Barnet Clinical Commissioning Group

# Barnet Primary Care Guide During Covid-19

(Patient Age ≥ 12)

Version 5.0: 29 March 2020
Review Date: 31 March 2020

**This pathway was created for GPs during uncertain times, using clinical judgement and are currently not evidence based. HR, RR & o2 sats are taken from sepsis and NEWS2 score – these may or not be sensitive for Covid-19.** REMEMBER: don't forget bread and butter medicine, not everything is Covid.

## Telephone Triage
Patient with Covid19 symptoms (fever and/or continuous cough)
SOB around day 6 (3-64%), myalgia (11-15%), nasal symptoms (4-24%), sore throat (14%), GI (1-10%), headache (6-34%), anosmia (1-66%)

STAY HOME

**Category 3**
Mild symptoms: stay at home, self-care advice, contact NHS 111 if urgent health needs (whether related to COVID-19 or another health issue).

**Category 2**
Moderate symptoms: needs further assessment by GP Primary Care Service (in-hours) or Barndoc LCW or 111 (out of hours)

**Category 1**
Severely unwell: Check ceiling of care and CMC. Check DNAR status. Need to admit patient to hospital. Call ambulance and inform call handler of COVID-19 risk. No need to telephone the medical registrar

**Ask patient: how is your breathing today?**
**THEN**
**Ask patient: are you so breathless that you are unable to speak more than a few words?**
**Ask patient: are you breathing harder or faster than usual when doing nothing at all?**
**Ask patient: are you so ill that you've stopped doing all your usual daily activities?**
**If YES to any, THEN**
**Ask patient: is your breathing faster, slower, or the same as normal?**
**Ask patient: what could you do yesterday that you can't today?**
**Ask patient: what makes you breathless now that didn't make you breathless yesterday?**

Adults RR ≥25
Adults HR ≥115
Adults O2 Sats ≤93-94%
Roth Score ≤ 5 seconds
OR
Cardiac chest Pain,
Unable to complete sentences due to SOB,
Drowsy/unconscious
Unable to get out of bed or stand due to dizziness,
Confusion,
Reduced urine output,
Cold extremities or
Skin mottling

Organise Video Consultation (where possible)
Patients may have a smart watch, BP machine or sats probe at home. RR can be measured on video.

### Category 2A
Basic Assessment
Completing full sentences
No SOB or Chest Pain
Able to do ADLs
Able to get our bed
Roth Score ≥8 second

Advanced Assessment
Adults RR 14-20
Adults HR 50-90
Adults O2 Sats >96%

Patients can become unwell Day 6 to Day 8 and can rapidly deteriorate

If deteriorates

### Category 2B
Basic Assessment
Completing full sentences
Some SOB (new)
No Chest Pain
Able to do ADLS but lethargic
Roth Score 6-8 seconds

Advanced Assessment
Adults RR 21-22
Adults HR 90-110
Adults O2 Sats >95%

See BNF for antibiotic dosing

If deteriorates

### Category 2C
Basic Assessment
Completing full sentences
SOB on exertion (new)
Mild chest tightness
Able to do ADLS but lethargic
Roth Score 6-8 seconds

Advanced Assessment
Adults RR 23-24
Adults HR 110-114
Adults O2 Sats 94%

CHECK CEILING OF CARE / CMC

Management

### Category 2A
Treat temperature: Paracetamol, Fluids

Patients directed to use new NHS 111 online algorithm

**Safety Netting.**
**Please tell patients if SOB/DIB or rapidly unwell to call 999 or go to A&E.**

**Advised to call Practice (or 111 OOH) if symptoms are worse**

Management

### Category 2B
Treat temperature: Paracetamol, Fluids
Prevent Secondary Bacterial Pneumonia: Amoxicillin 500mg tds 5/7 and Clarithromycin 500mg bd 5/7 (Erythromycin 500mg qds 5/7 in pregnancy) OR
Doxycycline 200mg stat, 100mg od 7/7

If known Asthma/COPD exacerbation, increase SABA or similar use. Only use nebuliser if patient uses them regularly for management. Do not prescribe nebulisers for those not already using them. BTS do not consider nebulisers viral aerosol generating. Oral steroids are safe to use in patients with exacerbation of Asthma (non-covid). In ? Covid use with caution as can increase viral shedding.

**Safety Netting. Tele/Video review in 24-48 hours (or earlier if unwell)**

Management

### Category 2C
Treat temperature: Paracetamol, Fluids
Prevent Secondary Bacterial Pneumonia: Augmentin 625mg tds 5/7
and Clarithromycin 500mg bd 5/7
OR
Azithromycin 500mg od 5/7
*(if no other option)*

**If significant chronic disease or immunocompromised, consider discussion with medical team.**

**Safety Netting. Tele/Video review in 24 hours (or earlier if unwell)**

**Notes:** clinicians should also look at the NHSE London Clinical Networks "Resource pack for use during Covid-19"

**HOT CLINIC** = suspected / known covid that need F2F assessment either to avoid hospitalisation or if discharged from hospital and need step-down review – **EDGWARE COMMUNITY HOSPITAL** *(coming soon)*
**COLD CLINIC** = non-covid patients and no URTI symptoms but need urgent F2F assessment (e.g. abdo pain). GP led clinic – **FINCHLEY MEMORIAL HOSPITAL**
**COLD NURSE CLINIC** = non-covid and no URTI symptoms and are routine but essential for patients (e.g. children imms). Should be Nurse / Pharmacist led clinic (GP virtual supervision)

**SITREP – Practices should complete these when status changes. CCG will contact RED practices**

**Home Visit:** *(coming soon) – x2 GPs to confirm needed* - Broken down into 3 sub-categories:
1. Diagnostic Pack/Tablet undertaken by non-clinician
2. Nurse-Led Obs not sufficient Home Visit
3. GP-Led Obs not sufficient Home Visit

**ROTH SCORE** – ask the patient to take a deep breath and count out loud from 1 to 30 in their native language. Count the number of seconds before they take another breath.
8 seconds = if the counting time is 8 seconds or less, this has a sensitivity of 78% and specificity of 71% for identifying a pulse oximeter reading of <95%.
5 seconds = if the counting time is 5 seconds or less, sensitivity is 91%
If unsure – see the practical video on how to do a Roth Score

*Only prescribe hydroxychloroquine if in a clinical trial – otherwise not licensed.*

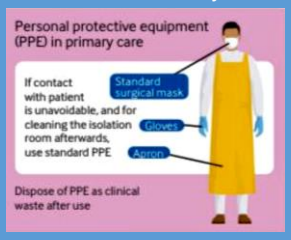
## Telephone Triage
Patient with non-Covid19 symptoms

Initially manage all patients virtually by telephone or video consultation

**LIST FOR COLD NURSE CLINIC**

Child imms AND urgent blood tests (e.g. drug monitoring like azathioprine, methotrexate, mycophenolate, cyclosporine, sirolimus, tacrolimus, warfarin, lithium) AND urgent injections (cancer, etc.) AND urgent dressings

*Nothing else is essential, including an agreement with clinicians that smears are no longer essential while PPE is in shortage. All other care should continue but all must be done virtually*




**OTHER ACUTE NON-COVID ILLNESS**

GPs should try and manage all patients virtually and avoid F2F unless absolutely necessary to mitigate spread of infection.

GP feels despite virtual management patient needs F2F

**Clinical scenarios include (non-covid)**
- acute abdominal pain,
- urgent gynae patients,
- unwell diabetics,
- vascular cases.

Practices that have no GPs or need help, they can book into the EAS telephone triage service

**Practice to complete SITREP and send to CCG**

**G** **A** **R**

**"Green" or "Amber" (where possible) practice to manage / see own patients.**

*Practices should ensure they have PPE. Fluid repellent face mask, gloves, apron (see picture above).Eye wear is optional.*

**"Red" or "Amber" (second priority) can refer to the Advance Assessment Clinic (GP Fed) at FMH.**

Practices should ensure they have used the **TEMPLATE** for tele/video consultations and book the apt through EMIS

Barnet Federated CCGs

Video Consultation (re-triage) by GP at Advance Assessment Clinic

F2F apt given at Cold Clinic

Discharged back to usual GP

Home Visit completed BARNDOC HEALTHCARE Primary Care at its Best

coming soon

Home Visit Pathway – Page 3

housebound

*Author: Dr Nick Dattani*

**Pathways for patients with PRE-EXISTING lung conditions or comorbidities**

**Asthma** – most patients with asthma have mild to moderate disease and normal underlying lungs. They should be treated for wheeze or bronchospasm in a conventional manner. If they have a peak flow meter at home they can monitor this themselves. They can be given one for self-monitoring if they have mild/moderate COVID-19 symptoms. They can be treated according to their normal asthma management plan including oral corticosteroids. The physiological parameters from the pathway should apply to asthmatic patients as to others when considering admission for COVID-19 symptoms.

**COPD** – Oral corticosteroids should be avoided in COVID-19 suspected infection. Infective exacerbations should be treated with antibiotics in the conventional manner. Oral corticosteroids can be considered if known concomitant asthma and / or history of eosinophils ≥ 0.3 or known steroid responsiveness. Consider admission according to algorithm physiological parameters but if baseline O2 pulse oximetry sats are available:
• Mild deterioration would be defined as up to 2% below their baseline
• Moderate deterioration would be defined as between 3-4% below their baseline
• Severe deterioration would be defined as 5% or more below their baseline

If on Long Term Oxygen Therapy (LTOT) discuss ceiling of care and consider admission if sats <88% on their standard dose of LTOT.

**Interstitial Lung Disease** – Consider ceiling of care. Many patients who have established pulmonary fibrosis, of any cause, will not do well with intubation and mechanical ventilation. Patients are likely to become hypoxic very quickly as they will not have much reserve. They will have often had advance care planning as part of their specialist care. Consider admission according to the pathway physiological parameters but if baseline saturations are available:
• Mild deterioration would be defined as up to 2% below their baseline
• Moderate deterioration would be defined as between 3-4% below their baseline
• Severe deterioration would be defined as 5% or more below their baseline

Pirfenidone and nintedanib antifibrotic therapy can be safely paused for 4-8 weeks during illness. Do not stop long term prednisolone and consider increasing baseline doses. Mycophenolate, mofetil and azathioprine and other immune suppressive medication would normally be paused during significant infective illnesses and restarted two weeks after recovery. Patients with interstitial lung disease should be following self-isolation guidance and if also on immune suppression consider extending this to the shielding approach.

**Obstructive Sleep Apnoea** – Most patients will have normal lungs but require CPAP overnight to correct daytime sleepiness. This does not affect their gas exchange and should be managed as there is no pre-existing lung disease. If they need admission for hypoxia, they should take their CPAP machine with them as they may need to use it on the wards.

**Bronchiectasis** – During exacerbations of bronchiectasis with purulent sputum, we do not recommend routine collection of sputum samples for culture and sensitivities. If thought to be a usual exacerbation, treat with standard antibiotics (doxycycline or amoxicillin for 10-14 days) or guided by previous sputum cultures. If no response, then try empirical course of ciprofloxacin/levofloxacin and obtain specialist advice. If suspected COVID infection, treat according to pathway.

Barnet Clinical Commissioning Group

# Barnet Primary Care Guide During Covid-19

(Patient Age < 12)

Version 5.0: 29 March 2020
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Telephone Triage
Child with Covid19 symptoms. Children <6m of age should be managed cautiously and discussed with Paediatric team on-call if any concerns (esp. in <3m)

**Category 3**
Mild symptoms: stay at home, self-care advice, contact NHS 111 if urgent health needs (whether related to COVID-19 or another health issue).

**Category 2**
Moderate symptoms: needs further assessment by GP Primary Care Service (in-hours) or Barndoc LCW or 111 (out of hours)

**Category 1**
Severely unwell: Need to admit patient to hospital. Call ambulance and inform call handler of COVID-19 risk. Please telephone the paediatric consultant at Barnet.

**Organise Video Consultation (where possible)**
Parents may have a smart watch, BP machine or sats probe at home

**Category 2A**

Basic Assessment

Completing full sentences (if able)
Normal activity
A little off food, drinking fluids
Passing urine / wet nappies

Advanced Assessment

Child 6-12m RR <40, HR 160
Child 1-2 RR <35, HR <150
Child 2-5 RR <30 HR <140
Child 5-11 RR <20, HR <100

If deteriorates

**Category 2B**

Basic Assessment

Completing full sentences (if able)
Playing but not as much
Off food but drinking fluids
Passing urine / wet nappies

Advanced Assessment

Child 6-12m RR <45, HR 165
Child 1-2 RR <40, HR <155
Child 2-5 RR <35 HR <145
Child 5-11 RR <25, HR <105

Parental concern about behaviour or mental state, not passing urine, sleepy child, reduced urine output

OR
Any advance assessment above the maximum parameter

AND/OR
Parents unable to manage temperature

AND/OR
Known asthmatic and acutely wheezy and may need admission or nebulisers

Management

**Category 2A**

Treat temperature: Paracetamol, Fluids

**Safety Netting. Advised to call Practice (or 111 OOH) if symptoms are worse**

If deteriorates

Management

**Category 2B**

Treat temperature: Paracetamol, Fluids

Prevent Secondary Bacterial Pneumonia:
Amoxicillin dose as per BNF tds 5/7
OR
Clarithromycin dose as per BNF bd 5/7

If considering the use of nebulisers or steroids, discuss with Paediatric team on-call at local hospital

See BNF or NICE for antibiotic dosing.

**Safety Netting. Tele/Video review in 48 hours (or earlier if unwell)**

If deteriorates

**Review of Category 2B**

Treat temperature: Paracetamol, Fluids

Assessment similar (no worse but no improvement) – consider discussion with Paediatric Team on-call. They may advise you to continue treatment or switch treatment to:

Azithromycin 200mg/5mls as per age/weight 5/7

*It is recommended to seek clarification with secondary care before prescribing Azithromycin*

**Safety Netting. Tele/Video review in 24 hours (or earlier if unwell) and referral to Paediatric Team on-call if no improvement**

**Children**

Parameters have been adapted from Sepsis Trust / UK guidance. There is no evidence that this pathway has been based upon. Clinicians should use their own judgement when making decision.

**NB – no patients with covid or URTI symptoms should be seen whatsoever**

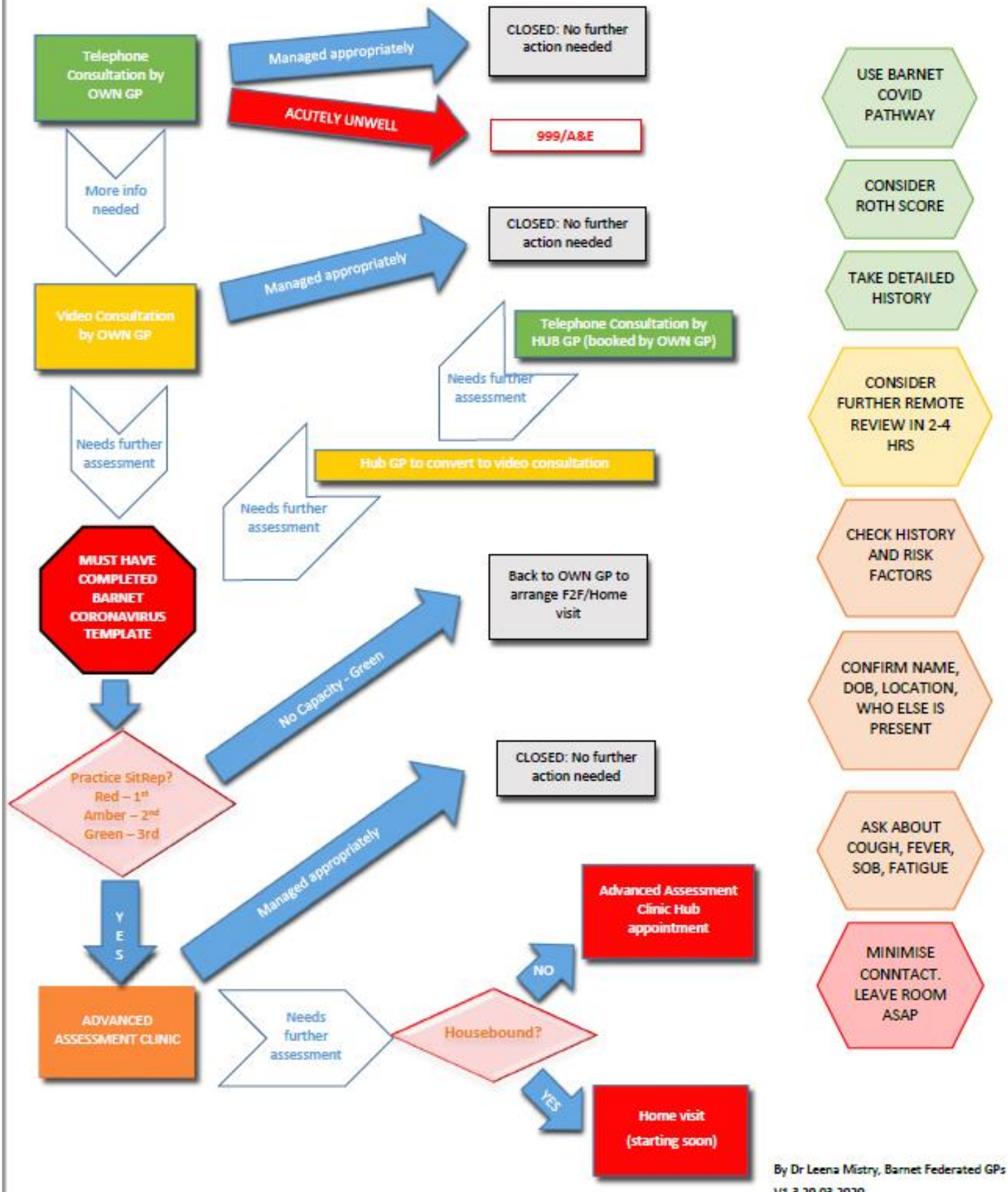
**Children that may need F2F should follow the non-covid cold clinic pathway as per Page 1**

*Author: Dr Nick Dattani*

Barnet Federated GPs

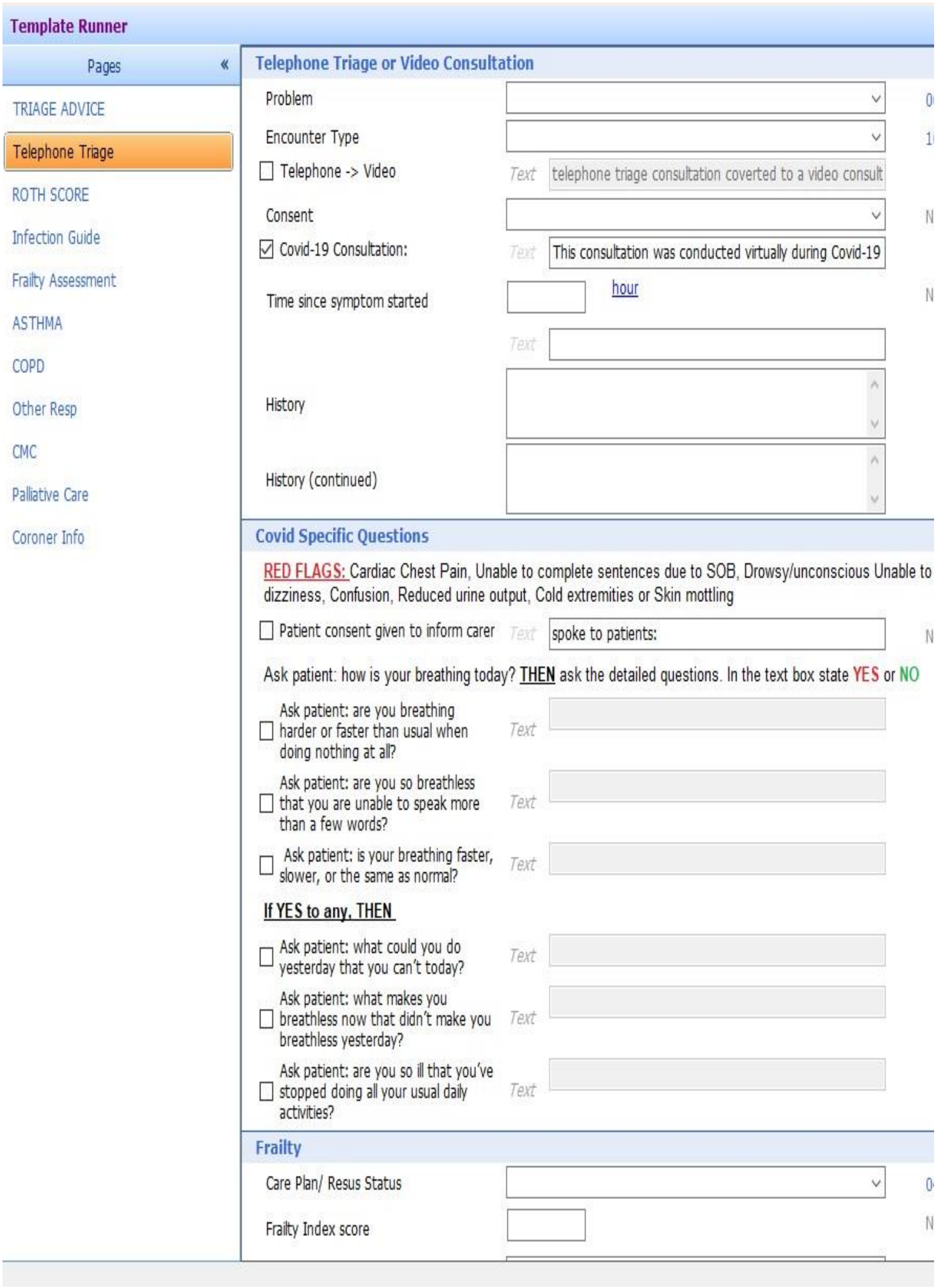
# Advanced Assessment Clinic Operational Model

## NON-COVID PATHWAY




By Dr Leena Mistry, Barnet Federated GPs

V1.3 29.03.2020



Template Runner

Pages «

- TRIAGE ADVICE
- Telephone Triage
- ROTH SCORE
- Infection Guide
- Frailty Assessment
- ASTHMA
- COPD
- Other Resp
- CMC
- Palliative Care
- Coroner Info

**Telephone Triage or Video Consultation**

Problem

Encounter Type

☐ Telephone -> Video — Text: telephone triage consultation coverted to a video consult

Consent

☑ Covid-19 Consultation: — Text: This consultation was conducted virtually during Covid-19

Time since symptom started — hour

Text

History

History (continued)

**Covid Specific Questions**

RED FLAGS: Cardiac Chest Pain, Unable to complete sentences due to SOB, Drowsy/unconscious Unable to dizziness, Confusion, Reduced urine output, Cold extremities or Skin mottling

☐ Patient consent given to inform carer — Text: spoke to patients:

Ask patient: how is your breathing today? THEN ask the detailed questions. In the text box state YES or NO

☐ Ask patient: are you breathing harder or faster than usual when doing nothing at all? — Text

☐ Ask patient: are you so breathless that you are unable to speak more than a few words? — Text

☐ Ask patient: is your breathing faster, slower, or the same as normal? — Text

**If YES to any, THEN**

☐ Ask patient: what could you do yesterday that you can't today? — Text

☐ Ask patient: what makes you breathless now that didn't make you breathless yesterday? — Text

☐ Ask patient: are you so ill that you've stopped doing all your usual daily activities? — Text

**Frailty**

Care Plan/ Resus Status

Frailty Index score

# **DRAFT MODELLING – NOT YET STARTED**

Author: Daniel Glasgow (Barnet CCG) and Dr Laura Geddes (Barndoc)

## Practice

Patient Contacts GP Practice → Clinical Triage/ Assessment → Requires further assessement?

No → Managed within Practice → No Onward Referral

**Digital**

EMIS Community will be platform for the model with slots provided by the GP Federation for practices to book into for Video consultations.

Federation will provide respective Hot/Cold sites and Barnodc will provide the Home Visiting service with the relevant appointment slots created.

This solution is wholly contained within the EMIS Clinical Infrastructure for al fully integrated digital solution.

**GP Federation Video Consultation Service**

Federation will provide a video consultation service available to all practices which will be manned by senior clinicians.

This service will then be able to book patients into downstream face to face services in a hub or domiciliary environment where absolutely necessary.

To ensure physical contact is minimised, face to face and domiciliary visit will operate differently to current practice.

## Centralised Assessment

Yes → Book into Federation Slot for Video Consultation → Video Assessment

## Categorisation and Clinical Intervention

**Category 3**
Mild Symptoms

**Category 2**
Moderate Symptoms – Requires Further Assessment

**Category 1**
Requires Admissions or Secondary Care

LAS Possible COVID

**Category 2A**
See Page 1

**Category 2B**
See Page 1
F2F being considered

**Category 2C**
See Page 1

For Active Treatment

**Category 2B – F2F Required**
HOT CLINIC: Edgware (coming soon)
COLD CLINIC: FMH

When referring the patient to a site, provide them with the number to call when they arrive at the site, instruct them to wait inside the car until they are called in for their appointment.

**Offer patient mask if actively coughing. REMEMBER HAND HYGIENE & WEAR PPE. Clean room after each patient.**

**Category 2B – Home Visit**

Broken down into 3 sub-categories:

1. Diagnostic Pack/Tablet undertaken by non-clinician
2. Nurse-Led Obs not sufficient Home Visit
3. GP-Led Obs not sufficient Home Visit

**Minimal patient contact and consultations completed using the video platform.**

See Page 1

**Consultation Details sent back to patient registered GP practice**

**PPE**
The category 2B elements of the pathway assumes that sufficient PPE is available for undertaking hub or domiciliary consultations.

**Equipment**
Assumption is that all equipment will be cleaned between patient contacts. (F2F and HV)

Only visit at home if there is no remote alternative. Discuss need to visit with senior colleague/peer. Consider what information will be gained from it that cannot be ascertained remotely and how this will change the outcome

• Review PPE guidance daily and adhere to the recommendations

• Ask the patient to wear a mask during the consultation to protect them and the case worker- Suggest passing mask through letterbox to patient prior to entry

• Minimise physical contact with the patient and carer and keep 2m distance if possible

• Do not perform for chest physiotherapy, spirometry, PEFR, CO monitoring or FeNO or any other aerosol generating procedure

• Sputum samples for management of bronchiectasis should be discussed with specialist

• Viral swabs should not be collected

• Monitor patients using SpO2, RR, HR (and BP if required)

• Discuss advanced care plans if appropriate and document on CMC that day

• Escalate by calling 999 if required and appropriate

• Otherwise, make a plan for future monitoring e.g. telephone / video or face to face

• Dispose of all PPE at visit end according to national guidance

With the emergence of Covid-19, the service has deployed a complete telephone triage system in order to minimise patient contact. This document aims to provide clinicians with support in undertaking telephone and video triage during these unusual times, and help adopt lower thresholds for telephone and video advice, management and prescribing in a safe manner. **It is not a substitute for your own clinical judgement and every encounter needs to be managed accordingly**.

Basic structure of telephone triage:

1. Introduction
2. Confirm patient and/or carer details
3. Establish the history and gather clinical information
4. Management plan
5. Conclusion – safety netting, follow-up etc.

**Top tips:**

- Ask what the patient is currently doing *e.g. child watching TV/playing is less concerning than lying in bed not wanting to do anything at all*
- Ask patients to self-examine if they have equipment at home:
  - BP machine
  - Thermometer
  - Pulse Oximeter
  - Peak flow
  - Fitness tracker with heart rate monitor e.g. Fitbit, Apple watch
- Is the patient talking in full sentences on the phone? If so, less worried about respiratory rate
- Is the patient dizzy on standing? This may indicate postural drop/low BP
- For rashes offer video consultation
- Assess mobility and/or joint function by asking patients if they can do certain movements e.g. stand/walk/bend/twist
- When considering a delayed antibiotic script, give **specific** on advice on when to start and on when to seek further medical review to avoid repeat consultations
- Ask yourself whether an investigation will change your management plan and if it is absolutely necessary
- Document everything clearly in the patient's notes
- **Lower threshold** to prescribe antibiotics over the phone

**Assessing shortness of breath:**

- Normal exercise tolerance vs how far they can walk now
- Are they able to do normal daily activities e.g. dressing, without getting SOB?
- Are they talking full sentences on the phone? **Document** this. If talking to a parent, it may be useful to speak to the child briefly to ascertain this.
- If increase inhaler frequency, specifically ask how often e.g. Ventolin QDS+ more concerning
- Lower threshold to give oral steroids in Asthma/COPD patients
- Lower threshold to prescribe antibiotics in >65y with co-morbidities (e.g. T2DM, IHD)
- N.B croup risk for steroids with covid – video consult to catch a barking cough.

**2ww Criteria:**

Note all 2ww pathways are currently still running.

Any 2ww should be referred if presence of red flag from telephone consult. E.g. post menopausal bleeding, breast lump or rectal bleeding.

Urgent b/t can be done in surgery if clinical risk high.

Remember most radiology tests will be delayed, can still get CXR if needed.

Prescribe antibiotics in accordance with NICE/PHE 2019 guidelines (click link below):

https://www.nice.org.uk/Media/Default/About/what-we-do/NICE-guidance/antimicrobial%20guidance/summary-antimicrobial-prescribing-guidance.pdf

****THIS LIST IS NOT EXHAUSTIVE SO PLEASE USE YOUR CLINICAL JUDGEMENT****

| | |
|---|---|
| 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.<br>Consider delayed abx prescribing.<br>https://ctu1.phc.ox.ac.uk/feverpain/index.php |
| 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*<br>https://www.nice.org.uk/guidance/ng91/resources/visual-summary-pdf-4787282702 |
| Acute Otitis Externa | 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 systemic upset.<br>If >10 days - delayed or immediate abx + consider nasal steroid drops/spray. |
| Acute Exacerbation of COPD | Low threshold for oral steroids if any SOB above baseline.<br>Ensure rescue packs are replenished.<br>Remember if COVID +COPD – caution re steroids.<br>Use functional baseline of mobility to assess sats as Roth score will not work. |
| 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:<br>1. Confusion<br>2. Cannot talk full sentences<br>3. Reduce UO<br>4. Dizzy on standing (low BP)<br>Low threshold to treat with abx – use BCCG pathway for prescribing |
| 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. |
| 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.<br>Can you get obs done – devices the patient has, bp machine access.<br>Escalation to a&e if vomiting and dizziness. |
| 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), BRAT diet.<br>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.<br>Dizziness – must have obs check, consider if RR team needed for obs but remember their service is limited. |
| Conjunctivitis | Self-limiting 7-14 days. Poor evidence base for topical antibiotics. Consider video consultation to reassure. Delayed abx.<br>Note risk of preseptal cellulitis – video if swelling reported. |

**THIS LIST IS NOT EXHAUSTIVE SO PLEASE USE YOUR CLINICAL JUDGEMENT**

| | |
|---|---|
| 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 (Non urgent so really can wait a few months |
| Squint | Telephone/Video only |
| Conjunctivitis | Telephone/Video only |
| Dry Eye | Telephone |
| FB in the eye | Telephone/Video and advice<br><br>If not successful may need **F2F** for removal. High risk due to aerosol of eye fluids so will need full FFP3 |
| Corneal abrasions.ulcers / minor trauma | Telephone/Video -Will need close up examination **F2F** with FFP3 due to contact with eye fluids |
| Herpes Zoster and the eye | Telephone/Video- Will need close up examination **F2F** (especially as elderly without video facilities) with FFP3 due to contact with eye fluids |
| Iritis | Telephone/Video- Will need close up examination **F2F** (especially as elderly without video facilities) with FFP3 due to contact with eye fluids |
| Acute loss of vision Optic atrophy, retinal detachment, Flashing lights, Retinal Vein Thrombosis, Retinal Artery 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 |
| Double Vision | Telephone only. Realistically many GPs 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** |
| 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 lens problems | Telephone. Will we have access to local optician to ask advice? |

****THIS LIST IS NOT EXHAUSTIVE SO PLEASE USE YOUR CLINICAL JUDGEMENT****

**Neurology:**

| | |
|---|---|
| General | Consider neuro advice line if concerns |
| Headache: Tension | Telephone only |
| 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 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<br>Ask the patient if they can weight bare when assessing foot/knee injuries and/or pain<br>X-rays often do not change management plans. **Avoid** unless suspected bony injury/diagnostic uncertainty<br>The majority of MSK conditions can be managed through self-help measures and adequate analgesia – ask specifically what they are taking, doses, timings etc.<br>Encourage self-help exercises and signpost patients accordingly<br>o https://www.circlehealth.co.uk/integratedcare/msk - good website with videos for each conditions<br>o http://www.hasantahir.com/exercise.php - basic exercise sheets<br>Consider video consultation to assess '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 weeping/itchy/bleeding<br>Consider telephone review in 24-48hrs to assess if improving |
| Petechial | A&E |
| Other rashes/eczema/psoriasis | manage with video consultations (if elderly patients that do not have a mobile – ask if can use family members mobile) |
| Other | Telephone |

**THIS LIST IS NOT EXHAUSTIVE SO PLEASE USE YOUR CLINICAL JUDGEMENT**

| | |
|---|---|
| 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) |
| 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 |
| 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 |
| General | Video/telephone consultation- can try and self-examine<br>Ask about associated symptoms/fever – Video and may need Face 2 face<br>**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.<br>Fever but no vomiting - Rx for cholecystitis – next day review. Consider how to get obs check<br>Fever + vomiting – a&e<br>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.<br>Women – think pelvic pathology – severity may dictate investigation – remember delays in USS.<br>May need to consider examination if lacking diagnostic clarity – discuss with gynae doctor in surgery.<br>Consider UTI → urine can be left for MSU or dip depending on your clinical concern.<br>Think access to obs. |
| RIF pain | Video consult always – jump test. Might need examination or escalate to a&e.<br>Always discuss with 2nd doctor before making appt. |
| LIF pain | Pelvic/ bowel symptoms – as for lower GI pain. |
| Hernia | Difficult to assess- may need examination – note routine hernias can wait.<br>Ask for symptoms of strangulation/ reducibility. |
| Rectal symptoms | Consider treating and follow up call for piles/haemorrhoids – always setup review. |
| Bloating | Consider ovaries – test first if concerns. Rv if ongoing.<br>Most other symptoms without red flags can wait |
| PR Bleeding | If heavy/dizzy -> consider A&E;<br>If risk significant pathology, consider 2ww/F2F cold clinic (assuming not in association cough/fever/Covid symptoms) |
| Diarrhoea/Vomiting | Hx to assess hydration status/PMHx/medications.<br>?unwell, altered responsiveness, e.g. irritable/lethargic, decreased urine output, pale/mottled skin, cold extremities<br>May benefit from video to eyeball patient. If persistent/unwell, need to consider F2F/2ww/a&e |

# ROTH SCORE

Ask the patient to take a deep breath and count out loud from 1 to 30 their native language.

## COUNT 1 TO 30

Count the number of seconds before they take another breath

**8 SECONDS**

If the "counting time" is 8 seconds or less, this has a sensitivity of 78% and specificity of 71% for identifying a pulse oximeter reading of <95%.

If the counting time is 5 seconds or less, sensitivity is 91%.

RCGP Royal College of General Practitioners

Remote Assessment for Asthma and COPD medication review

**Based on 4C-ABLE (Foreseeable) framework**

The availability of primary care records of patients with asthma and COPD has transformed consultations for review of their disease. We know that many patients may have the incorrect diagnosis, may not have had evidenced based value interventions, or be on medications that are not appropriate for their stage of disease (either too much or too little).

Thus patient s are at risk of being teated for the wrong condition, be at risk of side effects from the wrong medications or may not receive the best evidenced based treatment.
The 4C-ABLE approach is an attempt to structure a consultation using the electronic records of the patient to prepare before seeing the patient. This 2 step approach ensures that the information necessary to conduct a meaningful review has already been obtained before the patient enters the room. This then maximises the time spent with the patient to explore their understanding of the disease, their aims for the treatment, the barriers that may exist to prevent them achieving those aims, and then finally an agreed plan of action.

The first step (4C) involves interrogating the electronic primary care record to determine if the patient has the correct diagnosis, their stage of disease, and how effective their current treatment is in controlling their disease. The second step (ABLE) involves consulting with the patient if they are available to determine what they understand of the disease, what they would like to achieve, the barriers that may prevent this from happening and then agreeing a way forward to help achieve those goals.

The 4C steps should be clearly documented to save time repeating this process, and the results of the ABLE consultation can be easily recorded on a template to inform the next consultation.

We are adapting the 4C-ABLE approach to do remote respiratory medication reviews in the light of the COVID experience to reduce potential harm from patients using unnecessary high dose inhaled corticosteroids. Many patients may have been stepped up to high dose treatment because of poor technique or poor compliance, or if under control, may not have been stepped down again. We will give some general principles of treatment.

The 4C-ABLE approach consists of:
1. **C**onfirm diagnosis and stage disease
2. **C**urrent treatment (pharmacological and non-pharmacological)
3. **C**ontrol - assess level
4. **C**ompliance - assess level
5. **A**gree Aims
6. **B**arriers to success
7. **L**earning and self efficacy
8. **E**mend and agree management

## Asthma

Examine patient electronic record beforehand:

1. **Confirm diagnosis** and stage disease using:
- Spirometry/Peak flow – look for variability in FEV1 or peak flow (>20% variation)
- Secondary care review/letters stating diagnosis and evidence for diangosis
- Recent RCP questions/ACT score and exercise tolerance to ascertain control
- Current treatment level

2. **Current treatment** (pharmacological and non-pharmacological)
- Smoking status – support to stop if current smoker
- Triggers
- Atopy
- Current medication – are they prescribed high dose ICS?

3. Assess level of **Control**
- Number of admissions/A&E visits for asthma in last 2 years – should be 0
- Number of courses of steroids for asthma in last 2 years – should be 0
- Number of salbutamol inhalers in last 12 months – should be less than 3 if well contolled and taking regular preventer

4. **Compliance/Concordance** - assess level
- Number of ICS/LABA+ICS in last 12 months – ideally 75% (8-12 inhalers in a year)
- Spacer used if appropriate
- Inhaler technique last checked?

## Stepping down ICS in asthma.

If patient has been prescribed a high dose ICS but has received less than 50% of their inhalers in last 12 months, it should be safe to reduce their dose immediately by 50% or switch to a MART/SMART approach.

If patient is on high dose ICS and has been compliant with medication and well controlled (no exacerbations or ED visits, using salbutamol less than 3 times a week), reducing the overall daily dose of ICS by 25% every three months is a safe and effective strategy, reviewing control as part of an agreed self-management and clinical partnership. In patients on ICS and Long-Acting Beta-Agonists (LABA) combination, the ICS dose should be reduced to practical minimum (usually 400mcg BDP equivalent in adults, 200mcg in children), or consider if suitable for MART/SMART regimen.

Patients with high risk may be less amenable to dose reduction, but a holistic review including self management, concordance, inhaler technique and anticipatory/emergency care planning should be considered, recognising that this patient group are characteristically difficult to contact, but that contingency planning and practice processes can be effective despite difficulties in patient review.

## COPD

1. **Confirm diagnosis** and stage disease using:
- Age – COPD highly unlikely <40 years unless alpha-1 anti-trypsin def or heavy cannabis use
- Spirometry/lung function available – should have FEV1/FVC ratio <0.7 or <LLN for age or repeated occasions. Look for any variation in FEV1 as >20% may suggest asthmatic component.
- Secondary care review/letters – with spirometry
- MRC score and exercise tolerance – O2 sats
- Historical eosinophilia

2. **Current treatment** (pharmacological and non-pharmacological)
- Smoking status (<20 pack year history of smoking with COPD would suggest chronic asthma or cause other than smoking related COPD). Support to stop if current smoker
- Flu/pneumonia vaccination
- Pulmonary rehab within last 18 months
- Current medication

3. **Control -** assess level
- Number of admissions/A&E visits for chest conditions in last 2 years
- Number of courses of antibiotics for chest infections in last 2 years
- Number of courses of steroids for chest condition in last 2 years
- Any episodes of pneumonia in last 2 years if on ICS/LABA

4. **Compliance/Concordance** - assess level
- Number of salbutamol inhalers in last 12 months
- Number of LAMA/LABA/LABA+ICS in last 12 months
- Spacer used if appropriate
- Inhaler technique last checked?

**Stepping down ICS in COPD.**
Indications for ICS in COPD are:
- Features of asthma (variability in FEV1 and large response to bronchodilator with reversibility testing (>15% or 400ml), features of atopy).
- Historical eosinophilia (>0.3) with at least one documented exacerbation a year.
- More than 2 exacerbations a year or one exacerbation and one admission with AECOPD in last 12 months.

There is no indication for high dose ICS in smoking related COPD in absence of asthma. High dose ICS increases risk of pneumonia and other steroid related side effects. If patients with COPD need ICS, they can be managed on a moderate dose (usually 800micrograms of beclomethasone equivalence a day using a fixed triple (Trimbow or Trelegy) or combination ICS/LABA. Patients on high dose ICS who need to remain on ICS can step down to lower dose immediately. Patients who do not require any ICS:

- If on moderate dose ICS/LABA – can switch to LAMA/LABA combination inhaler immediately and review after 3 months
- If on high dose ICS/LABA – can switch to moderate dose ICS/LABA for 3 months and review – if stable can stop ICS/LABA and switch to LAMA/LABA as above and review after further 3 months.

Because of the heightened awareness of the possibility that the victim may have COVID-19, Resuscitation Council UK offers this advice:

## Adult advice

Recognise cardiac arrest by looking for the absence of signs of life and the absence of normal breathing. Do not listen or feel for breathing by placing your ear and cheek close to the patient's mouth. If you are in any doubt about confirming cardiac arrest, the default position is to start chest compressions until help arrives.

Make sure an ambulance is on its way. If COVID 19 is suspected, tell them when you call 999.
If there is a perceived risk of infection, rescuers should place a cloth/towel over the victims mouth and nose and attempt compression only CPR and early defibrillation until the ambulance (or advanced care team) arrives. Put hands together in the middle of the chest and push hard and fast.

Early use of a defibrillator significantly increases the person's chances of survival and does not increase risk of infection.

If the rescuer has access to personal protective equipment (PPE) (e.g. FFP3 face mask, disposable gloves, eye protection), these should be worn.

After performing compression-only CPR, all rescuers should wash their hands thoroughly with soap and water; alcohol-based hand gel is a convenient alternative. They should also seek advice from the NHS 111 coronavirus advice service or medical adviser.

## Paediatric advice

We are aware that paediatric cardiac arrest is unlikely to be caused by a cardiac problem and is more likely to be a respiratory one, making ventilations crucial to the child's chances of survival. However, for those not trained in paediatric resuscitation, the most important thing is to act quickly to ensure the child gets the treatment they need in the critical situation.

For out-of-hospital cardiac arrest, the importance of calling an ambulance and taking immediate action cannot be stressed highly enough. If a child is not breathing normally and no actions are taken, their heart will stop and full cardiac arrest will occur. Therefore, if there is any doubt about what to do, this statement should be used.

It is likely that the child/infant having an out-of-hospital cardiac arrest will be known to you. We accept that doing rescue breaths will increase the risk of transmitting the COVID-19 virus, either to the rescuer or the child/infant. However, this risk is small compared to the risk of taking no action as this will result in certain cardiac arrest and the death of the child.

MCCD for registration purposes
• A medical certificate can be accepted from any medical practitioner so long as they are able to state to the best of their knowledge the cause of death.
• Registrars can accept MCCDs without referral to the coroner, provided it contains an acceptable cause of death, and indicates that a medical practitioner has seen the deceased either within the 28 days prior to death, or after death (this does not need to be the certifying medical practitioner).
• While these provisions are in force, if it is indicated that a patient was seen in the 28 days prior to death by video link (such as skype) this should be accepted as
seen. This (video link) does not however meet the requirement for seen after death.
• Advice on Covid-19 as a cause of death was provided in circular 02/2020
Signing of the MCCD
• Provision for any registered medical practitioner to issue a MCCD without having personally attended the deceased, provided they are sufficiently able, from the available information, to ascertain the cause of death.
• The declaration on MCCDs will be amended as necessary by certifying doctors. This will show whether or not they have been in medical attendance and if not whether another doctor has seen the deceased after death and/or within 28 days prior to death.
• The after-death requirement will be through the existing ringed boxes on the MCCD.
• If there is no other reason for the death to be referred to the coroner, the MCCD should be accepted. If possible, registration officers should liaise with their local surgeries and hospitals to ascertain a list of possible signatories and their GMC numbers.

The registration
• Permission is granted to remove the requirement for a death or still-birth informant to attend and provide details in person and the requirement for them to sign the register where a local authority can no longer offer face to face service registrations or where this is needed by way of additional contingency.
• This will enable the information for the registration to be collected by telephone. When registering by telephone, in the signature box (space 8 of the death entry) registrars should record the full name of the informant followed by the words 'information given by telephone' (the same wording should be used for still-birth registrations).
• It is possible for telephone registration to be undertaken from the office or remotely and each authority should direct on practice for their area.

Remote registration
• If working remotely registrars will still require secure e-mail links in order to receive and send information.
• If without print facilities, registrars will need to register manually, although information will still be able to be captured onto RON. In such cases the RON entry should be completed after the register page has been signed by the registrar and they have added their designation. After capturing to RON, the entry can be locked.
• The disposal form can also be completed manually and as an option, once signed off, it can be photographed and sent on to the relevant authority as an email attachment with the original being retained.
Qualified Informants
• The list of qualified informants is temporarily extended to include a funeral director (where they are acting on behalf of the family)
• Funeral directors are an addition to the existing list of qualified informants rather than a replacement, family members are still allowed (and may be preferred).
• Where a funeral director does act as informant their designation shall be recorded as "Causing the body……" and the words 'Funeral Director' should be recorded after their surname, in the informant surname field.

Electronic transmission of documents
• The provisions also allow for the electronic transfer of documents relating to the certification and registration process (e.g. transfer of the MCCD from the medical practitioner to the registrar and the form for burial or cremation (the Green), from the registrar to the relevant authority).
• It is not envisaged that scanned documents should be received via a third party.
• Under this arrangement these documents can be scanned or photographed and sent as an attachment, though a wet signature is still required on the original.
• For MCCDs medical practitioners should be provided with a secure (local authority) email address to send to.
• Disposal forms can be completed manually and similarly scanned or photographed for onward sending. Registrars should engage to find an email address for the relevant authority (local burial and crematorium authority); which could be a local authority shared mailbox (as long as the relevant person at the crematorium or cemetery can access it) as well as an address for returning counterfoils.
• After the emergency period, arrangements should be made to have all original forms sent to the register office to be processed in the normal manner.

## End of Life Care - Breathlessness Management Guidelines:

For community professionals to use to care for patients with known or suspected COVID-19 in community settings. Key principles:

- This guidance is intended for the management of breathlessness in patients who are known to be in the last weeks / days of life dying with COVID-19 or suspected COVID-19
- This should be read in conjunction with local palliative care symptom control guidelines.
- The goal of care is to manage symptomatic breathlessness and associated anxiety. These symptoms are managed with non-pharmacological interventions, opioids and benzodiazepines. These medications should not be withheld for fear of respiratory depression as they give great comfort and are the mainstays of symptom management. Most people need low doses of medication to achieve symptom relief; some will need higher doses, and the doses may need to be increased as the patient deteriorates. The guidance overleaf suggests sensible safe starting doses for people who may be in the last weeks / days of life.
- Consider alternatives to subcutaneous routes by switching early to patches or buccal preparations to ensure symptom control is not affected by availability of staff to given PRN medication or set up syringe drivers.
- Both opioids and benzodiazepines are likely to be sedative. Adequate symptom control in a deteriorating / dying patient who is significantly hypoxic may result in sedation, such that the patient becomes drowsy / semi-conscious or unconscious. This needs to be carefully communicated in advance to the patient (if appropriate), family and those important to the patient, and professional carers.
- Support informal carers in becoming confident with administration of oral/buccal/transdermal medications and consider supporting them in the administration of subcutaneous medication where appropriate (see separate guidance)
- All doses are starting doses for opioid naïve patients. Please reduce or use alternatives in renal or liver impairment and titrate up/convert as appropriate for patients already on strong opioids. Contact your local palliative care team for further advice.
- Vital observations should be stopped and comfort observations used. Oxygen (if it has been part of treatment) may no longer be useful. If of no benefit it can be stopped; many find an oxygen mask difficult to tolerate at this time.

| Symptom | Non-pharmacological approaches | Starting doses in opioid naïve patients | | | |
|---|---|---|---|---|---|
| | | Oral route | Subcutaneous route | Syringe driver doses | Medications via alternative routes |
| **Breathlessness** | Cool flannel around the face and nose<br><br>Draught from an open window<br><br>**NB:** Fan therapy is *not* advised due to infection control risks for others | Morphine sulphate immediate release 1-2mg PO PRN hourly and titrate to response<br>or<br>Morphine sulphate modified release 5mg PO BD and titrate to response<br><br>In renal failure, consider Oxycodone – seek advice from Palliative Care | Morphine sulphate 1-2mg SC PRN hourly and titrate to response<br><br>In. renal failure, consider Oxycodone – seek advice from Palliative Care | Morphine sulphate 10mg/24 hours and titrate according to response<br><br>In renal failure, consider halving dose or oxycodone – seek advice from Palliative Care | Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days<br><br>Concentrated oral morphine solution (20mg/ml) at dose of 2.5-5mg (0.125-0.25mls) administered buccally (draw up in syringe then inject into side of mouth and rub cheek to enable absorption).<br><br>Seek advice from palliative care team |
| **Agitation / anxiety – likely to be contributing to breathlessness** | See above<br><br>Consider relaxation CDs, breathing exercises (extend 'out' breath) etc | Lorazepam 500mcg-1mg sublingually QDS | Midazolam 2.5-5mg SC PRN hourly | Midazolam 10mg/24 hours and titrate according to response<br><br>(reduce to 5mg/24 hours if eGFR <30) | Midazolam 10mg/2mls for buccal or nasal administration 0.5-1ml PRN hourly<br><br>Prefilled midazolam buccal solution (Buccolam 10mg/2ml or Epistatus 10mg/ml)<br><br>Rectal diazepam 10mg PR PRN |
| **Respiratory secretions** | Positioning<br><br>Reassurance for carers | N/A | *Glycopyrronium 200-300mcg SC hourly (max 1.2mg/24 hrs)<br><br>*Hyoscine butylbromide 20mg SC hourly (max 120mg/24 hrs)<br><br>*Hyoscine hydrobromide 0.4mg SC hourly (max 1.6mg/24 hrs)<br><br>*Choice depends on local formulary | *Glycopyrronium 0.8-1.2mg/24 hours<br><br>*Hyoscine butylbromide 60-120mg/24 hours<br><br>Hyoscine hydrobromide 1.2-1.6mg/24 hours<br><br>*Choice depends on local formulary | Hyoscine hydrobromide patches (Scopoderm) 1mg 72 hourly (can use 2 patches)<br><br>Glycopyrronium injection applied buccally 200-300mcg SC hourly (max 1.2mg/24 hrs) |
| **Fever** | Cool flannel | Paracetamol 1g PO QDS | N/A | N/A | Paracetamol suppositories 1g QDS PR |

*Summarised & Written by: Dr Sarah Shelley*

## End of Life Care - Guidance for community professionals on medications that can be administered by traditional and alternative routes (i.e. non-oral / non-subcutaneous) routes for symptom control

- Patients entering the last days of life often require medications to control pain, nausea, respiratory tract secretions and agitation, which are normally administered orally or subcutaneously.
- Local Palliative Care / symptom control guidelines on care and medication to use in this situation should continue to be followed wherever possible.
- However, in the presence of the COVID-19 pandemic, there will be an increase in the number of patients dying, an increased burden on healthcare staff whose exposure to COVID-19 should be minimised, and the potential for a lack of syringe drivers.
- In this situation, those important to the patient will have an increasing role in administering medication for symptom control in the last days of life, with virtual professional support from GPs / district nursing / specialist palliative care teams.
- Healthcare professionals involved in a patient's care continue to have responsibility for advising those important to the patient how to use the medications that they have recommended / prescribed
- Where possible, it is safest for those important to the patient to administer medications via the oral route for as long as possible, and when this is not possible, to use a non-oral, non-subcutaneous i.e. transdermal, buccal, rectal route.
- The evidence base and experience in the non-oral, non-subcutaneous route of administration is limited, and therefore increases the risk.
- In exceptional circumstances a decision may be taken to train and support those important to the patient to administer subcutaneous medications.
- Local Medication and Administration records (MAAR) should continue to be used to record and administer such medication

In preparation for this situation, the NHSE/I (London region) End of Life Care Clinical Network has drawn up:

- a list of medications that can be administered via a non-oral, non-subcutaneous route to control symptoms in the last days of life. This list has been reviewed by two paediatric palliative care teams (Great Ormond Street and Royal Marsden) who use this route more commonly
- a proforma that Palliative Care teams can use to document their preferred oral / subcutaneous / non-oral, non-subcutaneous medications for local use. (we have also included a completed proforma as an example)
- a quick guide to train and support those important to the patient to administer subcutaneous medications

| Symptom | Non-pharmacological approaches | Starting doses in opioid naive patients (if patients are not responding consider titrating within dose and range and seek advice) | | | |
|---|---|---|---|---|---|
| | | Oral route | Subcutaneous route | Syringe driver doses | Medications via alternative routes |
| **Pain** | Heat pads over affected areas<br><br>Massage | Morphine sulphate immediate release 2.5-5mg PO PRN hourly and titrate to response<br>or<br>Morphine sulphate modified release 5mg PO BD and titrate to response<br><br>In renal failure, consider Oxycodone – seek advice from Palliative Care | Morphine sulphate 2.5-5mg (1.25mg if elderly, frail, low weight) S PRN hourly and titrate to response<br><br>In. renal failure, consider Oxycodone – seek advice from Palliative Care | Morphine Sulphate 10mg/24 hours and titrate according to response<br><br>In renal failure, consider halving dose or oxycodone – seek advice from Palliative Care | Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days<br><br>Concentrated oral morphine solution (20mg/ml) at dose of 2.5-5mg (0.125-0.25mls) administered buccally (draw up in syringe then inject into side of mouth and rub cheek to enable absorption).<br><br>Seek advice from palliative care team |
| **Nausea & Vomiting** | | Varies by cause:<br>Metoclopramide 10mg PO TDS<br>Domperidone 10mg PO QDS<br>Cyclizine 50mg PO TDS<br>Haloperidol 0.5-1mg PO BD<br>Levomepromazine 6.25mg PO | Haloperidol 0.5-1.5mg SC PRN hourly | Haloperidol 3-10mg/24 hours | Olanzepine 5-10mg tablets orodispersible PRN<br><br>Or<br>Hyosicne hydrobromide patches (scopoderm) 1mg 72 hours (can use 2 patches) |
| **Agitation / anxiety** | Consider relaxation CDs, breathing exercises (extend 'out' breath) etc | Lorazepam 500mcg-1mg sublingually QDS | Midazolam 2.5-5mg SC PRN hourly | Midazolam 10mg/24 hours and titrate according to response<br><br>(reduce to 5mg/24 hours if eGFR <30) | Prefilled midazolam buccal solution (Buccolam 10mg/2ml) administer 0.5-1ml PRN hourly |
| **Respiratory secretions** | Positioning<br><br>Reassurance for carers | N/A | *Glycopyrronium 200-300mcg SC hourly (max 1.2mg/24 hrs) | *Glycopyrronium 0.8-1.2mg/24 hours | Hyoscine hydrobromide patches (Scopoderm) 1mg 72 hourly (can use 2 patches)<br><br>Glycopyrronium injection applied buccally 200-300mcg SC hourly (max 1.2mg/24 hrs) |
| **Breathlessness** | Cool flannel around the face and nose<br><br>Draught from an open window<br><br>**NB:** Fan therapy is *not* advised due to infection control risks for others | Morphine sulphate immediate release 1-2mg PO PRN hourly and titrate to response<br>or<br>Morphine sulphate modified release 5mg PO BD and titrate to response<br><br>In renal failure, consider Oxycodone – seek advice from Palliative Care | Morphine sulphate 1-2mg SC PRN hourly and titrate to response<br><br>In. renal failure, consider Oxycodone – seek advice from Palliative Care | Morphine sulphate 10mg/24 hours and titrate according to response<br><br>In renal failure, consider halving dose or oxycodone – seek advice from Palliative Care | Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days<br><br>Concentrated oral morphine solution (20mg/ml) at dose of 2.5-5mg (0.125-0.25mls) administered buccally (draw up in syringe then inject into side of mouth and rub cheek to enable absorption).<br><br>Seek advice from palliative care team |
| **Fits** | | As per individual normal prescribed medication | Midazolam 5-10mg SC stat | Midazolam 20-30mg/24 hours if unable to take oral anti epilepsy medication | Prefilled midazolam buccal solution (Buccolam 10mg/2ml) administer 1-2mls stat |
| **Fever** | Cool flannel | Paracetamol 1g PO QDS | N/A | N/A | Paracetamol suppositories 1g QDS PR |

*Summarised & Written by: Dr Sarah Shelley*

# What you can do to practically care for someone who is in their last days and hours of life

NHS

It is important to be aware of what to expect and how to make the experience as comfortable as possible.

Your health team will advise you on the medications that can help with controlling symptoms experienced at the end of life.

## Communication and environment

When approaching the end of life, people often sleep more than they are awake and may drift in and out of consciousness.

**Try to imagine what the person you are caring for would want. Provide familiar sounds and sensations, a favourite blanket for example, or piece of music. Keep the environment calm by not having too many people in the room at once and avoid bright lighting. This can reduce anxiety even when someone is unconscious. Even when they cannot respond, it is important to keep talking to them as they can most probably hear right up until they die.**

## Pain

Some people may be in pain when they are dying. If they are less conscious they may grimace or groan to show this. There are medicines that can be given to ease pain.

**Always check their positioning in bed to see if this can also help. They may be too weak to move and this can cause discomfort. Consider if they have any areas that are known to hurt, for example a bad back, and remember this when positioning them.**

## Feeling sick

Sometimes people can feel nauseated or sick when they are dying.

**If vomiting, and unable to sit up, turn the person on their side to protect their airway. There are medicines that can be given to help relieve this.**

## Going to the toilet

Towards the end of life, a person may lose control of their bladder and bowel. Even though we expect someone to go to the toilet less as they eat and drink less, contact the health care team that is looking after them if they have not passed any urine for 12 hours or more as it can be uncomfortable.

**Keep the person comfortable by regularly washing them and changing pads if they are wet or soiled.**

## Moving

The person will require washing at least once a day and regular turning every 2-4 hours to protect their skin from developing pressure sores.

**Alternate their position from lying on their back to each side. You can use pillows or rolled up towels to support them and also to support under their arms and between and under their legs. When you are washing the person, look for signs of redness, or changes in the colour or appearance of their skin. Check the back of the head and ears, the shoulder blades and elbows and the base of the spine, hips and buttocks, ankles, heels and between the knees.**

## Mouth care

While people rarely complain of thirst at the end of life, a dry mouth can be a problem due to breathing mostly through their mouth.

**It's important to keep lips moist with a small amount of un-perfumed lip balm to prevent cracking. Regularly wet inside their mouth and around their teeth with a moistened toothbrush whether he or she is awake or has lost consciousness. Check for sore areas and white patches on the tongue, gums and inside the cheek which can be sore. If this happens tell the person's healthcare professionals as it can be treated easily.**

## Breathlessness and cough

Breathlessness and cough can be another cause of agitation and distress and it can make it difficult to communicate. Don't expect the person to talk and give them time and space to respond. Reassure them that the unpleasant feeling will pass.

You can offer reassurance by talking calmly and opening a window to allow fresh air in. If possible, sit the person up with pillows rather than lying flat as this can help the sensation of not being able to breathe.

Before someone dies their breathing often becomes noisy. Some people call this the 'death rattle'. Try not to be alarmed by this, it is normal. It is due to an accumulation of secretions and the muscles at the back of the throat relaxing. There are medicines that can be given to help dry up secretions if it is a problem.

## Agitation or restlessness

Some people can become agitated and appear distressed when they are dying. It can be frightening to look after someone who is restless. It's important to check if the cause is reversible like having a full bladder or bowel which can be reversed by using a catheter to drain the urine or medicines to open the bowels. Your health team can assess if this is necessary.

Check if their pad is wet to see if they are passing urine or if they are opening their bowels. If it's not either of these things, there are things you can do and give to help. Try to reassure the person by talking to them calmly and sitting with them. Touch can be effective in doing this too. There are also medicines that can be given to help settle and relax someone.

## Looking after yourself

Caring for a dying person can be exhausting both physically and emotionally. Take time out to eat and rest. Try to share the care with other people when possible and remember it is OK to leave the person's side to have a break.

## Washing

Sometimes it may be too disruptive for the person to have a full wash. Just washing their hands and face and bottom can feel refreshing.

To give a bed bath, use two separate flannels, one for the face and top half of the body and one for the bottom half. Start at the top of the body, washing their face, arms, back, chest, and tummy. Next, wash their feet and legs. Finally, wash the area between their legs and their bottom. Rinse off soap completely to stop their skin feeling itchy. Dry their skin gently but thoroughly. Only expose the parts of the person's body that are being washed at the time – you can cover the rest of their body with a towel. This helps to keep them warm and maintains their dignity.

## Eating

As the body shuts down it no longer needs food and fluid to keep it going. When a person is dying they often lose their desire to eat or drink and finally their ability to swallow. They can lose weight rapidly.

This is often difficult to accept because we often equate food with health and feeding people as an act of love. However, hunger and thirst are rarely a problem at the end of life.

Continue to offer a variety of soft foods and sips of water with a teaspoon or straw for as long as the person is conscious (but allow them to refuse it). It's important **not** to force food or drink onto someone who no longer wants it. **Remember to sit them up when offering food and fluids to avoid choking.**

When a person is no longer able to swallow some people want them to have fluids via other routes like a drip, but at the end of life this offers little, if any, benefit. The body cannot process the fluid like a healthy body can and it can be harmful to artificially feed and hydrate. Risks include infection at the insertion site or in the blood, and fluid overload resulting in swelling or even breathing problems.

**Minimum Required Data for Care Plan Approval**

The following fields are a representation of the minimum information required for a care plan to be approved and then published (only published care plans are visible to the urgent care services). We encourage clinicians to fill out as much relevant information as possible to ensure as full a picture is available to the urgent care services and that the patient's preferences are fully represented and the clinical guidance on what to do when there is a deterioration. However these are the mandatory fields which must be completed for care plan approval. The aim is to provide meaningful information to the Urgent Care teams responding to the patient during a significant deterioration.

**1. Patient Consent Screen**

- Patient details – first name, surname, NHS number, gender & DOB (auto-populated from NHS spine)
- Type of patient consent -including justification if the care plan is being created following a clinical / Lasting Power of Attorney (LPA) decision taken on behalf of the patient if they lack capacity (Lasting Power of Attorney refers to Health and Welfare option only)
- Date consent obtained

**2. Patient Details Screen** (auto-populated from NHS spine)

- First name
- Surname
- Date of Birth
- Gender
- Main (primary) address (including postcode)
- GP practice and/or name of GP
- NHS number

**3. Significant Medical Background Screen**

- Main diagnosis
- WHO performance status
- WHO performance status date

**4. Preferences Screen**

- Preferred place of care (options for 'not yet discussed' etc.)
- At least one preferred place of death (options for 'not yet discussed' etc.)

**5. Cardiopulmonary Resuscitation Discussion Screen (from Resuscitation Council UK)**

- Has discussion about resuscitation taken place with patient or LPA?
- Date of discussion
- Summary of discussion with patient or LPA or reason why not discussed
- Has discussion about resuscitation taken place with the family?
- Date of discussion
- Summary of discussion or reason why not discussed
- Should CPR Commence? 'Decision Not Yet Made' is available
- If answer YES no further action except to record the date
- Date of CPR Decision
- Should CPR commence? If answer NO there are 8 further fields (mostly drop down options)
- Date of CPR decision
- Mental capacity?
- Aware of advance decision?
- Is there LPA for Health and Welfare?
- Reasons why CPR would be inappropriate, unsuccessful, or not in the patient's best interests (summary)
- Clinician RECORDING the decision (clinician who RECORDS the decision but not necessarily who authorises the DNACPR decision)
- Date and time
- Clinician REVIEWING and ENDORSING (the clinician who authorises the DNACPR decision)

**6. Ceiling of Treatment -** mandatory and requires consistency with the CPR decision

**7. Medication Screen – Allergies**

- NB If no allergy information is available, record a category of 'No Known Allergies' and then (drop down options) either 'I don't know' or 'No allergies known by patient'

**8. Approval Screen**

- Review Date (default 3 months but can be up to a year – whatever is clinically appropriate)
- Clinician (who will review the CMC care plan). Only registered CMC users can be searched for here

## Coordinate My Care

Early identification tool for End of Life Patients

www.england.nhs.uk/london/london-clinical-networks/our-networks/end-of-life-care/end-of-life-care-key-publications

## Example 'script' for calling patients to discuss ACP/CMC

Introduction 'Hello my name is…'

Make sure talking to the right person

Ensure they can clearly hear and understand you

I know it must be very hard at the moment with all the endless news reports saying don't worry this only affects the elderly and frail with underlying health issues. I can imagine it makes you feel quite vulnerable.

Just wanted to let you know we are here and working at the practice and that if you have any concerns or symptoms you can call us.

We are also aware that a lot of our patients are too worried to bother us in case we are too busy so I just wanted to touch base and make sure you are ok. Is there anything worrying you at the moment or that you would like to ask me?

It would also be a really good time to make sure we have all your contact and next of kin details up to date – can we check these please?

What support if any do you have at the moment? Do you have carers coming in, someone to do shopping/get any medications or things you might need during an extended time of staying at home?

We really are living through an unprecedented time, and we know for some people it makes them start thinking about what they want and what they do not want when it comes to medical treatment. I am sorry to bring this up over the phone like this and if you prefer not to talk about it, that is completely fine. However, if you feel you would like to talk about it, or let me know what those wishes are, so that everyone involved in looking after you knows and is aware what your wishes are, then I would be very happy to discuss that now or another time soon if that is better for you.

## Conversation about patient's wishes:

There is a digital system that we have been using across GPs, the ambulance service and the hospitals to share this important information about our patients so we can share information about your medical history and ensure your next of kin details are known by everyone, would you be happy for me to create a record for you on this system, called 'Coordinate My Care'?

We will be in regular contact to check on you but please do call us on XXX Or the out of hours service 111 or if it is an emergency call 999.

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Every effort will be made to keep this guidance up to date. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Bereavement teams, mortuary teams and Coroners Offices can be contacted for additional support and guidance (contact details at the end of this document).

# Important considerations for Care immediately before and after Death where COVID-19 is suspected or confirmed

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family/significant other/s

## BEFORE DEATH

Decisions regarding escalation of treatment will be made on a case by case basis

If death is imminent and family wish to stay with their loved one, staff must advise them that they should wear full PPE (see PPE Requirements on final page of this document).

Faith deaths & Spiritual Care – see separate flow chart "Chaplaincy & Spiritual Care Flow Chart Covid-19 Outbreak"

## VERIFICATION OF DEATH

Inform and support family and/or Next of Kin

Appropriately trained professional completes Verification of Death process wearing required PPE and maintaining infection control measures.

Verification of death process should be completed as per local policy/guidelines.

Any equipment used in the Verification of Death process should be either disposed of or fully decontaminated with Chlorclean solution

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Every effort will be made to keep this guidance up to date. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Bereavement teams, mortuary teams and Coroners Offices can be contacted for additional support and guidance (contact details at the end of this document).

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family/significant other/s

## MEDICAL CERTIFICATE OF CAUSE OF DEATH

Appropriate Doctor completes Medical Certificate of Cause of Death as soon as possible

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Covid-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death
Covid-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009.
That Covid-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status.

↓

If the deceased is to be cremated, doctors will not be able to physically see the deceased due to risk.
AWAITING CONFIRMATION OF WHAT CREMATORIUMS WILL ACCEPT AS IDENTIFIERS

↓

Where next of kin/ or a possible informant are following self-isolation procedures, arrangements should be made for an alternative informant who has not been in contact with the patient to collect the MCCD and attend to give the information for the registration. See further section on "Registering the Death".

↓

If referral to HM Coroner is required for another reason, a telephone conversation should take place as soon as possible with HM Coroner's Office and local guidelines should be followed alongside this guidance.

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Every effort will be made to keep this guidance up to date. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Bereavement teams, mortuary teams and Coroners Offices can be contacted for additional support and guidance (contact details at the end of this document).

## CARE AFTER DEATH

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family/significant other/s

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

If deceased has been tested for covid-19 and no results please treat has high risk.

↓

Full PPE should be worn for performing physical care after death. Information on PPE can be found in the "PPE requirements" table on the final page of this document.

↓

Mementoes/keepsakes e.g. locks of hair, handprints etc. must be offered and obtained during physical care after death by person/s wearing full PPE, as they will not be able to be offered at a later date. They should be placed in a sealed plastic bag and families advised to open for 7 days.

↓

The act of moving a recently deceased patient onto a hospital trolley for transportation to the mortuary might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk - a body bag should be used for transferring the body and those handling the body at this point should use full PPE (see PPE Requirements on final page of this document).

↓

Registered nurses to complete Notification of Death forms fully including details of COVID-19 status (NEW SECTION) and place in pocket on body bag along with body bag form, ID band with patient demographics placed through loops in body bag zip.

↓

The outer surface of the body bag should be decontaminated (see environmental decontamination https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/wuhan-novel-coronavirus-wn-cov-infection-prevention-and-control-guidance#decon) immediately before leaving the clinical area. This may require at least 2 individuals wearing PPE (see PPE Requirements on final page of this document), in order to manage this process.

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Contact Porters to transfer to mortuary, ensuring that they are aware of confirmed or suspected Covid-19.

↓

Deceased's property should be handled with care as per policy by staff using PPE.
Items that can be safely wiped down such as jewellery should be cleaned with Chlorclean and securely bagged before returning to families.
Clothing, blankets etc. should ideally be disposed of. If they must be returned to families they should be double bagged and securely tied and families informed of the risks.

↓

Refer all suspected or confirmed Covid-19 deaths to Bereavement team (contact details at end of this document)

NB - ORGAN/TISSUE DONATION IS HIGHLY UNLIKELY TO BE AN OPTION AS PER ANY OTHER ACTIVE SYSTEMIC VIRAL INFECTION

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

Staff should be aware that this guidance is subject to change as developments occur. Every effort will be made to keep this guidance up to date. Additional information can be found here; https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response. Bereavement teams, mortuary teams and Coroners Offices can be contacted for additional support and guidance (contact details at the end of this document).

## REGISTERING THE DEATH

All deaths must be registered in person by an informant

Where the deceased's next of kin or a possible informant are following self-isolation procedures, arrangements should be made for an alternative informant who has not been in contact with the patient to collect the MCCD and attend to give the information for the registration. Where there is no alternative informant available, a member of Bereavement Service/Office staff can register the death as an "occupier".

Wherever possible, the following information is required to be given to the Registrar by whoever is registering the death;

- NHS number
- Date of death
- Full name at death
- Details of any other names that the deceased has been known by
- Maiden name if applicable
- Date of birth
- Place of birth
- Occupation and if deceased retired
- Marital status
- Full Name of spouse/civil partner if applicable
- Spouse/Civil Partner occupation and if retired
- Full address and postcode of deceased
- For statistical information date of birth of spouse and the industry they work/worked in and if they supervised staff

Should a member of Bereavement Service staff need to register the death on behalf of the family, payment by card can be arranged via the General Office. The member of staff registering the death can then request the cash from General Office.
A receipt must be obtained by the staff member from the Registry office to go with the petty cash slip as evidence.

Green "release" paperwork can be taken to chosen Funeral Directors

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family/significant other/s

Emotional/Spiritual/Religious needs of the deceased and their family/significant other/s

## PPE REQUIREMENTS

### Transmission based precautions (TBPs): Personal protective equipment (PPE) for care of deceased during COVID-19 pandemic

| | Low risk Procedures*: Admission of deceased, Preparation for viewing, Release of deceased | Medium risk Procedures**: Rolling deceased, Undressing deceased, Significant manual handling | High risk Procedures: Autopsy, Other invasive procedures |
|---|---|---|---|
| Disposable gloves | Yes | Yes | Yes |
| Disposable plastic apron | Yes | Yes | Yes |
| Disposable gown | No | No | Yes |
| Fluid-resistant (Type IIR) surgical mask (FRSM) | Yes | No | No |
| Filtering face piece (class 3) (FFP3) respirator | No | Yes | Yes |
| Disposable eye protection | Yes | Yes | Yes |

* If procedure likely to cause droplet contact, use medium risk procedure
** If procedure likely to generate aerosols, use high risk procedure

Adapted from '*COVID-19: Guidance for infection prevention and control in healthcare settings*' (Department of Health and Social Care, Public Health Wales, Public Health Agency (PHA) Northern Ireland, Health Protection Scotland and Public Health England, 2020)

## USEFUL CONTACT INFORMATION AND RESOURCES

Public Health England https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response

Guidance from Cruse Bereavement Care, including information about grieving in isolation and traumatic bereavement.

https://www.cruse.org.uk/get-help/coronavirus-dealing-bereavement-and-grief

Macmillan and Marie Curie being updated regularly

https://www.mariecurie.org.uk/help/support/coronavirus