COVID-19 Palliative Care Guidance for Community Professionals 4.5.2020

This guidance was updated on 28.4.2020 to incorporate CHFT guidance so that GPs and community professionals employed by CHFT see the same guidance.

Existing symptom control guidance for patients who do NOT have Covid-19 infection is available here

OVERGATE HOSPICE INPATIENT UNIT

Overgate Hospice Inpatient Unit remains open for specialist palliative care and end of life care for patients with a life-limiting illness whose palliative needs cannot be met anywhere else.

We now have a supply of PPE. ***Providing a patient does not need aerosol-generating procedures*****, we are now able to accept referrals for patients who have suspected or confirmed Covid-19 infection if they meet our other referral criteria, while also keeping our other patients and staff safe.**

Our **visiting arrangements** are under constant review – please see our **website**

PALLIATIVE CARE GUIDANCE for COMMUNITY PROFESSIONALS during the COVID-19 PANDEMIC

There is increased demand in community for palliative care support.

Guidance in this document is based on national guidance and local expertise.
Click **here** to see the full ***NICE COVID-19 rapid guideline: [NG163] managing symptoms (including at the end of life) in the community,*** released 4.4.2020.
Click **here** to read the full guidance from the **Association for Palliative Medicine** (updated regularly)

Update 14.4.2020 Please note that to preserve supplies of key medication during the pandemic, only **those with a prognosis of weeks or less should be prescribed a new supply of anticipatory medication**. Please prescribe **only 3 ampoules of each anticipatory medication** in community, rather than the usual 5. This should allow the first few doses to be given urgently as needed. **Use of the first dose should trigger prescription and supply of a more substantial supply**.

The key steps for effective palliative care are:

1. **Identify**
2. **Assess**
3. **Plan**
4. **Care after death**

COVID-19 Palliative Care Guidance for Community Professionals 4.5.2020

Identify

Identify those most at risk from Covid-19
SHIELDING GUIDANCE is **here**

Identify those unlikely to benefit from escalation of treatment
(Will my patient benefit from hospital admission / NIV / ITU /intubation?)
- **FRAILTY SCORE is here**
- **ESCALATION PLANNING** guidance is **here**

Assess

STAYING SAFE IN PRIMARY CARE – Remote assessments

BMJ guidance on Covid-19: a remote assessment in primary care

Visual summary for remote consultations

Calderdale Community Specialist Palliative Care Team

- Work hours have temporarily increased ***7 days/week, 9-5***

Monday – Friday, 9am to 5pm

- Team members are working remotely, and prioritising patients with current and urgent need. Please continue to refer to the via email (preferred) **communityspecialist.palliativecare@nhs.net** or by phone **01422 310874**.
- The team still supports patients and families via phone assessment, escalating concerns to GP teams as needed, and is available to give advice to professionals. (Each GP Team and CHFT Community service Hubs have CNS mobile contact details listed for direct / urgent access).

Saturday & Sunday, 9am-5pm

- the team will undertake urgent reviews and work and can be reached via the Overgate Hospice advice line.**01422 379151**

Outside those hours (i.e. 5pm – 9am)

- please call the Overgate Hospice for advice on **01422 379151**

Out-of-Hours Palliative Care service

- The service has extended its hours **(7-day service 8pm to 7am**) and works alongside other OOH DN teams.
  Now operates from the central Halifax Hub.
- All calls to the OOH Nursing services are triaged **07917106263.**

Plan

Planning care and treating symptoms in patients with Covid-19 infection

Advance Care Planning

- **DNA CPR**
- **Escalation of care – who amongst your patients would not benefit from admission to hospital, NIV, intubation, ITU?**

Common Symptoms in those dying from Covid-19 infection, and how to treat

Support line for families, carers and professionals

Care home staff education and resources

IDENTIFY

SHIELDING

Link to full gov.uk guidance is here

People falling into this extremely vulnerable group include:

1. Solid organ transplant recipients.
2. People with specific cancers:
   - people with cancer who are undergoing active chemotherapy
   - people with lung cancer who are undergoing radical radiotherapy
   - people with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment
   - people having immunotherapy or other continuing antibody treatments for cancer
   - people having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors
   - people who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs
3. People with severe respiratory conditions including all cystic fibrosis, severe asthma and severe COPD.
4. People with rare diseases and inborn errors of metabolism that significantly increase the risk of infections (such as SCID, homozygous sickle cell).
5. People on immunosuppression therapies sufficient to significantly increase risk of infection.
6. Women who are pregnant with significant heart disease, congenital or acquired.

Shielding is for your personal protection. It is your choice to decide whether to follow the measures we advise. Individuals who have been given a prognosis of less than 6 months to live, and some others in special circumstances, could decide not to undertake shielding. This will be a deeply personal decision. We advise calling your GP or specialist to discuss this.

ASSESSING FRAILTY

Link to detail regarding this scale is here

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

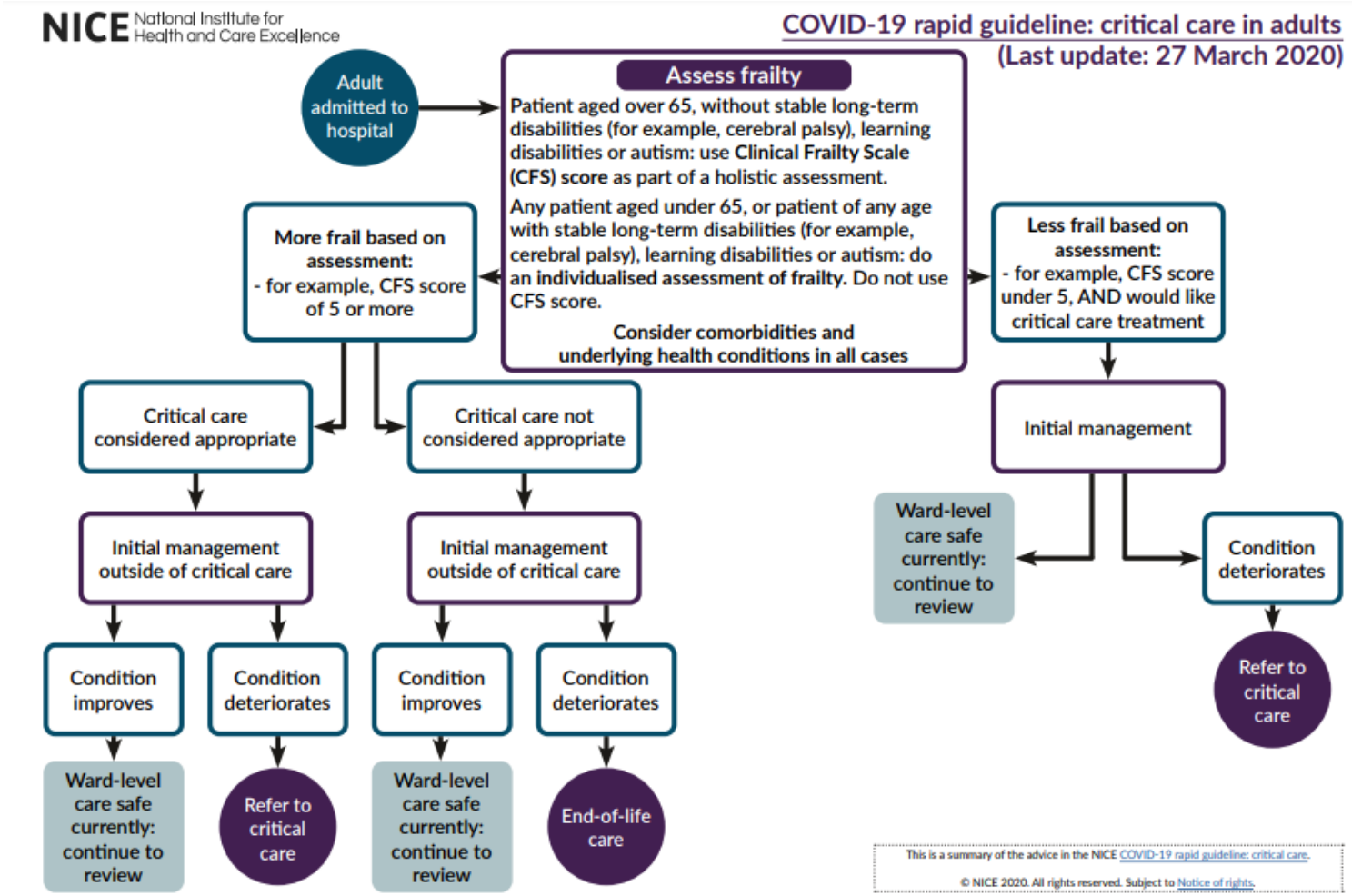
* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

DALHOUSIE UNIVERSITY Inspiring Minds

IDENTIFY

ESCALATION PLANNING

Link to the full NICE guidance on escalation planning during the Covid-19 pandemic is here



PLAN – Advance Care Planning

Who makes decisions about DNA CPR and escalation plans?

Where the **professional believes a treatment has a good chance of success,** then it's the **patient's decision** about whether they would want the treatment.

Ask the patient what they want.

KEY QUESTIONS to ASK YOURSELF as a PROFESSIONAL:

- Would CPR revive this patient?
- Would this patient survive ITU, and be successfully weaned from a ventilator?
- Would this patient's prognosis be improved by being admitted to hospital?

If the answer to these questions is "**yes**" then **ask** the person whether they would want the treatments.

Then document that plan on the electronic record (EPaCCS if you have access) and on paper notes in the house (OOH handover form).

Where the **professional knows a treatment would not help** someone, it is the professional's decision.

In this situation, **the professional must "tell" (not ask)** – ie explain that the treatment won't be offered.

KEY QUESTIONS to ASK YOURSELF as a PROFESSIONAL:

- Would CPR revive this patient?
- Would this patient survive ITU, and be successfully weaned from a ventilator?
- Would this patient's prognosis be improved by being admitted to hospital?

If the answer to these questions is "**no**" then **don't ask** what the person wants.....**explain** that these treatments would not work.

Then document that plan on the electronic record (EPaCCS if you have access) and on paper notes in the house (OOH handover form).

DNA CPR & Advance Care Planning (ACP) Decisions & Discussions

Decisions must be made on an individual patient basis.

Useful video about CPR here

Involve the patient, and their family (with patient consent) wherever possible.

Decisions **about whether or not to offer CPR should be based on existing guidance from the GMC and the Resuscitation Council**

Decisions about escalation **should be based on NICE guidance**

Tips for talking to patients about advance care planning, DNA CPR etc during the Covid-19 pandemic are available from VITALtalk, including suggested responses to angry or distressed comments from patients and family members.

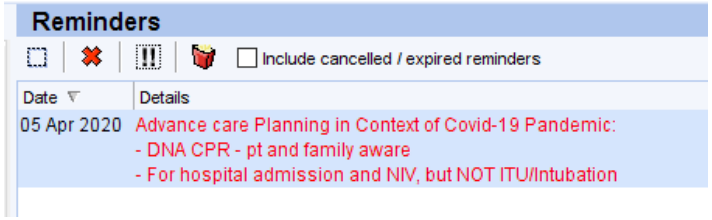
https://www.vitaltalk.org/guides/covid-19-communication-skills/

VITALtalk

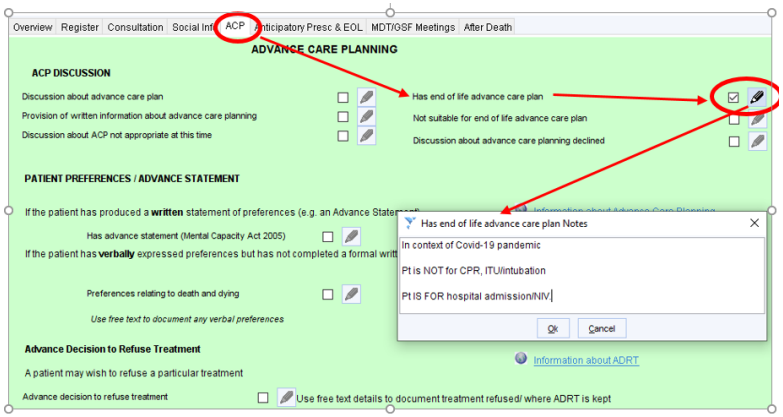
Documenting decisions

Important places to document outcomes of ACP are:

1. **Out of Hours Palliative Care Handover Form** in the patient's house
2. **Font page of SystmOne/ EMIS record** (S1 example below – high priority reminder on front page)



3. **EPaCCS** (S1 example below)



Common Symptoms of Covid-19 & treatment at the end of life

To ensure that all community staff see the same guidance whether they are employed by CHFT or not, the Overgate guidance has been replaced by CHFT guidelines.

Click here to see CHFT guidance

Thanks to CHFT and Kirkwood for sharing their guidance

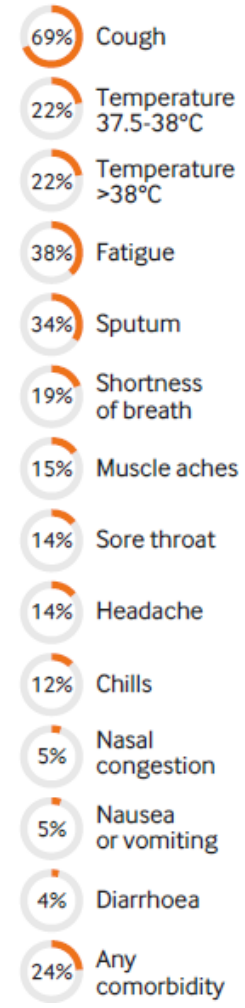
Breathlessness and delirium can be severe in some patients dying from Covid-19 infection

Deterioration from Covid-19 infection can be very rapid if inflammation is severe

If patient needs medication, give PRN loading doses, even if starting a syringe driver.

Training on setting up a syringe driver is available here

Frequency of symptoms in Wuhan



Care after Death - following Covid-19 Infection

Link to guidance: https://www.effs.eu/files/effs/content/AT%20Joint-Statement-on-Coronavirus-Act-2020-002.pdf

VERIFICATION OF EXPECTED DEATH (VOED) Training link for VOED is here

Nurses may verify the death of a patient who has died of Covid-19 infection, providing other criteria are met for usual nurse verification of expected death.
Updated 11.5.2020 the Calderdale policy for community nurses allows them to undertake **VOED in additional situations – see new local working instruction here**

CERTIFICATION (Medical certificate of Cause of Death)

Email copy of MCCD to register.office@calderdale.gov.uk

If the doctor who attended the person before death is unavailable, another doctor can sign the MCCD for all deaths which are natural, including Covid-19.

- This will only be when the certifying doctor is able to access the deceased's notes and the information supports a natural death.
- There is still a requirement for the deceased to be seen after death or within 28 days prior to death by a doctor.
- The same MCCD form will be used and amended as necessary.

There is no need for the certifying doctor to have attended the deceased during their last illness.

The time period for the deceased to have been seen by a doctor, prior to death, is extended from 14 to 28 days.

- There is still a requirement for the body to be seen after death if they were not seen by a doctor up to 28 days prior to death.
- Currently, the **certifying** doctor needs to see the deceased 14 days before death, or after death. This has now been extended to allow for any doctor to have seen the deceased after death or within 28 days prior to death.

Video consultation (e.g. Skype) can be accepted for the purposes of "being seen within 28 days". However, it cannot be used to see the body after death.

CREMATION FORMS

1. The requirement to complete the **confirmatory** ("Part 2") medical certificate (form Cremation 5) is suspended. Cremations should be authorised on the basis of form Cremation 4 only.
2. Form Cremation 4 remains unchanged and a PDF version continues to be available here. It can be submitted electronically, and an electronic signature includes being sent from the secure email account of the person completing the form Cremation 4.
3. The requirement for form Cremation 4 to be completed by the attending medical practitioner is suspended. Any medical practitioner can now complete form Cremation 4, even if they did not attend the deceased during their last illness or after death, if the following conditions are fulfilled:
   i. The medical practitioner who did attend the deceased is unable to sign the form Cremation 4 or it is impractical for them to do so and,
   ii. A medical practitioner has seen the deceased (including audio-visual/video consultation) within 28 days before death or has viewed the body in person after death.
4. Examination of the body is not required for completion of form Cremation 4 if the deceased was seen by a medical practitioner (including audio-visual/video consultation) in the 28 days before death.
5. When a medical practitioner who did not attend the deceased completes form Cremation 4, the following applies:
   i. Question 5. 'Usual medical practitioner'. Where the certifying doctor did not themselves attend the patient either during their illness or after death, the certifying doctor should provide the GMC number and name of the medical practitioner who did
   ii. attend at Question 9. This should also include the date when the deceased was seen and a report of the record made by the attending doctor.
   iii. Question 6. 'Not applicable' is acceptable.
   iv. Question 7. 'Not applicable' is acceptable.
   v. Question 8. 'Not applicable' is acceptable. As at (iii) above, if the form Cremation 4 is being completed on the basis of another medical practitioner having seen the deceased after death, the date, time and nature of their examination should be recorded at Question 9.
6. Any completed cremation forms 5 that you may receive will not form part of the application and there will be no duty to retain them. There will be no need for a medical referee to re-authorise any cremation that they have already authorised under the arrangements.

After death – handling the deceased and their effects

Following a patient's death, staff should **continue to wear PPE including Fluid Resistant Surgical Mask, apron, gloves and goggles/eye protection** when handling the body of the deceased, including laying out/last offices.

Use of body bags is not a requirement but may be practical for other reasons.

The patient's belongings can be returned to the Next of Kin in a **sealed plastic bag**; the bag must **not be opened for seven days** to ensure that the virus has died following any surface contamination of the possessions.

Link to specific guidance from NHS England is here, and from gov.uk is here.

After death – information for families

- During the Covid-19 pandemic, families will need to register a death by telephone. They must phone to make an appointment: 01422 288080
- They will need to have the following information ready for the discussion.

Details required	Guidance notes	Deceased details
Date of death		
Place of death	This will be the name of the hospital or nursing home, the name or number of the house, the name of the street and village town etc. If the death took place in an ambulance, car etc then please record circumstances i.e. the locality of the vehicle when the death occurred and the intended destination.	
Name and surname	This should be the name they were known as at the time of his or her death. You should also establish if they are known by any other name currently or previously. These too should be recorded with some notes as to the circumstances to help the registrar ascertain how to record the information in the entry.	
Sex	Male or Female	
Maiden surname of woman who has married	This is the surname in which a woman contracted her (first) marriage.	
Date of birth	Please provide approximate dates if exact date not known.	
Place of birth	Town and county/London borough or country of birth and only country if born outside UK.	
Occupation	Please provide as much information as possible relating to the most recent occupation. Please also record whether the deceased was retired.	
Usual address	This should include the name or number of the house, name of the street and village or town. Where the death occurred in a hospital the deceased's usual address should be recorded.	

FUNERALS

Families should be warned that conditions for funerals, and numbers of mourners at cremations and burials, are restricted. (details can be seen here)

“Hear” to Help

Like many of you, Overgate wants to do everything we can to help the local fight against Covid-19. We are hearing so many stories of families who have lost loved ones in the most desperate circumstances. Supporting people through bereavement is something that we do every day at Overgate and we know how important the right support is when you are overwhelmed with grief. Our team have the skills and experience to be there for these families.

We also know the intense emotional strain the outbreak is having on our health and social care colleagues; the doctors, nurses, care workers who are working on the front line in this fight.

In response to this, working with the local Clinical Commissioning Group, we have launched a new telephone support and advice service from Monday 20th April 2020. Our team will be just a phone call away, ready to listen and provide support to the following people:

- Relatives of patients being cared-for in any health or social care facility in relation to COVID-19

- All relatives of end-of-life patients

- Bereaved relatives who can only attend funerals at the crematorium or burial in restricted numbers

- Any health professional providing a frontline service in response to COVID-19

Our phone lines are open seven days a week from 10am until 6pm.

01422 387172