



COVID-19
(New Coronavirus)
Outbreak in Sri Lanka

Interim Guidelines for Sri Lankan Primary Care Physicians

Version 3.1
23rd April 2020



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This Guideline is based on the Circulars and Guidelines issued by the Director General of Health Services (DGHS) & other related International Guidelines (WHO,CDC,NHS-UK) for managing COVID-19 Pandemic.

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We strongly recommend Primary Care Physicians to continue their clinical practice if they can adhere to these guidelines.

1. INTRODUCTION

Coronaviruses (CoV) are a large family of enveloped viruses that cause illness ranging from the common cold to more severe diseases such as Middle East Respiratory Syndrome (MERS-CoV) and Severe Acute Respiratory Syndrome (SARS-CoV). Coronavirus disease (COVID-19) is a new strain that was discovered in 2019 and has not been previously identified in humans. The World Health Organization (WHO) recently declared COVID-19 as a global pandemic.

Incubation period of the virus is 2-14 days (1). The median incubation period is estimated to be 5.1 days and 97.5% of those who develop symptoms will do so within 11.5 days (2). During the incubation period, the virus may not be identified with the currently available Reverse Transcriptase Polymerase Chain Reaction (RT -PCR) test with a single sampling. However, people are contagious when they are most symptomatic.

The virus spreads by droplets. Direct spread occurs when a person facing a patient who talks, coughs or sneezes. The droplets can spread to a distance of 1-2 meters and directly get into another person's airways. More importantly it can spread when the virus lands on a surface and when a person touches the contaminated surface and then the face. Its survival on that surface will be determined by the temperature, humidity and the type of the surface. The third method of spread identified is by inhalation of the aerosolized virus which can exist in the air for up to three hours.

Primary Care Physicians (PCPs) are in the frontline of patient care in any healthcare crisis as the closest healthcare professionals to the family. They have a major responsibility in looking after high-risk groups, identifying suspected cases, preventing spread and opportunistic patient education during the current pandemic of COVID-19.

This guideline is for Primary Care Physicians in (a) Private Family Practice/General Practice Clinics (b) Primary Medical Care Units (PMCU), and (c) the Divisional Hospitals (d) Doctors working in Outpatient Departments (OPDs) of secondary & tertiary care institutions and private hospitals delivering primary curative care (3).

2. CASE DEFINITIONS

UPDATED INTERIM CASE DEFINITIONS ON COVID-19 AND ADVICE ON INITIAL MANAGEMENT OF PATIENTS (version dated 04.04.2020)

The present recommendation is to isolate and test all clinically/epidemiologically suspected cases of COVID-19 infected patients.

All patients with medical/surgical, obstetrics/gynecological or paediatric conditions should receive the usual standards of care in keeping with clinical status, in a designated area. Management of these patients should NOT be delayed under any circumstances pending COVID-19 test result.

All confirmed cases once stable should be transferred to a designated COVID-19 Treatment Centre.

Clinically Suspected Case:

A. A person with ACUTE RESPIRATORY ILLNESS (with cough, shortness of breath, sore throat; one or more of these) with a history of FEVER (at any point of time during this illness), returning to Sri Lanka from ANY COUNTRY within the last 14 days.

OR

B. A person with ACUTE RESPIRATORY ILLNESS (with cough, shortness of breath, sore throat; one or more of these) AND having been in **close-contact*** with a confirmed or suspected COVID-19 case during the last 14 days prior to onset of symptoms;
***Close-contact:** A person staying in an enclosed environment for >15 minutes (e.g. same household/workplace/social gatherings/travelling in same vehicle). OR who had direct physical contact.

OR

C. A person with ACUTE RESPIRATORY ILLNESS (with cough, shortness of breath, sore throat; one or more of these) with a history of fever (at any point of time during this illness) with a **history of travel to or residence in a location designated as an area of high transmission of COVID-19** disease as defined by the Epidemiology Unit, MoH, during the 14 days prior to symptom onset.

OR

D. A patient with acute pneumonia (not explainable by any other aetiology) regardless of travel or contact history as decided by the treating Consultant.

- Management of such patients should NOT be delayed under any circumstances.
- Patients should receive the standards of care in keeping with the known underlying cause in a designated area (ETU/isolation unit/designated respiratory unit/designated ward-HDU/ICU).

- A sample for the PCR test obtained and sent (not the patient) to a designated laboratory.
- Once the result is available, if positive, the patient (once stable) can be transferred to a designated COVID-19 treatment center.

OR

E. A patient with fever and in respiratory distress as evident by RR>30 per minute, SpO₂ <90% on room air, regardless of travel or contact history and without a definable cause, as decided by the treating Consultant.

- Management of such patients should NOT be delayed under any circumstances.
- Patients should receive the standards of care in keeping with the clinical condition in a designated area (ETU/isolation unit/designated respiratory unit/designated ward-HDU/ICU).
- A sample for the PCR test obtained and sent (not the patient) to a designated laboratory.
- Once the result is available, if positive, the patient (once stable) can be transferred to a designated COVID-19 treatment center.

F. Any person irrespective of the presence of symptoms, with an epidemiological link to a confirmed COVID-19 case who needs testing, as decided by the Regional Epidemiologist or the Central Epidemiology Unit.

Confirmed Case:

A person with laboratory confirmation of COVID-19 infection, irrespective of clinical signs and symptoms.

Disposition of cases:

Disposition of suspected cases

- All patients fitting to the above suspected case definitions (A, B, C) should be admitted and transferred by ambulance to the closest designated hospital (refer updates on the list of designated hospitals) for confirmatory testing and management. **This should be done only after stabilizing the patient and in prior consultation with the respective designated hospital**, adhering to necessary infection prevention and control (IPC) precautions.
- In case of D and E, patient should be managed in the same hospital in a designated area (ETU/isolation unit/designated respiratory unit/designated ICU). A sample for the PCR test obtained and sent (not the patient) to the designated laboratories. Once the result is available, if positive, the patient (once stable) can be transferred to a designated COVID-19 treatment center. In case of F, all COVID-19 positive individuals will be admitted to a designated treatment facility.

Disposition of confirmed cases

All confirmed cases should be transferred to a COVID-19 Treatment Centre.

The above case definition was adopted from ‘**Updated interim case definitions on COVID-19 and advice on initial management of patients (Version dated 04.04.2020)**’

3. PRIMARY CARE CONSULTATION

It is advisable to discourage patients with respiratory symptoms with or without fever visiting your practice for treatment. This recommendation is valid also for any chronic disease consultation.

It is **strongly recommended to establish a remote consultation service (hotline / video conferencing)** with your patients which will enable you to advise them and clarify queries related to respiratory symptoms and fever regardless of your availability in your practice due to the situation in the country (4).

3.1 REMOTE CONSULTATION

During the COVID-19 pandemic it is recommended to initiate all first contact care consultations as remote consultations over the phone. This will enable you to triage COVID-19 suspected patients appropriately with minimum exposure to healthcare staff and other patients. At the same time, it enables non-COVID patients to be managed appropriately. Patients with respiratory symptoms should be discouraged from visiting primary care settings without a prior telephone consultation.

Modes of communication for remote consultations

- *With audio only* -Telephone calls etc.
- *With audio and video* – WhatsApp, Viber, Video conferencing with Zoom, Google hangouts, Skype etc.

Of the two methods, telephone consultations are familiar to the majority and they would be adequate in most instances such as for delivery of general information, consultation of uncomplicated patients with mild symptoms and provision on routine/periodic care (4). However, video consultations can provide additional visual diagnostic clues and therapeutic presence. Thus, video conferencing could be suitable for patients who are more ill or more anxious.

Preparation

A notice could be displayed outside your clinic indicating the above facts. (*Sample notice in Annex 1*)

Documentation of remote consultations

Use the ‘*Doctor – Patient telephone consultation record*’ (Annex 2) or the usual medical record to document the remote consultation. If documented in existing medical records use it as a guide. Record keeping is even more important in this crisis situation as consultations without active follow-up is of less value.

Tips for a successful remote consultation

- Be proactive – doctor-initiated consultations for high risk patients
- Introduce yourself
- Confirm the identity of the patient

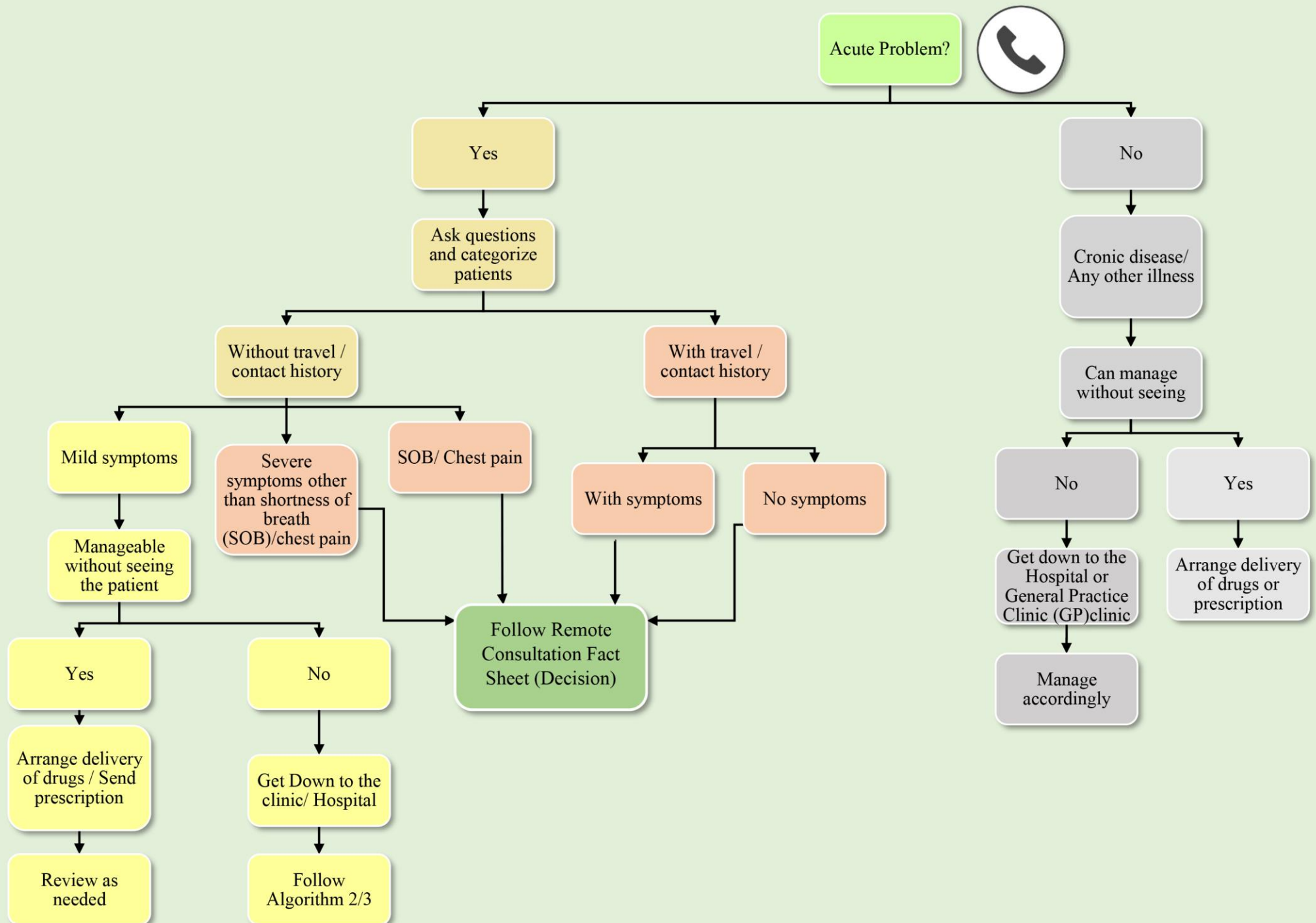
- Open ended questions and closed ended questions for triage purpose.
- Listen with a third ear – pick not only the literal meaning but also the emotions and context
- Check for understanding
- Give opportunity to clarify
- Use simple culturally appropriate non-medical language

When to avoid remote consultation

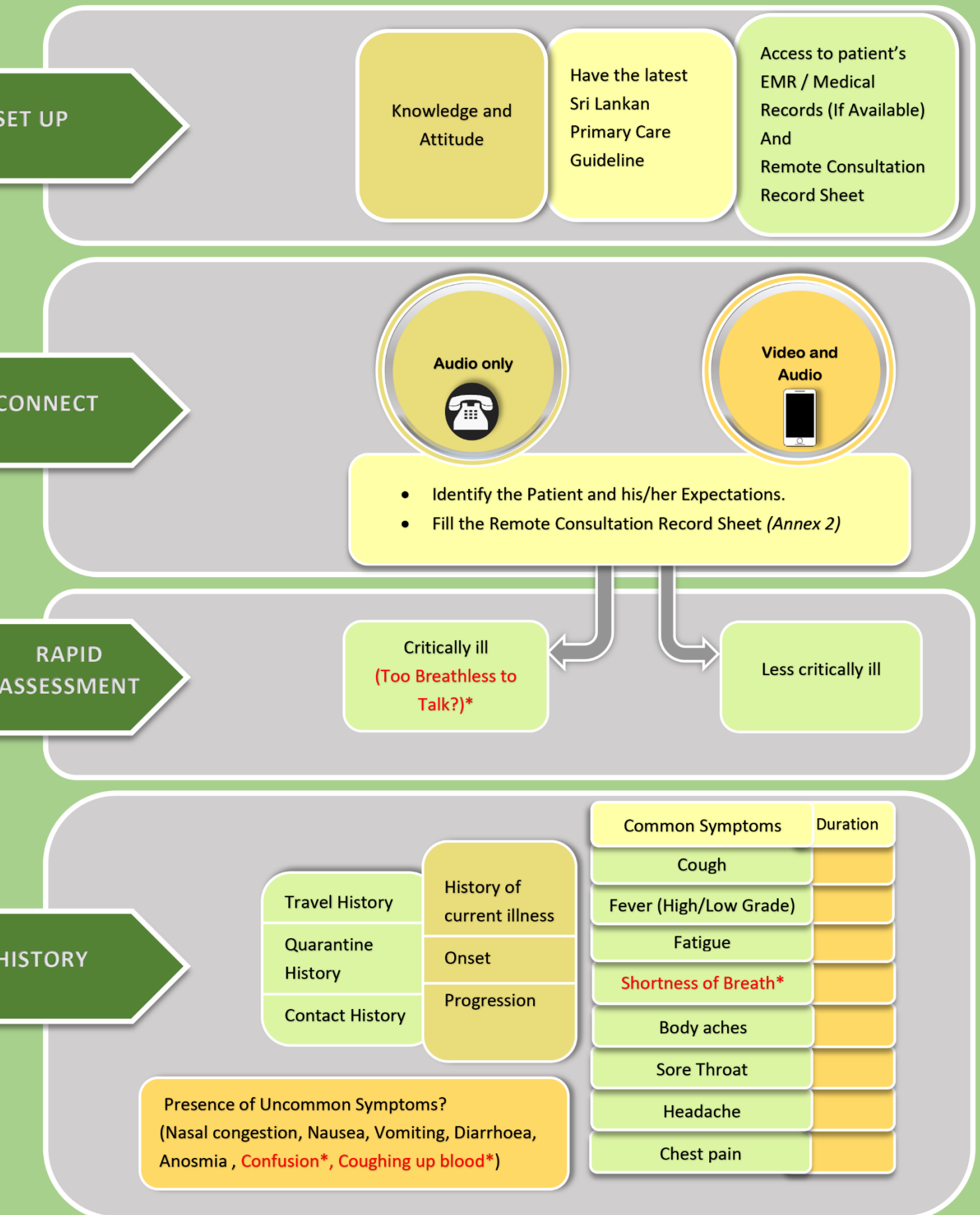
- To assess patients with serious or potentially high risk conditions requiring a physical examination (5)
- When a physical examination is required to support the clinical decision making
- When a patient's ability to communicate via telephone or video is compromised and there is no one to assist during the consultation
- When the doctor has any doubt about the clinical appropriateness of a remote consultation

Figure 1 (Algorithm on Remote Consultation) and the Figure 2 (Quick Fact Sheet) will provide you guidance on carrying out a successful Remote Consultation.

Figure 1. REMOTE CONSULTATION



**Figure 2. REMOTE CONSULTATION WITH SUSPECTED COVID-19 PATIENT
“QUICK FACT SHEET” FOR PRIMARY CARE PHYSICIANS**



EXAMINATION

Audio only



Ask the Patient/ Guardian to describe breathing pattern. (Regular , Irregular, Laboured)

Ask to complete a full sentence

Video and Audio



Look for

Shortness of Breath*

Look for cyanosis*

Ill Appearance

Ask for Home Measurement of Blood Pressure / Temperature / Pulse Rate/ Respiratory Rate

ASSESSMENT

No contact / Travel history



With contact / Travel history

Mild symptoms

Severe symptoms other than SOB/chest pain

SOB / chest pain

Symptoms

No symptoms

Follow algorithm 1

Acute management

Discuss with RE

Admit to the closest hospital / Isolation centre after RE's advice

Inform MOH/PHI/Police

Admit to nearest hospital with facilities

Home Isolation

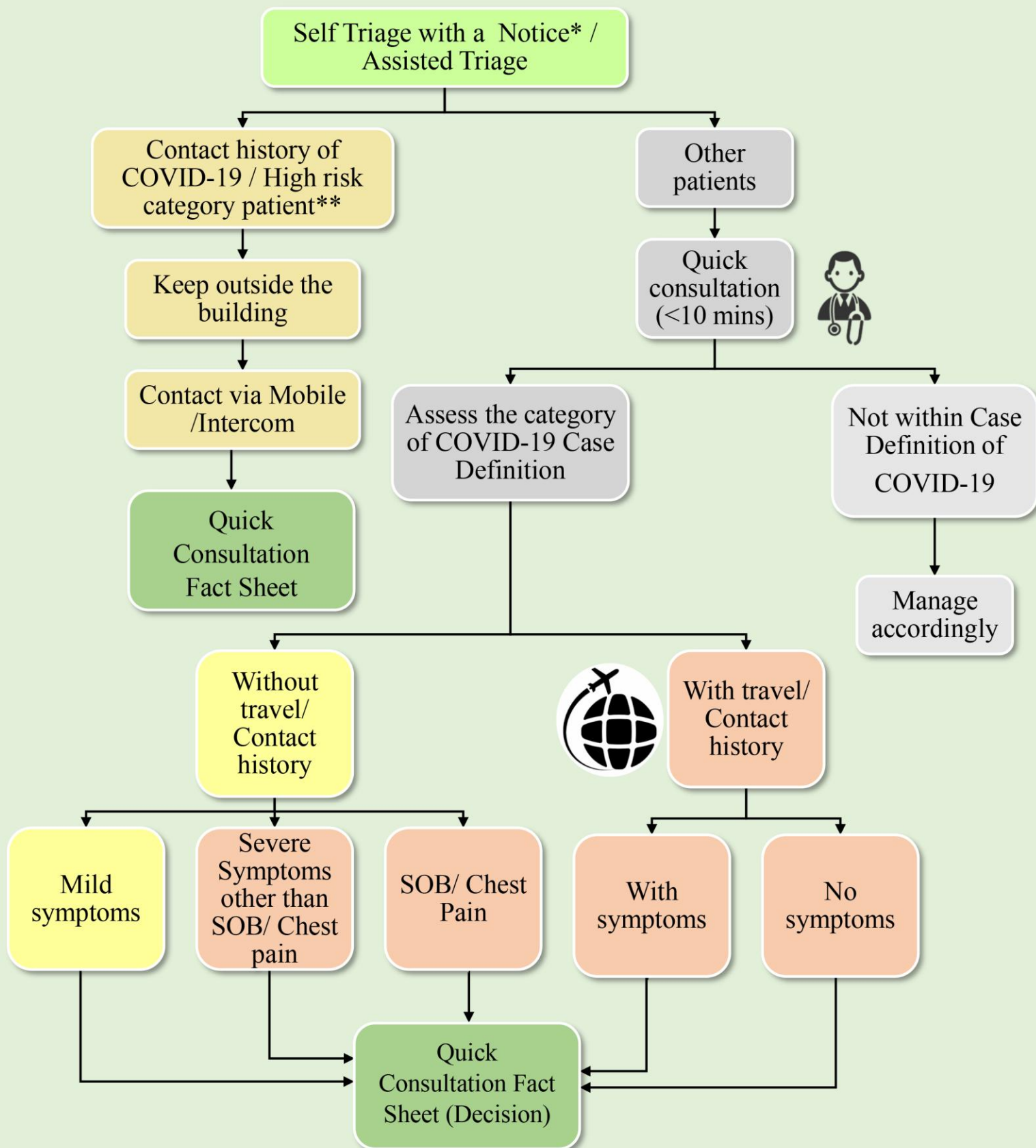
DECISION



* RED FLAGS - NEED TO ADMIT ASAP

• RE – Regional Epidemiologist

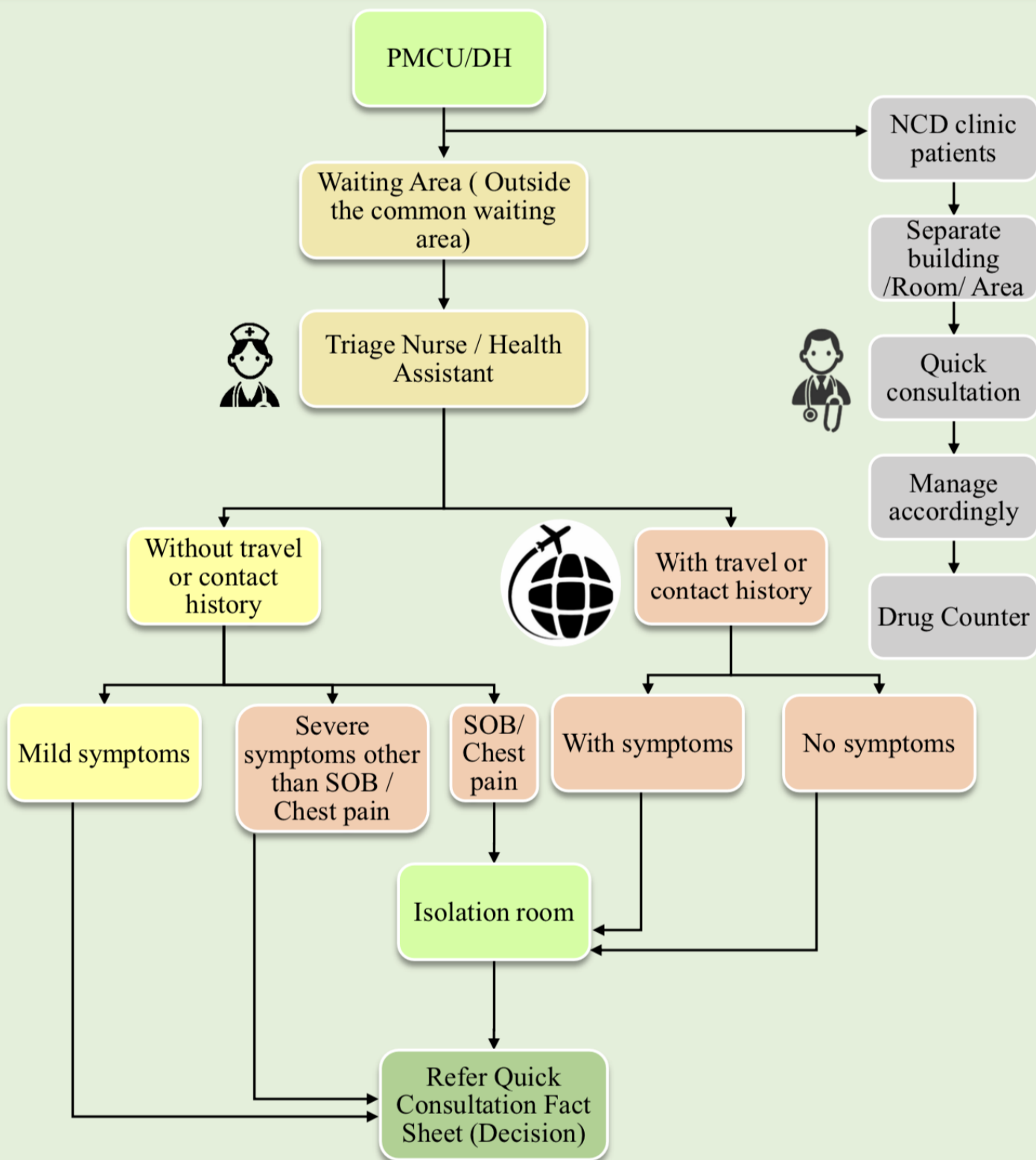
Figure 3. MANAGEMENT AT GP CLINIC



*Annex 5

** Page 15

**Figure 4. MANAGEMENT AT PRIMARY MEDICAL CARE UNITS (PMCU)/
DISTRICT HOSPITALS (DH)**

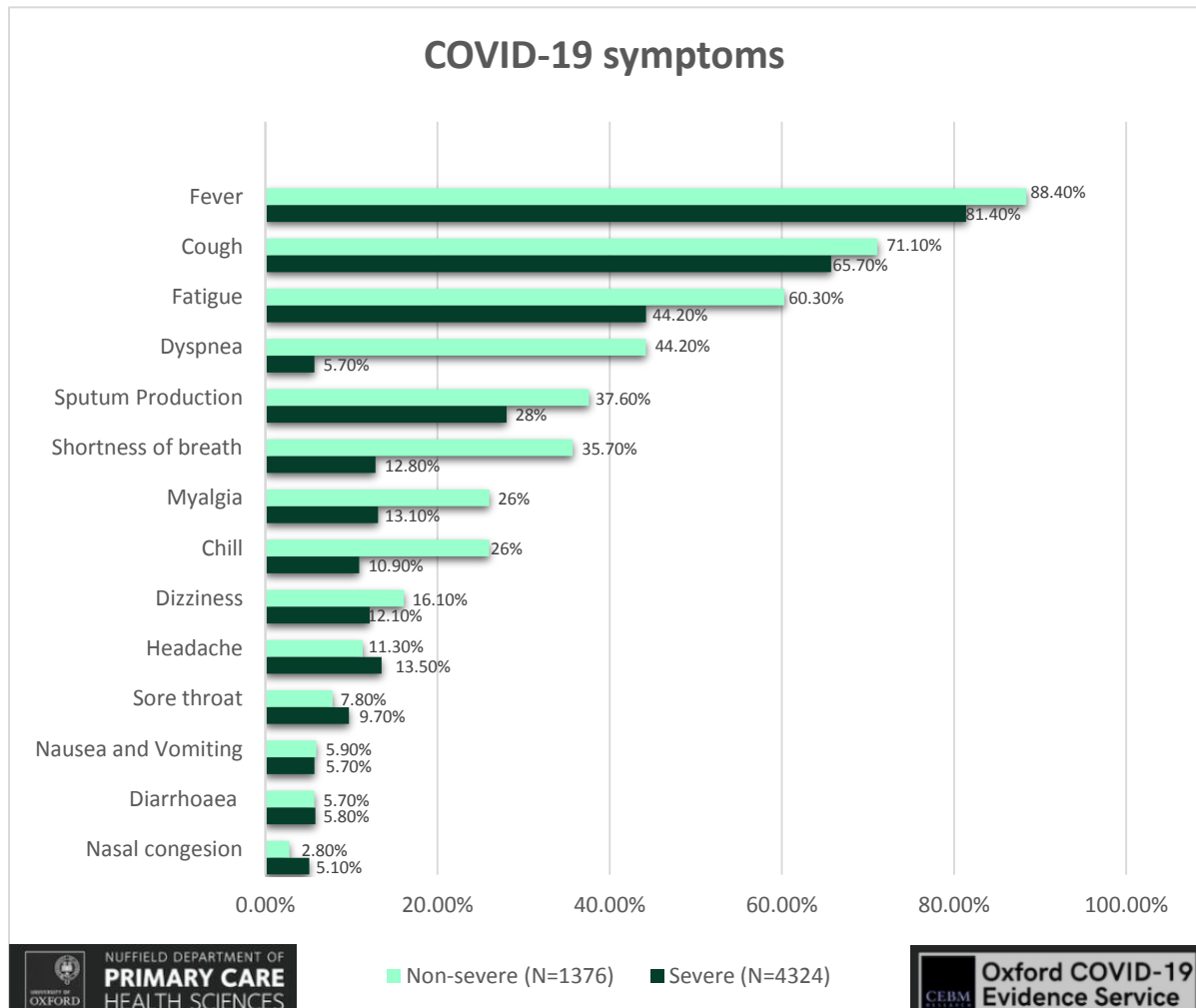


- Please refer [page 21](#) and 22 for safety precautions for Primary Care Physicians (6) (7) (8).

4. HISTORY

The majority of the patients with COVID-19 identified up to now have a clear contact history. This makes a detailed history extremely important in a primary care setup.

Important points to elicit in the history; (9)



- Elderly patients can present with atypical symptoms (confusion, drowsiness) (10)
- Anosmia and ageusia can be early symptoms of COVID-19 (11).
- Travel and social history is extremely important.
 - Recent visit to any foreign country (within 1 month)
 - Coming into contact with a suspected or a confirmed COVID-19 patient within last 14 days
 - Coming into contact with a person that arrived from abroad within last 14 days
 - Residing in or recent visit to an area of high transmission of COVID-19/lock down area

- Contacts of the current high-risk healthcare workers
- Employees in aviation, tourism and hotel industry
- Recently released from a quarantine centre / self-quarantine
- Staff or armed forces who have worked in quarantine facilities
- Family members, relations or associates of any of the above groups

Patients at risk of developing complications from COVID-19

Patients with non-communicable diseases (NCDs) and multiple comorbidities are at a higher risk of developing complications. This makes it a high priority for primary care doctors to pay extra attention to this group of patients. Minimizing exposure by social isolation should be the top preventative strategy and the patients should be discouraged from visiting clinics. The caregivers should be requested to come instead and get the prescription refills if needed. Alternatively, such patients should be offered remote consultations and e-prescriptions could be issued. (as above)

Patients should be permitted to contact you at any time of the day and get your advice. It would help them to not feel alone and helpless.

Following categories of patients are at higher risk.

- Older adults (above 50 years of age) are at higher risk and the elderly patients above 70 years of age are the most susceptible to develop severe disease from the COVID-19 infection (12).
- PCPs are advised to specially focus on the following groups of patients (13).
 - a) Patients with chronic medical conditions - heart disease, lung disease (cystic fibrosis, asthma and COPD), diabetes, hypertension, liver disease, kidney disease
 - b) Smokers, alcohol consumers and patients with substance abuse (14).
 - c) People with Body Mass Index of (BMI) 40 kg/m² or above
 - d) Patients with psychiatric disorders
 - e) Immunocompromised patients - patients on steroids, immunosuppressive therapy, undergone organ transplantation, cancer, HIV/AIDS
 - f) Patients living alone
 - g) Patients living in elderly homes
- Pregnant women - all newly registered and high risk expectant mothers whose period of amenorrhea (POA) of more than 32 should be followed up at routine antenatal clinics. For more details, please refer to the specific guideline issued by the Ministry of Health (15). [Interim Guidelines for field maternal and child care services during the outbreak of COVID -19](#)

5. EXAMINATION

Key equipment: Infrared / digital thermometer, fingertip pulse oximeter and stethoscope. It is advisable not to use a mercury thermometer and to avoid taking oral/anal temperature.

- Limited examination is recommended. Auscultation is not essential if overall clinical judgment is clear about respiratory illness status. It is advisable to all doctors not to examine the throat of patients.
- Assessing blood pressure increases contact time significantly, thus should be considered only in essential decision making unless you have a digital blood pressure meter (16).
- For cleaning of equipment please refer to the environmental cleaning guideline by the Ministry of Health (7). (Annex 7)

Initial presentation: No specific signs would be found in the early staged of COVID-19.

Late presentation: Change in vital signs, lung signs (reduced air entry and added sounds), tachypnoea (respiratory rate>30) and low oxygen saturation (SpO₂ <90%) may be found.

Look for atypical signs in elderly patients. (Confusion, drowsiness)

6. INVESTIGATIONS

- There is **no specific clinical or laboratory investigation to screen** for COVID-19 at the moment.
- We do not recommend FBC, CRP to arrive at a diagnosis of a probable COVID 19.
- Reverse transcription polymerase chain reaction (RT-PCR) test is available for ‘suspected cases’ of COVID-19 as a confirmatory test at government hospitals and some approved private hospitals after admission.
- Patients should be informed that the PCR is not a screening test. In addition, it is important to explain that even if the PCR is negative, the patient may harbour the virus during the incubation period (17).
- Although detection of IgM/IgG to diagnose COVID-19 has been suggested, it cannot replace RT-PCR in acute diagnosis and management of patients due to late antibody response. It would miss the patients in early stages of the disease (18).

7. TREATMENT

- **Do not use any medications specific to COVID-19 in primary care**, specifically chloroquine, hydroxychloroquine, azithromycin or any other antiviral drug **for treatment or for prophylaxis** (19).
- **Treatment with ACE inhibitors and ARBs**
Currently there is no evidence for discontinuation of ACE inhibitors and ARB in those with confirmed COVID-19 (20).

8. MANAGEMENT AND DISPOSITION OF THE PATIENTS AND NOTIFICATION

	Contact/travel history	Symptoms	Problem definition	Action
Category 1	NO	Mild symptoms	Non COVID-19	Reassure, treat accordingly (see page 18)
Category 2	NO	Severe symptoms other than SOB/chest pain	Unlikely to be COVID-19	1990 and admit to nearest hospital
Category 3	NO	SOB/ Chest pain	Possible case of COVID - 19 (Case definition – D, E)	Inform RE and arrange admission to nearest hospital through 1990. Inform Hospital.
Category 4	Present	NO	Asymptomatic contact (Case definition – F)	Inform RE and MOH/PHI for home quarantine* and follow-up through the public health team.
Category 5	Present	Present	Suspected case of COVID-19 (Case definition – A, B,C,F)	-Inform RE, MOH/PHI -Admit to the nearest COVID acute care isolation hospital. -Follow-up through public health team -Inform hospital.

RE: Regional epidemiologist, MOH: medical officer of health, PHI: public health inspector

The above table summarizes the circular ‘Interim guideline for risk assessment referral system to rationally manage COVID-19 case load in isolation centers by DDG-MS-1/23/2020 dated 6/4/2020’ (21).

* [Patient information leaflet on home quarantine](#) is available at epidemiology website.

- If you suspect a patient to have COVID-19 infection according to the above ‘suspected case’ definitions (Category 3 and 5/A to F), unless you have used appropriate PPE, immediately leave the consultation room to avoid further exposure.

Follow the precautionary methods (22) and relevant environmental cleaning procedures provided by MoH.

- Stabilize the patient and preferably contact the relevant hospital before transferring.
- Call and get down an ambulance (*Suwasariya* - 1990) and transfer the patient to the closest designated hospital (*see Annex 3*) (23) adhering to necessary infection prevention and control (IPC) precautions without exposing the general public.
- If any patient refuses to admit / home isolation, seek police/legal support in accordance with the Quarantine Law.

9. PROCEDURE FOLLOWING A CLOSE CONTACT

A Primary Care Physician and the staff with high or medium risk exposure to a patient suspected of having COVID-19 infection (until excluded) should refrain from working for 14 days after the last exposure with self-quarantine measures (24). They should be actively monitored by the local public health authority by establishing regular communications to assess the development of any clinical features such as fever or respiratory symptoms. In low risk exposure, self-monitoring by taking their temperature twice a day and remaining alert for respiratory symptoms would be adequate. If they develop fever or respiratory symptoms further medical evaluation is needed.

The risk exposure categories are given in the *Annex 4*. (25)

10. MANAGING ASYMPTOMATIC PATIENTS WITH POSSIBLE EXPOSURE

- **Close contacts of a patient with confirmed or suspected COVID-19:** Advice on strict home quarantine after discussing with the regional epidemiologist. Inform the medical officer of health (MOH), public health inspector (PHI) and police.
- **Low risk exposure to a patient with confirmed COVID-19:** Reassure and advise to be vigilant about symptoms.

11. MANAGING OTHER PATIENTS WITH URTI SYMPTOMS

A face-to-face consultation **is not required** for symptoms of common cold and upper respiratory tract symptoms within the first 2-3 days of the illness. There is no clinical examination that can differentiate COVID-19 from other common viral upper respiratory tract infections (URTIs).

Even though community spread is not visible at the moment, the risk cannot be excluded. It is best to advise all your patients with respiratory symptoms (with or without fever) to rest at home without exposing themselves to the community as much as possible. Although it is advisable to wear a facemask when going out of the house, they should be encouraged to strictly practice social distancing, respiratory hygiene and hand washing frequently (26).

Medical certificates could be issued for a few days depending on the severity of illness. Obtain patient's contact details and maintain a register for patients with fever and respiratory symptoms.

(Refer above Quick Fact Sheet and the Algorithms)

12. FOLLOW-UP OF COVID-19 PATIENTS AFTER DISCHARGE

Patients are discharged when they are clinically well, fever free for more than 72 hours with two (2) negative PCR tests more than 24 hours apart (12).

Patients should be advised to follow **strict home isolation for a minimum period of three weeks** as viral shedding may be prolonged. Medical certificates for that period should be issued by the government institution treating the patient.

The patient should be advised to stick to remote/telephone consultations as much as possible. The immediate follow-up could be done together with the MOH office.

13. COVID-19 AND MENTAL HEALTH

13.1 For the people who are suspected to have COVID-19 or in quarantine centres / under home quarantine stress the following.

- Trust medical professionals who are treating you
- It is not your fault that you contracted COVID-19
- It is alright to be scared and anxious but don't be overwhelmed - request a referral to a mental health professional if you need help

13.2 Ask these two questions from the people to assess their psychological status

Over the last 2 weeks,

Interest or pleasure in doing things

Feeling down, depressed, or hopeless

13.3 People in self-quarantine / quarantine facilities

- You are doing the right thing - however, distressing and uncomfortable it may be

- Stay connected and maintain your social networks
- Even when isolated, try as much as possible to keep your personal daily routines or create new routines
- During times of stress, pay attention to your own needs and feelings
- Engage in healthy activities that you enjoy and find relaxing
- Exercise regularly, keep regular sleep routines and eat healthy food
- Seek information updates and practical guidance from credible sources

Any queries contact consultant psychiatrist hotline 0712 578578 (8.00 am to 8.00 pm) (27) (28).

14. HOME VISITS

It is best to avoid visiting patients with respiratory tract infections considering your safety. Home visits may be arranged according to your clinical judgement in situations involving patients with a disability or other specific circumstances. PPE should be worn on such a visit. History should be obtained over the phone before visiting the patient to screen the risk factors for COVID-19 (29).

15. HANDLING DEATHS AT PRIMARY CARE SETTINGS

In case a Primary Care Physician is required to handle a death of a patient in any of the following settings, the doctor and the supporting staff should wear appropriate personal protective equipment (PPE).

1. A death of a patient treated in a Divisional Hospital (DH)/PMCU
2. A dead body is brought to a DH / PMCU
3. A GP is called to confirm a death that has taken place at home
4. A dead body is brought in to the general practice

The PCP should go through the history and find out whether the diseased person fits in to the COVID-19 case definition. If the diseased person fits into either suspected or high risk COVID-19 case definitions, the PCP should not give a cause of death, but should take steps to inform the police, MOH/PHI and the RE. Handling of the body and the quarantining the family members of the diseased should be done according to the instructions received from the RE.

If the diseased person does not fall into the case definition of COVID-19, the PCP may give the cause of death according to the usual practice (12).

16. Guidance for Primary Care Doctors/GP's and the staff for clinic preparation and precautionary measures.

BEFORE WORK



1. Recommended attire for doctors: Short-sleeved shirts or tops. Wear covered shoes. No ties. No sarees or *osarees*. No jewelry and accessories. Better to avoid mustaches, beards and fold and tie long hair.



2. Bring your food and beverages in a disposable container.



3. Encourage the staff not to use public transport. Arrange a private vehicle for their transport if possible.



4. The doctor and the staff should wear appropriate PPE (goggles, surgical mask, overall).
5. Display a notice outside the clinic asking patients to kindly wait outside **without entering** if they have a possible contact history or if they belong to high-risk exposure category, and instead to contact the doctor over the phone. (See *annex 4*)



6. Make arrangements to provide handwashing facilities to the patients before entering and at the time of leaving the clinic or provide 70% alcohol hand rub.



7. Display notices in appropriate languages with pictures at the entrance and inside the practice to alert, remind and educate patients about the disease, its symptoms and hygienic practices.

8. Discourage using handkerchiefs and make facial tissues available with a pedal bin in the waiting area.



9. It is best if you could reorganize the waiting area to have a separated area for patients with respiratory symptoms. If not arrange seating facilities in the waiting area to keep 1m distance between patients. You can also inform them to wait in their vehicle (if available) until called in.



10. Try to reduce waiting time for the patients who are presenting with fever with respiratory tract symptoms. Give them priority without keeping them waiting in the waiting area.

11. Discontinue the use of toys, magazines, pens and other shared items in the waiting area.

12. During the consultation, **keep at least one to two meters (1-2m) distance from the patient** by placing the chair at that distance. Keep the chairs of the doctor and patient at 90° to each other.

If you cannot maintain at least 1m distance, it is advisable to wear goggles/face shield in addition to the surgical face mask. Placing a transparent screen (glass or polythene) in between you and the patient would be an alternative method that could be adopted.

DURING WORK



13. Perform necessary examinations only and try to perform the examination steps from behind as much as possible. Do not talk to the patient while examining.
14. Keep the consultations related to patients with upper respiratory tract infections as brief as possible. Reduce the waiting time at the dispenser and the cashier.



15. Hand washing is the gold standard and irreplaceable.

Use soap and water to wash hands for 20 seconds after seeing each and every patient. Follow the correct handwashing technique.

16. If soap and water are not accessible, use 70% alcohol hand rub. Isopropyl alcohol could also be used.



17. Staff at risk (dispenser, health assistants, cashier) could frequently wash hands or if not practical, provide 70% alcohol rub to be used after each patient.

18. Cancel group health activities that you have planned.

19. Postpone elective procedures like minor surgeries and cosmetic procedures.

Avoid unnecessary aerosol producing procedures such as nebulization as much as possible. Instead, bronchodilator MDIs with spacer could be used. Staff should wear N95 masks in unavoidable procedures such as emergency nebulization. Keep other patients away from the area.



20. After each consultation with a patient with respiratory symptoms, disinfect the utensils (stethoscope, thermometer, goggles, phone etc), consultation table, counter and the doorknobs with 70% alcohol. 1% Hypochlorite could be used to clean spills.



21. Clinical waste segregation is strictly advisable and all infected waste (including PPE and Mask) should be removed by no-touch techniques (pedal bins) preferably after adding 0.5% hypochlorite solution.

22. At the end of the session clean the clinic floor and walls with 0.1% Hypochlorite spray.



23. It is advisable to take a shower after the practice and wash all the clothes before having contact with family members.



24. Work shoes should be wiped with 0.5% hypochlorite & left at work or leave outside in garage/outside the front door when you enter the home.

25. Focus on wellness activities/exercises at least 30 min/day.



26. Prioritize your self-care: take breaks, have a good sleep and engage in stress relieving activities. Spend time talking to your colleagues.

27. Primary Care Physicians/General Practitioners with risk factors (old age and other comorbidities) are advised to self-monitor their health and strictly adhere to the above precautionary measures.

Disclaimer

This guideline is produced by a group of Family Physicians / General Practitioners representing academia, government and private sectors, the expert advice from other relevant specialist colleagues and it has been peer reviewed and published with the approval of Ministry of Health.

Management of your patients may vary according to the epidemiological progression within Sri Lanka, clinical picture and the context in which you see the patient. Therefore, this guideline will be a dynamic one that will be updated according to the prevailing situation in the country.

General advice that could be given to patients by PCPs are found in Annex 6.

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Notice

Please contact the doctor first over the phone and get advices before coming here if you have cough, cold or fever.

That is for your own safety.

Please call

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ඔබට උණ , කැස්ස හෝ සෙම්ප්‍රතිශ්‍යාව වැළඳී ඇත්නම්, එක වර වෛද්‍යවරයා වෙත නොපැමිණ දුරකථන ඇමතුමක් හරහා සුදුසු උපදෙස් ලබාගැනීම වඩා යෝග්‍ය වේ.

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ඇමතන්න

அறிவுறுத்தல்

உங்களுக்கு காய்ச்சல், இருமல், தடிமன்
இருக்கும் பட்சத்தில் சிகிச்சை
நிலையத்தினை நாடுவதற்கு முன்பு
தொலைபேசி மூலம் உங்கள்
வைத்தியரைத் தொடர்பு கொண்டு
ஆலோசனை பெறவும்.
இது உங்கள் சுய
பாதுகாப்புக்கானதாகும் .

தொலைபேசி

Doctor – Patient Telephone Consultation Record (Remote Consultation)	
Provider (Dr)	Patient Record No:
<div style="display: flex; justify-content: space-between;"> Patient Name: Age: D.O.B: </div> <div style="display: flex; justify-content: space-between;"> Address: E-mail: </div> <div style="display: flex; justify-content: space-between;"> Contact No: </div>	
Reason For Encounter:	
Current Medication:.....	
<div style="border: 1px solid black; padding: 5px;"> <input type="checkbox"/> Travel History - *Country..... Arrival Date: <input type="checkbox"/> Contact History - Date..... <input type="checkbox"/> Quarantine History Common Symptoms: <div style="display: flex; flex-wrap: wrap;"> <div style="width: 50%;"><input type="checkbox"/> Fever</div> <div style="width: 50%;"><input type="checkbox"/> S.O.B</div> <div style="width: 50%;"><input type="checkbox"/> Headache</div> <div style="width: 50%;"><input type="checkbox"/> Chest Pain</div> <div style="width: 50%;"><input type="checkbox"/> Cough</div> <div style="width: 50%;"><input type="checkbox"/> Fatigue</div> <div style="width: 50%;"><input type="checkbox"/> Sore Throat</div> <div style="width: 50%;"><input type="checkbox"/> Body Ache</div> </div> Less Common Symptoms: <input type="checkbox"/> Anosmia <input type="checkbox"/> Nasal Congestion <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea Other Symptoms : </div>	
Existing Condition: <input type="checkbox"/> CVD <input type="checkbox"/> DM <input type="checkbox"/> HTN <input type="checkbox"/> Cancer <input type="checkbox"/> Chronic Respi	
Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No Current Condition (Diagnosis / Problem Definition):	
Plan : <input type="checkbox"/> Referred to Hospital..... <input type="checkbox"/> Discuss with RE <input type="checkbox"/> Inform MOH/PHI/Police <input type="checkbox"/> Need Face to Face Consultation:-Appointment Date/Time: Treatment: Given <input type="checkbox"/> Not Given <input type="checkbox"/> Advices:	
Prescription	
Prescription Via : <input type="checkbox"/> Unmanned Counter <input type="checkbox"/> Whatsapp/Viber <input type="checkbox"/> E-mail	
Provider : Rate this Tele Consultation Session (Scale of 1-10) :	
Patient: Did you receive the expected support through Tele Consultation : <input type="checkbox"/> Yes <input type="checkbox"/> Somewhat <input type="checkbox"/> No <input type="checkbox"/> Not sure	

The Ministry of Health has named the following 32 hospitals with isolation facilities to admit and treat suspected patients.

National Hospital of Sri Lanka (NHSL)	District General Hospital Vavuniya
National Hospital Kandy	District General Hospital Polonnaruwa
Colombo South Teaching Hospital (CSTH)	District General Hospital Chilaw
Castle Street Hospital for women (CSHW)	District General Hospital Monaragala
Lady Ridgeway Hospital for children (LRH)	District General Hospital Hambantota
North Colombo Teaching Hospital, Ragama	District General Hospital Matara
Teaching Hospital Karapitiya	District General Hospital Hambantota
Teaching Hospital Jaffna	Base hospital Minuwangoda
Teaching Hospital Anuradhapura	Base Hospital Kattankudi
Teaching Hospital Batticaloa	Base Hospital Homagama
Provincial General Hospital Badulla	Nevil Fernando (Teaching) Hospital (For maternal care)
Provincial General Hospital Kurunegala	Colombo East Base Hospital Mulleriyawa
Provincial General Hospital Ratnapura	Base Hospital Beruwala
District General Hospital Negombo	District General Hospital Kalutara
District General Hospital Gampaha	
COVID-19 Treatment Centres	
<ul style="list-style-type: none"> • Iranawila special COVID Hospital • National Institute of Infectious Diseases (IDH) – Colombo East Hospital • Base Hospital Welikanda • Kotelawala Defence University Hospital ICU 	

Risk exposure for Healthcare Professionals

Close contact for healthcare exposures is defined as follows: a) being within approximately 6 feet (2 meters), of a person with COVID-19 for a prolonged period of time (such as caring for or visiting the patient; or sitting within 6 feet of the patient in a healthcare waiting area or room); or b) having unprotected direct contact with infectious secretions or excretions of the patient (e.g., being coughed on, touching used tissues with a bare hand).

High-risk exposures

High-risk exposures refer to healthcare professionals (HCP) who have had prolonged close contact with patients with COVID-19 who were not wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Being present in the room for procedures that generate aerosols or during which respiratory secretions are likely to be poorly controlled (e.g., cardiopulmonary resuscitation, nebulizer therapy) on patients with COVID-19 when the healthcare providers' eyes, nose, or mouth were not protected, is also considered high-risk.

Medium-risk exposures

Medium-risk exposures generally include HCP who had prolonged close contact with patients with COVID-19 who were wearing a facemask while HCP nose and mouth were exposed to material potentially infectious with the virus causing COVID-19. Some low-risk exposures are considered medium-risk depending on the type of care activity performed. For example, HCP who were wearing a gown, gloves, eye protection and a facemask (instead of a respirator) during an aerosol-generating procedure would be considered to have a medium-risk exposure. If an aerosol-generating procedure had not been performed, they would have been considered low-risk.

Low-risk exposures

Low-risk exposures generally refer to brief interactions with patients with COVID-19 or prolonged close contact with patients who were wearing a facemask for source control while HCP were wearing a face mask or respirator. Use of eye protection, in addition to a face mask or respirator would further lower the risk of exposure.

Reference: Interim U.S. Guidance for Risk Assessment and Public Health Management of Healthcare Personnel with Potential Exposure in a Healthcare Setting to Patients with Coronavirus Disease (COVID-19)

Notice

Do you have fever, cough, cold, muscle pain, vomiting or diarrhoea?

and

Are you or any of your close contacts

- **Coming from abroad?**
- **Was under quarantined in a quarantined centre or under home quarantine?**
- **Doing any job related to the tourist industry?**
- **Employed in the health sector?**
- **Employed in tri- forces or the Police?**
- **Working in a quarantine centre?**
- **Employed in the hotel industry?**

Or

Did you spend time with anyone who falls in to one of the above categories within the last two weeks?

If so, please wait outside this medical centre without coming in, and call the doctor via below number.

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ඔබ උණ , කැස්ස, සෙම්ප්‍රතිශ්‍යාව, මස්පිඩු වේදනාව,
චමනය , හෝ අපිරණ තත්වයකින් පෙළෙන්නේ ද?

එමෙන්ම ඔබ හෝ ඔබේ සම්පතමයෙකු

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- නිරෝධායන මධ්‍යස්ථානයක හෝ නිවසේ ස්වයං
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உங்கள் கவனத்திற்கு

உங்களுக்கு காய்ச்சல், இருமல் அல்லது தடிமன் தசைவலி ,சத்தி மற்றும் வயிற்றோட்டம் இருக்கிறதா ?

நீங்கள் அல்லது உங்கள் குடும்ப உறுப்பினர்கள் யாராவது பின்வருவோரில் ஒருவராக இருந்தால், மற்றும்,

நீங்கள் அல்லது உங்கள் நெருங்கிய தொடர்புகள் யாராவது பின்வருவோரில் ஒருவராக இருந்தால்,

- ✓ வெளிநாட்டில் இருந்து வந்தவர்
- ✓ தனிமைப்படுத்தல் நிலையங்களிருந்து அல்லது வீடுகளில் தனிமைப்படுத்தப்பட்டிருந்தால்
- ✓ சுற்றுலாத்துறைக்கு சம்பந்தமான வேலையில் உள்ளவர்
- ✓ சுகாதாரத்துறை ஊழியர் ,
- ✓ முப்படை அல்லது காவல்துறையில்
- ✓ தனிமைப்படுத்தல் நிலையத்தில் வேலை செய்பவர்
- ✓ ஹோட்டல் துறை தொடர்புடைய துறையில் பணி புரிபவர்

அல்லது

மேற்குறிப்பிட்ட யாருடனாவது கடந்த இரண்டு வாரங்களினுள் நீங்கள் தொடர்பில் இருந்திருப்பின் ?

அவ்வாறாயின், தயவுசெய்து இந்த மருத்துவ நிலையத்திற்கு வெளியே காத்திருந்து கீழேயுள்ள இலக்கம் வழியாக மருத்துவரை அழைக்கவும்

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Annex 6

General advices that can be given to the public by primary care physicians

- Promote using face masks among people who are under quarantine, immunocompromised patients, care givers of the immunocompromised patients, all the patients with respiratory symptoms and fever.
- Frequent hand washing with soap and water following correct hand washing techniques. When soap and water is not accessible, use 70% alcohol hand rub.
- Maintain social distancing by keeping at least 1 metre distance between two people specially with anyone who is coughing or sneezing.
- Advice patients who are at high risk categories (immunosuppressed, hypertension, diabetes, CKD) against leaving home.
- Avoid touching face, eyes, nose and mouth
- Maintaining coughing etiquette to protect respiratory hygiene.
- Avoid crowded places and public transport as much as possible. If unavoidable, choose transport with minimal congestion.
- Avoid social gatherings.
- Drink adequate water and liquids to maintain good hydration.
- Consume foods containing vitamin C and zinc to ensure good immunity.

Environmental Cleaning Guidelines to be used during the COVID-19 outbreak –
15/03/2020

1. Environment Cleaning/ surface cleaning in isolation units and Triage areas

- Hypochlorite at 0.5% (equivalent 5000ppm)
- Door knobs of isolation rooms- Wipe with 70% Ethyl alcohol after each use
- Other metal surfaces in the isolation and triage- 70% Ethyl alcohol

2. Reusable dedicated equipment (e.g., thermometers, stethoscope, BP cuffs) between uses

- 70% Ethyl alcohol

3. Metal equipment (Kidney trays etc)

- Autoclave

4. Environment Cleaning/ surface cleaning in other vulnerable areas (OPD, Medical wards, ICU etc)

- Hypochlorite at 0.1% (1000ppm)

5. Spill cleaning-

- Hypochlorite at 1%(10,000ppm) , contact time at least 10 min

6. Soiled bedding, towels and clothes from patients with COVID-19

- Washing by machine with warm water (60-90°C) and laundry detergent.
- If machine washing is not possible soak linen in 0.05% chlorine for approximately 30 minutes. Finally, rinse with clean water and let linen dry fully in the sunlight.
- (If there is any solid excrement on the linen, such as feces or vomit, scrape it off carefully with a flat, firm object and put it in the commode or designated toilet before putting linen in the designated container. If the latrine is not in the same room as the patient, place soiled excrement in covered bucket to dispose of in the toilet)

7. Bedpans

- Hypochlorite at 0.5% after disposing of excreta and cleaning with a neutral detergent and water. (Chlorine is ineffective for disinfecting media containing large amounts of solid and dissolved organic matter. Therefore, there is limited benefit to adding chlorine solution to fresh excreta and, possibly, this may introduce risks associated with splashing.)
Contact time at least 10min
- Use washer disinfectant if available

8. Reusable PPE

- Boots- Hypochlorite at 0.5%
- Goggles- Soap and water and Ethyl 70% alcohol

9. Ambulances

- Hypochlorite spray at 0.1%

EMERGENCY CONTACTS

 Suwasariya Ambulance Service 1990	 Police Emergency Call Centre 119	 Health Promotion Bureau 1999
 Tourist Police 011-2421052	 National Hospital Colombo 011-2691111	 Fire and Rescue / Ambulance 110
 Information and Complaints regarding quarantine process 113	 National Emergency Operation Center / President Task Force 117	 Disaster Unit - Ministry of Health and Indigenous Medical Services 011-3071073
 Women's Help Line 1938	 Hotline for Pregnant Mothers 071-0301225	 Child Line 1929



**World Health
Organization**
Sri Lanka



සෞඛ්‍ය ප්‍රවර්ධන කාර්යාංශය
சுகாதார மேம்பாட்டுப் பணியகம்
Health Promotion Bureau

