Care Home Advice for Discussions and Symptom Management in COVID 19

DO ensure ALL residents have a ReSPECT plan with a valid CPR decision

DO contact the GP Practice if you cannot find the ReSEPCT plan **ASAP**

DO follow the ReSEPCT plan, which may mean ……

NOT calling 999 without reading the ReSEPCT plan for care instructions

DO follow the symptom management as prescribed by the GP/ANP for your residents:

Discussions about goals of care
(adapted from RCP, 2018)

The UK population is ageing and many more people are living with chronic illness and multiple comorbidities. A third of patients admitted unexpectedly to hospital (rising to 80% in those living in 24-hour care) are in the last year of their lives. (Clark *et al*, 2014) Despite such facts, few have ever had discussions about ceilings of treatment or resuscitation.

Timely honest conversations about the person's preferences and priorities, including advance decisions to refuse treatment, is part of advance care planning for anybody who has a progressive life-limiting illness. In the context of people who have severe COVID-19 disease, honest conversations about goals of care and treatment escalation planning should be initiated as early as is practicable so that a personalised care and support plan can be developed and documented. This will need to be revisited and revised as the situation changes. Families and those close to the person should be involved in these discussions as far as possible and in line with the person's wishes. This is standard good practice in palliative and end of life care.

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 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.

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 (Brighton & Bristowe, 2016) but, in the current COVID-19 outbreak, such conversations with the population described may become even more difficult, as health professionals may have to triage residents and

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prioritise certain interventions and ceilings of treatment. This is not only to ensure 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 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 (DoH, 2015; NPEoLCP, 2015), honest conversations are often what patients and those close to them actually want. (Choice, 2015)

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?; no 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, health professionals should 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
- 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.

ALSO BE MINDFUL OF THE POSSIBLE SYMPTOMS OF COVID 19

BREATHLESSNESS
- Keep the resident cool and comfortable
- Sit the resident upright if comfortable for them – use of pillows

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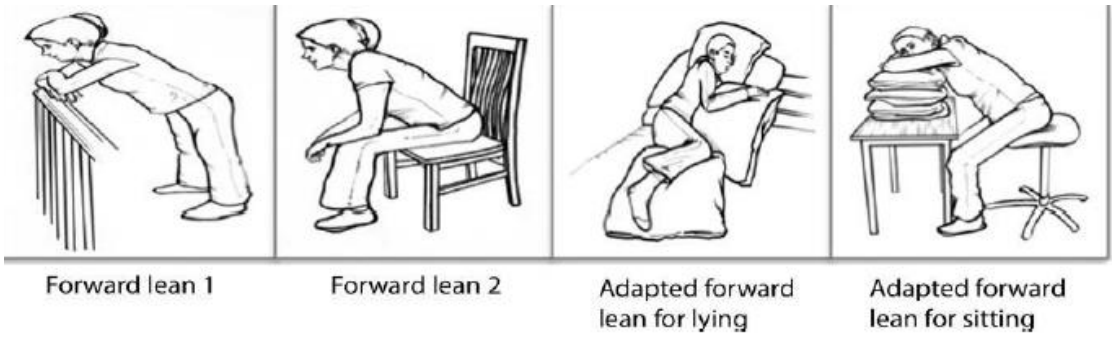
- Ensure good air circulation – open a window or use an oscillating fan if patient's own (do not use communal fans as they can spread infection)
- Encourage resident to breathe in through their nose and out through pursed lips, this reduces perception of breathlessness
- Ensure effective mouth care to 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



MEDICATION THAT MAY BE PRESCRIBED FOR BREATHLESSNESS

- Oramorph and Oxycodone solution can be given hourly as prescribed
- Morphine, Diamorphine and Oxycodone injections can be given hourly as prescribed
- Doses will depend on any background analgesia already in use
- Doses for breathlessness are generally I/2 the normal dose for paim management

AND FOR ANXIETY (ANXIETY CAN WORSEN BREATHLESSNESS)

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

RESPIRATORY SECRETIONS (DEATH RATTLE)

- Hyoscine Butylbromide can be given every 2 hours if needed subcutaneously.

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 their GP who can arrange this.

Please remember that Jill Davies and Diana Gibson (End of Life Care Facilitators) are here to support you. They can be contacted on:
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