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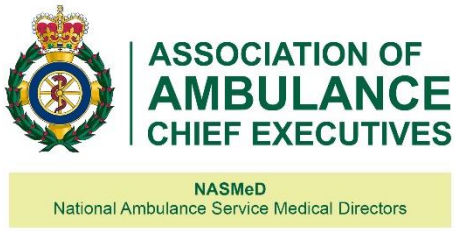

COVID-19 pandemic response: managing symptoms (including at the end of life) in the community

This guidance has been adapted from the new NICE guideline NG163 managing symptoms (including at the end of life) in the community, available at: https://www.nice.org.uk/guidance/ng163

Key Points

- **It is very important to recognise whether the patient is nearing the end of life or whether they may have a reversible condition and therefore should be conveyed to hospital.**
- Consider the overall health status of the patient and the likely reversibility of the acute illness, to further guide management.
- Evidence has indicated that patients with Covid-19, particularly those in at risk groups, may become symptomatic very quickly and rapidly deteriorate in a few hours or less. Therefore, symptom control is a priority.
- Patients at the point of dying will likely experience respiratory distress and may not benefit from oxygen. Consider pre-existing comorbidities like COPD or heart failure.
- Refer to JRCALC end of life care guideline and morphine sulphate for the management of pain in adults at end of life
- It is crucial that ambulance clinicians follow any admission criteria in place locally and do not convey a patient to hospital where escalation would not be appropriate. Support best interest decisions and consider locally available pathways.
- No decision should be made in isolation.
- If appropriate, communicate openly with the patient's family and carers when considering a clinical plan, referral or admission.
- It is recognised that this is very difficult time for clinicians. Support is available to you-see appendix

1. Introduction

This guidance is for ambulance clinicians to support patients that present with COVID-19 symptoms who are not being conveyed to hospital.

All patients not conveyed should be safety-netted and information given to the patient and relatives/carers using the guidance below. Where there is a need for additional support for the patient to stay in the community, local pathways should be followed. Refer the patient to community, primary and palliative care services, especially where there is, or may be, a need for medication to manage symptoms that is beyond the scope of an ambulance clinician.

If the patient has an advance care plan and anticipatory ('just in case' (JIC)) medications are already in place, follow current JRCALC end of life care guidance in conjunction with guidance below.

2. Communicating with patients and minimising risk

For patients with COVID-19 symptoms explain:

• that the key symptoms are cough, fever, breathlessness, anxiety, delirium and agitation but they may also experience fatigue, muscle aches and headache

• that they, and people caring for them, should follow the UK guidance on self-isolation and the UK guidance on protecting vulnerable people

• that if the symptoms are mild and the patient is not in a high risk group they are likely to feel much better in a week

• who to contact if their symptoms get worse, for example NHS 111 online or 999.

Communicate with patients and support their mental wellbeing, signposting to charities and support groups where available, to help alleviate any anxiety and fear they may have about COVID-19.

3. Treatment and care planning

When possible, discuss the risks, benefits and possible likely outcomes of the treatment options with COVID-19 patients and their families and carers, so that a shared decision can be made at the time but also with consideration to any future care planning decisions.

For patients with pre-existing advanced comorbidities, find out if they have advance care plans or advance decisions to refuse treatment, including do not attempt CPR resuscitation decisions.

Note that a DNACPR does not equal a 'do not treat' order and patients can be for full care, even with a DNACPR order.

4. General advice for managing COVID-19 symptoms

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 presenting symptoms and availability of anticipatory medicines

• that older patients with comorbidities, such as chronic obstructive pulmonary disease (COPD), asthma, hypertension, cardiovascular disease and diabetes, severe frailty, may have a higher risk of deteriorating more rapidly and need monitoring or more intensive management, including the

consideration of hospital admission. Consider local pathways and clinical support to aid decisions regarding conveyance and benefits of hospital admission.

• that patients with severe symptoms of COVID-19 may deteriorate rapidly.

5. Breathlessness

Reversible causes of breathlessness should always be considered first.

In many patients with COVID-19, signs of respiratory distress may be minimal despite significant hypoxia, therefore every patient should have oxygen saturations measured. A careful decision should be made around the need for conveyance to hospital.

Breathing discomfort varies in intensity and may not be associated with hypoxia, tachypnoea or bradypnoea.

5.1 Managing breathlessness

Be aware that severe breathlessness often causes anxiety, which can then increase breathlessness further.

As part of supportive care, the following may help to manage breathlessness:

- keeping the room cool
- encouraging relaxation and breathing techniques and changing body positioning
- cooling the face by using a cool flannel or cloth;
- encouraging patients who are self-isolating alone, to improve air circulation by opening a window or door **(do not use a fan because this can spread infection)**
- oxygen is only beneficial in hypoxaemic patients (patients with low oxygen saturations). At end of life oxygen should only be administered to patients with severe hypoxaemia or where benefit is reported. Non drug approaches should be tried before oxygen in non-hypoxaemic patients.

Techniques to help manage breathlessness:

Controlled breathing techniques include:

- Positioning.
- Pursed-lip breathing. 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.
- Breathing exercises.
- Coordinated breathing training.
- 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.
- Breathing retraining aims to help the person regain a sense of control and improve respiratory muscle strength. Physiotherapists and clinical nurse specialists can help patients learn how to do this (bearing in mind that this support may need to be done remotely).

Administration of morphine in breathlessness:

If the patient is distressed and breathless, has no anticipatory medicines in place, and you are unable to access rapid community/palliative care consider administration of small amounts of sub cutaneous or oral morphine as per dosage table below. Morphine often reduces the subjective sensation of breathlessness and works well for breathlessness at rest and at end of life. Low dose morphine does NOT cause respiratory depression in the context of advancing illness.

Be aware that administering morphine for breathlessness is your own individual responsibility. Consider discussing with a senior clinician for advice and support, preferably a clinician with expertise in end of life care before administering morphine for breathlessness. Follow local pathways to access senior clinician support.

Morphine dosage table:

Clinical scenario	**Oral Treatment (able to swallow)**	**Parenteral Sub cutaneous administration**
Opioid naive (not currently taking opioids)	Morphine sulphate oral solution immediate-release 2.5 mg to 5 mg	Morphine sulphate 1 mg to 2 mg subcutaneously
Already taking regular opioids for other reasons	Morphine sulphate oral solution 5 mg to 10 mg	

If the patient remains breathless, consider prompt referral to community/palliative care to consider administration of appropriate medications such as subcutaneous morphine administration via a syringe driver. Follow local procedures for access to local pathways and how to access senior clinician support. Other medications may need to be administered for breathlessness and anxiety such as lorazepam, midazolam, antiemetic- haloperidol and a stimulant laxative (senna).

6. Managing cough

Be aware that older patients or those with comorbidities, frailty, impaired immunity or a reduced ability to cough and clear secretions are more likely to develop severe pneumonia. This could lead to respiratory failure and death.

If possible, encourage patients with cough to avoid lying on their back because this makes coughing ineffective. Consider repositioning and propping with pillows.

Use simple measures first, including getting patients with cough to take a teaspoon of honey (for patients aged over 1 year) or seeking pharmacy advice.

Patients may already have symptom management such as ‘just in case’ or anticipatory medicines for cough such as simple linctus, codeine or opioid immediate release solution (Oramorph or Oxynorm).

7. Managing fever

Be aware that, on average, fever is most common 5 days after exposure to the infection.

Advise patients to drink fluids regularly to avoid dehydration (no more than 2 litres per day).

Do not use antipyretics with the sole aim of reducing body temperature.

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.

Continue only while the symptoms of fever and the other symptoms are present.

Refer to JRCALC for Paracetamol doses.

8. Managing anxiety, delirium and agitation

Address reversible causes of anxiety, delirium and agitation first by:

• exploring the patient's concerns and anxieties

• ensuring effective communication and orientation (for example explaining where the person is, who they are, and what your role is)

• ensuring adequate lighting or consider dimming lighting to create a calm environment

• explaining to those providing care how they can help.

Consider reversible causes of anxiety or delirium, with or without agitation, for example hypoxia, urinary retention, pain, positioning and constipation.

Consider any 'just in case' medications already prescribed.

Refer to community primary and palliative care as per local pathways for prescribing benzodiazepine to manage anxiety, agitation and delirium (lorazepam, midazolam, haloperidol).

Appendix 1: Frequently Asked Questions

Key points

We cannot change the outcome, but we can change the journey. We are all doing our best to work through difficult times and you are likely to be faced with the burden of making difficult decisions. Remember that a caring and compassionate approach can make a significant difference. Suffering is only intolerable when nobody cares.

Doing 'nothing' is always hard. Doing 'something' active towards clinical care fits in with our core narrative as ambulance clinicians. Some patients may not require medications, however going back to the basics of compassionate care and good communication skills, in the absence of needing clinical intervention, can make just as much of an impact on a patient's experience.

Frequently asked questions

1. **I feel like I am making very difficult decisions on my own, who can I talk to?** We strongly encourage you to share the decision making and contact another clinician for support and advice. There should be referral pathways available locally for you such as calling Hospice/Specialist Palliative Care and community Teams, Primary Care clinicians. There should also be pathways within your Trust to be able to contact senior clinicians, for example via the control room. Follow local guidance and pathways.

2. **Can I seek advice from the palliative care team, even if the patient is not known to them?** Yes, most teams will be able to offer support and advice. Follow local guidance and pathways.

3. **I am overwhelmed with the published guidance. I don't know where to start or what is applicable to me.** Refer to the JRCALC End of Life Care guideline and Morphine Sulfate for End of Life Care guideline. Search 'end o' in the search bar of the JRCALC app.

4. **Have the rules changed for death verification (ROLE) with COVID-19 and care after death (expected and unexpected deaths)?** Verification (ROLE) and care after death should be completed as normal and according to locally agreed processes and pathways.

5. **I'm coming across some unfamiliar medications for patients at the end of life, what dosages should I give?** If you come across an unfamiliar medication, seek advice. Check the prescribed (PRN-as required/as needed or continuous subcutaneous infusion CSCI) dose of anticipatory medicines. Refer to JRCALC End of Life Care guideline for further guidance on typical end of life medications.

6. **Can I give additional breakthrough medication if a patient has a syringe driver** (**continuous subcutaneous infusion CSCI)?**
   Yes, refer to JRCALC End of Life Care guideline. Check dosing charts carefully.

7. **What should I do if the patient does not have an advance care plan?** If appropriate discuss the situation with the patient and relatives/carers. Seek clinical advice from hospice/specialist palliative care or community team preferably that know the patient. They may be able to advocate for the patient's wishes or know their pre-COVID condition.

8. **Other guidance encourages use of the Clinical Frailty Scale (Rockwood) to help make decisions around End of Life. What do we do with younger patients & those with learning difficulties?** The Clinical Frailty Scale should NOT be used in isolation and should not be used in younger people, people with stable long-term disabilities (for example, cerebral palsy), learning disability or autism. An individualised assessment is recommended in all cases where the CFS is not appropriate. Note the CFS should be calculated on what is "normal" for the patient (usually around 2 weeks before the acute episode), not as the patient presents at the time of a 999 call/face to face assessment

9. **What do I do if there is disagreement and I believe that a patient should be conveyed?** Share your decision making with other professionals. Consider local procedures and seek senior clinical support. Try and understand the reasons, there may be fear about going to hospital during Covid-19 pandemic.

10. **What do I do if I attend a care/nursing home and despite there being an advance care plan to support patient staying at home, the staff insist on conveyance?** Ascertain the concerns of the staff. Speak with the patient and relatives. Consider accessing additional community support if possible, to support the care staff. Explain concerns around admission to acute care and visiting restrictions. Consider local procedures and seek senior clinical support. Patients, carers or relatives cannot insist on conveyance or treatment, care must be delivered according to patient's best interest.

11. **What should I do if care/ nursing home staff are reluctant for patients to be conveyed?** As above, ascertain concerns staff have. Include the patient and their relatives in the discussion if possible. Share the decision with other professionals, if the solution is not clear. Consider local procedures and seek senior clinical support. Patients, carers or relatives cannot insist on conveyance or treatment, care must be delivered according to patient's best interest.

12. **What should I do if families request hospital admission for the patient and this is not aligned with current guidance- What do I say?** If admission for these patients is not possible, after exploring all the options open to us at the time, we need to be open and honest with patients and their families, to discuss realistic options open to them. Consider local procedures and seek senior clinical support. Patients, carers or relatives cannot insist on conveyance or treatment, care must be delivered according to patient's best interest.

Appendix 2: Difficult conversations / breaking bad news

Difficult conversations (breaking bad news) can seem daunting, however using a strategy with a toolkit can help. Below is an example of a short strategy AND a toolkit.

A difficult conversations strategy:

- Establish what patient/family know
- Establish what they want to know
- Give a 'Warning shot'
- Deliver information using skills /toolkit below
- Allow patients /relatives reaction & support
- Develop a management plan (shared and agreed with patient/family)

Cardiff six-point toolkit

Comfort

The physical setting, sitting, lighting etc.

Bad news is inherently uncomfortable and upsetting be mindful that if patients do show emotions, this is a normal reaction.

Language (keep it simple)

Language is far more than the spoken word.

Endeavour to use vocabulary familiar to the patient, acknowledging that at times of stress the processing of information is very likely to be slower.

Question style

Question style is crucially important. As a general rule, the more open the question the greater the amount of information obtained.

Open – useful at the start of the consultation to explore the patients understanding/agenda and build rapport.

Focused – focus down on a particular area, e.g. 'You mentioned you have strong views about hospital admission, can you tell me about this?'

Hypothetical – These are a type of focussed question which involves a possibility or probability for the future e.g. 'Have you ever wondered what might happen when…….?' 'Have you any thoughts on…?'

Listening (use of silence)

Listen with your eyes, your ears, your heart … look to pick up cues (Cues are key words or phrases- often mentioned more than once….dropped into the conversation more than once).

A key tool in communicating is listening. So often the doctors/paramedics talk too much. Often healthcare practitioners will interrupt the patient/ relatives dialogue prematurely with the aim of 'problem solving' or to follow their own agenda.

Be mindful that when patients/families are receiving 'bad news' the information is new to them, they have to process it. In their heads when the news is said they will have many different/ varied thoughts – their mind will be 'busy'- during this time whilst the patient is processing the healthcare practitioner will hear silence. Do not interrupt that silence. Wait for the patient/ family to process the information, once they have they will then engage in conversation again with whatever is important to them. In this way you will be ascertaining and following the patient/ family's agenda.

Reflection

Good use of reflection makes the patient feel you are listening to them.

Reflection can also be used to pick up on key words (cues) said by a patient/relative and signal that they are being followed up on.

E.g. Patient – it's all so very difficult, Paramedic – Difficult? Patient - well yes, it's so very difficult to know what to do for the best….What do you think I should do?

Summarising

Useful especially for structure or when one is unsure where to go with the consultation/ interaction or if mind goes blank.

Recapping with: 'So what you're saying is…' demonstrates that the patient/ family are being listened to and allows the healthcare practitioner to check that all the information that is important to the patient has been included.

Summarising can be very useful to introduce difficult topics when used alongside a hypothetical question.

E.g. 'You mentioned the cough, high temperature and the breathing difficulty … have you ever wondered what these symptoms might mean?'

Appendix 3: Useful communication phrases

Understanding

"Can you tell me your understanding about what is happening at the moment/with your condition?"

Honesty

"I don't know the answer to that. I can ask someone else to help us understand"

Put the patient's agenda first.

"Is there anything that you can tell us about 'Frank' that would help us to care for him better?"

'I can hear how worried you are…'

"I understand that what I am saying is extremely difficult for you to hear"

"I can only begin to understand how difficult this is for you"

Be assertive.

"Time is likely to be short for him now"

"(Intervention, e.g. resuscitation) is not going to work for 'Frank' so we won't do that because we don't want to cause him more harm"

Check back, make sure everyone is on the same page

"Things have moved on quite quickly and the situation is now very different"

"I can see that this is a lot of information for you to take in at the moment"

"Can you tell me what you understand I have explained to you?"

Use words such as death & dying

"'Frank' is very sick/unwell and his body is very tired. He may die in the next few hours to days"

"'Frank' is very sick and his body is getting tired. Unfortunately, he's now so unwell that he could die in the next hours to days."

"there is a risk you are dying – what is important to you?"

Advance care planning

"Have you recorded your wishes?"

"What are your expectations?"

"There are treatments which might help 'Frank' get better but these might not be successful"

Appendix 4: Staff wellbeing

We fully acknowledge the additional pressure, anxiety and strain that this pandemic may have on clinicians.

The Association of Ambulance Chief Executives (AACE) and College of Paramedics have endorsed the following health and wellbeing resources for specific use during COVID-19 pandemic:

- Living life to the full – Coronavirus health worker resource
- Staff wellbeing virtual sessions – weekly NHS England and NHS Improvement sessions
- College of Paramedics: Guidance for managers on psychosocial support
- Oxford Centre for Anxiety Disorders and Trauma: Evidence-based tools for frontline staff, which are being shared via NHS England and NHS Education for Scotland.

Further resources to promote staff wellbeing are available from the following organisations:

- The Ambulance Staff Charity: https://www.theasc.org.uk/
- Zero Suicide Alliance: www.zerosuicidealliance.com/
- Mind: www.mind.org.uk
- The Samaritans: www.samaritans.org
- Online resources based on a cognitive behaviour therapy approach are available free of charge to all NHS staff at: www.code.llttf4.com.