GOOD PRACTICE GUIDE FOR END OF LIFE CARE IN CARE HOMES DURING THE COVID-19 PANDEMIC

A practical guide for Care Home Staff

Abstract

This guidance will help care home staff to care for End of Life residents safely and effectively during the COVID-19 pandemic. It is based on the most current guidance available at the time of writing.

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Good Practice Guide for the Management of the COVID-19 Pandemic in Care Homes

The COVID-19 pandemic raises particular challenges for care home residents, their families and the staff that look after them. This guidance has been developed to help care home staff and NHS staff who work with them to support residents through the pandemic.

Key recommendations

1. Care homes should have in place standard operating procedures for individual residents with suspected and confirmed COVID-19 infection, including appropriate infection control precautions to protect staff and residents.

2. Care home staff should be trained to check the temperature of residents displaying possible signs of COVID-19 infection, using a tympanic thermometer (inserted into the ear).

3. Where possible, care home staff should be trained to measure other vital signs including blood pressure, heart rate, pulse oximetry and respiratory rate. This will enable external healthcare practitioners to triage and prioritise support of residents according to need.

4. All staff working with care home residents should recognise that COVID-19 may present atypically in this group. It may be necessary to use barrier precautions for residents with atypical symptoms following discussion with General Practitioners or other primary healthcare professionals.

5. Where possible, primary care clinicians should share information on the level of frailty of residents (mild, moderate, severe frailty) with care homes, and use the Clinical Frailty Scale to help inform urgent triage decisions.

6. If taking vital signs, care homes should use the Rockwood Assessment tool in combination with the NICE COVID-19 Rapid Guideline to recognise deterioration in residents, measure vital signs and communicate concerns to healthcare professionals. Guidance on this is located on page 3.

7. Care homes should have standard operating procedures for isolating residents who ‘walk with purpose’ (often referred to as ‘wandering’) as a consequence of cognitive impairment. Behavioural interventions may be employed but physical restraint should not be used.

8. Care homes should work with General Practitioners, community healthcare staff and community geriatricians to review Advance Care Plans as a matter of urgency with care home residents. This should include discussions about how COVID-19 may cause residents to become critically unwell, and a clear decision about whether hospital admission would be considered in this circumstance.

9. Care homes should be aware that escalation decisions to hospital will be taken in discussion with paramedics, general practitioners and other healthcare support staff. They should be aware that transfer to hospital may not be offered if it is not likely to benefit the resident and if palliative or conservative care within the home is deemed more appropriate. Care Homes should work with healthcare providers to support families and residents through this.

10. Advance Care Plans must be recorded in a way that is useful for healthcare professionals called in an emergency situation. A paper copy should be filed in the care home records and, an electronic version used which can be shared with relevant services i.e. Health and Social Care Summary Record/ReSPECT form.

11. Care homes should remain open to new admissions as much as possible throughout the pandemic. They should be prepared to receive back care home residents who are COVID positive and to isolate them on return, as part of efforts to ensure capacity for new COVID cases in acute hospitals. They should follow the advice from Public Health England when accepting residents without COVID back when there are confirmed COVID cases within a home.

12. Care homes should work with GPs and local pharmacists to ensure that they anticipate palliative care requirements and order anticipatory medications early in the illness trajectory. These should be ordered in the normal way.

13. All professionals should consider setting up multiprofessional local or regional WhatsApp groups, or other similar fora, to provide support to care home staff who may feel isolated and worried by the pandemic.

Derby and Derbyshire CCG are setting up a special telephone number for care home staff to dial into 24 hours a day 7 days a week if support is needed, the call will be handled by someone with clinical experience. Still continue to call your GP practice as usual.

What is COVID-19 (also referred to as Coronavirus)

COVID-19 is a new illness that can affect your lungs and airways. It's caused by a virus called coronavirus. The main symptoms of coronavirus (COVID-19) are a high temperature and a new, continuous cough.

What do we need to do?

Everyone must stay at home to help stop coronavirus (COVID-19) spreading. Washing your hands with soap and water often will help to reduce the risk of infection.

Mild coronavirus (COVID-19) symptoms can usually be treated at home. However, if someone in your care has severe symptoms, you may need additional support and medical care until your resident recovers.

Why do we need to take precautions?

Approximately 400,000 older people in the UK live in care homes and many of these are frail. Many residents also have cognitive impairment, multiple health conditions and are physically dependent. Many may be in their last year of life.

The evidence from other countries who are ahead of the UK in the COVID-19 pandemic suggests that care home residents are particularly vulnerable to the infection and that many residents have a

lower chance of survival. They have found that acute hospitals and intensive care units can rapidly become overwhelmed by COVID-19 infections which puts strain on services and their level of care.

Many care home staff (especially those without nursing), are expert in supporting people with cognitive impairment and behavioural symptoms but they are often less experienced in dealing with acutely unwell residents and providing end-of-life care.

This guide is designed to help you care for your residents safely and effectively with other NHS staff supporting you.

Identifying residents who may have COVID-19 and how to respond

Public Health England have suggested that COVID-19 should be suspected in any resident with a new continuous cough and/or high temperature (at least 37.8°C). However, COVID-19 in care home residents often presents with non-respiratory tract symptoms, such as new onset/worsening confusion or diarrhoea. As you know your residents well, care home staff are often excellent at spotting these subtle signs and changes ('soft signs') that might indicate a resident is less well.

Care home staff in residential homes have not usually been asked to take observations on their residents. It is important, in this outbreak, that all care homes can take a temperature using a tympanic thermometer (inserted into the ear) and have staff trained to be able to do this. This will help to diagnose the illness quickly. Being able to monitor oxygen saturation levels (using a pulse oximeter) can also help to diagnose when a resident is becoming less well.

The Rockwood Assessment Tool is a way of calculating someone's frailty status. This should be done for all residents as a baseline. If a resident deteriorates then the Rockwood score should be repeated. Using the critical care guide the decision on whether to escalate the resident into hospital/critical care will help to inform decision making and may help during discussions with relatives.

As a minimum, you need to be able to record a temperature and ideally record someone's oxygen saturation. For advice on how to do this see the guidance below:

Tympanic method (in the ear)

1. Use a clean probe tip each time and, follow the manufacturer's instructions carefully.
2. Gently tug on the ear, pulling it back. ...
3. Gently insert the thermometer until the ear canal is fully sealed off.
4. Squeeze and hold down the button for 1 second.
5. Remove the thermometer and read the **temperature**.

How to use a Pulse oximeter

During a **pulse oximetry** reading, a small clamp-like device is placed on a finger, earlobe, or toe. Small beams of light pass through the blood in the finger, measuring the amount of oxygen. It does this by measuring changes of light absorption in oxygenated or deoxygenated blood. This is a painless process

You can purchase a tympanic thermometer and probe tips via **** They cost approx..******

If you have a suspected case or you have any concerns about the health of any of your residents, irrespective of whether this is related to COVID-19, you need to note the new way of contacting external support.

How to get medical support and advice during the pandemic

Continue to contact your GP surgery as you currently do, if they are unable to help or it is in the 'out of hours' period there will be a specific telephone number to give you support. This telephone line will put you through to a clinician.

For any general queries you must ring your GP surgery or this number whilst the pandemic is on. Do not phone 111 or ring 999 (unless it is a real emergency, such as a suspected fracture from a fall).

Tel. 111*8
This advice line is available 24 hours a day, 7 days per week

Primary care providers will work with care home staff to enable video consultations, in order to inform triage and medical decisions. Consider getting access to SKYPE or ZOOM on a laptop at work so this might be possible. These apps are all free to install and use. If this is not possible your GP practice may face time you.

Please ensure that you have the following information available:
SITUATION – What the issue is?
BACKGROUND – A brief summary?
ASSESSMENT – what you can see/have found out?
RECOMMENDATION – what you want/need?
e.g. 85yr old man with mild dementia, who has COPD and Diabetes (controlled on tablets and diet). He has developed a temperature of 37.9 and is breathless at rest. His respiration rate is 32 breaths per minute and his oxygen saturation is 88%. He has a ReSPECT form in place that says he should go to hospital for potentially reversible causes of infection. He is not for resuscitation. He is more confused than normal and is restless. I need advice on what to do, whether he should go to hospital and what I can give him.

Suspected or confirmed cases of COVID-19

Once you have a suspected case you need to isolate that resident to their room and commence use of the personal protective equipment (PPE) provided by NHS England. This comprises of gloves, aprons and face masks.

- fluid repellent facemask
- apron
- gloves
- eye protection if there is a risk of splashing or exposure to respiratory droplets.

The resident's GP, or alternative primary care support team on the advice line, will advise on any medical treatment plan and isolation requirements, to prevent transmission of COVID-19 to other residents. These requirements may change over a short time period, so we have not specified them here. Please see the guidance below regarding the donning and doffing of PPE.

- **How to wash your hands (from nhs.uk)**
  https://www.nhs.uk/live-well/healthy-body/best-way-to-wash-your-hands/

Putting on PPE for non-aerosol generating procedures (AGPs)

Before you put on PPE:

- ensure healthcare worker is hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available.

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1. Perform hand hygiene.
2. Put on apron and tie at waist.
3. Put on facemask - position upper straps on the crown of your head, lower strap at nape of neck.
4. With both hands, mould the metal strap over the bridge of your nose.
5. Don eye protection if required.
6. Put on gloves.

Source: Public Health England, Putting on personal protective equipment (PPE) for non-aerosol generating procedures (AGPs) and Public Health England, Covid-19: infection prevention and control [updated 21 March]

Taking off PPE for non-aerosol generating procedures (AGPs)

- PPE should be removed in an order that minimises the risk of self-contamination
- Gloves, aprons (and eye protection if used) should be taken off in the patient's room or cohort area

1. Remove gloves.

- Grasp the outside of glove with the opposite gloved hand; peel off.
- Hold the removed glove in the remaining gloved hand.
- Slide the fingers of the un-gloved hand under the remaining glove at the wrist.
- Peel the remaining glove off over the first glove and discard.

2. Clean hands.

3. Remove apron.

- Unfasten or break apron ties at the neck and let the apron fold down on itself.
- Break ties at waist and fold apron in on itself – do not touch the outside – this will be contaminated. Discard.

4. Remove eye protection if worn.

- Use both hands to handle the straps by pulling away from face and discard.

5. Clean hands.

6. Remove facemask once your clinical work is completed.

- Untie or break bottom ties, followed by top ties or elastic, and remove by handling the ties only.
- Lean forward slightly. Discard.
- DO NOT reuse once removed.

7. Clean hands with soap and water.

Source: Public Health England, Taking off personal protective equipment (PPE) for non-aerosol generating procedures (AGPS) and Public Health England, Covid-19: infection prevention and control [updated 21 March]

In light of the latest government advice, about staying at home, and the need to shield care home residents, it is recommended that care homes do not allow visiting. This might be challenging, especially if a resident is nearing the end of their life, and for residents who 'walk with purpose' (often called 'wandering') but require isolation (where families might previously have been asked to support).

Care homes should take advantage of videoconferencing software on smartphones, tablets and portable computers as much as possible to maintain human contact for residents. They, and healthcare professionals supporting them, must recognise and respond to the strain that social isolation puts on residents and their families.

In the event of large numbers of residents with suspected or confirmed COVID-19, care homes are advised to work with local infection teams to separate symptomatic and non-symptomatic residents within the care home, if possible. Please contact the advice line for help with how to do this.

Residents who 'walk with purpose' require specific consideration. Physical restraint should not be used. Your prior knowledge of the resident, their behaviours and what this can lead to, might help you to understand their behaviour and try to modify it where possible. Care homes may need the advice of the dementia teams in these situations. The advice line will help to redirect you to professionals who might be able to help.

Please note, that at the time of writing, there is no relaxation of Deprivation of Liberty Safeguards (DoLS) associated with the pandemic and care homes should ensure that they adhere to the DoLS guidelines.

Care homes should be prepared for the possibility that they might have to receive residents from hospital who are COVID positive in order to isolate them in the care home. They should do what they can to support this, in order to ensure that the whole health and social care system has capacity to care for the sickest people, following official guidance.

Other things to be aware of and get in place

Easy Read Guide on COVID-19 for patients to explain what it is and what this means

COVID Easy Read Insert link

Advance care planning and escalation

Many care home residents are in the last year of their life. The dangers of hospitalisation for care home residents, such as delirium and confusion, are well-known and many residents admitted to hospital would prefer to be treated at home.

The COVID-19 pandemic has received much coverage in the news and residents and their families will have almost certainly considered what this means for them (e.g. most hospitals are stopping relatives from visiting, residents would be cared for in unfamiliar surroundings, cared for by staff who are strangers). This is a good time for care home staff to revisit, or visit for the first time, Advance Care Planning, including plans about escalation to hospital for all their residents. Where a person has capacity, as defined by the Mental Capacity Act, this Advance Care Plan should always be discussed with them directly. Where a person lacks the capacity to engage with this process then it is reasonable to produce such a plan, following best interest guidelines, with the involvement of family members or other appropriate individuals. This should include discussions about how the COVID-19

pandemic may affect residents with multiple comorbidities. (We know that people over 80 years of age, with existing comorbidities, do not respond well to hospital treatment). Care homes also need to consider whether people want to be admitted for other long-term conditions, such as COPD or heart failure, bearing in mind they may have their last days of life in hospital.

The recent advice to stop outside visitors into the care homes means that, where residents lack capacity to make decisions about treatment and care for themselves, these discussions may need to involve relatives by telephone, or using videoconferencing software on tablets or phones. This is not ideal. Please see attached guidance which might help you to have an Advance Care Plan discussion and to avoid confusion or distress as much as possible.

Advance Care Plans should include decisions about whether hospital transfer would be considered (for oxygen therapy, intravenous fluid and antibiotics) for COVID-related illness. Advance care plans should be shared with the GP/primary care out-of-hours service. Please be aware that the life expectancy of an older person with co-morbidities being admitted to hospital with COVID 19 is very short.

link to ACP discussion

Decisions about escalation of care to hospital

Because most care home residents live with frailty and multiple medical conditions, there may be occasions where paramedics, general practitioners, or other healthcare professionals make decisions not to escalate their care to hospital. These decisions will not be taken lightly, and care home staff must be prepared to work with healthcare providers to support families and residents if such difficult decisions have to be taken. Healthcare professionals may find the Clinical Frailty Scale (CFS) to be a useful resource in making and discussing escalation decisions.

At the time of writing, the NICE guidance on escalation of COVID positive patients to critical care suggests frailty will play an important part in decision-making. It has been suggested that those with a CFS of 5 or more are less likely to benefit from critical care. Primary care providers may wish to consider this in their discussions with residents and relatives, and decisions about escalation to acute care. For information on the CFS see below:

https://em3.org.uk/foamed/24/4/2017/lightning-learning-clinical-frailty-scale

Symptom Management at End of Life

If you need to prepare for a resident who may be approaching the end of their life, normal procedures for ordering anticipatory/just in case medicines apply. At the time of writing, it is not possible for care homes to hold a stock of anticipatory medications for use when residents are approaching the end of life. Care homes should therefore work with GPs and local pharmacists to recognise, and anticipate, residents who are approaching the end of life and to ensure that anticipatory medications are prescribed in a timely fashion.

BE MINDFUL OF THE POSSIBLE SYMPTOMS OF COVID 19

BREATHLESSNESS

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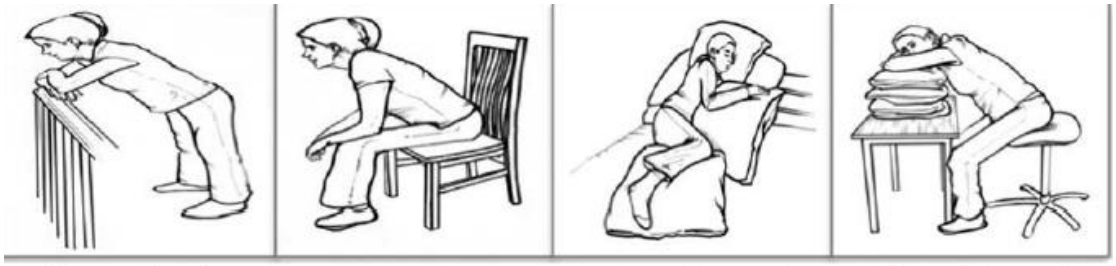
- Keep the resident cool and comfortable
- Sit the resident upright if comfortable for them – use pillows to help
- Ensure good air circulation – open a window or use an oscillating fan if this is the patient's own (do not use communal fans as they can spread infection)
- Encourage the resident to breathe in through their nose and out through pursed lips, this reduces perception of breathlessness
- Ensure effective mouth care to keep the mouth moist
- Ensure loose fitting clothes
- Some people prefer to lean over a bedside table as this expands the chest
- Ensure you review the resident regularly (at least hourly if not more often) throughout the day and frequently throughout the night



Forward lean 1 | Forward lean 2 | Adapted forward lean for lying | Adapted forward lean for sitting

MEDICATION THAT MAY BE PRESCRIBED FOR BREATHLESSNESS

- Oramorph and Oxycodone solution can be given hourly as prescribed
- Lorazepam 0.5mg given 2 hourly sub lingually (under the tongue) as prescribed
- Morphine, Diamorphine and Oxycodone injections can be given hourly as prescribed
- Doses will depend on any background pain relief already in use
- Doses for breathlessness are generally I/2 the normal dose for pain management

FOR ANXIETY (ANXIETY CAN WORSEN BREATHLESSNESS)

- Lorazepam 0.5mg can be given under the tongue every 2 hours
- Diazepam 2mg can be given orally every 4 hours
- Midazolam injections 2.5 – 5mg can be given hourly if needed

RESPIRATORY SECRETIONS (DEATH RATTLE)

- Hyoscine Butylbromide 20mg can be given hourly if needed subcutaneously.

DELIRIUM

- Haloperidol 1.5-3mg given orally or subcutaneously every 4-6 hours as prescribed
- Levomepromazine 6.25mg – 12.5mg – 25mg every 4-6 hours as prescribed (2nd line)

Follow local guidelines and prescriptions for other palliative symptom control. See Derbyshire Alliance for End of Life care website for resources and drug algorithms.
https://derbyshire.eolcare.uk

If your resident needs a syringe driver please contact the advice line or GP who can arrange this.

CARING FOR RESIDENTS AT END OF LIFE – WHAT TO EXPECT

Link to Practical Care

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CONTINUING HEALTHCARE FUNDING (CHC)

If one of your residents deteriorates and looks to be entering the dying phase (i.e. last few weeks/days of life) then you can apply for fast track (FT) funding.

Inform the GP/Advanced Nurse Practitioner/Community Matron and ask them to 'virtually' review the resident using SKYPE, facetime etc. They may need to amend the ReSPECT form and DNACPR status and prescribe anticipatory/just in case medications.

In this case the GP/ANP/Community Matron will complete the FT form. Please note that during the COVID-19 pandemic it is unlikely that additional staff will be provided to residential homes. Ensure that communication takes place with relatives to inform them that the resident is deteriorating.

If the resident is in a nursing home, the GP/ANP should be informed and virtually review the resident. If they agree the resident is at end of life, the nursing home may be allowed to complete the FT form.

WHAT TO DO IF YOU ARE ASKED TO DO TASKS YOU HAVE NEVER DONE BEFORE

During the pandemic you may be asked to perform tasks that would normally be done by another member of the health and social care team. This might include things like giving insulin or an injection to make a resident comfortable at the end of life. Whilst this is not ideal, in order to keep residents comfortable when staff shortages and waiting times increase, it might be necessary for care home staff to undertake these procedures. This will be done with the support of the clinician on the support line number.

The following website gives assurances that indemnity cover is provided in these cases:

- https://resolution.nhs.uk/2020/03/19/covid-19-and-business-continuity/

Below is some guidance on the following tasks and procedures:

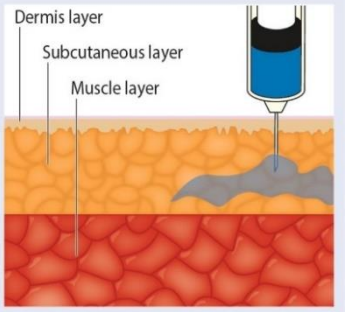
- How to give a subcutaneous injection
- How to insert a saf-t-intima subcutaneous cannula
- How to put up a T34 McKinley syringe driver, it is unlikely that non nurses will do this
- Verification of expected death procedure
- Breaking bad news

How to give a S/C Injection (under the skin)

Introduction

Drugs administered by the subcutaneous route are deposited into subcutaneous tissue (Fig 1); small volumes (up to 2ml) of non-irritant, water-soluble drugs can be administered by subcutaneous injection.

Fig 1. **Tissue structure and subcutaneous injection**

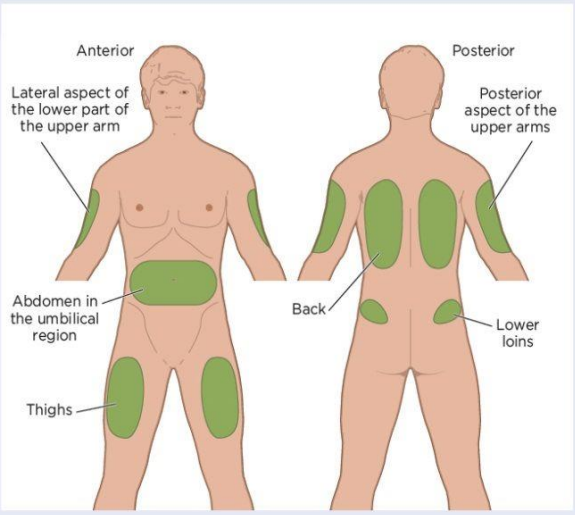


Unlike muscle, subcutaneous tissue does not have a rich blood supply, and absorption of drugs delivered via this route is therefore slower than the intramuscular route. This slower rate of absorption is beneficial when continuous absorption of a drug is required; for example, with insulin. Factors affecting blood flow to the skin, including exercise and changes in environmental temperature, can affect drug absorption.

Complications associated with subcutaneous injections include abscesses and, in patients who require frequent injections, there is a risk of lipohypertrophy; this is characterised by an accumulation of fat under the skin. Lipohypertrophy occurs when multiple injections are repeatedly administered into the same area of skin. It can be painful and unsightly, and affect drug absorption, but can be prevented by avoiding using the same injection site(s) repeatedly.

Preparation - Site selection
Recommended sites for subcutaneous injection include the lateral (outer) aspects of the upper arm and thigh, and the umbilical (belly button) region of the abdomen. The back and lower loins can also be used (Fig 2).

Fig 2. **Subcutaneous injection sites**

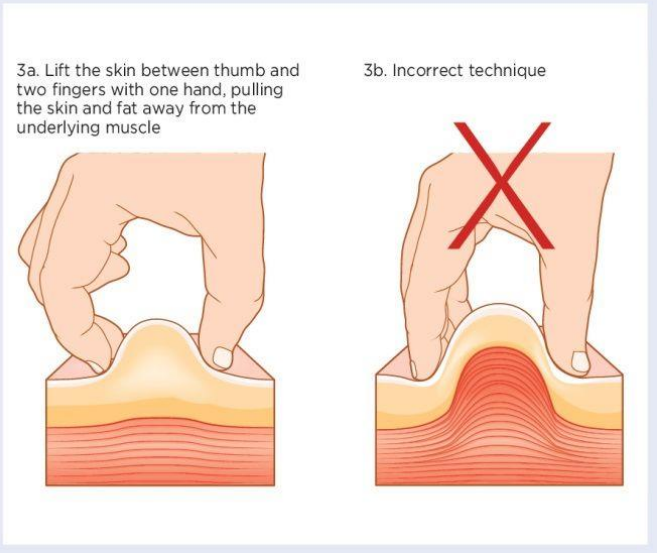


Injection sites should be:
Clean;

- Free of infection, skin lesions, scars, birthmarks, bony prominences, and large underlying muscles, blood vessels, nerves or lymphoedema swellings.

As the amount of subcutaneous fat varies between patients, individual patient assessment is vital before carrying out the procedure. A lifted skinfold technique (pinching or bunching the skin) can be used to lift the subcutaneous layer away from the underlying muscle (Fig 3). This method reduces the risk of inadvertent intramuscular injection when undertaken correctly.

Fig 3. **Lifted skinfold technique**



Needles

Safety needles should be used for subcutaneous injections to reduce the risk of needle- stick injury. Some drugs such as heparin come in a pre-loaded syringe and patients prescribed insulin may use insulin delivery devices.

Needle size is measured in gauges (diameter of the needle) – a 25G is commonly used for subcutaneous injections (orange). Needle size depends on the viscosity (thickness) of the liquid being injected.

Needles need to be long enough to inject the drug into the subcutaneous tissue. They come in lengths of 4-8mm. For most patients an orange needle is the needle of choice.

Skin preparation

There is debate around the use of alcohol-impregnated swabs to clean injection sites. If a patient is physically clean and generally in good health, swabbing of the skin before injection is not required. In older patients and those who are immunocompromised, skin preparation using an alcohol-impregnated swab (70% isopropyl alcohol) may be recommended.

Aspiration

It is common practice to draw back on a syringe after the needle has been inserted to check whether it is in a blood vessel. This is **NOT** recommended for subcutaneous injections, as there are no major

blood vessels in the subcutaneous tissue and the risk of inadvertent intravenous administration is minimal.

Gloves

Nurses need to assess risk in each individual patient and be aware of local policies for glove use. In confirmed or suspected COVID-19 patients, gloves, apron and facemask should be worn.

Angle of injection

It is recommended that subcutaneous injections, particularly of insulin, are administered at a 90-degree angle to ensure that the medication is delivered into the subcutaneous tissue. However, patient assessment is vital – patients who are cachectic (thin and emaciated) and therefore have minimal amounts of subcutaneous tissue may require injections to be delivered at a 45-degree angle. Public Health England (2013) recommends that subcutaneous injections are given with the needle at a 45-degree angle to the skin and the skin should be pinched together.

Equipment

- Needles (one of which should be a safety-engineered device) and syringe or prefilled syringe.
- Drug for administration.
- Medicines administration chart/prescription.
- Receiver or tray to carry the drug.
- Sharps container.

Procedure

1. Explain the procedure to the patient and gain consent.
2. Screen the patient to ensure privacy during the procedure.
3. Check whether the patient has any allergies.
4. Check the prescription is correct and follow the ‘five rights’ of medicines administration (Box 1) and local medicines administration policy to reduce the risk of error.
5. Wash and dry hands to reduce the risk of infection.
6. Assemble the syringe and needle and then draw the required amount of drug from the ampoule. Some drugs are available in pre-filled syringes and manufacturer’s instructions should be followed.
7. Disperse any air bubbles from the syringe. This can be done by flicking the syringe so the air goes to the top where it can be expelled.
8. Change the needle to ensure that the one you are about to use for injecting the drug is sharp, thereby reducing pain i.e. don’t draw up and then inject the person with the same needle in case it has been blunted on the rubber seal or glass ampoule. To reduce the risk of sharps injury, a safety-engineered needle should be used for injection.
9. Dispose of the needle used to draw the drug in a sharps container according to local policy.

10. Place the injection in a tray and take it to the patient, along with a sharps bin so the used needle can be disposed of immediately after the procedure.
11. Check the patient's identity according to local medicines management policy.
12. Position the patient comfortably with the selected injection site exposed (Fig 2).
13. Check the site for signs of oedema (swelling), infection or skin lesions. If any of these are present, select a different site.
14. Wash and dry hands.
15. Put gloves on.
16. Ensure the skin is clean or follow local policy on skin cleansing.
17. If skin cleansing is considered necessary, swab for 30 seconds with isopropyl alcohol and then allow to dry for 30 seconds.
18. Inform the patient that you are going to carry out the injection. Use distraction and relaxation techniques to reduce anxiety if needed.
19. Hold the syringe and needle in your dominant hand and pinch the skin together using the non-dominant hand to lift the tissue away from underlying muscle (Fig 3).
20. Insert the needle at the required angle (usually 90 degree) using a dart-like action.
21. Depress the plunger and inject the drug slowly over 10-30 seconds.
22. Wait 10 seconds before withdrawing the needle – this will prevent backtracking of the drug – and then withdraw the needle. Do not massage the area, as this can lead to bruising following administration of heparin and speed up absorption times with insulin.
23. Release the lifted skinfold.
24. Dispose of sharps directly into the sharps bin and dispose of the syringe according to local policy.
25. Ensure the patient is comfortable and wash hands.
26. Record administration on the prescription chart. Also record administration site so that the same site is not repeatedly used. This is to avoid lipohypertrophy.
27. Monitor the patient for any effects of the prescribed medicine and any problems with the injection site.

Box 1. 'Five rights' of medicines administration

- Right patient
- Right drug
- Right time
- Right dose
- Right route

Your GP or the clinicain on the support line will help you with this

Video demonstrating s/c injection

https://www.youtube.com/watch?v=T4NWm7mqbHI

How to insert a Saf-T-Intima S/C cannula

A subcutaneous cannula can be inserted if more than one injection is likely to be given (as is often the case in end of life patients). S/C cannulas are especially useful if the person is thin and emaciated as injections are likely to be more painful. They can be sited in any of the areas where a S/C injection can be given. In confused patients, it may be wise to site the cannula in the top of the shoulders where they are less likely to be able to pull it out. A clear dressing should always be used over site so that skin can be observed for redness, pain, swelling or leakage. If it is difficult to inject the drug and resistance is felt, then the site may have tissued (blocked off). If any of these signs/symptoms occur, the cannula should be removed and another re-sited. Continue to observe the site and contact the advice line if the site looks to be getting red/infected. Document where the cannula is sited and the date changed, to ensure that the same site is avoided. A cannula can usually be left up to 72 hours before it needs to be re-sited.

Video demonstrating insertion of a saf-t-intima s/c cannula

https://www.youtube.com/watch?v=BpMUPQ21eEo

Setting up a syringe driver

It is unlikely that you will be asked to put up a syringe driver, but we have included guidance just in case this is needed. The same applies as above for care of the site. The total volume to be used in the Luer Lock syringes is as follows and the total is made up of water for injection.

Total volumes for 20ml syringe and 30ml syringe needs to be determined. Suggest 18ml and 23 ml respectively as can get more drugs in in case S/Ds are scarce

Need to identify where homes get consumables from??DCHS

The consumables needed to put up a syringe driver e.g. giving set, cannula, luer lock syringes, clear dressings, water for injection, needles etc. can be obtained from **********

This is on how to draw drugs up and prime the line

https://www.youtube.com/watch?v=yyKUUWTL_vw

This tells you how to set the pump up.

https://www.youtube.com/watch?v=jb0nb4IBGSg

Nurse Verification of Death

It is unlikely that you will be able to get a professional to come out and verify that a person has died. Below, you will find links to the theoretical knowledge and practical skills that are required to undertake this procedure. The powerpoint gives you the underpinning knowledge which can be cross referenced with the theoretical and practical assessment document. The VOD recording form

lists all the practical observations that are required to verify a death and who else needs to be contacted. It acts like a checklist to ensure that all procedures and tasks have been completed.

Once the procedure has been followed the funeral director can then be contacted to remove the body.

powerpoint

Assessment form

VOD recording form

How to break bad news

It is always difficult to have to tell someone that their relative/friend is deteriorating or has died. However, in the context of COVID-19, the person is likely to have become ill and deteriorated quite quickly so the opportunity for discussion and involving them in decision making may be limited or lost.

Families and those close to them may be shocked by the suddenness of these developments and may themselves be ill and/or be required to self-isolate. There may be multiple members of the family ill at the same time, but as far as possible it remains important to offer these conversations. Being kept honestly informed helps to reduce anxiety, even if the health care professionals do not have all the answers and even if the conversations need to be conducted behind PPE or, in the case of families who are self-isolating, by telephone or by using other technology solutions such as skype or face time.

It should be acknowledged that talking to residents and those close to them about prognosis, ceilings of treatment and possible end of life care is often challenging but, in the current COVID-19 outbreak, such conversations with the population described may become even more difficult, as health and social care professionals may have to triage residents and prioritise certain interventions and ceilings of treatment. This not only to ensures that those with significant potential to recover receive appropriate care, but also that those who are very unlikely to survive also receive appropriate end of life care in an environment they know and with familiar people around them.

Such decisions may have to be made when health and social care professionals need a discussion with those close to the resident over the telephone or via internet-based communication facilities. While this is less than ideal, honest conversations are often what patients and those close to them, actually, want.

Key points to consider when discussing ceilings of treatment
Don’t make things more complicated than they need to be; use a framework such as SPIKES:
o **S**etting / situation: read clinical records, ensure privacy, no interruptions
o **P**erception: what do they know already? Don't make assumptions
o **I**nvitation: how much do they want to know?
o **K**nowledge: explain the situation; avoid jargon; take it slow
o **E**mpathy: even if busy, show that you care
o **S**ummary / strategy: summarise what you’ve said; explain next steps

Ensure discussions take place around ceilings of treatment and include ethical issues, for example where escalation to hospital is thought not to be appropriate due to frailty, comorbidity or other reasons, you may need to be prepared for anger / upset / questions. Remember:

- these are usually not aimed directly at you, but you may have to absorb these emotions and react professionally, even if they are upsetting / difficult at the time
- residents or those close to them may request a 'second opinion - this should be facilitated wherever possible. Your GP may be able to support you
- be honest and clear
- don't use jargon; use words residents and those close to them will understand
- sit down; take time; measured pace and tone; use silences to allow people to process information
- avoid using phrases such as "very poorly" on their own – is the patient "sick enough that they may die"? If they are – say it

While palliative, end of life and bereavement care professionals cannot take over responsibility for this aspect of care and have the conversations for you, they should be able to support, advise and provide follow up care.

The following link may be useful. It is based on approaches used in Italy with COVID-19 cases.

Link to Communication Guidance

Verifying deaths during COVID-19 outbreak

A carer can verify death when confident to do so, if not please call the 24 hour support line to talk you through this. You can then inform the chosen undertaker to collect the resident. You need to inform the residents GP as soon as possible. If the resident had confirmed COVID-19 you must inform the undertaker prior to them collecting the resident.

Certifying deaths during COVID-19 outbreak (can only be done by a Dr)

The process for certifying deaths has changed during the coronavirus outbreak.

27 March 2020

In England and Wales, the Coronavirus Act 2020 makes changes to the requirements for death certification to recognise that the doctor who saw the patient during their last illness may be unable to sign the certificate or it might be impractical for them to do so - for example, if they are self-isolating.

If practicable, the practitioner who attended the deceased during their last illness should complete the medical certificate of cause of death (MCCD), as was the case before.

According to guidance for doctors on completing medical certificates of cause of death (MCCD) in England and Wales, "There is no clear legal definition of 'attended'", but it is generally accepted to mean a doctor who has cared for the patient during the illness that led to death and so is familiar with the patient's medical history, investigations and treatment. The certifying doctor should also

have access to relevant medical records and the results of investigations. This means that a doctor from the practice may be able to do this if your regular GP is unable to attend.

If that is not possible or practical, another doctor can complete the certificate if they believe they're able to give a cause of death (for example, by relying on the clinical records).

The Act also allows an MCCD to be completed if the patient was not seen by any medical practitioner during their last illness. If that happens, a doctor would need to state the cause of death to the best of their knowledge and belief.

What does it mean for relatives trying to register a death?

MCCDs completed under the new arrangements will be accepted by the registrar of births, deaths and marriages. It means the death can be registered without automatically having to refer the death to the coroner (as was the case previously) provided the deceased has been seen by a doctor within the last 28 days.

What impact does this have on cremation forms?

The Act removes the need for a confirmatory medical certificate (Form 5) for cremations. This means that a second doctor is not required

When should a death be referred to the coroner?

New regulations about when a death needs to be notified to the coroner came into effect in 2019. This means if the doctor attending the deceased in their last illness is not available, or is unlikely to become available in a reasonable time, another doctor can certify the medical cause of death. If this happens and another doctor is able to give a cause of death to the best of their knowledge and belief, there is no need to refer the death to the coroner. If there is no doctor at all who can sign the MCCD - for example, because a patient who was previously well dies suddenly and unexpectedly at home - the coroner must be informed of the death.

Registering a death

Coronavirus (Covid-19) update

From 30 March, registration of a death will be undertaken by telephone. The medical certificate issued by the doctor will be emailed to the registry office instead of being handed to the relative. Once the doctor has confirmed that this has occurred then the relative will need to ring their local registrar to speak to the Customer Service Centre who will advise them accordingly. It may not be possible to speak to the registrar immediately.

Bereavement Advice

What does this mean for residents who are dying and their families when that resident has been diagnosed with Covid-19?

Good Practice Guide for End of Life Care in Care Homes in COVID-19 Pandemic, 1 April 2020 by Jill Davies (Community EOLC Facilitator)

- Covid-19 may exacerbate co-existing illnesses which means they may die sooner than had been anticipated
- Advance care planning, having conversations with the resident where appropriate and their relatives is part of good end of life care.
- Should visiting restrictions be in place, consider other forms of contact such as SKYPE, telephone etc.

If someone dies of Covid-19 or complications resulting from the virus, a number of things may be particularly hard for family and friends to deal with for instance: -

- Infection controls may mean that family members do not have an opportunity to spend time with someone who is dying, or to say goodbye in person.
- Depending on the person, the illness may have progressed and become serious very quickly, which can lead to feelings of shock. If they were not able to be present for the death and cannot view the body, it may be difficult to accept the reality of a bereavement.
- At times of considerable trauma, people tend to look for certainty. However, when certainty is not there, this can amplify any feelings of angst and distress.
- Bereaved people may be exposed to stories in the media which highlight the traumatic nature of death in these circumstances, or they may have witnessed distressing scenes directly. People may become disturbed by mental images, which in a severe form can become Post-Traumatic-Stress Disorder (PTSD).
- If the health services become stretched, friends or family may also have concerns about the care the person received before they died. This in turn can lead to feelings of anger and guilt. Make sure the bereaved know they can contact the home at any time for help and support.

Ten ways to support people who are bereaved: This might be useful advice to give to those recently bereaved:

1. Support them to not become emotionally isolated. Even if people cannot visit to offer support, condolences can be given in different ways; such as texts, emails and messages through social media, as well as phone calls. Encourage them to use their network for support.
2. Advice the person to feel and react in a way that is natural to them. We sometimes say that ‘grief is the price we pay for love’, and there is no doubt that it can be painful.
3. Encourage them to keep conversations going with the people they are closest to e.g. family or close circle of friends.
4. Encourage them to reach out to people who may not be physically near, reach out to them and telephone someone each day.
5. Having ‘conversations’ through WhatsApp or through Facebook can mean there is a regular flow of communication throughout the day. This is a reminder that people are thinking about them. Encourage them to keep such lines of communication open with friends/relatives.
6. Remind people to eat and to keep hydrated. The body has needs and grief is hard work.
7. Keeping some routine can be helpful and mealtimes play an important part in this. So too does bedtime and getting-up time. Encourage people to stick to their normal routine as much as possible. Try getting out in the garden, if possible.
8. If there are children in the family, suggest they check-in with them often. Answer their questions honestly. Don’t ‘fob them off’.

9. Children may appear sad and happy in the space of minutes. It can be likened to jumping in an out of puddles. Let children set their own pace.
10. Try to encourage them to limit how much news and social media they consume – when feeling very sad, regular news can be distressing.

Remember: In grief you can only do the best you can, try to be tolerant and kind to yourself

Cruse Bereavement Care - Coronavirus: dealing with bereavement and grief

https://www.cruse.org.uk/get-help/coronavirus-dealing-bereavement-and-grief

Guidance on Infection Prevention Control in a Health Care Setting:
https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/covid-19-personal-protective-equipment-ppe

The Derbyshire Alliance for End of Life Care also contains resources and guidance regarding EOL and includes advice regarding syringe driver set up (T34)

https://derbyshire.eolcare.uk

PLEASE NOTE THAT INFORMATION CONTAINED IN THIS DOCUMENT IS CORRECT AT THE TIME OF WRITING BUT MAY BE SUBJECT TO CHANGE

*****************Sections that have outstanding information to be inserted/still being worked on:**

References

This guidance has been developed using a range of resources and links from other national and international bodies. In addition to the links inserted during the text, the following resources have been used in the development of this practical guide:

Association of Palliative Medicine

https://apmonline.org/

British Geriatric Society

https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes

e-Learning for Health

https://www.e-lfh.org.uk/programmes/coronavirus/

European Association of Palliative Care

https://www.eapcnet.eu/publications/coronavirus-and-the-palliative-care-response

GOV.UK

https://www.gov.uk/search/all?keywords=is+COVID+19

Helix Centre

https://helixcentre.com/project-end-of-life-toolkit

Public Health England,

Taking off personal protective equipment (PPE) for non-aerosol generating procedures (AGPS)

Public Health England,

Covid-19: infection prevention and control *[updated 21 March]*

Pulse Today

http://www.pulsetoday.co.uk/clinical/clinical-specialties/respiratory-/gps-can-certify-death-via-telephone-under-new-emergency-legislation/20040466.article