

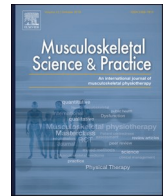


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Professional issue

## Safety netting; best practice in the face of uncertainty

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### ABSTRACT

Safety netting is a recognised General Practitioner (GP) diagnostic strategy often used in the face of uncertainty to help ensure that a patient with unresolved or worsening symptoms knows when and how to access further advice. It is an important way of reducing clinical risk. In the context of the COVID-19 pandemic and the rapid move to mainly remote consultations within the musculoskeletal field, safety netting is an important strategy to embed within all consultations. Only those presenting with potentially serious conditions are offered face to face consultations. Screening for Red Flags and any indication of a serious cause of symptoms is always first line in any consultation, however, clinical presentations are not always black and white with patients falling into a clear diagnostic category. With patients minds more focussed on COVID-19 symptoms this can be problematic. With the additional ramifications of public health social restrictions, onward management can be a conundrum. Many people with risk factors of serious pathology are also as a consequence, vulnerable to contracting COVID-19. In situations of uncertain clinical presentations, to avoid unnecessary social contact, safety netting can help to monitor symptoms over time until the clinical context becomes more certain. Embedding safety netting within physiotherapy best practice could be a silver lining in this pandemic black cloud.

### 1. Introduction

The COVID-19 pandemic is arguably one of the greatest global public health challenges of our time with many countries worldwide imposing a reduction in social exposure (Vrdoljak et al., 2020). Priorities and activity in the workplace have fundamentally changed during the pandemic, not least the rapid move within the musculoskeletal field to remote consultations. Across the world, physiotherapy associations have developed guidance on remote service delivery options, including advice on telephone and video consultations in musculoskeletal practice (WCPT, 2020. CSP, 2020). The recommendation is that once a triage decision has taken place the majority of consultations should be conducted remotely, with few if any face to face. Yet despite COVID-19 the time frames of emergency and urgent management for musculoskeletal conditions remain the same; therefore communication skills have never been more important than now.

At a time when social distancing is of paramount importance, monitoring remotely over time is an essential diagnostic tool. Watchful waiting (Cook et al., 2018) allows symptoms to be safely monitored for any change that may cause concern. Working 'closely' with patients in a therapeutic alliance in monitoring symptoms over time in the shared decision making process of ongoing management is critical. This safety

netting approach needs to be developed more strongly within physiotherapy generally and it also needs to be firmly embedded in remote consultations to provide appropriate assurances. Safety netting is an already well-established General Practitioner (GP) diagnostic strategy which ensures that patients can be monitored over time until their symptoms resolve or become more florid (Evans et al., 2018).

Viewpoint; Safety netting was introduced by the influential work of Roger Neighbour in 1987. Neighbour, a GP and medical educator, considered no patient to be safe unless the consultation includes safety netting (Neighbour, 2005). Although now firmly embedded within GP training, safety netting is not necessarily considered a core physiotherapy skill within the consultation.

Musculoskeletal physiotherapists have a very important role to play as the COVID-19 pandemic does not eliminate the development of other serious conditions. The focus of all consultations should encompass the exclusion of potential serious pathology and when necessary, signpost to appropriate services via the emergency or urgent care pathway (NHS, 2020). Whilst this is common sense, clinical reasoning is not always straight forward and patients do not always fall into clear diagnostic categories (Comer et al., 2019); remote consultations can sometimes result in the decision making being even more of a challenge. With the additional ramifications of social restrictions around the world,

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appropriate onward management can also be a conundrum. The decision to suggest to a patient, especially one recognised as at risk of contracting COVID-19, that they break their shielding status to be examined or investigated for a suspected musculoskeletal condition requires very robust clinical reasoning. In the context of the current health care crisis both clear communication and time can be important diagnostic tools.

COVID-19 pandemic guidance supports the option of seeing the patient face to face as long as the correct personal protective equipment (PPE) is available and the patient is fit and well and it is safe to do so. Many people that fall into the serious pathology risk categories are also vulnerable to the risk factors of contracting COVID-19 and so the question of patient safety has wider ramifications than those usually encountered. Risk factors of serious spinal pathology and risk factors of COVID 19 which overlap include;

- Over 70s regardless of medical condition
- A weakened immune system; comorbidities that cause immunosuppression include diabetes, HIV/AIDS, rheumatoid arthritis, pre-existing infections, alcohol abuse, smoking and some medication including long-term use of steroids.
- People with cancer and currently having active treatment.
- BMI of 40 or over

(Public Health England, 2020. Finucane et al., 2020).

Some decisions will be easier to make remotely than others. For instance a 75 year old patient with ongoing treatment for prostate cancer presenting with worsening unfamiliar back pain, much worse during the night and precluding sleep would be worrying. Therefore a decision to move them along a potential serious spinal pathology local pathway would be appropriate. However, a 75 year old with no history of cancer and a recurrence of episodic back pain, slightly different to usual, with the patient in a current shielding situation is a different matter. The risks of bringing this patient out of shielding could far outweigh the benefits. Social isolation has added a significant new dimension to the clinical decision of making a risk benefit analysis. The last patient may or may not have a serious cause for back pain, however if they move from a shielding situation they are at increased risk of contracting COVID-19 with potentially fatal consequences. We need to work closely with our patients in these situations using shared decision making skills and consider using 'time' as a tool in our reasoning process (Cook et al., 2018). Safety is fundamental within every patient consultation; safety netting using clear communication allows us to do that.

Within the musculoskeletal setting, physiotherapists deal with patients with symptoms that may or may not be musculoskeletal in origin and may or may not be serious. Particularly in the prodromal early stages of cancer, symptoms are non-specific and indistinguishable from other common conditions (Bankhead et al., 2011). The clinical consequence of this early uncertainty is that diagnoses of some cancers are often delayed. Managing this uncertainty on a daily basis requires clinical skills that not only require in-depth clinical knowledge but robust communication skills. In the current climate embedding safety netting within our consultations is therefore not optional. Easton (2016) points out that this safety net must anticipate those at risk of the worst case scenario and clearly outlining actions to take should this worst case prove a reality. However, in the context of current global social restrictions this is not straight forward. For patients, the fear of COVID-19 is overshadowing other health concerns. Potential oncology patients are now more focussed on.

COVID-19 symptoms and may downplay signs of cancer (Vrdoljak et al., 2020) Globally there has been a reduction in health seeking for serious conditions with visits to emergency departments

Falling by 25% and a reduction in new cancer cases presenting (Thornton, 2020, Vrdoljak et al., 2020). Safety netting advice in the current pandemic must include red flags to be aware of and clearly articulate potential risks and consequences of not seeking timely health care for serious conditions.

Principal features of safety netting include:

- Providing information for patients
- Empower patients to recognise Red Flags and seek timely and appropriate health care
- Advice on how and where to seek help if Red Flags develop
- Likely natural history and time scale of illness (Jones et al., 2019)

A recently published Red Flag International Framework provides more detail about the relationship of a number of Red Flags to specific serious spinal conditions. It gives clear guidance on timely management and supports the safety netting approach (Finucane et al., 2020).

The process of watchful wait, (watching how symptoms develop over time), can allow many self-limiting conditions to resolve whilst more sinister conditions become more evident as Red Flags develop (Cook et al., 2018). Timely intervention is key when using a watchful wait approach. Despite improvements in survival and mortality in recent years, cancer outcomes in England fall far behind the best outcomes in Europe (Bankhead et al., 2011). This is said to be related mainly to late presentation (Ellis-Brookes et al., 2012). It is well known that those from socially deprived backgrounds, the elderly, alcoholics, drug addicts and males have a tendency to seek medical help late in the disease process. This is an extremely important concept to recognise in our current situation. Fear of contracting COVID-19 will confound the patient's decision of 'what to do' (Vrdoljak et al., 2020). As clinically astute as we aspire to be, if the patient does not present with developing symptoms at an early stage, early diagnosis of a serious condition is impossible. Safety netting including an organised appointment may be the safest course of action if there is any doubt, even if this is by telephone.

Almond et al. (2009) considers safety netting to be essential when the diagnosis is uncertain but the patient presents with risks of significant complications such as age or comorbidity. Almond confirms the safety net advice should include specific clinical features (red flags) that the patient should be aware of, along with time scale for symptom development as well as the time and location for health seeking. They consider safety netting goes wrong in three ways; correct information is not given in high risk situations, the language used is not heard or understood and the content of information is unclear. A qualitative study on Cauda Equina Syndrome (CES) patients found that patients had an inability to concentrate when consumed by very severe acute pain and their ability to express subtle symptom progression was also negatively affected (Greenhalgh et al., 2016). As a consequence, CES credit cards were developed for patients at risk of CES, by CES sufferers and are a good example of safety netting advice (Greenhalgh et al., 2016).

We have a duty of care to be clear in our communication to help patients make important decisions about when to seek help. Let us return to our 75 year old during the current COVID 19 epidemic. There is no history of cancer but a recurrence of episodic back pain, feeling slightly different to usual. In addition they are in a shielding situation and likely to be fearful of leaving the safety of home. To avoid leaving the protection of shielding, safety netting can keep this patient safe by explaining the best ways to manage back pain using an evidenced based approach and how symptoms may respond over time. It is crucial that the explanation clearly outlines any Red Flags to be aware of such as escalating or band-like pain, lying flat increasing pain, sleep or gait disturbance. Ensure they understand exactly what to do if these symptoms do begin to emerge. If the patient falls into the group that may be reticent to 'bother' the clinician, arrange another remote appointment. Work with the patient as another valuable member of the clinical team to monitor symptoms over time.

## 2. Conclusion

Safety netting is considered best practice when faced with uncertainty in any clinical setting. Safety netting should involve working closely with the patient and guidance should include:

- The likely time course of symptoms
- Specific Red Flag warning symptoms and signs of serious disease
- Specific information about when and how to re-consult if symptoms do not resolve in the expected time frame
- Clear documented safety netting instructions

In our life-time globally, there has never been more uncertainty than now. For some time there has been a gradual shift towards digital health care and the COVID-19 pandemic has accelerated this move. It is likely that the future of musculoskeletal practice around the world will have a new normal with innovative developments in our practice likely to stay. There potentially may be reticence within the population to seek face to face health care once national lockdown restrictions are released, particularly from those who know they are considered to be vulnerable. Within this future musculoskeletal practice model, whether consultations are remote or face to face, we need to consider the process of safety netting to be best practice in any physiotherapy setting to facilitate early presentation with a serious condition.

Communicating uncertainty is a challenge but the on-going monitoring of Red Flag symptoms is essential. In the context of social distancing and protecting those at risk, work collaboratively with the patient to reach those decisions and involve the wider multi professional team where the decision is complex. Working together is the key to getting through these difficult times. Working with patients as partners more than ever before will be one of the silver linings to this very black cloud with safety netting embedded within physiotherapy best practice.

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Not applicable.

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#### Declaration of competing interest

None declared.

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