SUPPORTING PEOPLE WITH COVID-19 RELATED ILLNESS IN THE COMMUNITY SETTING: CLINICAL MANAGEMENT OF THOSE WITH MODERATE TO SEVERE ILLNESS

This guidance has been developed to support the GP led clinical management (including appropriate use of oxygen) of people with Covid-19 related symptoms in the community setting during usual practice hours and out of hours.

1. Who is covered by this guidance?

This guidance relates to people with moderate to severe Covid-19 related symptoms who, after a person-centred care planning conversation and careful weighing up of harms and benefits, are assessed as being more likely to benefit from being cared for in a community setting rather than in a hospital setting.

This may include people who:

- do not wish to be admitted to hospital
- would gain no overall benefit from being admitted
- are unlikely to respond to medical procedures such as non-invasive positive pressure ventilation or mechanical ventilation.

Such care planning conversations should take account of:

- the person's current wishes, if known
- previous care planning discussions or advance directives
- family and carer/s views and knowledge of the individual's previously expressed wishes
- the person's clinical condition (consider frailty score) and likely benefit of specific hospital interventions (Note frailty score should not be used in those under age 65).

2. Who is not covered by this guidance?

This guidance does not relate to any person who is unwell, and who, in your clinical opinion would be likely to gain additional benefit from more intensive hospital based care which cannot be provided in the community. People in this group should be admitted in accordance with their care plan and wishes, following the national clinical guidance.

3. Context

Our current understanding (from learned experience and emerging international evidence) is that 80% of people who are affected by Covid-19 will have mild

symptoms, however a small number (estimated at around 5%) will become seriously ill and require intensive care management.

Covid-19 can more severely affect people with frailty, in particular our care home population and people with underlying long term conditions.

Recent research from the European Respiratory Journal suggests that approximately 15-22% of people with Covid-19 symptoms with frailty and/ or other co-morbidities who are managed in the community will die. This means most will recover. It is important to ensure that those people who remain in the community have access to life- sustaining care, including oxygen where this is appropriate, as well as good palliative care where that is needed. As with any potentially life limiting illness these are not mutually exclusive, and should be considered as part of the anticipatory care planning process.

Support from frailty in-reach, respiratory and palliative care teams should all be available to primary care community teams, with clear plans in place for managing a person in the community 24/7.

Wherever possible, direct professional to professional communication lines and use of video-consulting should support all staff working in settings such as care homes and out- of hours to provide holistic care whilst minimising risk of infection.

All staff providing care to people with Covid-19 symptoms being managed in the community should follow HPS infection and control guidance at all times.

It is essential to note that community pathways are not mutually exclusive from acute hospital care and the clinical situation may change very rapidly. Clinical decision making and care plan review should reflect this.

There will be times when some treatments will cease to provide benefit and palliative care should become the primary approach. It will be important to prepare families and care givers about that possibility and keep them informed and consulted.

4. Supportive treatments with hope of recovery

The most common Covid-19 symptoms are breathlessness, cough and fever. Patients at any age can present with varying degrees of symptoms, from mild flu-like symptoms, to becoming rapidly unwell in a matter of hours. More information can be found in the Scottish Primary Care Covid-hub triage guide

As we learn more about the progress of this disease, it is recognised that:

- people with milder symptoms may begin to deteriorate after the first week
- older people may present with less typical symptoms, including confusion, bladder and bowel problems.

a) Treatment options include:

- good hydration
- medication review if appropriate
- -breathing techniques
- -Proning

(It has been found that some patients in hospital may benefit from changing positions. This may be considered in the community setting, but only where it is felt clinically appropriate to do so)

- cooling using wet wipes (discarded in clinical waste after single use)- **NO FANS**
- psychological support
  - Importance of explanation re PPE
  - Connections with family and carers through information sharing and technology.
- consider
  - delirium
  - bladder and bowel function
  - anxiety
- treatment of fever with paracetamol
- thromboprophylaxis is used to support care in the acute hospital setting. Consider this in the community setting on a case by case basis, seeking advice from local secondary care Covid-19 lead colleagues before prescribing.
- pain/breathlessness-consider oral dose morphine, or benzodiazepines if tolerated.

b) links to further information

https://www.nice.org.uk/guidance/ng163/chapter/managing-breathlessness

5. Use of oxygen

See Appendix A for flow chart

a) Points to consider

The primary role of oxygen in the management of Covid-19 is to correct hypoxaemia in order to try to improve outcome for the person

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- Is this clinically appropriate? (is the patient acutely breathless, SPO2 < 92% and RR>24)

  (Patients with suspected Covid-19 related breathlessness, and SpO2 > 92% in room air do not require oxygen.)

  - oxygen may be used on a "trial for benefit" basis- does the person's breathlessness improve, do oxygen saturation levels improve?

- Does the clinical situation merit reconsideration of hospital admission?

- Is it safe to administer? (e.g. smoker in household, other risks)

- Is oxygen supply easily available?
  - Follow national guidance and contact local Health Board lead for supply
  - See Appendix B for information and Appendix C for list of local contacts.

- How will this be monitored and how will you know if the person is getting benefit- e.g. reduction in breathlessness symptoms, oxygen saturations are improved?

- SpO2 levels should be checked at least four times daily - are staff available and clinically competent? Is there a supply of pulse oximeters?

- Monitoring will support clinical decision making, which may include:
  - reconsideration for admission
  - titration of oxygen levels
  - consider withdrawing if not helping.

- Are there non Covid-19 related issues e.g. COPD or other risks for hypercapnoeic respiratory failure? This will need to be taken into account when assessing for target SpO2

- How long will it take to source sufficient supply?

Anecdotal evidence from Scottish clinicians suggests that the majority of people with Covid-19 related breathlessness, if they are going to respond to oxygen therapy, are likely to do so within approximately 30 minutes of starting oxygen. This might be helpful to consider when using emergency bag or other locally available supplies.

b) Administration of oxygen

Start oxygen, via nasal cannula, (simple masks should not be used for flow rates below 5L/min) starting at 2 L per minute, titrating up to a maximum of 4 L per minute, aiming for the following:

For patients NOT at risk of hypercapnoeic respiratory failure

- Aim for target SpO2 92-94%

For patients at risk of hypercapnoeic respiratory failure (e.g. existing COPD, severe frailty)

- Aim for target SpO2 88-92%

c) Sources of support

- local oxygen lead (see Appendix B for list of contacts)
- respiratory liaison team
- Covid-19 lead consultant

ASK FOR HELP IF UNSURE ABOUT USING OXYGEN – SUPPORT IS ALWAYS AVAILABLE

6. Acutely ill and palliative care required

A key part of the decision to manage a person in the community is to ensure that through person centred care planning, the person and their family are aware of the possibility that active treatment may not work, and a clinical decision may be made to provide supportive palliative care only.

Where a person is deteriorating rapidly, and is felt clinically to be towards the end of life, it is important to ensure they are kept comfortable, that family and next of kin are informed, and where possible allowed to visit (with all risks explained, wearing appropriate PPE and in strictly limited numbers).

Electronic means of communication such as a tablet or mobile phone can provide immense comfort for people and their loved ones, and should be considered.

Contact details of next of kin, including email addresses, should be confirmed.

Guidance to support communication can be found here.

a) Points to note

- **Decline may be rapid**
- Wear appropriate PPE; treat reversible causes and confirm rapid irreversible decline
- High breathlessness/distress/delirium/agitation/fever/risk of death within hours - prescribe ACP drugs at HIGHER, EFFECTIVE DOSES FROM OUTSET
- Syringe driver best option, but takes 4 hours to full effect .REMEMBER TO PRESCRIBE
- If oxygen is no longer helping, titrate down with view to stopping
- Use s-c butterfly if syringe driver equipment/expertise unavailable, use alternatives if needed - patients can be managed effectively with four- hourly subcutaneous injections to get medication levels to a steady state
- Patient positioning, excess bedding, cool wipes to face, cool room - DO NOT USE FAN
- Ensure DNA-CPR/nurse verification form/prescription chart completed as appropriate.

b) Sources of support

- palliative care team (See Appendix B)
- community pharmacist
- SPOT APP

ASK FOR HELP IF UNSURE ABOUT PRESCRIBING OR DOSES NOT SUFFICIENT – SUPPORT IS ALWAYS AVAILABLE

c) Prescribing if family/carer attending to patient (s-c route **NOT** available):

- For pain, breathlessness, cough and fever:
  - Oral morphine sulphate (10mg/5ml bottle); 5mg hourly ORAL PRN AND
  - Paracetamol 500mg-1000mg qds ORAL PRN

- For secretions:
    - Hyoscine hydrobromide 1.5mg patches; 1-4 patches every 72h TRANSDERMAL OR
    - Hyoscine hydrobromide 300 microgram tabs; one tab every 6 hours ORAL

- For distress:
    - Midazolam buccal (Epistatus® 10mg/ml or Buccolam® 5mg/ml); 2.5mg hourly BUCCAL PRN OR
    - Lorazepam 1mg scored tabs; 500 microgram every 4h SUBLINGUAL PRN (the dispenser may be able to split the tablets if required).

d)links to further information

https://www.palliativecareguidelines.scot.nhs.uk/

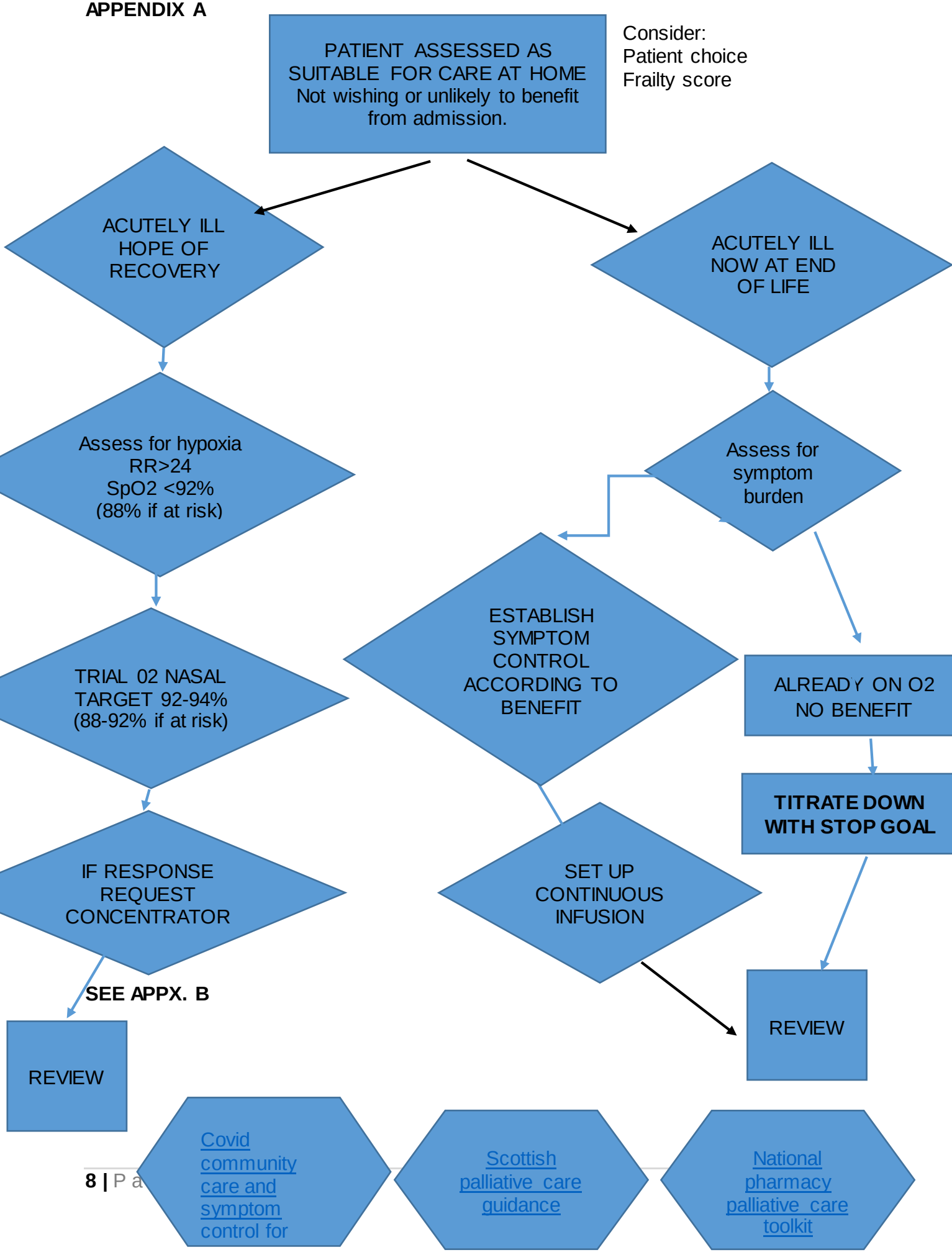
https://www.palliativecareguidelines.scot.nhs.uk/covid-19-guidance.aspx

National pharmacy palliative care toolkit

Scottish rapid review breathlessness and end of life care:
https://scotpalcovid.wordpress.com/2020/04/22/dyspnoea-management/

Covid community care and symptom control for GP's

APPENDIX A


PATIENT ASSESSED AS SUITABLE FOR CARE AT HOME
Not wishing or unlikely to benefit from admission.
Consider:
Patient choice
Frailty score
ACUTELY ILL HOPE OF RECOVERY
ACUTELY ILL NOW AT END OF LIFE
Assess for hypoxia
RR>24
SpO2 <92%
(88% if at risk)
Assess for symptom burden
TRIAL 02 NASAL
TARGET 92-94%
(88-92% if at risk)
ESTABLISH SYMPTOM CONTROL ACCORDING TO BENEFIT
ALREADY ON O2
NO BENEFIT
TITRATE DOWN WITH STOP GOAL
IF RESPONSE REQUEST CONCENTRATOR
SET UP CONTINUOUS INFUSION
SEE APPX. B
REVIEW
REVIEW
Covid community care and symptom control for
Scottish palliative care guidance
National pharmacy palliative care toolkit

APPENDIX B

Current Process For Home Oxygen Ordering

The Home oxygen service is provided by Dolby Vivisol,who are based in Stirling and have a network of field based engineers and depots across the country.

If an oxygen concentrator is required, this should be requested through nominated individuals in secondary care who have access to a Part A Scottish Home Oxygen Order Form (SHOOF). A note of the respiratory and palliative care contact for each Board has been provided in the table below. A target SpO2 should be stated in section 11 on the part A SHOOF to assist the attending health care professional.

Dolby Vivisol will be able to provide an oxygen concentrator that will provide up to 5 litres per minute. A recognised industry standard risk assessment will be carried out during installation, taking into account Covid-19 related infection control procedures.

Dolby Vivisol can provide a next - day and a same - day service**. For same day service a concentrator will be provided within 8 hours of receipt**. Their normal working hours are Monday to Friday 9 am – 5 pm. During the current Covid -19 outbreak their hours have been extended and they are also able to receive requests for concentrators and install them on a Saturday and Sunday. **Requests should state that the service is required for a Covid-19 patient.**

Where oxygen is required out of hours then please refer to the local oxygen contact who may be able to refer to a local interim arrangement using locally held Transportable Concentrators providing a maximum of either 2 or 3 litres per minute depending on the device held. Local teams are typically within OOH, Hospital at Home, REACT or other local arrangements with hospices.

Local teams would typically issue a device in the out of hours period a then make a request through Trakcare or SCI store requesting a standard concentrator from Dolby Vivisol which will be delivered in the specified time frame, using the standard 4 day service, next- day service or same - day service. When installed, local teams will retrieve the Transportable Concentrators and takethem back to their base for decontamination and reissue.

As part of the routine follow up and review, a judgement should be made as to whether the concentrator is still required. Where it is no longer required Dolby Vivisol should be contacted to arrange uplift. **Please note that you must advise them that the concentrator is to be uplifted from a Covid-19 positive patient.**

APPENDIX C

Healthboard	Contact	Designation (if known)	Contact E-Mail address	Telphone Number
NHS Ayrshire and Arran				
Respiratory Contact	Philip Hodkinson	Respiratory Physician - Crosshouse Hospital	Philip.Hodkinson@aapct.scot.nhs.uk	01292 617087
	Lorna MaKay	Respiratory Nurse Specialist Ailsa - Ayr/South Ayrshire	lorna.mckay@aaaht.scot.nhs.uk	01292 513161
Palliative Contact	Catriona Killin	Consultant in Palliative Medicine	Catriona.killin@nhs.net	07870554784
NHS Borders				
Respiratory Contact	Emma Dodds	Respiratory Nurse Specialist	emma.dodd@borders.scot.nhs.uk	01896 826635
	Debbie Cairns	Respiratory Nurse Specialist	debra.cairns@borders.scot.nhs.uk	01896 826635
Palliative Contact	Emma Dodds	Respiratory Nurse Specialist	emma.dodd@borders.scot.nhs.uk	01896 826635
	Michelle Scott	Palliative care nurse Consultant	michelle.scott@borders.scot.nhs.uk	01896 826829 or 01896 826000 ask for bleep 6828
NHS Dumfries and Galloway - Switch Board (01387 246246),				
Respiratory Contact	Phyllis Murphie	Respiratory Nurse Consultant	phyllis.murphie@nhs.net	01387 241860
	Yvonne Scott	Respiratory Nurse Specialist	yscott@nhs.net	01387 241007
Palliative Contact	Nigel Wilson	Specialist or McMillan nurses	nigelwilson@nhs.net	01387 241347
	Kirsty Gaffney	Specialist or McMillan nurses	kgaffney@nhs.net	01556 612360

	Barbara Maxwell	Specialist or McMillan nurses	barbaramaxwell1@nhs.net	01671 402587
	Katherine McMillan.	Specialist or McMillan nurses	katherinemcmillan@nhs.net	,01387244896
Palliative Contact	Ruth Morrison	Palliative care Associate Specialist	r.morrison@nhs.net	01387 241186
	Ruth Ginty	Speciality doctors in palliative care	r.ginty@nhs.net	Switch Board (01387 246246),
	Chamila Nagodavithana	Speciality doctors in palliative care	c.nagodavithana@nhs.net	, 07873211339
	Sarah Pickstock	palliative care consultant	s.pickstock@nhs.net	Switch Board (01387 246246),
NHS Fife				
Respiratory Contact	Margaret Stevenson	Respiratory Nurse Consultant	margaretstevenson@nhs.net	01592 643355
Palliative Contact	Margaret Vass	Pharmacy Technician Team Leader	margaret.vass@nhs.net	01383 565345 /07932676485
NHS Forth Valley				
Respiratory Contact	Olwyn Lamount	Lead Respiratory Specialist Nurse	olwyn.lamont@nhs.net	01324 566618 Internal: 66618
Palliative Contact	Sarah Miler	Palliative care consultant in the community	sarah.miller25@nhs.net	01324 826222

	Olwyn Lamount	Lead Respiratory Specialist Nurse	olwyn.lamont@nhs.net	01324 566618 Internal: 66618
NHS Greater Glasgow and Clyde				
Respiratory Contact	Kirsty Murray	Lead Respiratory Clinical Nurse Specialist	Kirsty.Murray4@ggc.scot.nhs.uk	0141 4516073
Palliative Contact	Jane Edgecombe	Consultant Palliative Medicine	Jane.Edgecombe@ggc.scot.nhs.uk	0141 301 7035
NHS Grampian				
Respiratory Contact	Margaret MacLeod	Senior Respiratory Physiotherapist	Gram-UHB.oxygen@nhs.net	01224 559569
Palliative Contact	TBC	TBC	TBC	TBC
Golden Jubilee				
Respiratory Contact	Karon Carson	SPVU Clinical Nurse Specialist	Karon.Carson@gjnh.scot.nhs.uk	0141 951 5771
	Rachel Thomson	Nurse Specialist	Rachel.Thomson@gjnh.scot.nhs.uk	
Palliative Contact	Sharon Robinson	Nurse Specialist	sharon.robinson@gjnh.scot.nhs.uk	0141 951 5000 x5350
	Karon Carson	SPVU Clinical Nurse Specialist	Karon.Carson@gjnh.scot.nhs.uk	0141 951 5771
	Rachel Thomson	Nurse Specialist	Rachel.Thomson@gjnh.scot.nhs.uk	

NHS Highland				
Respiratory Contact	Lorna Murray	Consultant Respiratory Physician	High-UHB.RaigmoreRespiratory@nhs.net	Switchboard 01463 704000 / 01463 706294
Palliative Contact	Lorna Murray	Consultant Respiratory Physician	High-UHB.RaigmoreRespiratory@nhs.net	Switchboard 01463 704000
NHS Lanarkshire				
Respiratory Contact	Tan, Dr Soong	Consultant Physician Respiratory Medicine	Soong.Tan@lanarkshire.scot.nhs.uk	01698 366074
Palliative Contact	Susan Jackson	Consultant in Palliative Medicine	Susan.Jackson@lanarkshire.scot.nhs.uk	01236 766951
NHS Lothian				
Respiratory Contact	Elspeth Christie	Advanced Respiratory Nurse Specialist	Elspeth.Christie@nhslothian.scot.nhs.uk	0131 242 1878
Palliative Contact	Gourab Choudhury,	Respiratory Consultant	Gourab.Choudhury@nhslothian.scot.nhs.uk	0131 536 1000
NHS Orkney				
Respiratory Contact	Wendy Lycett	Clinical Pharmacist	wendylycett@nhs.net	01856 888015
Palliative Contact	Wendy Lycett	Clinical Pharmacist	wendylycett@nhs.net	01856 888015
NHS Tayside				
Respiratory Contact	RLN team	RN	Tay.UHB-respiratoryliaisonservice@nhs.net	01382 496564
Palliative Contact	Deans Buchanan	Consultant in Palliative Medicine/ Lead Clinician	deansbuchanan@nhs.net	01382 623055 ext 32055
NHS Shetland				
Respiratory Contact	Pauline Wilson	Medical consultants	paulinewilson@nhs.net	01595 743326
Palliative Contact	David Fryer	Medical consultants	davidfryer1@nhs.net	01595 743000

	Dimitrios Amorgianos	Medical consultants	d.amorgianos1@nhs.net	01595 743000
	Dylan Murphy	Associate Medical Director and GP. Overseeing COVID Assessment Centre	Dylan.murphy@nhs.net	01595 693321
NHS Western Isles				
Respiratory Contact	Pauline Morrision	Respiratory Liaison Nurse NHS Western Isles	pmorrison@nhs.net	01851 708252
Palliative Contact	Gail Allan	Macmillan Lead Nurse Cancer, Palliative Care	gail.allan1@nhs.net	01851 763308

For out- of-hours supply, please follow local guidance.

This document has been developed by Dr Michelle Watts AND Dr Sian Tucker, Medical Advisers - Primary Care, Scottish Government with input from:

National primary care clinical leads
Scottish Government Clinical Cell (acute and primary care)
Scottish Government Professional Advisory group
Scottish palliative care leads
NSS and oxygen therapy service
SGPC and RCGP leads
Care home sector
SIGN

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