DDLMC – GPTF – GP Alliance

INTERIM GUIDANCE: End of Life Care for Patients with confirmed or presumed COVID-19

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With thanks to colleagues from Cambridge LMC and BBO LMC for allowing us to adapt their excellent documents

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PRINCIPLES

An experienced clinician needs to exclude reversible causes before the diagnosis of dying is made. Hospital admission should be considered for patients with respiratory distress of unknown cause.

When caring for a patient dying from suspected or confirmed COVID-19, continue to use standard principles of holistic, individualised care and symptom management. Many have mild respiratory symptoms and are already close to the end of their life with other conditions, so will require 'standard' palliative care prescribing.

DYING FROM COVID-19

Death from Covid-19 occurs via one or both of the following mechanisms:

- Type 1 Respiratory failure from Acute Respiratory Distress Syndrome (ARDS)
- Systemic shock from 'cytokine storm' that resembles **bacterial septic shock**

The most common terminal symptoms are: pyrexia, rigors, severe dyspnoea, cough, delirium and agitation. The terminal phase can be rapid, lasting just a few hours: these symptoms can develop rapidly and can be very distressing. Rapid access to medication is vital and often involves larger doses than in 'standard' palliative care practice.

MEDICATION OPTIONS

Most medications will be given via the oral route.

If someone is unable to take oral medications, then both buccal and subcutaneous administration options are advised.

If possible, insert a subcutaneous (SC) butterfly needle (or a paediatric venflon if available) so that medications can be administered without multiple injections. These can last up to 72 hours but need to be changed earlier if there are signs of erythema or pain at the site.

- The oral route may not be available in the dying phase, but Oramorph can be helpful if given early, this can be given sublingually or in the cheeks.
- Lorazepam, morphine and oxycodone can be given sublingually (SL) and midazolam given buccally (BUC).
- Viral shedding is thought to occur rectally, so the PR route is best avoided.

MEDICATION REGIME

Please see Appendix 1

EOL HOME VISITING

PLEASE SEE CCG RED VISITING GUIDANCE

Fundamental rule of NO PPE, NO SEE remains.

Most support for EOL patients can be done remotely.

‘GRAB BAGS’ AND CARER TRAINING

We recognise the need for a wholly different response to palliative care and as such are looking after a wealth of different options to enable a rapid, agile response to the demands of palliating at scale these include:

1. Grab Bags: Although issues with controlled drugs (CDs) remain. Oramorph, Lorazepam and Buscopan could be used on a non-named patient basis for grabbed bags. A prescription should be generated on issuing a ‘grab bag’.

2. Carer training: we are investing time in training carers in care homes in administration of subcutaneous end of life medications. This will be able to be adapted and adopted for selected private/ family member carers.

CLINICAL LEADS

Pauline Love, CCG EOL Lead

Sam Taylor, COVID Home Visiting (CoHV) response lead

Nicola Macphail, COVID Rapid Discharge and CHC Lead

OVERVIEW

For end of life patients with being discharged from hospital we will be adopting a Hub and spoke model for 'at scale' palliative care in Derbyshire. The 2 hubs will be based at Derby and Chesterfield DHU headquarters. Nominated co-ordinators from these hubs will ensure patients are discharged with anticipatory medications, administration sheets and up to date ReSPECT forms with signed DNACPR. It is expected that admin staff in the practice will transcribe this information onto the Derbyshire Health & Social Care Plan and e-mail it to DHU.

The co-ordinators will liaise with CAP teams who will liaise with the DN teams for practices who will liaise with the patient's GP. **The CAP number is: 01332 564900.**

The DN team will need to call their respective practice to liaise with the most appropriate person on a daily basis to discuss any EOL patient.

- COVID positive or suspected patients at EOL who require a visit will be seen by the DN in the red team for that day.
- If a GP HV is needed, then that will be with the COVID HV team.
- Any other EOL visits for non COVID patients will be done by the DN in the green team.

Admission Avoidance and Referrals from within the community - CHC

For any cases with increased care needs including End of Life requiring additional care to avoid hospital admission

1. For patients known to DNs AND where the increase care needs are identified by the DN (including end of Life needs) the DN will complete a short form assessment identifying nursing needs and care required or FT document and forward to the MSLCSU CHC team for brokerage of a care package.
2. **For all other cases** where increased care needs that require additional care to avoid hospital admission are identified – patient details should be passed to MLCSU – MLCSU will complete a telephone assessment and care prescription and broker care as required.

For End of Life I think we should ask the GP's to complete the Fast Track Doc – excluding the Nursing Assessment and send to the CSU. The CSU will contact the individual/family (which ever contact the GP provides) to undertake a telephone Nursing assessment to determine what support/type of care – Home or NH the individual requires and broker accordingly.

End of Life inbox for MLCSU CHC team: mlcsu.derbyshirechcfastrack@nhs.net

Direct contact number for GPs to contact: pending

We appreciate this feels like another 'ask' of general practice at this very busy time, but we are adapting to an unprecedented surge in EOL patients and the need to remotely support a large cohort of patients and their relatives.

We recognise 3 cohorts of Palliative Care Patient:

1. **COVID-19 Confirmed** – following rapid hospital discharge. Anticipated rapid decline via ARDS.
2. **COVID-19 Possible** – may be as above or in some decline will be due to another cause and reversibility will need to be assessed (remotely where possible) by an experienced clinician
3. **Non-COVID-19 Related EOL** – e.g. cancer, dementia. Provision is as before.

The flow chart below refers to category 1 and 2.

Preferred/ practical place of death

When EOL has been confirmed patients will be able to be cared for in one of the following places:

1. HOME
    a. Family member / carer support
    b. Remote support via practices in hours and DHU out of hours
    c. COVID-19 Home Visiting Service
2. CARE HOME
    a. For current residents up-skilling of carers to be able to administer medications
    b. Remote support via practices in hours and DHU out of hours
    c. COVID-19 Home Visiting Service
3. COMMUNITY BED
    a. Discussions are being had with DCHS to increase community hospital capacity to manage palliation at-scale
    b. Remote support via practices in hours and DHU out of hours
    c. COVID-19 Home Visiting Service

If you are within the CRH cohort of patients and have a patient with ReSPECT form this can be e-mailed to crhft.cito@nhs.net - preferably as a pdf with the subject line ReSPECT Form. In the event of a patient inadvertently being conveyed the form can then be accessed and the appropriate care package put in place.

FLOWCHART

EOL HUB hosted by DHU

2 hubs – Derby, Chesterfield

- CHC based in hubs, rapid access care put in place.
- Cascades rapid discharge pts and CoHV caseload to DN teams
- DN teams cascade any info to GP's

Dedicated 24/7 Palliative Care specialist support (see box below)

1) For Practice teams
2) For care homes and
3) Care home staff can call 111*6 for EoL support advice

Deploy Carers from CHC teams rapidly

EOL Support at Practice Level

Lead by DN teams

Remote support from practice teams

Where F2F review is required this will be via the CoHS or DN red team

see Appendix 2

Patient

Support from DN teams

Remote support from own GP practice Visits

via specific team/video consult with DN

If you require medical advice about symptom management contact the Palliative Medicine consultants.

For consultants based in Derby, in working hours call 01332 788794 and the secretary will locate an available consultant. Out of hours call RDH switchboard and ask for the Palliative Medicine consultant on-call.

LEGAL ISSUES AROUND DEATH

DEATH VERIFICATION

There is:

- NO requirement for a death to be verified by a doctor.
- NO requirement for the body of the deceased to be examined by a doctor
- NO contractual obligation on GPs to verify death or examine the body. do these

We advise against GPs verifying face to face the death of suspected COVID-19 patients.

The Births and Deaths Registration Act 1953 states deaths may be verified by:

a. any relative of the deceased person present at the death or in attendance during his last illness;
b. any other relative of the deceased residing or being in the sub-district where the death occurred;
c. any person present at the death;
d. the occupier of the house if he knew of the happening of the death;
e. any inmate of the house who knew of the happening of the death;
f. the person causing the disposal of the body.

DEATH CERTIFICATION

We have discussed with the Derbyshire Coroner's Office and they are likely to be under unprecedented strain during this pandemic, so post-mortems are being avoided unless absolutely necessary (due to infection control and workload). We agree that every effort should be made to give the most likely cause of death. The Coronavirus Act 2020 and local interpretation has amended procedures as follows:

- You do NOT need to report confirmed COVID-19 deaths to the coroner, but you must report the case to PHE in the usual way.
- For suspected COVID-19 deaths, any doctor may complete a medical certificate of cause of death providing they can give a cause (to the best of their knowledge), although we recommend that you discuss with the Coroner first as the local process is being discussed. Previously, all suspected COVID-19 deaths had to be reported and removed to the mortuary for swabbing, but the increasing numbers are prompting a review – hence the advice above.
- Certificate can be issued if **any** doctor has seen the patient (including via video-link) in the preceding 28 days (rather than 14 days which was required previously)

CREMATION FORMS

The GRO has mandated that (while it is acceptable for consultation before death) video-link is not acceptable for the examination of the deceased after death. We are urgently trying to get definitive guidance as we strongly advise against GPs examining the body of a deceased patient infected with coronavirus or suspected coronavirus in person due to the risk of infection.

If a GP does complete a Cremation Form 4 we would ask that they are completed legibly and as fully as possible. If you have not examined the deceased simply state in the box after Q8 that you have not seen the body and the reason for this e.g. risk of infection. It is then up to the medical referee to decide whether to accept or reject it.

Electronic Cremation form can be found in Appendix 4.

SUPPORTING OUR COMMUNITIES

CARER SUPPORT

In order to best support formal and informal carers we have added a wealth of materials within the appendices.

APPENDICES

This guidance is collated from various recently produced resources about palliative care for patients with COVID-19. It is intended as a digest, not as a replacement for full documents, which can be found on websites listed at the end of the document.

APPENDIX 1: MEDICATION TABLE

COVID-19 management of End of Life symptoms – Community settings (assumes patients unable to swallow medications safely)

1st Line					2nd Line			
	Breathlessness/ Pain (chest pain seen in some C19 cases)	Agitated delerium	Respiratory secretions	Anxiety (breathlessness if not held with 3 drugs)	Breathlessness/ Pain	Agitated delerium	Respiratory secretions	Anxiety (breathlessness if not held with 3 drugs)
Syringe driver Available**	Morphine 10-30mg/24 hrs CSCI (2.5-5mg SC PRN hourly x4/25hours) Diamorphine 7.5-20mg/24hrs CSCI (1.25-5mg PRN hourly x 4/24hours)	Haloperodol 5mg/24hrs CSCI (0.5-1.5mg SC PRN 4 hourly x 4/24 hours)	Hyoscine Butylbromide 60-120mg/24 hrs CSCI	Midazolam 10-30mg/24hrs CSCI (1.25-5mg SC PRN up to hrly x4/24 hrs)	Oxycodone 10-20mg/24hrs CSCI (1.25-5mg SC PRN hourly x4/24 hrs	Levomepromazine 25mg/24 hrs CSCI (12.5-25mg SC PRN 4 hrly x 3/24 hours)	Glycopyrronium 600-1200mg/24hrs CSCI (200-300mg SC PRN 4hrly x4/24hrs	Levomepromazine if not already on haloperidol. See also Lorazepam SL/Oral
Healthcare professional Available (but no syringe driver)	Fentanyl patch 12-25mcg/hr Replace 48 hrly Diamorphine inj 5mg SC PRN hrly x4/24hrs Morphine inj 2.5-5mg SC PRN hrly x4/24hrs	Haloperidol 5mg SC Once Daily (1.5mg SC PRN 4hrly x4/24hrs	Hyoscine Butylbromide 40mg SC 12hrly increase to 8 hrly if symptoms persist (20mg SC PRN 4hrly x4/24hrs	Lorazepam tablet Blue SL/White Oral 0.5-1mg 12hrly (0.5-SL/oral PRN 6hrly x2/24 hrs	Buprenorphine patch 15-35mcg/hr replace as per instructions or sooner (if no morphine, Oxycodone 2.5-5mg SC hrly PRN x4/24hrs)	Levomepromazine 25mg SC Once daily (12.5-25mg SC PRN 4hyrly x 4/24 hrs)	Glycopyrronium 400mg SC 8hrly (400mg SC PRN 4 hrly x3/24hrs)	Midazolam 1.25 -5mg SC PRN up to hrly x4/24hrs
If SC trained carer available		As row above. If you are not sure about the need for an as required injection then please telephone/support from the community support available.						
Lay carer available but unable to give SC meds	Fentanyl patch Dose as above Oral Morphine 20mg/ml up to 1ml (0.5ml in each cheek) PRN 2hrly x4/24hrs)	Levomepromazine Oral (1 tablet crushed with water) 25mg Once Daily 12.5mg PRN 4hrly x3/24hrs	Scopolamine patch 1mg/day replace 48hrly	See above Lorazepam	Buprenorphine patch as above	Olanzapine oro-dispersible 10mg daily Buccal (5mg Buccal PRN 4 hrly x4/24 hrs	Atropine 1% eye drops 1-2 drops sublingually 6-8 hrly	

These drugs are used off label as is acceptable practice for most end of life drug use.
If 4 drugs are required in the syringe driver then this may be appropriate in 'extreme circumstances' COVID-19 is extreme. DW Palliative Care team if concerned, we may not be able to tie up 2 syringe drivers with one patient.
In all cases consider positioning – sit upright if comfortable.
Keep cool – use a tepid flannel on the head or neck, open a window. Ensure good mouth care, Oxygen is deemed of little benefit in the last days of life.

NOTES

*All drugs in this table are used ‘off-label’ as is accepted practice for most drug use when a person is recognised to be dying. Typical starting does of drugs are given. However, these may need to be adapted to specific patient circumstances, e.g. frail elderly (use even lower doses of morphine), or renal failure (use an alternative to morphine). Seek appropriate advice from the relevant specialists including specialist palliative care teams.

** 4 drugs may be required in one syringe driver. Covid-19 is an extreme circumstance when there will not be sufficient syringe drivers for one person to have more than one syringe driver. If you have concerns discuss with your local specialist palliative care team. If a continuous subcutaneous infusion (CSCI, syringe driver) is needed we usually use a T34 syringe driver. If one is not readily available, other pumps can be used such as for insulin/nitrate infusions; or it may be necessary to take an alternative approach as detailed in the table above.

‡In all cases consider positioning and other non-pharmacological interventions

#These suggestions are made assuming all other medications are unavailable, inappropriate or contraindicated.

Additional notes re patches:

- Patches are usually used only for stable pain and take 12-24 hours to reach effective blood levels.
- Recognising the slow onset of pain relief and titration with opioid patches – if a patient is breathless and/or in pain and the facility to set up a syringe driver or give subcutaneous prn medication is not available, it is better to use an unusual treatment, which we are not used to, but should work, rather than nothing.
- Patients with fever are likely to absorb the drug more rapidly. Furthermore, dying patients may be unable to report their patch becoming less effective after 2 days; hence the recommendation to change patch earlier than in usual practice. Bear in mind however that in spite of fever absorption may be poor in very cachectic patients.

These drugs are used ‘off label’ as is acceptable practice for most end of life drug use. If 4 drugs are required in the syringe driver then this may be appropriate in ‘extreme circumstances’ COVID-19 is extreme. DW Palliative Care team if concerned, we may not be able to tie up 2 syringe drivers with one patient.

In all cases consider positioning – sit upright if comfortable. Keep cool – use a tepid flannel on the head or neck, open a window. Ensure good mouth care,

Oxygen is deemed of little benefit in the last days of life.

some suggestions are made assuming all other medications are unavailable (DIAMORPHINE in particular), inappropriate or contraindicated. Also recognising the slow onset of pain relief and titration with Opioid transdermal patches If a patient is breathless and/ or in pain and the facility to setup a Syringe Driver or give SCPRNs is not available then better to use an unusual treatment which we are not used to but should work, rather than nothing.

** Patches - patients with fever are likely to absorb the drug more rapidly hence the recommendation to change earlier than usual practice. Also, EOL patients may be unable to report their patch becoming less effective after 2 days.

- usually only for stable pain and will take 12-24hours to reach effective blood levels. In spite of fever, absorption may be poor in very cachexic patients.

Covid-19 specific syringe driver available prescription

Covid-19 specific syringe driver available prescription - blank prescription

Covid-19 SPECIFIC BREAKTHROUGH ANTICIPATORY prescription with suggested dose ranges

Covid-19 Specific JIC prescription if not subcut administration available with suggested does range

Covid-19 Specific fentanyl dose blank JIC prescription if no subcut administration available

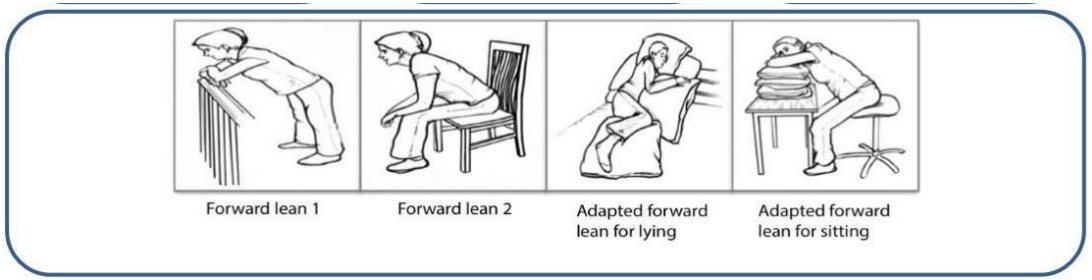
Covid-19 Specific JIC prescription no syringe driver but sub cut available with suggested dose rangeCovid-19 Specific JIC prescription no syringe driver but sub cut available morphine fentanyl dose blank prescription

Management of common symptoms experienced in COVID-19

Breathlessness

Non drug measures:

- Different positions may be helpful



a. Reduce room temperature
b. Cool the face by using a cool flannel or cloth
c. Relaxation techniques, for example, quietly reading a favourite book to the patient, listening to preferred music
d. Portable fans are not recommended for use during outbreaks of infection; if a patient is at home you might open a window

Drug treatment:

If patient can manage oral medication:

- Morphine modified release initially 5mg bd – usual maximum 30mg daily AND
- Morphine sulphate immediate release solution (Oramorph)2.5-5mg PO when necessary (prn); frequency 2 hourly
- Consider adding lorazepam 0.5mg sublingual when necessary (prn) for anxiety/fear; frequency 2 hourly

If patient cannot manage oral medication use a parenteral opioid *and* a sedative anxiolytic:

- If opioid naïve:
    - give a stat dose of **morphine** 5mg SC OR **diamorphine** 5mg SC + **midazolam** 5mg SC (2.5mg in the elderly)
    - start **diamorphine** 10mg/24h + **midazolam** 10mg/24h by CSCI/syringe driver

  - prescribe **morphine** 5mg OR **diamorphine** 5mg + **midazolam** 5mg SC when necessary (prn); frequency 1 hourly (both 2.5mg in the elderly)
- Review regularly and titrate both prn and regular doses to obtain satisfactory relief – seek advice if your patient is distressed

If already taking PO **morphine** or another opioid convert to the equivalent parenteral 24h and prn doses: see https://derbyshire.eolcare.uk/content/documents/uploads/toolkit-docs/Symptom-Management- EOL-Guidance-update-2020-1.pdf

- Consider a 25-33% increase in dose from baseline to manage current symptoms
- In renal or hepatic failure, alternate opioids may be preferable, contact the palliative care team
- Ensure patients receiving regular opiates are considered for laxatives e.g. senna and docusate

Cough (without significant breathlessness)

Non drug measures:

- Oral fluids
- Honey & lemon in warm water Suck cough drops / hard sweets
- Elevate the head when sleeping
- Avoid smoking

Drug treatment:
A strong opioid is the most effective cough suppressant. If already on **morphine** for breathlessness, this may suffice. Otherwise: Morphine sulphate immediate release solution (Oramorph) 2.5mg PO 4 hourly Sodium cromoglicate 10 mg inhaled 4 times a day (can improve cough in people with lung cancer within 36-48 hours)

If patient cannot manage oral medication use a parenteral opioid:

- If opioid naïve:
  - give a stat dose of **morphine** 5mg SC OR **diamorphine** 5mg SC (2.5mg in the elderly)
  - start **diamorphine** 10mg/24h by CSCI
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Consider a 25-33% increase in dose from baseline to manage current symptoms

In renal or hepatic failure, alternate opioids may be preferable, contact the palliative care team Ensure patients receiving regular opiates are considered for laxatives e.g. senna and docusate

Fever

Non drug measures:

- Wear loose clothing Reduce room temperature
- Cool the face by using a cool flannel or cloth
- Avoid alcohol
- Portable fans are not recommended for use Drug treatment:

Drug Treatment

- Paracetamol 1G PO q.d.s. (500mg when ≤50kg)
- Concerns about NSAIDs are irrelevant if the patient is believed to be dying.

Delirium (mild to moderate – if severe see p6)

Non drug measures:

- Identify and manage possible reversible cause or combination of causes
- Reorientate and reassure (for example explaining where the person is, who they are, and what your role is)
- Ensure adequate lighting

Drug treatment:

Haloperidol 500mcg-1mg SC/PO and titrate in 500 microgram increments

Consider a higher starting dose if patient's distress is severe or there is a danger to self/others

Guideline for the symptomatic management of dying patients with presumed COVID-19:

Severe breathlessness & agitation ** All drugs are given subcutaneously**

Step 1:
Diamorphine 5mg **OR** Morphine 5mg
AND
Midazolam 5mg
AND
If severely agitated or delirious add: Levomepromazine 12.5mg **OR** Haloperidol 3mg

Step 2:
Prescribe anticipatory medication as follows, to be used at 30 minute intervals: Diamorphine 5mg **OR** Morphine 5mg
Midazolam 5mg
Levomepromazine 12.5mg **OR** Haloperidol 3mg

If no effect after 30 minutes they should be repeated
If patient remains unsettled after 1 hour in spite of repeated dosing call for advice

Step 3:
Prescribe a CSCI/syringe driver as the patient may survive long enough to benefit: Over 24hrs:
Diamorphine 10mg, Midazolam 30mg, Levomepromazine 50mg
OR
Diamorphine 10mg, Midazolam 30mg, Haloperidol 10mg

Notes:

Experience has shown that, when death from COVID-19 occurs, it happens quickly

This guideline (page 6) is for patients who are **dying (believed to be in their last hours of life)** of COVID-19 irrespective of age, frailty or co-morbidities **who are overtly symptomatic.**

Some patients die of COVID-19 without symptoms. Use clinical judgement to determine what is necessary. Guidance for mild/moderate symptoms, or if survival is anticipated, is given in the first part of this document.

The on-call palliative medicine consultant is contacted via switchboard for advice 24/7

https://derbyshire.eolcare.uk/content/documents/uploads/toolkit- docs/Symptom-Management-EOL-Guidance-update-2020-1.pdf

APPENDIX 2 - VISITING FLOWCHART

https://www.derbyshirelmc.org.uk/redclinicflowchart

APPENDIX 3 - PERSCRIPTION SHEETS

https://www.derbyshirelmc.org.uk/anticipatoryendoflifeprescriptionsheet

https://www.derbyshirelmc.org.uk/sypringedriverendoflifeprescriptionsheet

APPENDIX 4 - ELECTRONIC CREMATION FORM

https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/832911/cremation-form-4-medical-certificate.pdf

APPENDIX 5 - ADVICE SHEETS FOR INFORMAL CARERS LOOKING AFTER PATIENTS WITH CONFIRMED ? PRESUMED COVID-19 NOT WANTING HOSPITAL ADMISSION

Thank you for caring for your loved one at this incredibly difficult time. We want you to know that you are not alone and this advice sheet will give you practical guidance on how you can best help manage any symptoms.

As people become more unwell there are common symptoms, these may include marked shortness of breath, confusion, agitation and restlessness.

Where possible medications taken by mouth can be used to help. In addition, there are some practical things that can be done.

If someone is unable to take medications, or becomes too sleepy, drugs to help them can be given either by putting them on the gums or via a small needle called a ‘butterfly needle’ that can go underneath the skin and be secured.

In this situation, family and friends can be supported to give medications by injection or onto the lining of the mouth to keep patients as comfortable as possible should a doctor or nurse not be available. This is completely legal: if you are happy to take on this role, you will be trained by a healthcare professional on how to recognise the symptoms that need treating and how to give the medications.

Sometimes the patient dies shortly after they have been given medication. It is very important that you are clear that these two things are not related, and the medication has not ended their life. At the doses used, the drugs will not hasten the end of life but make them comfortable.

MEDICATIONS

You will be given clear written instructions of what drugs and doses are suitable for your situation, including the maximum number of doses that can be given in a 24-hour period. Common drugs and doses used will vary between people. Common drugs and their uses include:

- Shortness of breath: Morphine – oramorph / diamorphine / oxycodone
- Agitation / panic: Midazolam or lorazepam
- Respiratory secretions ‘ A rattly chest’: Glycopyrronium or hyoscine butylbromide
- Fever where the patient appears uncomfortable: paracetamol

OTHER MEASURES

Some simple techniques can help give some symptom relief without needing drugs. These include

- Keep them cool and comfortable (eg a cold compress)
- If they are more comfortable, sit them up
- Ensure good air circulation – open a window
- Encourage the patient to breath in through their nose and out through pursed lips, this reduces the feeling of breathlessness
- Keep a cup nearby as sips as water can help keep their mouth moist

HYGINE ADVICE / CLEANING

Caring for someone with COVID-19 means there is virus within your home. As a carer you will be at risk of contracting the virus. It is therefore very important to follow all the hygiene advice:

- Wash hands regularly for at least 20seconds each time
- Make sure hands are washed before you eat
- Avoid touching your face where possible
- Avoid fans which can disperse the virus

- Keep towels / bedding separate and do laundry regularly
- Wipe surfaces down regularly with an antibacterial cleaner and consider areas which are regularly touched eg door handles.

If the medications are oral it will state every 1-2hours. If the medications are via a needle under the skin, you will be able to receive 24hour support line. Details will be given to you by your local team.

Should there be a delay in getting in contact with them, it is fine to give the medications and let them know afterwards

ADVICE SHEET – HOSPICE UK

Hospice UK have produced excellent COVID specific advice for carers available at https://www.hospiceuk.org/what-we-offer/clinical-and-care-support/what-to-expect/caring-for-your-dying-relative-at-home-with-covid-19

APPENDIX 6 - INSTRUCTIONAL VIDEOS

How to give a S/C Injection

Text/Picture instruction: https://www.nursingtimes.net/clinical-archive/assessment-skills/injection-technique-2-administering-drugs-via-the-subcutaneous-route-28-08-2018/

YouTube video s/c injection: https://www.youtube.com/watch?v=T4NWm7mqbHI

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

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

Setting up a syringe driver
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

NB.We will need to be clear on total volume for drawing up drugs as there is regional variation!!

APPENDIX 7 - ADVICE FOR CARE HOMES

https://www.derbyshirelmc.org.uk/goodpracticeguideforcarehomesincovid19pandemic

APPENDIX 8 - USEFUL WEBSITES

NHS England specialty guidance Palliative Care and Coronavirus: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0081-Speciality-guide-Palliative-care-and-coronavirus-FINAL-02.04.20.pdf

RCGP guidance for End of Life Care with Coronavirus, including care after death, death certification

https://elearning.rcgp.org.uk/mod/page/view.php?id=10537

For general advice regarding managing COVID-19 in care homes see also: https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes

Guidance for care after death: https://www.gov.uk/government/publications/covid-19-guidance-for-care-of-the-deceased/guidance-for-care-of-the-deceased-with-suspected-or-confirmed-coronavirus-