# Kent and Medway Standard Operating Policy for Out of Hospital Treatment Pathways for Adult Patients for Covid-19

## Background and Context:

The Covid-19 pandemic was formally declared in England in February 2020. At this time Kent and Medway Clinical Commissioning Group (CCG) was still eight separate organisations and therefore there were different community services available in different areas to support people in their own homes (including care homes). During the first wave of the pandemic, a number of initiatives were developed to help people living with frailty to make decisions about their care and receive care in their normal place of residence if that was the preferred option. Examples of these initiatives included development of a Frailty Home Treatment Service in East Kent, increased access to virtual consultation from primary care and development of a single treatment escalation plan (TEP) for use across Kent and Medway. During this period there were very limited treatment options available to people with Covid-19 who wanted to remain at home and so much of the clinical input to this group of patients was based on symptom management and, when appropriate, palliative care.

The second wave of Covid-19 has now started and there is an opportunity to use the learning from the first wave to increase the treatment options available to people outside of hospital.

NHS England and NHS Improvement have undertaken a review of the evidence for use of a number of community treatments in collaboration with the British Geriatric Society and there is formal guidance awaiting publication. In Kent and Medway this SOP has been developed to support implementation ahead of the formal publication of the guidance but informed by the consensus that is emerging through that development process.

### Purpose of this guidance:

This SOP sets out the Kent and Medway position on community treatments for Covid-19 in adults. It is intended to reflect the growing national consensus on the evidence and will be updated when formal guidance is published in this area. The SOP outlines the principles that should inform the clinical decision to initiate and monitor a treatment pathway as well as guidance on prescribing and identifying indicators that a treatment should be stopped. This document includes considerations of the risks and benefits of these pathways and the potential ethical issues related to the rapid introduction of these treatments.

As the services in Kent and Medway are still arranged differently in each of the Integrated Care Partnership (ICP) areas, this guidance will need to be implemented flexibly to reflect the local service providers, capacity and resource. It is important to note that the complexity of clinical needs is such in many of these patients that if they were being managed similarly in the hospital settings, the decision making would involve many specialists and their multidisciplinary team. Therefore clinicians in the community are encouraged to seek further guidance whenever in doubt from our acute specialists in any given situation.

Individual provider organisations will need to ratify this guidance through their own governance structures. The standard forms provided in the appendix are intended as useful resources and again can be adapted to organisation specific formats if required.

### Patient Group:

This SOP has been developed primarily for adults living with frailty as the effect of Covid-19 on this group during the first wave was disproportionate compared to other groups. However it may be beneficial to follow these pathways for other patient groups and this should be done at the discretion of the senior treating clinicians. If appropriate other specialist services should be asked to support the process. For example, these pathways may be appropriate for people with Learning Disabilities living in a care home environment but should only be initiated with specialist Learning Disability support to plan implementation tailored to the individual.

### Development:

This SOP has been developed by a small clinically led group with wider engagement with the following organisations:

* Kent and Medway Clinical Commissioning Group (including Primary Care Clinical Leads)
* Kent Community Health NHS Foundation Trust
* Medway Community Healthcare
* Virgin Care
* Pilgrims Hospices
* Heart of Kent Hospice
* Ellenor Hospice
* Integrated Care 24
* South East Coast Ambulance Service NHS Foundation Trust
* Kent Surrey Sussex Academic Health Sciences Network

As the pathways are implemented in each ICP area, there is an expectation that local engagement with patient groups and third sector providers will be undertaken.

### Treatment Pathways:

This SOP sets out guidance for the use of the following treatments in Community Hospitals, Care Homes and peoples own homes:

* Oxygen
* Dexamethasone
* Anticoagulant
* Fluid Management

### Referral routes:

Patients who may be appropriate for these pathways will be identified by their care home, community hospital staff, general practice and community services. If a person is confirmed as having Covid-19, they will be referred into the Covid Virtual Ward in their locality for regular monitoring of their saturation levels, dependent on their risk. If the CVW identifies that a patient is deteriorating and developing hypoxia then they can refer to the appropriate locality service (e.g. Frailty/ Acute Response) for consideration of these treatment pathways. Initially, these community treatment pathways will be separate from the CVW and it is anticipated that relatively small numbers of patients will be on the treatment pathways. In the future if the numbers rise and the CVWs are well established, there may be more opportunity to co-ordinate monitoring between the pathways.

### Treatment Escalation Plans:

During the first wave of Covd-19 a single TEP (treatment escalation plan) was agreed across Kent & Medway although there was some local variation in the forms. A revised version has now been agreed across Kent and Medway that is standard for use during the second wave (see appendix 1). The TEP is underpinned by the principle that all patients should have the opportunity to make informed decisions about the care that they receive. If a patient is unable to engage in this process then a decision can be made in their best interests but this should be done in conjunction with family members and adhere to the principles of the Mental Capacity Act in ensuring it reflects the patient’s previous behaviours and beliefs.

The TEP should be completed by a clinician that knows the patient and can also be supported by other professionals who know the patient such as care home managers or carers. The TEP should be the formal documentation of a good quality conversation/ or conversations that has taken place between the patient, their family and the appropriate clinicians and professionals. The TEP is an essential part of this SOP as it provides the patient perspective that should underpin treatment decisions. If a TEP is not in place then it should be completed as part of the acute episode prior to initiating any of the pathways documented here.

Prior to initiating treatment, the senior clinician should review the TEP in the context of the patient’s current presentation and the wider context of the health system. This will allow the clinicians to present an accurate reflection of the potential risks and benefits of treatments in different environments. This is particularly important in the context of Covid-19 as the pressures on different parts of the system at any one time may change the treatment options available. The importance of using language that is clear, unambiguous and understood by the patient and their families is vital. As is clear clinical documentation of ceilings of care and with pros and cons of the options shared with patient, including risk of deterioration and death as a consequence of choices made.

### Ethical Considerations and clinical support

The pathways in this SOP have been developed based on new evidence and clinical consensus from the first wave of Covid-19 and therefore clinicians working in the community should feel supported to seek senior review or advice prior to initiating these pathways.

Clinicians may have to make decisions in challenging circumstances or when resources are limited. It is not possible to anticipate all of these risks and circumstances in this document and therefore the role of the senior clinician in assessing the risks and benefits of potential treatments is crucial. These decisions should be made using: Planning for and managing Covid-19: Ethical decision-making tool (appendix 2). The principles in this document are that decisions should be based Fair, Inclusive, Transparent, Reasonable, Accountable and Responsive to the maximum extent possible. The tool provides steps to follow to support decision making. As with any complex ethical dilemmas involving clinical decision making, senior colleagues within each organisation, such as the Frailty/Acute Response teams and acute clinicians, should be consulted. The reasoning for decisions should be clearly documented to support any future reflections.

## Oxygen:

### Principles of use

During the first wave of Covid-19, some community clinicians used flow rates of up to 4L/min to support patients with mild to moderate hypoxia. In adopting an oxygen treatment pathway of this type in the community, reference should be made to the NHS South East: Oxygen therapy outside acute settings during the Covid-19 pandemic v3.3 (see appendix 3). This guidance helps to identify the factors that should be considered before initiating this pathway and the clinicians who should be involved in decision making and monitoring. This guidance is being adopted across Kent and Medway.

If the Oxygen treatment pathway is initiated, it is essential that the core standards are adhered to as follows:

* Oxygen should be prescribed on the prescription chart along with specific target saturation levels
* The clinical indication should be clearly documented
* Pulse oximetry should be in place and recorded at a minimum of 4 times daily
* Patients should have a risk assessment completed prior to initiation of oxygen
* Equipment provided should be checked daily
* Oxygen should be stored safely
* Staff must be appropriately trained

### Pathway

See appendix 4 and 5 for pathway documents in different settings.

Patients with confirmed or suspected Covid-19 should have a TEP in place and so if there is not a TEP, an appropriate referral should be made to ensure one is completed prior to treatment starting. Patients should also be reviewed clinically, under the guidance of the general practitioner to identify any deterioration in presentation. If deterioration is noted then the pathways in appendix 4 and 5 should be used to support treatment decisions.

The decision to initiate treatment should be made by an appropriate senior clinical decision maker (SCDM). If possible this should be in conjunction with specialist community respiratory teams, or at a minimum, the respiratory team should be informed. Secondary care teams should be used for advice and guidance if indicated.

Oxygen should be prescribed on the standard chart (appendix 6) and supply requested via the Home Oxygen Ordering Form (HOOF). This is done online via the following link and will require the Clinicians PIN number and a risk assessment form (IHORM - Initial Home Oxygen Risk Mitigation).

<https://www.dolbyvivisol.com/services/healthcare-professionals/home-oxygen-services/england/ihorm-and-hoof-part-a/>

Treatment should be monitored as per the pathways with the SCDM monitoring for identified risks, appropriate use of equipment and training needs. It is likely that community services such as community nursing and rapid response will support ongoing monitoring. The decision to stop treatment will be clinically judged with reference to the indicators in appendix 7.

## Dexamethasone:

### Principles of use:

Dexamethasone can be prescribed for people with severe or critical Covid-19 based on the published NICE guidance (appendix 8), in most cases it should be used in conjunction with Oxygen as per the previous section.

If the dexamethasone pathway is initiated, clinicians should consider use of gastro protection as prompted on the prescribing form (appendix 6). If the patient is diabetic then close blood monitoring should take place.

### Pathway

See appendix 4 and 5 for pathway documents in different settings.

Patients with confirmed or suspected Covid-19 should have a TEP in place and so if there is not a TEP, an appropriate referral should be made to ensure one is completed. Patients should also be reviewed clinically under the guidance of the general practitioner to identify any deterioration in presentation. If deterioration is noted then the pathways in appendix 4 and 5 should be used to support treatment decisions.

The decision to initiate treatment should be made by an appropriate SCDM. The SCDM is likely to be a clinician from a community response service such as a frailty team or acute response team. The initiation of treatment should be managed in conjunction with the patient’s GP who should be able to support prescribing and provision of necessary monitoring equipment as appropriate.

Treatment should be monitored as per the pathways with the SCDM monitoring for identified risks and training needs. It is likely that community services such as community nursing and rapid response will support ongoing monitoring. The decision to stop treatment will be clinically judged with reference to the indicators in appendix 7.

## Anticoagulants

### Principles of use

Patients with Covid-19 have an increased risk of venous thromboembolism and therefore VTE prophylaxis should be considered to align the standard of community care with that delivered in acute patient settings.

Based on usual protocols within hospital, if the risk assessment indicates VTE prophylaxis is indicated then either a once daily injection of low molecular weight heparin or a direct oral anticoagulant (DOAC) should be offered.

If the anticoagulation pathway is initiated, it is essential that the following criteria are met:

* Resources should be in place to take baseline bloods to support prescribing
* The location (community hospital, care home or patients home) need to be able to support subcutaneous injections or a DOAC should be prescribed unless contraindicated.
* Patients medical history and renal function must be considered and appropriate medication prescribed
* If a DOAC is considered then the patients existing medication should be reviewed for any interactions
* A bleeding risk assessment should be completed to support decision making
* Patients should be aware the use of DOAC is off label though has been regularly used without problems and is licensed for similar treatments

### Pathway

See appendix 4 and 5 for pathway documents in different settings.

Patients with confirmed or suspected Covid-19 should have a TEP in place and so if there is not a TEP, an appropriate referral should be made to ensure one is completed prior to treatment. Patients should also be reviewed clinically under the guidance of the general practitioner to identify any deterioration in presentation. If deterioration is noted then the pathways in appendix 4 and 5 should be used to support treatment decisions.

The decision to initiate treatment should be made by an appropriate SCDM. The SCDM is likely to be a clinician from a community response service such as a frailty team or acute response team. The initiation of treatment should be managed in conjunction with the patient’s GP who should be able to support prescribing and review of existing medications. See appendix 9 for the prescribing chart. A standard dose of pharmacological VTE prophylaxis is now recommended for most patients by NICE but the patients GP should advise on dose adjustments if required (e.g. due to renal function).

A bleeding assessment should be completed (see appendix 9).

Treatment should be monitored as per the pathways with the SCDM monitoring for identified risks and training needs. It is likely that community services such as community nursing and rapid response will support ongoing monitoring. The decision to stop treatment will be clinically judged with reference to the indicators in appendix 7.

## Fluid Management

### Principles of use

Dehydration and acute kidney injury (AKI) in patients with Covid-19 is common and associated with an increased risk of dying. Maintaining fluid status reduces the risk of AKI. Risk factors for AKI include pre-existing chronic kidney disease, heart failure, liver disease, history of AKI and aged over 65.

Reference should be made to the NICE Covid-19 rapid guideline: acute kidney injury in hospital.

### Pathway

See appendix 4 and 5 for pathway documents in different settings.

Patients with confirmed or suspected Covid-19 should have a TEP in place and so if there is not a TEP, an appropriate referral should be made to ensure one is completed prior to treatment. Patients should also be reviewed clinically under the guidance of the general practitioner to identify any deterioration in presentation. If deterioration is noted then the pathways in appendix 4 and 5 should be used to support treatment decisions. Current medications should be reviewed and treatments suspended as appropriate e.g. SGLT2 inhibitors, ACE inhibitors, diuretics, metformin, ARBs, NSAIDs.

The decision to initiate treatment should be made by an appropriate SCDM. The SCDM is likely to be a clinician from a community response service such as a frailty team or acute response team. Assessment of fluid status should be based on clinical examination and appropriate investigations where available. Review of routine medications should be considered in conjunction with the patients GP. Where appropriate, oral hydration should be used to increase fluid intake. Where this is not possible, subcutaneous fluid should be considered if there are the resources within the community to deliver this.

Treatment should be monitored as per the pathways with the SCDM monitoring for identified risks and training needs. It is likely that community services such as community nursing and rapid response will support ongoing monitoring. The decision to stop treatment will be clinically judged with reference to the indicators in appendix 7.

## Palliative care:

The decision to provide palliative care to a patient should be made with reference to their TEP and in discussion with the patient and family.

The pathways in appendix 4 and 5 indicate where a palliative approach should be considered and should be used to support decision making.

Where a palliative pathway is initiated, appropriate palliative care services should be involved and medication should be in place proactively to support symptom management. The charts in appendix 10 and 11 can be used for prescribing of medication for end of life care. Clinicians and care staff should be extra vigilant for the sudden deterioration such patient may develop and informing the patient, families and supportive teams involved proactively.

The Kent and Medway symptom control guidelines are in appendix 12.

## Out of hours considerations:

These guidelines are primarily for use within hours (to be locally defined, service permitting, 8am – 8pm, Monday – Sunday). It is anticipated that treatments will be started within these hours by a senior clinician within an appropriate community service such as a specialist frailty or acute response team. If oxygen is started at the end of a shift then there is potential for the oxygen to arrive after the service has closed. On delivery staff will be trained by the supplier and so out of hours (OOH) services should not need to be contacted unless there is a change in presentation.

If a patient deteriorates then OOH services should be accessed as per normal pathways of care and escalation. The OOH contact details should be clearly shared and emphasised to the patient, their families and carers involved. The OOH clinicians should be made aware of any treatment pathways that a patient is on and informed of the content of the TEP. Clinicians should be aware that OOH services may not be able to view TEPs electronically and therefore patients in their own home or care home staff should be reminded to share TEPs with out of hour’s providers.

As per the pathways charts in appendix 4 and 5, anticipatory medication should be provided to patients on treatment pathways in case they deteriorate out of hours. Please see the Anticipatory End of Life prescribing policy in appendix 12. Clinicians should be aware that access to anticipatory medications can be challenging overnight and so anticipatory prescribing is recommended.

## Appendix 1: Treatment Escalation Plan



## Appendix 2: Ethical decision-making tool



## Appendix 3: SE Oxygen Guidance



## Appendix 4: Care Home Pathways



## Appendix 5: Community Hospital Pathways



## Appendix 6: COVID-19 Community Active Treatment Bundle Chart



## Appendix 7: Indications to stop treatment



## Appendix 8: NICE Guidance for Dexamethasone



## Appendix 9: Anticoagulation chart and bleeding risk assessment

 

## Appendix 10: COVID-19 (‘Just in Case’ oral and injectable) chart



## Appendix 11: Example of a Standard Palliative chart



## Appendix 12: Covid Symptom Control Guidelines

