CONTENTS PAGE

Updates from V7.0 to V7.1
Additional advice to Clinical Guidelines >12 marked in red (page 2)
Additional changes to Death Information 1 marked in red (page 20)
Minor changes to Pulse Oximeter SOP 1 (page 31)

Barnet Clinical Commissioning Group

Barnet Primary Care Guide During Covid-19

(Patient Age ≥ 12)

This pathway was created for GPs during uncertain times, using clinical judgement and are currently not evidence based.

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%)

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%
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

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

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

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 7/7 and Clarithromycin 500mg bd 7/7 (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 7/7
and Clarithromycin 500mg bd 7/7
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)

OTHER MANAGEMENT ADVICE

Managing "cough"
- If possible, encourage patients with cough to avoid lying on their back because this makes coughing ineffective.
- Use simple measures first, including getting patients with cough to take honey (for patients aged over 1 year).
- For patients with COVID-19 consider short-term use of codeine linctus, codeine phosphate tablets or morphine sulfate oral solution to suppress coughing if it is distressing

Managing "fever"
Advise patients to take paracetamol if they have fever and other symptoms that antipyretics would help treat. Tell them to continue only while the symptoms of fever and the other symptoms are present. Until there is more evidence, paracetamol is preferred to non-steroidal anti-inflammatory drugs (NSAIDs) for patients with COVID-19

Managing "breathing"
Controlled breathing techniques include positioning, pursed-lip breathing, breathing exercises and coordinated breathing training.

In pursed-lip breathing, people inhale through their nose for several seconds with their mouth closed, then exhale slowly through pursed lips for 4 to 6 seconds. This can help to relieve the perception of breathlessness during exercise or when it is triggered.

Relaxing and dropping the shoulders reduces the 'hunched' posture that comes with anxiety.

Sitting upright increases peak ventilation and reduces airway obstruction.

Leaning forward with arms bracing a chair or knees and the upper body supported has been shown to improve ventilatory capacity.

Secondary Bacterial Pneumonia
Offer an oral antibiotic for treatment of pneumonia in people who can or wish to be treated in the community if:
- the likely cause is bacterial or
- it is unclear whether the cause is bacterial or viral and symptoms are more concerning or
- they are at high risk of complications because, for example, they are older or frail, or have a pre-existing comorbidity such as immunosuppression or significant heart or lung disease (for example bronchiectasis or COPD), or have a history of severe illness following previous lung infection.

Hypoxia
Patients may be comfortably hypoxia. When assessing, please check if there has been any deterioration in the template questions from the day before. Consider organising a pulse oximeter reading by using the SOP and a volunteer

BE AWARE
- Additional safety netting may ne required:
- <10 days since symptoms onset
- Vulnerable groups
- RR >22
- Patient lives alone

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**
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)

When managing COVID-19 symptoms, take into account:
•that not all patients will have COVID-19
•the patient's underlying health conditions, severity of the acute illness and if they are taking multiple medicines
•that older patients with comorbidities, such as chronic obstructive pulmonary disease (COPD), asthma, hypertension, cardiovascular disease and diabetes, may have a higher risk of deteriorating and need monitoring or more intensive management, including hospital admission

Some COVID-19 patients may deteriorate rapidly in the second week with a 'cytokine storm'. This is cytokine release syndrome, a systemic response to the virus when the immune system trips into over-drive with a systemic hyper-inflammatory response leading to a flood of immune cells and inflammatory proteins into the lungs and other organs leading to respiratory distress syndrome and multiple organ failure. Crucially cytokine storm can occur rapidly, like sepsis, leading to a rapid clinical deterioration and death. It is thought that some of the younger, fitter people who become very unwell and die from COVID-19 may have a genetic 'host' factor that puts them at greater risk of a cytokine storm. The sooner this syndrome is recognised, the better the prognosis.

•Whilst the vast majority of patients in the community will have a mild illness with COVID-19, we need to be aware of the risk of the 'second week deterioration' and safety net appropriately
•In patients with on-going fever and respiratory symptoms and signs, it is not possible to clinically distinguish between viral and secondary bacterial pneumonia so have a low threshold for antibiotic cover
•Patients may deteriorate rapidly due to either sepsis or the cytokine storm syndrome, requiring urgent admission, and this needs appropriate safety netting

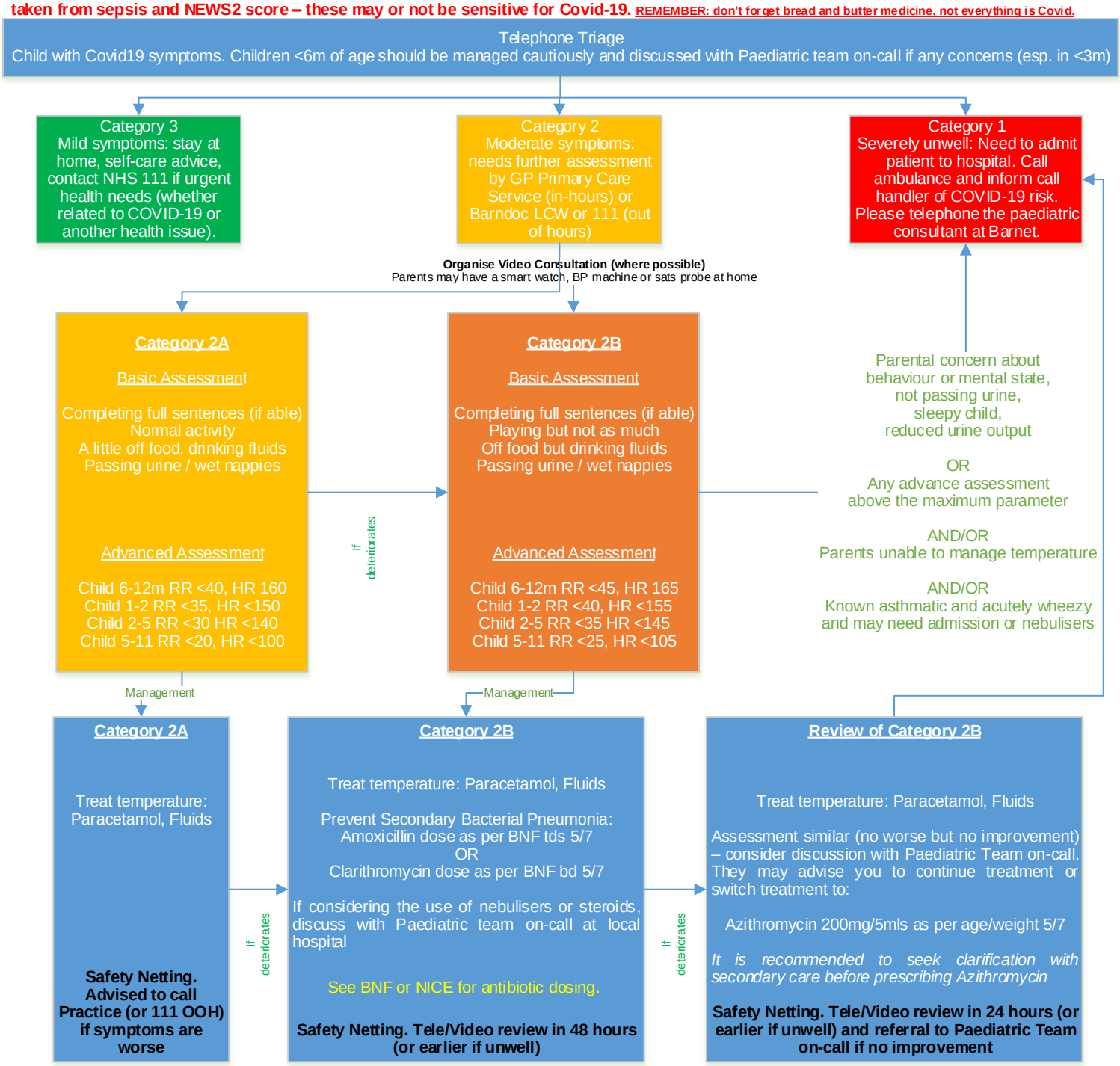
Author: Dr Nick Dattani

Barnet Clinical Commissioning Group

Barnet Primary Care Guide During Covid-19

(Patient Age < 12)

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.



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 hot/cold clinic pathway

Author: Dr Nick Dattani

Barnet Primary Care Guide During Covid-19
SERVICES FOR GP PRACTICES

Name of Service	Who Can Use It?	Criteria	Exclusions	How to Book
Advanced Assessment Clinic (AAC) Provided by BFG Monday to Sunday 8am to 8pm Includes: • *Senior clinical oversight* • *Video consultation* • *Face to face consultation at FMH (cold) and ECH (hot)* • *Home visiting (Barndoc)*	Barnet practices and 111 to book patients assessed as requiring potential face to face consultation	• Barnet practice registered patient • GP Practice or 111 has completed telephone and video assessment on the Barnet Triage Template (in EMIS) (where possible) • For COVID19 symptoms where face to face may change the management plan • For mild COVID19 symptoms but with other acute, urgent conditions that need face to face • For non-COVID19 symptoms with other acute, urgent conditions where GP Practice cannot see 'cold' patients • For housebound patients	• Patients that can be seen by GP Practice remotely or face to face • On-going remote management of COVID19 patients at home • Patients who have OPTED OUT of record sharing	• Complete Barnet Triage Template (in EMIS) where possible • Complete AAC Referral Form (in BARglobal) • Book EMIS slot (no time given): **AAC** • The BFG admin will check the criteria and referral then the BFG senior clinician will video call the patient and book on as necessary • Do **NOT** raise expectations with patients or give out appointment or location details
Extended Access Service (EAS) Provided by BFG Monday to Sunday 9am to 9pm Includes: • *Telephone and video consultations*	Barnet practices and 111 (when not directly to practices) to assist with remote telephone and video assessments	• Barnet practices who have no clinicians or are struggling with video consultations • 111 overflow from practices • Assessment and consultations after hours	• Patients who have OPTED OUT of record sharing	• Book EMIS appointment slot: **EAS**

Barnet Clinical Commissioning Group

Barnet Primary Care Guide During Covid-19
Advanced Assessment Clinic (hot/cold) & Home Visiting

Telephone Triage
Patient with Covid19 symptoms

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

GP Practice manages Covid symptoms (e.g. antibiotics for secondary bacterial pneumonia, etc.)

Category 2 Suspected or Confirmed Covid-19 patient, that cannot be managed remotely and need to be seen F2F

(please see page 4 for inclusion and exclusion criteria)

Referral made by EMIS – GP Practice to complete BARGLOBAL template

Book into Advanced Assessment Clinic slot on EMIS

111 direct booking of Suspected Covid Patient

Patient is a Barnet resident and confirms data sharing with BFG?

NO → Returns to NHS 111

YES

Notes
Check template completed
(speak to GP if not completed)
Appointment booked

Senior Clinician Re-Triages Patient

Offers F2F

Patient seen F2E

Assessment and/or Examination

and

Management Plan (e.g. antibiotics)

and

Discharged back to host GP Practice with follow-up plan

or

Arrange hot clinic follow-up within 48hours (e.g. weekend)

HOUSEBOUND
Needs Home Visit

Book Home Visit on EMIS with Barndoc

Home Visit Pathway

Home Visit completed

Discharged back to usual GP

Managed Virtually

Discharged back to GP

Key

- GP Practice
- BFG Senior Clinician
- BFG Administrator

Telephone Triage
Patient with non-Covid19 symptoms

Initially manage all patients virtually by telephone or video consultation

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

Needs F2F and GP Practice is unable to see

Practice to complete SITREP and send to CCG

G

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

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

A / **R**

"Red" or "Amber" (second priority) or "Green" (third priority) to refer COLD patients

Practices who have no clinician to do tele / video consults

Book into Extended Access Service slot on EMIS for support

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.

Vaccines - Pneumococcal, shingles etc for all patients where they are recommended.

- Prioritise vulnerable patients in high risk groups, such as:
  - patients with a solid organ transplant.
  - undergoing active chemotherapy or radical radiotherapy for lung cancer.
  - with leukaemia, lymphoma or myeloma at any stage of treatment.
  - having immunotherapy or other antibody treatments for cancer.
  - having other targeted cancer treatments which can affect the immune system.
  - had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs.
  - severe respiratory conditions.
  - with rare diseases and inborn errors of metabolism that significantly increase the risk of infections.
  - on immunosuppression therapies sufficient to significantly increase risk of infection.
  - pregnant with significant congenital heart disease.

Childhood imms

- Practices/PCNs to consider the safest way of delivering these, ensuring that risk of Covid-19 exposure is minimised. The Newborn and Infant Physical Examination (NIPE) can be delayed until 8 weeks of age to coincide with the first primary childhood immunisations.

Essential injections – e.g. Prostap, aranesp, clopixol, testosterone

- RCGP suggest considering teaching patients to self-administer if appropriate.
- Practices/PCNs to consider the safest way of delivering these, ensuring that risk of Covid-19 exposure is minimised.

Vitamin B12 injections

- If possible, maintenance administration of B12 injections can continue. However, ensure that frequency is not more than 12 weekly. RCGP suggests considering teaching appropriate patients to self administer.

Postnatal checks – where possible combine with childhood immunisations, may need designated clinics.

- Baby checks:
  - Remote consultation for verbal assessment of maternal and baby health and well-being and concerns prior to immunization appointment.
  - Baby check to be carried out at appt for imms at 8/52. As short time as poss for physical encounter.
  - To minimise risk of Covid-19 exposure, must mitigate risks of environment, staff, equipment etc, and ensure thorough infection control measures

Smears

- The NHS Cervical Screening programme states that practices should continue to offer smears to those women at risk due to history of abnormal results who have failed to attend colposcopy and remain on early recall AND cases where a delay to screening would significantly raise levels of anxiety and have a detrimental effect on the mental health and wellbeing of the women.

Wound dressings/management

- Consider whether self care with remote monitoring is possible.
- Need to ensure that physical care site has minimized risk of exposure.

FULL GUIDANCE

https://www.rcgp.org.uk/-/media/Files/Policy/A-Z-policy/2020/covid19/RCGP-guidance/202003233RCGPGuidanceprioritisationroutineworkduringCovidFINAL.ashx?la=en

o ENT examination: Inspection of the neck can be viewed by video with good light or patients can upload/send pictures to the practice if any lumps or abnormality are visible. Although tonsils can also be examined in this manner we are awaiting further guidance on the risk this poses to the person performing the examination if it is not the patient doing this directly. The feverpain score should be utilised for assessment of tonsillitis, RCPCH guidance recommends that the need for antibiotics can be based on this assessment alone without examination.

o MSK examination:This can be performed via video. It is possible to inspect and observe functionality including passive
and active movements, and strength. Some specific tests can be carried out with clear patient guidance including demonstration by clinician.

o Dermatological examination: Dermatology diagnoses are best made by taking a full history and the patient electronically sending pictures of the affected area because still pictures give better resolution than video. Patients can also measure and carry our tests during a video consult, eg to determine whether blanching.

o Cardiovascular examination: Most CV diagnoses are based on the history and subsequent investigations. Remote examination can include pulse both rate and rhythm, a patient can be asked to tap out their pulse to determine the
rhythm. If the patient has a monitor, blood pressure can be provided and the patient can be instructed on how to check for peripheral oedema. Auscultation can be done remotely but the equipment required is not readily available.

o Respiratory examination: Remote examination is by general observation, respiratory rate and if available pulse oximetry. This provides a very limited respiratory examination but this has to be balanced against the risk of a face to face examination of an acute respiratory problem, as all such patients should be assumed to have Covid-19 infection until proven otherwise and all possible precautions and safeguards implemented.

o Gastrointestinal examination: An acute abdomen would need face to face assessment as signs of peritonitis may not be possible to observe remotely. It is possible to carry out a remote assessment of hydration status, general appearance and some obs. As a screening tool, a family member or carer can be instructed on abdominal palpation solely to elicit any signs of tenderness.

o CNS examination: A simple, basic CNS examination can be done via video, including some cerebellar signs. This could
give enough information to understand whether patient can continue to be safely managed remotely, or if a more detailed assessment is required urgently in primary care (or secondary care in an emergency situation).

o PNS examination: Neuropathy/weakness can be determined based on the history. Muscle wasting and fasciculations may be identified through video consultations, and it should be possible to observe active movements and global limb strength (tip-toes, squats, raising from chair, pushing up from chair with arms etc).

o Genito-urinary examination: o For acute urinary symptoms the diagnosis is normally based on the history supported by general examination observations and urinalysis.
o If a patient has a genital rash, lump or externally visible lesion it may be possible to examine this via video-link. In such a situation, you should be mindful of the following:
o The limitations and sensitivity of assessment via video-link;
o The possibility that a further assessment and/or investigations may be indicated (for example if genital herpes is identified, screening for other STIs may be indicated);
o The sensitive nature of the examination and the examination setting (for example, traditionally it is unusual for a GP to undertake an examination in this way, the patient may want to relocate to another room if there are other family members in the vicinity). It is therefore important to seek the consent of the patient, tailored to the specific circumstances of the remote examination;
o With the consent of the patient, a chaperone could be present with the GP and could witness the nature and extent of the video examination that was undertaken;
o The nature and extent of the examination (together with all the other aspects of the consultation) should be contemporaneously documented in the records.
You should also document whether or not a chaperone was offered and either declined or present (if a chaperone was present, you should record their identity, including their designation and the extent of the assessment witnessed [for example “present for the complete video-linked assessment”]).

Template Runner

Pages «

- TRIAGE ADVICE
- Telephone Triage
- Pulse Oximeter Referral
- Refer to HOT clinic
- 24-72hr Review
- Infection Guide
- Vulnerable Patients
- Extremely Vuln / Shielding
- Domestic Abuse
- ASTHMA
- COPD
- Other Resp
- CMC
- Palliative Care
- Death / Coroner Info
- Dug Monitoring
- Cancer during Covid19
- Services in NCL

Telephone Triage or Video Consultation

This is compulsory (especially when referring to GP Federation Acute Assessment Clinic)

Problem — 06-Aug-2019 **Cough** »

Encounter Type — 16-Mar-2020 **Consultation ...** »

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

Consent — No previous entry

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

Time since symptom started — hour — No previous entry

Text

History

History (continued)

☐ Patient consent given to inform carer — Text: spoke to patients: — No previous entry

Covid Specific Questions

RED FLAGS: 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

Do you have a fever >37.8C ? — No previous entry

Do you have a cough? If so, describe what type? — No previous entry

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 — Text

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.

Author: Dr Leena Mistry

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 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 Ask the patient if they can weight bare when assessing foot/knee injuries and/or pain X-rays often do not change management plans. **Avoid** unless suspected bony injury/diagnostic uncertainty The majority of MSK conditions can be managed through self-help measures and adequate analgesia – ask specifically what they are taking, doses, timings etc. Encourage self-help exercises and signpost patients accordingly o https://www.circlehealth.co.uk/integratedcare/msk - good website with videos for each conditions o http://www.hasantahir.com/exercise.php - basic exercise sheets 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 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 Ask about associated symptoms/fever – Video and may need Face 2 face 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. Fever but no vomiting - Rx for cholecystitis – next day review. Consider how to get obs check Fever + vomiting – a&e 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. Women – think pelvic pathology – severity may dictate investigation – remember delays in USS. May need to consider examination if lacking diagnostic clarity – discuss with gynae doctor in surgery. Consider UTI → urine can be left for MSU or dip depending on your clinical concern. Think access to obs.
RIF pain	Video consult always – jump test. Might need examination or escalate to a&e. 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. 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. Most other symptoms without red flags can wait
PR Bleeding	If heavy/dizzy -> consider A&E; 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. ?unwell, altered responsiveness, e.g. irritable/lethargic, decreased urine output, pale/mottled skin, cold extremities May benefit from video to eyeball patient. If persistent/unwell, need to consider F2F/2ww/a&e

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. Consider delayed abx prescribing. 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* 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. 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. Ensure rescue packs are replenished. Remember if COVID +COPD – caution re steroids. 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: 1. Confusion 2. Cannot talk full sentences 3. Reduce UO 4. Dizzy on standing (low BP) 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. Can you get obs done – devices the patient has, bp machine access. 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. 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. 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. Note risk of preseptal cellulitis – video if swelling reported.

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.

NCL CAMHS CRISIS PATHWAY

As of 30th March 2020

Young Person in MH crisis presenting to professional / services

Young Person self-presenting in crisis to the Hub

Mon-Sun 09:00 – 00:00
Contact NCL CAMHS Crisis Team

Tel:
020 3758 2056

Email:
rf.nclcamhsooh@nhs.net

No concerns requiring paediatric input

Weekdays 09:00 – 22:30
NCL CAMHS Crisis Hub
North: Holly Oak, Edgware Community Hospital
South: Northern Health Centre
Assessment by CAMHS crisis team worker / Seconded Community team worker
With Cons. Psychiatry support

Discharge home with 7-day f/u from local community team

Local intake numbers:

Camden:	020 8938 2241
Islington:	020 3316 1824
Barnet:	020 8702 4500
Haringey:	020 8702 3400
Enfield:	020 8702 4070
Herts:	030 0777 0707
CNWL:	080 0023 4650
NELFT:	030 0300 1600
SLAM:	080 0731 2864

EXCLUSION CRITERIA FOR NCL CAMHS CRISIS HUB:

1) Suspected/confirmed OD
2) New onset psychosis
3) Severe agitation/aggression
4) Suspected Medically Unexplained Symptoms
5) Eating disorders – decompensated
6) High risk of absconsion (ASD, LAC, LD)
7) Section 136 Chase Farm and Highgate
8) Covid +ve patients with MH presentation

Medical Clearance

00:00 – 09:00
RFH/WH/RFH-B ED Dept.

Via Switch

24hrs / 7days
Whittington Hospital ED
Royal Free ED
Barnet Hospital ED
Paediatric triage
Medical clearance
Parallel Assessment by **paediatricians & CAMHS crisis / local psychiatry arrangements (ST, liaison or CAMHS in-reach)**

ADMISSION
Assessing clinician to discuss with accepting team

24-48hrs
Paediatric bed –GOSH & all available NCL Hospitals
d/w accepting paediatrician; identify suitable 1:1 nurse

Emergency Tier 4 bed
Simmons House/Beacon/ Mildred Creak Unit
Form 1, clinician in charge

Tier 4 admission

Send Form 1 to BMS

Young Person self-presenting in crisis

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.

1. Medical certificate of cause of death

Any competent person can verify death including nursing home staff, nurses, paramedics, funeral director or family member.

a. Any medical practitioner with GMC registration can sign the MCCD, even if they did not attend the deceased during their last illness, if the following conditions are met:
i. The medical practitioner who attended is unable to sign the MCCD or it is impractical for them to do so and,
ii. the medical practitioner who proposes to sign the MCCD is able to state the cause of death to the best of their knowledge and belief, and
iii. a medical practitioner has attended the deceased (including visual/video consultation) within 28 days before death, or viewed the body in person after death (including for verification).

If another medical practitioner attended the deceased during their last illness or after death, the medical practitioner signing the MCCD should record the name and GMC number of the medical practitioner who attended the deceased during their last illness or after death at the 'last seen alive' section of the MCCD.
In addition to (i) to (iii) above, if no medical practitioner attended the deceased in the 28 days before death1 or after death, a medical practitioner can sign the MCCD if the following conditions are met:
iv. The medical practitioner who proposes to sign the MCCD is able to state the cause of death to the best of their knowledge and belief, and
v. the medical practitioner has obtained agreement from the coroner they can complete the MCCD.

Medical practitioners working in the same practice/hospital should find this straightforward as they can access patient records. Reasons it is impractical for the attending medical practitioner to complete the MCCD might include: severe pressure on NHS services and the need to ensure medical practitioners with appropriate skills are available to treat patients; and/or medical practitioners becoming infected with COVID-19 and needing to self-isolate. During periods of excess deaths due to COVID-19, healthcare providers are encouraged to redeploy medical practitioners whose role does not usually include direct

b. Medical practitioners are required to certify causes of death "to the best of their knowledge and belief". Without diagnostic proof, if appropriate and to avoid delay, medical practitioners can circle '2' in the MCCD ("*information from post-mortem may be available later*") or tick Box B on the reverse of the MCCD for ante-mortem investigations. For example, if before death the patient had symptoms typical of COVID-19 infection, but the test result has not been received, it would be satisfactory to give 'COVID-19' as the cause of death, tick Box B and then share the test result when it becomes available.

c. The period during which an attending medical practitioner completing an MCCD must have seen the deceased before death (the 'last seen alive' requirement) is extended from 14 days to 28 days before death. 'Seen' in this context includes consultation using video technology. However, it does not include consultation by telephone/audio only.

d. The MCCD can be scanned or photographed and sent from a secure email account to registrars as an attachment. We recommend electronic transfer of MCCDs is used as standard practice. We expect registrars to determine the appropriate email address – for example, a secure email account.

e. COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the MCCD.

2. Registration

a. As noted in 1(d), MCCDs can be scanned or photographed and sent by email to registrars as an attachment. We recommend electronic transfer of MCCDs is used as standard practice to reduce unnecessary contact between individuals and to accelerate processes.

b. Where electronic transfer is not possible, and the next of kin/informant is following self-isolation procedures, please arrange for an alternative informant who has not been in self-isolation to collect the MCCD and deliver to the registrar for registration purposes.

c. An informant can be someone who was present at the death, a hospital official, someone who is 'in charge of a body', or a funeral director.

d. If the deceased was not seen in the 28 days before death or after death by a medical practitioner, the MCCD can be completed if the conditions in 1a(iv)-(v) are met, but the death will need to be notified to the coroner. Medical practitioners are encouraged to work with registrars to establish processes to enable registration to be concluded rapidly where the cause of death is clear.

Following an expected death, there is no requirement in English law for a GP or other registered medical practitioner to see or examine the body of a person.[1] It has become custom and practice for GPs or another suitably qualified Health Care Professional (HCP) to visit in person and confirm death.

During this pandemic, GPs and other HCPs need to ensure they are able to support all patients, relatives and carers in the best way possible in the context of the epidemic.

Visiting care homes and people's homes to verify an expected death places health care professionals at increased and unnecessary risk of potentially acquiring Covid-19, and despite use of PPE, of transmission of contagion outside the deceased person's residence.

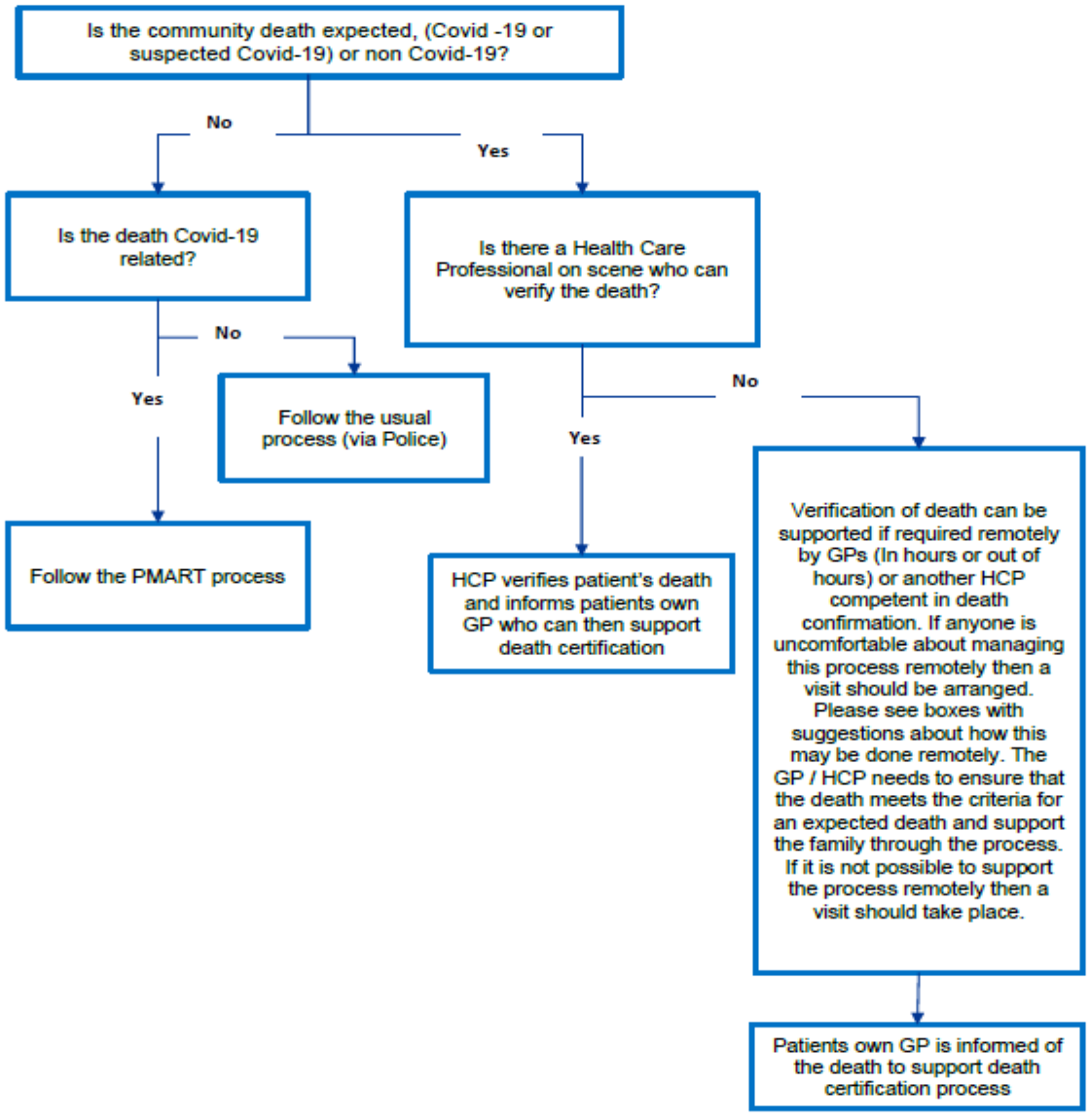
Health professionals entering care homes and people's homes also present a risk to those patients who have been deemed to be high risk and need to be shielded.

During the COVID-19 pandemic, GPs and other suitably trained HCPs should have the option of supporting the death verification process including performing this role remotely.

To be clear, this remote process is not mandated, but it is an option.

There may be circumstances where it is not possible to manage the process remotely. These include situations when someone may not have capacity, may not feel able to support it for whatever reason, or there may be a language barrier.
If there is any element of doubt or concern about supporting this process remotely, the GP or suitably trained HCP needs to attend in person to verify a death.

The following guidance applies if there has been a specific request for attention from a GP or other suitably qualified HCP to verify an expected death.



3. Coroners

a. COVID-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009.

b. The fact 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.

c. Where an attending medical practitioner cannot complete an MCCD (or the attending medical practitioner is unable to complete it in a timely manner), the death should only be notified to the coroner if there is no other medical practitioner who can complete the MCCD as outlined at Section 1 above.

4. Burial

a. Subject to secure local procedures being available and followed, the body can be released out of hours when the MCCD has been completed but without formal registration. Registration can take place later – though it should be noted that bodies cannot be disposed of until the registrar issues the green form.

5. Cremation

a. The requirement to complete form Cremation 5 is suspended during any period when the amended regulations apply. Cremations can be authorised on the basis of one medical certificate (form Cremation 4), without the requirement to also complete a confirmatory medical certificate (form Cremation 5).

b. The form Cremation 4 is an interactive PDF and can be completed and saved before sending, or paper copies can be scanned/photographed and submitted electronically. Electronic signature includes being sent from the secure email account of the person completing the form Cremation 4.

c. Any medical practitioner can complete form Cremation 4, even if they did not attend the deceased during their last illness, if the following conditions are fulfilled:

i. The medical practitioner who attended is unable to sign the form Cremation 4 or it is impractical for them to do so and,
ii. the MCCD has been completed because
iii. a medical practitioner has attended the deceased (including visual/video consultation) within 28 days before death or viewed the body in person after death (including for verification). i. after death by a medical practitioner (including verification), or
ii. by a medical practitioner in the 28 days before death (including visual/video consultation).

d. Examination of the body is not required for completion of form Cremation 4 if the deceased was seen either:

e. When a medical practitioner who did not attend the deceased completes form Cremation 4, the following guidance applies:

i. Question 5: ‘Certifying doctor’ is an acceptable medical role in relation to the deceased but the name, GMC number and role of a medical practitioner who attended the deceased should be entered at Question 9, along with the date the medical practitioner attended the deceased.
ii. Question 6: ‘Not applicable’ is acceptable.
iii. Question 7: ‘Not applicable’ is acceptable.
iv. Question 8: ‘Not applicable’ is acceptable. If the form Cremation 4 is being completed on the basis of another medical practitioner having seen the deceased after death, verification of the fact of death is acceptable. The date, time and nature of examination should be recorded at Question 9.

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 Draught from an open window **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 or Morphine sulphate modified release 5mg PO BD and titrate to response In renal failure, consider Oxycodone – seek advice from Palliative Care	Morphine sulphate 1-2mg SC PRN hourly and titrate to response In. renal failure, consider Oxycodone – seek advice from Palliative Care	Morphine sulphate 10mg/24 hours and titrate according to response In renal failure, consider halving dose or oxycodone – seek advice from Palliative Care	Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days 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). Seek advice from palliative care team
Agitation / anxiety – likely to be contributing to breathlessness	See above 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 (reduce to 5mg/24 hours if eGFR <30)	Midazolam 10mg/2mls for buccal or nasal administration 0.5-1ml PRN hourly Prefilled midazolam buccal solution (Buccolam 10mg/2ml or Epistatus 10mg/ml) Rectal diazepam 10mg PR PRN
Respiratory secretions	Positioning Reassurance for carers	N/A	*Glycopyrronium 200-300mcg SC hourly (max 1.2mg/24 hrs) *Hyoscine butylbromide 20mg SC hourly (max 120mg/24 hrs) *Hyoscine hydrobromide 0.4mg SC hourly (max 1.6mg/24 hrs) *Choice depends on local formulary	*Glycopyrronium 0.8-1.2mg/24 hours *Hyoscine butylbromide 60-120mg/24 hours Hyoscine hydrobromide 1.2-1.6mg/24 hours *Choice depends on local formulary	Hyoscine hydrobromide patches (Scopoderm) 1mg 72 hourly (can use 2 patches) 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 subcut aneous 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 Massage	Morphine sulphate immediate release 2.5-5mg PO PRN hourly and titrate to response or Morphine sulphate modified release 5mg PO BD and titrate to response 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 In. renal failure, consider Oxycodone – seek advice from Palliative Care	Morphine Sulphate 10mg/24 hours and titrate according to response In renal failure, consider halving dose or oxycodone – seek advice from Palliative Care	Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days 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). Seek advice from palliative care team
Nausea & Vomiting		Varies by cause: Metoclopramide 10mg PO TDS Domperidone 10mg PO QDS Cyclizine 50mg PO TDS Haloperidol 0.5-1mg PO BD Levomepromazine 6.25mg PO	Haloperidol 0.5-1.5mg SC PRN hourly	Haloperidol 3-10mg/24 hours	Olanzepine 5-10mg tablets orodispersible PRN Or 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 (reduce to 5mg/24 hours if eGFR <30)	Prefilled midazolam buccal solution (Buccolam 10mg/2ml) administer 0.5-1ml PRN hourly
Respiratory secretions	Positioning 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) Glycopyrronium injection applied buccally 200-300mcg SC hourly (max 1.2mg/24 hrs)
Breathlessness	Cool flannel around the face and nose Draught from an open window **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 or Morphine sulphate modified release 5mg PO BD and titrate to response In renal failure, consider Oxycodone – seek advice from Palliative Care	Morphine sulphate 1-2mg SC PRN hourly and titrate to response In. renal failure, consider Oxycodone – seek advice from Palliative Care	Morphine sulphate 10mg/24 hours and titrate according to response In renal failure, consider halving dose or oxycodone – seek advice from Palliative Care	Buprenorphine transdermal patches starting at 5-10mcg/hr every 7 days 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). 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

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).

CARE AFTER DEATH

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's 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.

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)

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

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

Oxygen Saturation Monitor "Drop and Collect" supports remote consultations in Primary Care Standard Operating Procedure (SOP)

This is a service to support clinical decision making during the COVID-19 pandemic 2020. The aim is to manage patients at home where possible, avoiding direct patient contact and hospital admission.

Indications for use following remote consultation (telephone/video) of patient with respiratory symptoms:

- Patient describes shortness of breath or chest pain/tightness
- Patient unable to complete full sentences / has increased respiratory rate
- AND saturation monitoring would change clinical management

Drop and Collect Protocol – PRACTICE TO PROVIDE VOLUNTEER WITH PRACTICE BYPASS NUMBER

1. Practice "pack" contains

- Oxygen Saturation monitor
- 2 pairs of gloves (size determined by volunteer)
- Specimen bag x2 per patient (one small clear bag containing the monitor and one waste bag)
- Patient instructions
- Hand Sanitiser (please provide a bottle that can be used for the day)

2. Reception contact "Drop and Collect" Volunteer/Driver

3. Volunteer/Driver collects "pack" from practice

4. Reception advise Volunteer/Driver to use alcohol hand gel before taking pack (if available)

5. Reception advise Volunteer/Driver of address and drop off location (ie door step)

6. Reception advice clinician that monitor has been collected allowing them to video call patient whilst monitoring if they wish

7. Volunteer/Driver arrives at drop off location and puts on the gloves provided

8. Volunteer/Driver takes the monitor, which is contained in a specimen bag and leaves it at the drop off location

9. Volunteer/Driver alerts patient to arrival of monitor by agreed method (ie doorbell, phone call)

10. Volunteer/Driver waits for monitoring to be complete

11. Patient puts monitor back in the bag and returns it to the drop location, alerting volunteer/driver by agreed method

12. Volunteer/Driver returns to drop location and with a gloved hand picks up the bag containing the monitor and places it into a waste bag.

13. Volunteer/Driver removes gloves into wastebag and seals waste bag and use hand sanitiser

14. Volunteer/Driver returns the "pack" to practice reception to allow decontamination process

15. Practice staff dispose of gloves, bags and clean the monitor using Clenil wipes as per protocol

Patient Instructions: How to Use the Pulse Oximeter (SpO2) Preparation

- You **MUST** remove any nail polish or false nail on one finger
- Get a pen & paper to write down the numbers
- Wash your hands to make sure they are warm & clean

Using the Pulse Oximeter

- Rest your hand flat on your leg, a table or arm of chair with nails facing upwards.
- **Place any finger (not thumb) into the probe.**
- Press the button so the screen lights up.
- Keep the probe on the finger for 30 – 60 seconds. After 30-60 seconds the numbers on the screen will have settled.

- **Write both numbers down**
- Your doctor may ask you to repeat these measurements after exerting yourself.

Returning the Pulse Oximeter

- Place the pulse oximeter, with this piece of paper (once completed), into the plastic bag and place in the drop off location for the driver to collect.

Please note the driver has been asked to respect "social distancing" and will not come within 2 metres of you. Please DO NOT approach the driver.

<u>Write Your Results Here</u>

Today's Date: ____/____/____ Time: _____:_____

Measurement: Your result

SpO2 (Oxygen Level) _____

PR (Pulse Rate) _____

Do not keep the Pulse Oximeter, it is needed by other patients
Please fold this piece of paper back into the bag so that your results are visible from outside of the bag