces mortality in patients who are hospitalised with proven SARS-CoV-2 infection and who require respiratory support, either through mechanical ventilation or oxygen support.

There was evidence of harm for patients with no oxygen requirement, e.g. oxygen saturation >92% on room air.

A large proportion of the population recruited into the trial were in the same age category as nursing home residents and more than half of the patients in the trial had significant morbidity.

Care home residents with SARS-CoV-2 infection and increasing oxygen requirements may therefore benefit from dexamethasone prescription.
It is important that potential risks and benefits associated with the decision to use dexamethasone and oxygen is discussed early with patients and their families, including limitations of oxygen delivery in care homes (maximum delivery of 5 L/min) and possible adverse effects of steroids (including the potential need for blood glucose monitoring).

Care home residents with confirmed or suspected SARS-CoV-2 infection who are felt to be suitable for hospital admission should continue to be admitted to allow optimisation of oxygenation, potential for continuous positive airway pressure (CPAP) therapy and consideration of dexamethasone and other potential therapies in that setting.

Those patients, with suspected SARS-CoV-2 infection, who are felt not likely to gain benefit from hospital admission or do not wish hospital admission, could be considered for treatment with oxygen and dexamethasone in their care home. The target oxygen saturation would be >94% with oxygen concentrators able to deliver a maximum of 4 or 5 L/min via nasal cannula.

**Oral dexamethasone at 6 mg daily for a maximum of 10 days can be prescribed with consideration of proton pump inhibitor (PPI) cover and blood glucose monitoring where appropriate.** (Subcutaneous administration could be considered if oral route compromised).

Common adverse effects could include: worsening of delirium, fluid retention/pulmonary oedema/exacerbation of heart failure, worsening glycaemic control, increased bleeding risk, insomnia, and, in this age group in particular, myopathy.

Patients who are not for escalation to secondary care and who have increasing oxygen requirements despite these treatments may require a more palliative approach.
8  Acutely ill and palliative care required

A key part of the decision to manage a person in the community is to ensure that through person-centred care planning, the person and their family are aware of the possibility that treatment intended to prolong life and aid recovery may not work, and a clinical decision may be discussed and agreed to focus goals of care on comfort and symptom management.

Where a person is deteriorating rapidly, and is felt clinically to be towards the end of life, it is important to ensure they are kept comfortable, that family and next of kin are informed, and where possible allowed to visit (with all risks explained, wearing appropriate PPE and in strictly limited numbers).

Electronic means of communication such as a tablet or mobile phone can provide immense comfort for people and their loved ones, and should be considered.

Contact details of next of kin, including email addresses, should be confirmed.

Guidance to support communication can be found here.

a) Points to note
- Decline may be rapid
- Wear appropriate PPE; treat reversible causes and confirm rapid irreversible decline
- High breathlessness/distress/delirium/agitation/fever/risk of death within hours - consider clinically appropriate prescribing (in line with the individual's anticipatory care plan) at higher / more frequent effective doses from the outset
- Syringe driver is the best option, but takes 4 hours to achieve full effect. REMEMBER TO PRESCRIBE
- If oxygen is no longer helping, titrate down with view to stopping
- Use subcutaneous butterfly if syringe driver equipment/expertise unavailable, use alternatives if needed - patients can be managed effectively with four-hourly subcutaneous injections to get medication levels to a steady state
- Patient positioning, excess bedding, cool wipes to face, cool room - DO NOT USE FANS
- Ensure DNA-CPR/nurse verification form/prescription chart completed as appropriate.
b) Sources of support
   - palliative care team (See Appendix B)
   - community pharmacist
   - Safer Prescription of Opiods Tool (SPOT) app (where available)
   ASK FOR HELP IF UNSURE ABOUT PRESCRIBING OR DOSES NOT SUFFICIENT
   - SUPPORT IS ALWAYS AVAILABLE

c) Prescribing if family/carer attending to patient (subcutaneous route NOT available):
   • For pain, breathlessness, cough and fever:
     - Oral morphine sulphate (10 mg/5 ml bottle); 5 mg hourly oral prn AND Paracetamol 500 mg-1000 mg four times daily
   • For secretions:
     - Hyoscine hydrobromide 1.5 mg patches; 1-4 patches every 72 hours transdermally OR
     - Hyoscine hydrobromide 300 microgram tabs; one tab every 6 hours orally
   • For distress:
     - Midazolam buccal (Epistatus® 10 mg/ml or Buccolam® 5 mg/ml); 2.5 mg hourly buccal prn OR
     - Lorazepam 1 mg scored tabs; 500 microgram every 4 hours sublingual prn (the dispenser may be able to split the tablets if required).

d) links to further information
   https://www.palliativecareguidelines.scot.nhs.uk/
   Scottish Government pharmacy palliative care toolkit
   Scottish rapid review breathlessness and end of life care
   Community Palliative, End of Life and Bereavement Care in the COVID-19 pandemic
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9 | Authors

Dr Michelle Watts  
Associate Medical Director NHS Tayside & Medical Adviser, Scottish Government

Dr Sian Tucker  
Clinical Director, Lothian Urgent Care Services & Medical Advisor, Scottish Government

10 | Acknowledgements

National Primary Care Clinical leads
National Services Scotland and oxygen therapy service
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Scottish Government Professional Advisory Group
Scottish Palliative Care leads
SGPC and RCGP leads
Representatives from the care home sector
Appendix A

PATIENT ASSESSED AS SUITABLE FOR CARE AT HOME
Not wishing or unlikely to benefit from admission

ACUTELY ILL
HOPE OF RECOVERY

Assess for hypoxia
RR>24
SpO₂ <94
(88% if at risk)

TRIAL O₂ NASAL
TARGET 94-96%
(88-92% if at risk)

IF RESPONSE
REQUEST CONCENTRATOR
CONSIDER DEXAMETHSONE

REVIEW

ACUTELY ILL
NOW AT END OF LIFE

Assess for symptom burden

ESTABLISH SYMPTOM CONTROL ACCORDING TO BENEFIT

ALREADY ON O₂
NO BENEFIT

TRITRATE DOWN WITH STOP GOAL

SET UP CONTINUOUS INFUSION

REVIEW

Community Palliative, End of Life and Bereavement Care in the COVID-19 pandemic
Scottish Palliative Care Guidance
Scottish Government COVID-19 Palliative Care Toolkit
APPENDIX B

Home Oxygen Ordering

The Home oxygen service is provided by Dolby Vivisol, who are based in Stirling and have a network of field based engineers and depots across the country.

If an oxygen concentrator is required, this should be requested through nominated individuals in secondary care who have access to a Part A Scottish Home Oxygen Order Form (SHOOF). A note of the respiratory and palliative care contact for each Board has been provided in the table below. A target SpO₂ should be stated in section 11 on the part A SHOOF to assist the attending health care professional.

Dolby Vivisol will be able to provide an oxygen concentrator that will provide up to 5 litres per minute. A recognised industry standard risk assessment will be carried out during installation, taking into account COVID-19 related infection control procedures.

Dolby Vivisol can provide a next - day and a same - day service. For same day service a concentrator will be provided within 8 hours of receipt. Their normal working hours are Monday to Friday 9 am – 5 pm. During the current COVID-19 pandemic, hours may be extended dependent on demand, and they may also able to receive requests for concentrators and install them on a Saturday and Sunday if required. Requests should state that the service is required for a COVID-19 patient.

Where oxygen is required out of hours then please refer to the local oxygen contact who may be able to refer to a local interim arrangement using locally held Transportable Concentrators, providing a maximum of either 2 or 3 litres per minute depending on the device held. Local teams are typically within out-of-hours, Hospital at Home, REACT or other local arrangements with hospices.

Local teams would typically issue a device in the out of hours period and then make a request through Trakcare or SCI store requesting a standard concentrator from Dolby Vivisol which will be delivered in the specified time frame, using the standard 4 day service, next-day service or same-day service. When installed, local teams will retrieve the Transportable Concentrators and take them back to their base for decontamination and reissue.

As part of the routine follow up and review, a judgement should be made as to whether the concentrator is still required. Where it is no longer required Dolby Vivisol should be contacted to arrange uplift. Please note that you must advise them that the concentrator is to be uplifted from a COVID-19 positive patient.
### Appendix C

<table>
<thead>
<tr>
<th>Health Board</th>
<th>Contact</th>
<th>Designation (if known)</th>
<th>Contact E-Mail Address</th>
<th>Telephone Number</th>
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<tr>
<td><strong>NHS Ayrshire and Arran</strong></td>
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</tr>
<tr>
<td><strong>Respiratory Contact</strong></td>
<td>Philip Hodkinson</td>
<td>Respiratory Physician - Crosshouse Hospital</td>
<td><a href="mailto:Philip.Hodkinson@aapct.scot.nhs.uk">Philip.Hodkinson@aapct.scot.nhs.uk</a></td>
<td>01563 825 134</td>
</tr>
<tr>
<td></td>
<td>Lorna McKay</td>
<td>Respiratory Nurse Specialist Ailsa - Ayr/South Ayrshire</td>
<td><a href="mailto:lorna.mckay@aaaht.scot.nhs.uk">lorna.mckay@aaaht.scot.nhs.uk</a></td>
<td>01292 513 161</td>
</tr>
<tr>
<td><strong>Palliative Contact</strong></td>
<td>Catriona Killin</td>
<td>Consultant in Palliative Medicine</td>
<td><a href="mailto:Catriona.killin@aapct.scot.nhs.uk">Catriona.killin@aapct.scot.nhs.uk</a></td>
<td>01292 269 200 or 07870554784</td>
</tr>
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<td><strong>NHS Borders</strong></td>
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<tr>
<td><strong>Respiratory Contact</strong></td>
<td>Emma Dodd</td>
<td>Respiratory Nurse Specialist</td>
<td><a href="mailto:emma.dodd@borders.scot.nhs.uk">emma.dodd@borders.scot.nhs.uk</a></td>
<td>01896 826635</td>
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<tr>
<td></td>
<td>Debbie Cairns</td>
<td>Respiratory Nurse Specialist</td>
<td><a href="mailto:debra.cairns@borders.scot.nhs.uk">debra.cairns@borders.scot.nhs.uk</a></td>
<td>01896 826635</td>
</tr>
<tr>
<td><strong>Palliative Contact</strong></td>
<td>Emma Dodd</td>
<td>Respiratory Nurse Specialist</td>
<td><a href="mailto:emma.dodd@borders.scot.nhs.uk">emma.dodd@borders.scot.nhs.uk</a></td>
<td>01896 826635</td>
</tr>
<tr>
<td></td>
<td>Michelle Scott</td>
<td>Palliative Care Nurse Consultant</td>
<td><a href="mailto:michelle.scott@borders.scot.nhs.uk">michelle.scott@borders.scot.nhs.uk</a></td>
<td>01896 826829 or 01896 826000 ask for bleep 6828</td>
</tr>
<tr>
<td><strong>NHS Dumfries and Galloway - Switchboard (01387 246246)</strong></td>
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<tr>
<td><strong>Respiratory Contact</strong></td>
<td>Stuart Little</td>
<td>Respiratory Consultant</td>
<td><a href="mailto:stuart.little@nhs.scot">stuart.little@nhs.scot</a></td>
<td>01387 246246 ext 33757</td>
</tr>
<tr>
<td></td>
<td>Yvonne Scott</td>
<td>Respiratory Nurse Specialist</td>
<td><a href="mailto:Yvonne.scott2@dg.nhs.scot">Yvonne.scott2@dg.nhs.scot</a></td>
<td>01387 241007</td>
</tr>
<tr>
<td><strong>Palliative Contact</strong></td>
<td>Nigel Wilson</td>
<td>Specialist or McMillan nurses</td>
<td><a href="mailto:nigelwilson@nhs.net">nigelwilson@nhs.net</a></td>
<td>01387 241347</td>
</tr>
<tr>
<td></td>
<td>Kirsty Gaffney</td>
<td>Specialist or McMillan nurses</td>
<td><a href="mailto:Kirsty.gaffney@dg.nhs.scot">Kirsty.gaffney@dg.nhs.scot</a></td>
<td>01556 612360</td>
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<td><strong>NHS Dumfries and Galloway - Switchboard (01387 246246)</strong></td>
<td>Barbara Maxwell</td>
<td>Specialist or McMillan nurses</td>
<td><a href="mailto:B.Maxwell@nhs.scot">B.Maxwell@nhs.scot</a></td>
<td>01671 402587</td>
</tr>
<tr>
<td></td>
<td>Katherine McMillan</td>
<td>Specialist or McMillan nurses</td>
<td></td>
<td>01387244896</td>
</tr>
<tr>
<td></td>
<td>Kirsty Morris</td>
<td>McMillan Nurse Specialist</td>
<td><a href="mailto:kirsty.morris9@dg.nhs.scot">kirsty.morris9@dg.nhs.scot</a></td>
<td>01387 246 246</td>
</tr>
<tr>
<td><strong>NHS Fife</strong></td>
<td>Margaret Stevenson</td>
<td>Respiratory Nurse Consultant</td>
<td><a href="mailto:margaret.stevenson@nhs.net">margaret.stevenson@nhs.net</a></td>
<td>01592 643355</td>
</tr>
<tr>
<td><strong>Respiratory Contact</strong></td>
<td>Margaret Vass</td>
<td>Pharmacy Technician Team Leader</td>
<td><a href="mailto:Margaret.vass@nhs.scot">Margaret.vass@nhs.scot</a></td>
<td>01383 565345/07932676485</td>
</tr>
<tr>
<td><strong>Palliative Contact</strong></td>
<td>Sarah Miller</td>
<td>Palliative Care Consultant in the Community</td>
<td><a href="mailto:sarah.miller25@nhs.net">sarah.miller25@nhs.net</a></td>
<td>01324 567 314</td>
</tr>
<tr>
<td><strong>NHS Forth Valley</strong></td>
<td>Donna Read</td>
<td>Lead Respiratory Specialist Nurse</td>
<td><a href="mailto:Donna.read@nhs.scot">Donna.read@nhs.scot</a></td>
<td>01324 566 618</td>
</tr>
<tr>
<td><strong>Respiratory Contact</strong></td>
<td>Kirsty Murray</td>
<td>Lead Respiratory Clinical Nurse Specialist</td>
<td><a href="mailto:Kirsty.Murray4@ggc.scot.nhs.uk">Kirsty.Murray4@ggc.scot.nhs.uk</a></td>
<td>0141 211 6763</td>
</tr>
<tr>
<td><strong>Palliative Contact</strong></td>
<td>Jane Edgecombe</td>
<td>Consultant Palliative Medicine</td>
<td><a href="mailto:Jane.Edgecombe@ggc.scot.nhs.uk">Jane.Edgecombe@ggc.scot.nhs.uk</a></td>
<td>0141 301 7042</td>
</tr>
<tr>
<td><strong>NHS Greater Glasgow and Clyde</strong></td>
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</tr>
<tr>
<td>Respiratory and Palliative Contact</td>
<td>Margaret MacLeod</td>
<td>Senior Respiratory Physiotherapist</td>
<td><a href="mailto:margaret.macleod3@nhs.scot">margaret.macleod3@nhs.scot</a></td>
<td>01224 555796</td>
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<tr>
<td>Respiratory Contact</td>
<td>Karon Carson</td>
<td>SPVU Clinical Nurse Specialist</td>
<td><a href="mailto:Karon.Carson@gjnh.scot.nhs.uk">Karon.Carson@gjnh.scot.nhs.uk</a></td>
<td>0141 951 5771</td>
</tr>
<tr>
<td></td>
<td>Rachel Thomson</td>
<td>Nurse Specialist</td>
<td><a href="mailto:Rachel.Thomson@gjnh.scot.nhs.uk">Rachel.Thomson@gjnh.scot.nhs.uk</a></td>
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<tr>
<td>Palliative Contact</td>
<td>Sharon Robinson</td>
<td>Nurse Specialist</td>
<td><a href="mailto:sharon.robinson@gjnh.scot.nhs.uk">sharon.robinson@gjnh.scot.nhs.uk</a></td>
<td>0141 951 5000 ext 5350</td>
</tr>
<tr>
<td></td>
<td>Karon Carson</td>
<td>SPVU Clinical Nurse Specialist</td>
<td><a href="mailto:Karon.Carson@gjnh.scot.nhs.uk">Karon.Carson@gjnh.scot.nhs.uk</a></td>
<td>0141 951 5771</td>
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<td></td>
<td>Rachel Thomson</td>
<td>Nurse Specialist</td>
<td><a href="mailto:Rachel.Thomson@gjnh.scot.nhs.uk">Rachel.Thomson@gjnh.scot.nhs.uk</a></td>
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<td><strong>NHS Highland</strong></td>
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<tr>
<td>Respiratory and Palliative Contact</td>
<td>Lorna Murray</td>
<td>Consultant Respiratory Physician</td>
<td><a href="mailto:lorna.murray@nhs.scot">lorna.murray@nhs.scot</a></td>
<td>Switchboard 01463 704000 / 01463 706294</td>
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<tr>
<td><strong>NHS Lanarkshire</strong></td>
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<tr>
<td>Respiratory Contact</td>
<td>Tan, Dr Soong</td>
<td>Consultant Physician Respiratory Medicine</td>
<td><a href="mailto:Soong.Tan@lanarkshire.scot.nhs.uk">Soong.Tan@lanarkshire.scot.nhs.uk</a></td>
<td>01698 366074</td>
</tr>
<tr>
<td>Respiratory Contact</td>
<td>Tracey Miller</td>
<td>Lead Respiratory Nurse Specialist</td>
<td><a href="mailto:Tracey.Miller@lanarkshire.scot.nhs.uk">Tracey.Miller@lanarkshire.scot.nhs.uk</a></td>
<td>01698 366508</td>
</tr>
<tr>
<td>Palliative Contact</td>
<td>Susan Jackson</td>
<td>Consultant in Palliative Medicine</td>
<td><a href="mailto:Susan.Jackson@lanarkshire.scot.nhs.uk">Susan.Jackson@lanarkshire.scot.nhs.uk</a></td>
<td>01236 766951</td>
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Supporting people with COVID-19 related illness in the community setting:
Clinical management of those with moderate to severe illness

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<tr>
<th>Health Board</th>
<th>Contact</th>
<th>Designation (if known)</th>
<th>Contact E-Mail address</th>
<th>Telephone Number</th>
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<td><strong>NHS Lothian</strong></td>
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<tr>
<td>Respiratory Contact</td>
<td>Elspeth Christie</td>
<td>Advanced Respiratory Nurse Specialist</td>
<td><a href="mailto:Elspeth.Christie@nhslothian.scot.nhs.uk">Elspeth.Christie@nhslothian.scot.nhs.uk</a></td>
<td>0131 536 1000</td>
</tr>
<tr>
<td>Palliative Contact</td>
<td>Gourab Choudhury</td>
<td>Respiratory Consultant</td>
<td><a href="mailto:Gourab.Choudhury@nhslothian.scot.nhs.uk">Gourab.Choudhury@nhslothian.scot.nhs.uk</a></td>
<td>0131 536 1000</td>
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<td><strong>NHS Orkney</strong></td>
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<tr>
<td>Respiratory and Palliative Contact</td>
<td>Wendy Lycett</td>
<td>Clinical Pharmacist</td>
<td><a href="mailto:wendyllycett@nhs.net">wendyllycett@nhs.net</a></td>
<td>01856 888015</td>
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<td><strong>NHS Tayside</strong></td>
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</tr>
<tr>
<td>Respiratory Contact</td>
<td>Sandy Rolfe</td>
<td>Respiratory Nurse Specialist</td>
<td><a href="mailto:sandy.rolfe@nhs.scot">sandy.rolfe@nhs.scot</a></td>
<td>01382 496564</td>
</tr>
<tr>
<td>Palliative Contact</td>
<td>Deans Buchanan</td>
<td>Consultant in Palliative Medicine/ Lead Clinician</td>
<td><a href="mailto:deansbuchanan@nhs.net">deansbuchanan@nhs.net</a></td>
<td>01382 623055 ext 32055</td>
</tr>
<tr>
<td><strong>NHS Shetland</strong></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Respiratory Contact</td>
<td>Pauline Wilson</td>
<td></td>
<td><a href="mailto:paulinewilson@nhs.net">paulinewilson@nhs.net</a></td>
<td>01595 743326</td>
</tr>
<tr>
<td></td>
<td>Mary McFarlane</td>
<td>Pharmacist</td>
<td><a href="mailto:mary.mcfarlane@nhs.net">mary.mcfarlane@nhs.net</a></td>
<td>01595 743 000</td>
</tr>
<tr>
<td>Palliative Contact</td>
<td>David Fryer</td>
<td></td>
<td><a href="mailto:davidfryer1@nhs.net">davidfryer1@nhs.net</a></td>
<td>01595 743000</td>
</tr>
<tr>
<td><strong>NHS Western Isles</strong></td>
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<td></td>
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</tr>
<tr>
<td>Respiratory Contact</td>
<td>Pauline Morrison</td>
<td>Respiratory Liaison Nurse NHS Western Isles</td>
<td><a href="mailto:pmorrison@nhs.net">pmorrison@nhs.net</a></td>
<td>01851 708252</td>
</tr>
<tr>
<td>Respiratory Contact</td>
<td>Liam Callaghan</td>
<td>Lead Pharmacist</td>
<td><a href="mailto:Liam.Callaghan@nhs.net">Liam.Callaghan@nhs.net</a></td>
<td>01851 708140</td>
</tr>
<tr>
<td>Palliative Contact</td>
<td>Gail Allan</td>
<td>Macmillan Lead Nurse Cancer, Palliative Care</td>
<td><a href="mailto:gail.allan1@nhs.net">gail.allan1@nhs.net</a></td>
<td>01851 763308</td>
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For out-of-hours supply, please follow local guidance.