

Version 4: 16/06/2020



COVID-19

PRIMARY AND COMMUNITY CARE GUIDELINE

IMPLEMENTATION PLAN

CHANGES TO VERSION 4:

- 1. Terminology updated under 4 key health care actions to reference community integrated services page 4**
- 2. Cluster Hub support changed to Community Integrated Services page 5**
- 3. BAME added to higher risk category page 5**
- 4. Learning disabilities added to higher risk category page 5**
- 5. Chronic respiratory disease replaces COPD and asthma as reference to generic respiratory conditions page 5**
- 6. Optimisation of frailty widened to reference optimisation of all higher risk groups page 6.**
- 7. Algorithm on page 7 amended to include safety netting, reference to loss of smell/taste.**
- 8. Algorithm on page 9 updated to include reference to AHP support, replace cluster hub support with community integrated services, and reminder that if patient is not suitable for ICU, they may still benefit from admission to hospital for oxygen therapy and non-invasive interventions**
- 9. Updated web links on page 10**
- 10. Added flowchart for management of borderline cases page 3**

Version Control table:

V	Date	Changes	Attachments
1	23/03/2020	N/A	Covering letter AG Community telephone consultation LTC-COVID 19 Wellbeing support at home  v1 attachments.zip
2	31/03/2020	- P6 flowchart: "admit to hospital" now clarified to "admit to acute hospital" - P6 rising respiratory rate reduced from >25 to >24 - Advice to use airflow to the face eg a fan has been removed. This is no longer advised.	Covering letter Home oxygen  Pathway attachments v2.zip
3	08/04/2020	- P8 References to support decision tree: - P19 NICE guidance on application of the clinical frailty score	NICE guidance on application of the clinical frailty score  NICE%20guidance%20on%20assessment%20of%20clinical%20frailty%20score.pdf Full NICE guidance (3/4/2020) https://www.nice.org.uk/guidance/ng165
4	16/06/2020	- Terminology updated page 4 - Cluster Hub support changed to Community Integrated Services page 5 - Additions to higher risk category to include BAME and learning disabilities page 5 - Reference to generic chronic respiratory disease replaces COPD and asthma page 5 - Optimisation of frailty widened to reference optimisation of all higher risk groups page 6 - Algorithm on page 7 amended to include safety netting and reference to loss of smell/taste. - Algorithm on page 9 updated to include reference to AHP support, replace cluster hub support with community integrated services, and reminder that if patient is not suitable for ICU, they may still benefit from admission to hospital for oxygen therapy and non-invasive interventions - Updated hyperlinks (page 10) - Added flowchart for management of borderline cases	Updated hyperlinks on self management/self-isolation (page 10): https://phw.nhs.wales/topic/latest-information-on-novel-coronavirus-covid-19/ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869144/Self-isolation_poster_for_patient_s.pdf Flowchart for management of borderline cases:  CAC Flow chart.CAC (003) (002).docx

THE PRE-HOSPITAL MANAGEMENT OF COVID-19 INFECTION

Pathway Purpose

The purpose of this pathway is to support primary care, community and paramedic colleagues in decision making regarding the management of patients presenting with suspected or actual Covid-19.

Who will use it?

This entire framework/pathway is to be used by any doctor, nurse, paramedic or allied health professional, anywhere in the community. Local Health Boards and Clusters will plan and deliver their services differently according to local needs and workforce, but will follow this framework.

Management Aim

We aim to treat all patients in a setting that is appropriate to their specific personal needs, whilst maintaining a functioning healthcare system in extraordinary circumstances. The framework provides a consistent approach to the management of patients during the Covid-19 Pandemic and is aligned to the all Wales secondary care guidance. It also complements PHW primary care guidance.

The Four Key Health Care Actions in the Community

1. Self-Care and Self-management at home
2. Supportive Care delivered in the home, GP surgery or community integrated services by a multi-professional team serving a cluster population
3. Palliative care delivered in the home, probably by a multi-professional cluster supportive care team
4. Referral to an acute hospital

KEY ASSUMPTIONS AND ENABLERS

Our ability to provide care as the number of patients infected with Covid-19 rises depends on a whole system approach to management. This model assumes that:

- That senior expert advice will be readily available by telephone
- That we have access to patient information resources regarding prognosis/clinical reasoning
- The pathways are based on an ethical framework
- That a Single Point of Access is available 24/7 for urgent referrals to Community Integrated services and Palliative Care
- That Community Integrated services and Palliative Care are able to respond rapidly within **2 hours of a call** and work collaboratively 24/7
- That capacity and sickness is actively tracked on a daily basis to enable new staff to redeploy and backfill gaps
- That non-essential and admin tasks are removed from clinicians (consider redeploying non-clinical staff to act as scribes, runners, etc)
- That enhanced respiratory training is made available
- That clinical governance arrangements are locally determined and may need to change during the course of the pandemic.

Some patients are more likely to develop complications of Covid-19 and require management which will be personalized according to their existing conditions and circumstances.

Higher Risk Categories

- Elderly
- BAME
- Multi-morbidity
- Learning disabilities
- Long term conditions
 - Respiratory
 - Cardiovascular, including Hypertension
 - Diabetes
 - Immunosuppressed

Key actions can be taken in advance

- Optimise the ability of the patient to resist infection and reduce complications.
- Optimisation of Long Term Conditions through clinical review and self-management
 - Chronic respiratory disease
 - Diabetes
 - Hypertension
 - Cardiovascular disease
- Optimisation of care of vulnerable/higher risk groups as above
 - Medication reviews
- Co-produce an Advance Future Care Plan (with or without a DNA-CPR) that clearly describes the preferences of the patient for ceilings of treatment for the patient if possible

THE PRE-HOSPITAL ALGORITHM FOR COVID-19 INFECTION

**New Concerns
or Symptoms**



111 Online/GP



A high temperature? A new continuous cough?

Loss of smell/taste

Atypical presentations may be common especially in the elderly

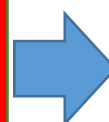


**Self-Care at Home if
symptoms are mild
With safety-netting**



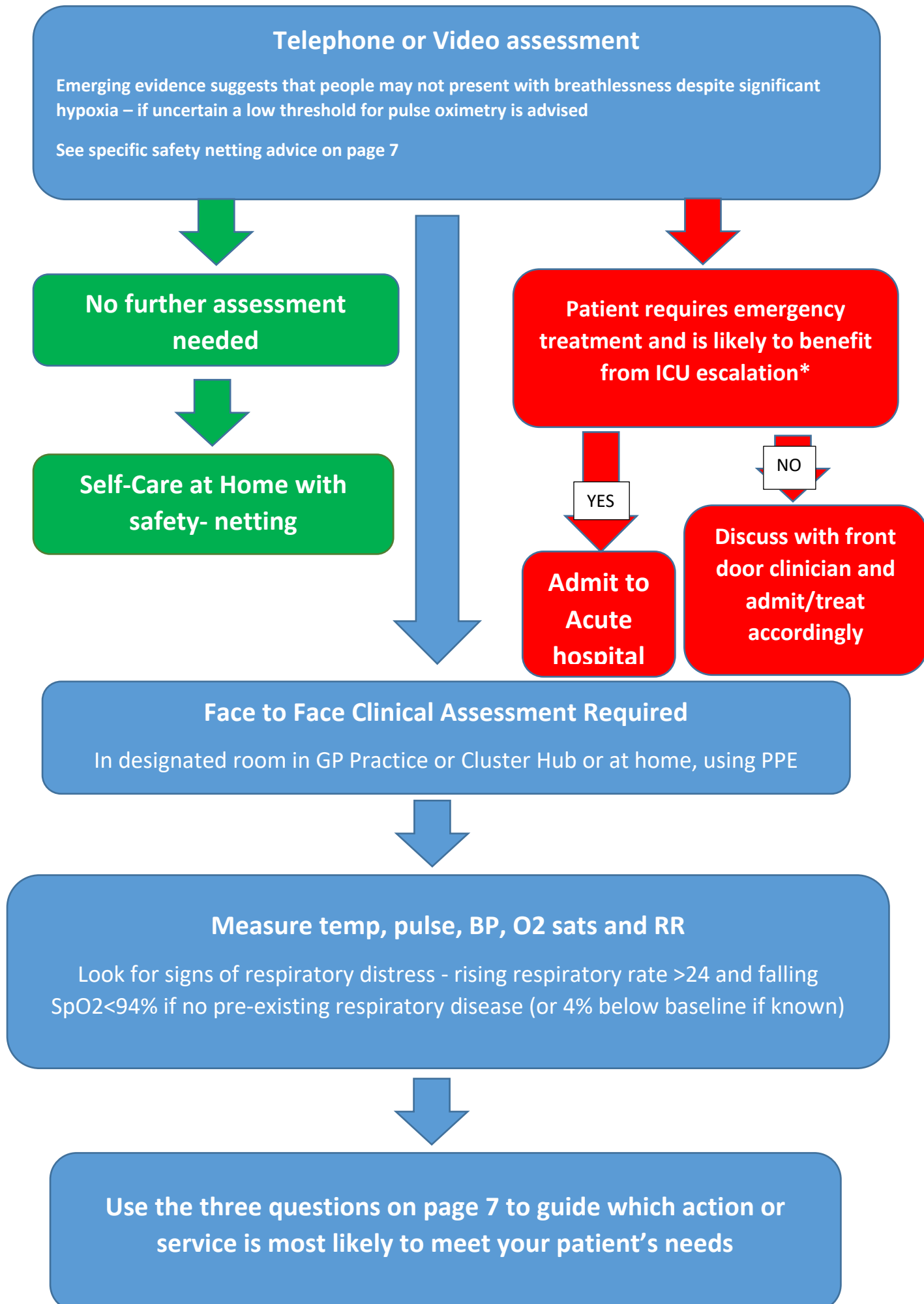
Safety-netting

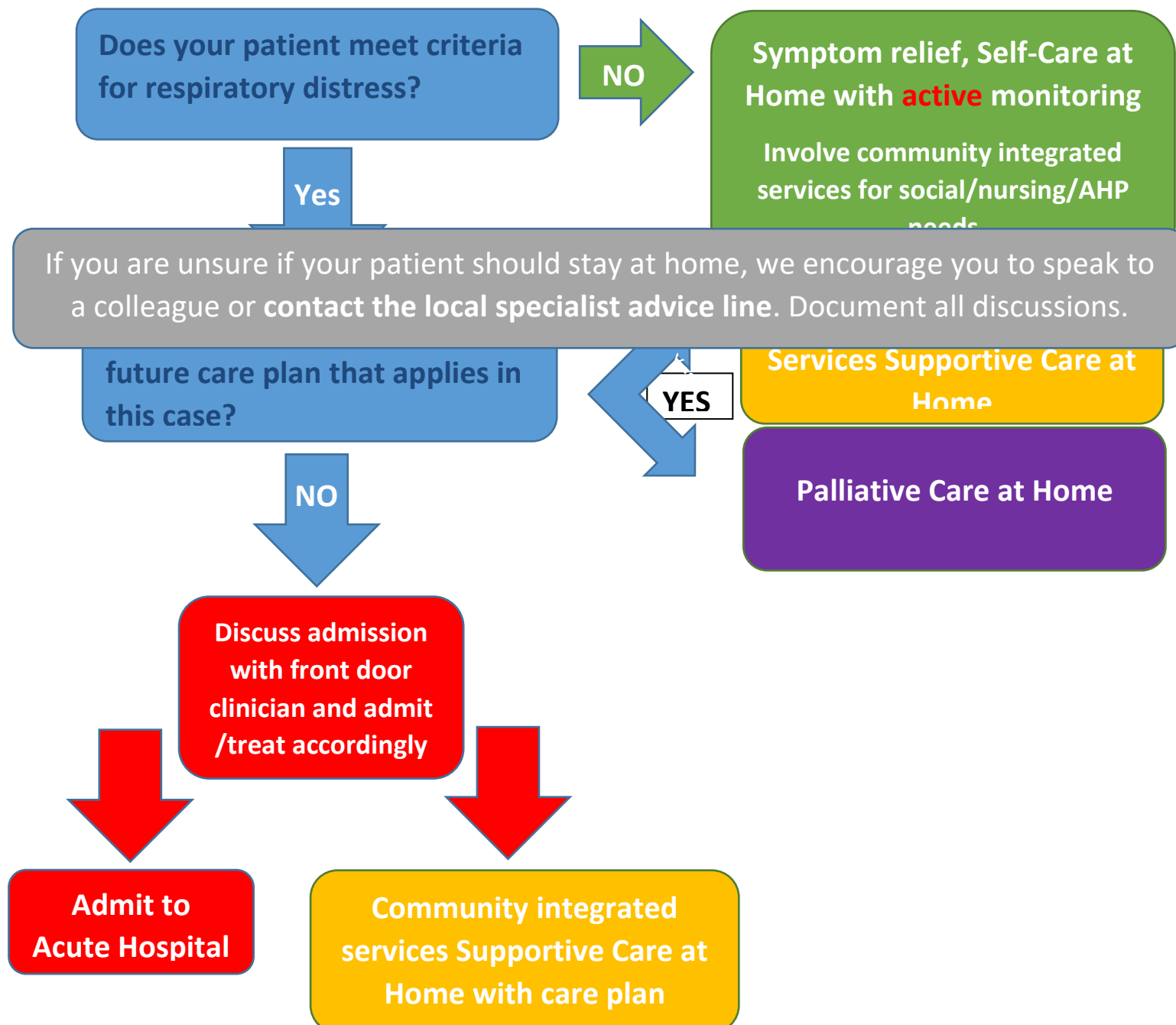
- no improvement in symptoms after 7 days
AND/OR
- worsening/non-resolving symptoms especially vomiting, breathlessness, fatigue, reduced ability to perform activities of daily living
- Emerging evidence suggests that people may not present with breathlessness despite significant hypoxia
 - Pay particular attention to high risk groups
- Other features described include but not limited to eg GI upset, skin manifestations



**Patient Calls
Own GP for
Telephone or Video
assessment**

This Community Framework/Pathway should be read in conjunction with PHW guidance for Primary Care. It focuses on presenting symptoms and clinical management irrespective of antigen or antibody test results





*Evidence shows that the following groups do not respond well to ICU escalation:
Clinical Frailty Score of 5 or above (see link page 17 and further NICE guidance)
Chronic severe cardiac or respiratory disease and other severe co-morbidities
On home oxygen or undergoing palliative chemotherapy

* Many patients who would not benefit from ICU escalation will benefit from hospital admission for oxygen therapy and other non-invasive interventions.

Self-Care & Self-Management at Home

This pathway links to Self-isolation advice which can be accessed via:

<https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/>

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/869144/Self-isolation_poster_for_patients.pdf

Cluster Hub Referral Pathway

Referrers:

Operational Hours:

The following PPE MUST BE USED for consultations of acute respiratory infection or influenza like illness

- Fluid Resistant Surgical Mask (FRSM)
- Disposable gloves
- Disposable plastic apron
- Appropriate eye protection, after risk assessment of need, if splashing or spraying of body fluids likely.

For aerosol generated procedures (AGP) e.g. NIV/CPAP or suctioning YOU MUST use

- FFP3 masks
- Disposable gowns
- Visors
- Disposable gloves

PPE MUST BE USED IN CONJUNCTION WITH EFFECTIVE HAND HYGIENE

For further information please refer to:

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-prevention-and-control> infection-

Referrer contacts team via SPA and provides patient details

Patient meets criteria and has consented to referral

NO

Referrer responsible for next course of action

YES

Referral logged by administration, triaged by Cluster Hub Support Team and allocated a telephone consultation appointment depending on urgency

Patient contacted via telephone using All Wales Telephone Consultation Form. Clinical intervention and further management dictated by patient's clinical condition

Home visit required

Patient well and discharged with stay at home advice

Further telephone call

Discharged with Stay at home advice

Continue intervention as clinically indicated

Palliative Care

Clinical management
Management is as for any viral pneumonia and is supportive
Encourage rest and oral fluid intake
Treatment for Pyrexia (Paracetamol)
Wheeze can be treated with bronchodilators
Steroids are not generally helpful and should be avoided unless there is another underlying respiratory condition.
Investigations are not generally required for the majority of cases

Please see appendices for additional cluster hub resources:

1. Patient Information Leaflet- Long term condition and pregnancy
2. Well-being support at Home
3. All Wales Community consultation form

Palliative Care at Home

Palliative care guidance in the context of Covid-19 epidemic

Palliative and end of life care in the community for patients who have suspected severe COVID-19 infection, where not admitting to hospital is being considered, and who are at risk of deterioration and death.

- Advance & future care planning (ACP/FCP)
 - If the patient is able to participate in decision making, support them to do so.
 - If they are not able to, find out whether any ACP/FCP or any kind of statement of wishes has been written and make use of it. For instance if there are clinical reasons not to admit, knowing that the person wanted to avoid hospital admission may make the decision and the discussion of it easier. Follow guidance on how to use.
 - If there is none, think about whether there's a chance to help write down any preferences or priorities the person has. Follow guidance on how to do this.
- Symptom control
 - **Summary:**
 - **For breathlessness and anxiety, give a stat dose of morphine 2.5mg + midazolam 2.5mg by injection then start continuous infusion of morphine 10mg + midazolam 10mg over 24h by infusion via a syringe driver.**
 - **If already on a regular opioid, bigger starting doses may be needed – see footnotes to table.**
 - **Use subsequent PRN doses freely.**
 - **Consider increasing both syringe driver and PRN doses if PRNs are needed frequently, or if the response is incomplete. Seek advice if this doesn't work.**
 - **If there is concern about drug toxicity, eg respiratory depression, seek advice.**

- **Remember that deterioration including a fall in conscious level is to be expected and does not mean toxicity. This pattern in severe COVID-19 infection, in those patients who are not expected to benefit from escalation, is likely to represent deterioration in condition not drug toxicity.**
- Experience of palliative and end of life care in severe COVID-19 infection is developing rapidly. Please look out for updates to this guidance and use the most recent version.
- What we know so far is that severe COVID-19 infection can cause severe and distressing symptoms that should respond well to quick use of commonly used symptom control drugs. Because patients may become very symptomatic very quickly, and deteriorate quickly, symptom control is very urgent.
- General tips
 - Look for the common symptoms & ask if there are any others.
 - Establish what the priorities are. Usually at the end of life good symptom control tops the list.
 - Explain what you're doing, explain how it serves the priorities, and explain that it is safe.
 - Adjust doses according to response. Some people need much higher doses than others.
 - If they're already taking regular strong opioids, ignore the starting doses in the table & see footnotes.
 - These principles also work in end of life care for other illnesses.
 - There is more detailed symptom control guidance for non-specialists [here](#).
 - If you need advice having consulted that, ask. Local arrangements are being confirmed.
- Common treatable symptoms of severe COVID-19 infection include
 - Breathlessness
 - Anxiety
 - Agitation
- Other symptoms may be due to the infection or due to pre-existing long term or life-shortening conditions
 - Pain

- Nausea & vomiting
- Respiratory secretions
- Injectable drugs are likely to be needed. Subcutaneous is usual first choice but intramuscular is OK. If the patient has suitable oral medications and can take them then these can be used for now but they're likely to become unable to take them if they deteriorate so don't rely on these. Sublingual or buccal medications may remain an option as the patient doesn't need to swallow them, but in acute distress they are harder to use.
- Sensible use of these drugs is safe and effective. We know that in other conditions good symptom control in end of life care doesn't hasten death, and although experience of COVID-19 is more limited there is no reason to think it's different in this respect. Dose titration may be required and sometimes to much higher doses.
- Some people with severe COVID-19 injection deteriorate very quickly at the end of life. Injected doses work quickly, in about half an hour. Use PRN doses freely to get control of the symptoms the patient has now.
- These symptoms are expected to be continuous rather than resolving, so if a syringe driver is available use that too to maintain control. Syringe drivers start to work slowly if that's all you do which is why you need stat & PRN doses too. While syringe drivers are useful, don't rely on them alone for what the patient needs today. If you are not able to set up a syringe driver, see if a nurse can visit quickly to do so.
- If no syringe driver is available or if there is no one to set one up, morphine + midazolam should be used at current PRN doses 4 hourly by sc injection via a butterfly if someone is available to give it – this is almost as effective as a driver and painless but needs round the clock doses.
- If inadequate response, dose increases are likely to be needed. Get advice if necessary.

Symptom	Drug	Route	Starting dose ¹ (if not already on regular opioid)	Frequency
Breathlessness	Morphine ⁶ Use together with midazolam	sc/im	2.5mg ²	PRN up to hourly
		sc	Typically 10mg ³	Over 24h by sc infusion
		Oral ⁴	5mg ⁵	PRN up to hourly
	Midazolam Use together with morphine	sc/im	2.5mg	PRN up to hourly
		sc	Typically 10mg	Over 24h by sc infusion
	Lorazepam Use 1 st line if no one to inject	Sublingual	500 micrograms	PRN up to hourly
	Oxygen	Any	Freely	Continuous
Anxiety & agitation	Midazolam	sc/im	2.5mg	PRN up to hourly
	Lorazepam Use 1 st line if no one to inject	Sublingual	500 micrograms	PRN up to hourly
Agitation (if hallucinations or if treating as for anxiety hasn't worked)	Haloperidol 1 st line	sc/im	1.5mg	PRN up to hourly
		Sc	Typically 3mg	Over 24h by sc infusion
	Levomepromazine	sc/im	12.5mg	PRN up to hourly
		Sc	25mg	Over 24h by sc infusion
Nausea & vomiting	Haloperidol	sc/im	1.5mg	PRN hourly
Pain	Morphine	sc/im	2.5mg	PRN up to hourly
		Po	5mg	PRN up to hourly
Respiratory secretions	Hyoscine hydrobromide	Sc	400 micrograms	PRN up to 4 hourly
	Glycopyrronium	Sc	200 micrograms	PRN up to 4 hourly

10mg oral morphine = 5mg morphine injection

Doses for pain and breathlessness are the same – keep it simple

- 1 Patients on regular opioids need, and tolerate, proportionately bigger starting doses – standard doses will not work unless the existing dose is quite small.
- 2 If already on regular oral morphine, to get the injected dose divide the current PRN oral dose by 2. Alternatively divide the current total daily dose

(usually double the dose of 12 hourly oral morphine + any PRN doses) by 12. Either way is fine. Either way, round up – to the nearest 2.5mg if up to 10mg or to the nearest 5 if over 10mg.

- 3 If already on oral morphine, to get the syringe driver dose take the total current 24 hour dose (usually double the dose of 12 hourly oral morphine + any PRN doses) & divide by 2.
- 4 This must be immediate release *eg* oramorph, sevredol. Do not use modified release for immediate relief of breathlessness – it takes too long to work.
- 5 If already on oral morphine, to get the oral dose for breathlessness just use their current PRN dose or divide the current total daily dose (usually double the dose of 12 hourly oral morphine + any PRN doses) by 12.
- 6 If they are already taking a different strong opioid (*eg* diamorphine, oxycodone, hydromorphone, fentanyl patch), for breathlessness you can use whatever immediate release version they are taking for pain and at the same dose. Give this + either midazolam or lorazepam. If an injection is needed and their usual opioid isn't available in injection form, just use morphine.

5mg oral oxycodone = 5mg morphine injection.

1.3mg oral hydromorphone = 5mg morphine injection.

Patients on fentanyl patches usually have immediate release morphine or diamorphine or sometimes oxycodone for pain so use that.

You can consult symptom control guidance, or get advice.

Referral to Acute Hospital

National Guidance Secondary Care – Covid-19



FINAL3 All Wales
COVID-19 Secondary

Clinical Frailty Scale

https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf

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.	 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).
 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.	 8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.
 3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.	 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.
 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.	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.
 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.	

Decisions regarding treatment and hospital admission should be always be made on an individual basis. NICE has issued a further statement on the application of the Clinical Frailty Score :

“The CFS should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disability or autism. An individualised assessment is recommended in all cases where the CFS is not appropriate.”

ETHICAL FRAMEWORK

Ethical summary statement

Some people benefit from rapid escalation to intensive care and ventilation. In some patients this will not work. Some can be identified early. We should use treatments that work, without disproportionate harm, subject to consent or best interest judgments, and provided they can be offered within the resources available. We should not use treatments that do not pass these tests. A treatment, however widely used and well known and however much the patient &/or those close to them think they would want it, should not be used if it stands no real chance of working in a particular patient or if it would cause disproportionate harm. Whatever treatments are being used, each patient should be given the best care available, helping them to survive if that can be achieved, and in all circumstances helping them to be comfortable, to live with dignity, and to be in the place of their choice if that is important to them. Guidance is offered to support decisions about which treatments will help, which will not, and how to maintain comfort. For some patients, there is nothing to gain by being in hospital. The question of what treatment is to be used may therefore help decide where the patient should be. If all the treatment being used can be done at home, and if some care is available, home (including a care home if that is the person's home) is usually the best place and often the place they would prefer.

The best that is available may be less good than we would want to provide. We should be as flexible as possible to get the patient as comfortable as possible within the limitations we face. There may not be enough capacity to offer every patient every treatment. Decisions not to use a treatment are likely to be needed much more often during a pandemic crisis. Making sure that patients are not given treatments that are not right for them helps them. It also helps the other patients who may then have a greater chance to have treatments that would work. This should be the basis of decisions and is the fairest way to decide when there is not enough to go around.