Bay Health & Care Partners

COVID-19 Community Resource Pack

>65 Out of Hospital Covid-19 Triage & Referral Centre

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BH&CP Covid-19 Clinical Protocol ALL ages

April 2020

The Triage & Referral Centre is NOT designed for patients under the age 65 for whom current channels of referral are appropriate e.g. 111, 999 and the Medical Admission Co-ordinators phone numbers at RLI and FGH. In addition most surgical cases would again be appropriate for current admission processes, NOT the C19 Triage & Referral Centre.

Version	Date
1.2.1	03/04/20

Description	By Whom	Complete
Drafting	Morecambe Bay Respiratory Network Clinical Lead	27/03/20
Review	Lead Respiratory ANP COVID19 Clinical Triage & Referral Support Lead	27/03/20
QA	Director (Clinical) Out of Hospital COVID 19 Command	27/03/20
Authorised	Clinical Reference Panel	27/03/20

Contents

1. OVERVIEW: Over 65s (inc. >65 Severely Frail) Out of Hospital COVID 19 Triage & Referral Service

Tel: **0300 xxx xxxx**

Purpose

On 20th March a COVID-19 out of hospital (OOH) patient flow (>65) project was approved by the Chief Executive of UHMBFT on behalf of Gold Command to direct the system response needed to support the imminent healthcare issues for the elderly and frail in Morecambe Bay arising from the current COVID-19 pandemic.

The clear concern is that during the pandemic the peak of admissions is forecast to exceed the planned acute bed capacity in both best and worst case scenarios.

Whilst our primary focus is keeping patients who are over 65, frail and elderly out of hospital where this is not in their best interests (and supporting them in the community), we equally need to make sure the hospital discharge process is optimised and primary care, community services, social care and 3rd sector support will be key to making this as good as it can be.

Launch of Out of Hospital COVID-19 Command Service (Over 65s ONLY)

Today a new Over 65s Out of Hospital COVID 19 Triage & Referral Service will go live for the use of Primary Care (GP and GP Out of Hours), Community Services, North West Ambulance Service and Nurses in Care Homes to support decision making around the admittance of over 65s (severely frail/Covid-19 related) where admittance is considered appropriate. The purpose of the service is to:

- Assist in your clinical decision making by using a new COVID-19 clinical protocol for the over 65s
- Support referrals to community, social services and 3rd sector support where it is in the best interests of the patient to stay in a home setting
- Send pre-admission information to the acute hospital to assist in their admission and discharge at a future point
- Access shared record information, anticipatory care plans where these exist, DNR information and other intelligence around bed capacity to optimise hospital use and provide the best possible support to our most vulnerable patients including in the community

There will three elements to the Over 65s Out of Hospital Triage & Referral Service:

- A call handling team with colleagues at Cumbria Health On Call Service (CHOC) who will liaise with colleagues across primary care, community services and NWAS to take details of the patient's situation. You will be able to contact them on **0300 xxx xxxx**

A Clinical Decision-Making Team who will triage patients, using patient's situation notes, access to their shared GP Record, reviewing their frailty information and using the newly approved COVID-19 Triage Protocol. They will

- Support the admittance by electronically sending a pre-admission note to the hospital or sending to our referral team for support in the patient's own home
- The Referral Co-ordination Team will identify the appropriate support needed to keep the patient at home and make onward referrals to primary, community, social services or 3rd sector support to make that happen. From 6th April this will include referring patients to new primary care 'Red Hubs' being established in response to COVID-19

This service is for ALL MBCCG GP PRACTICES. We would also ask all primary care (inc. CHOC & PDS), community services, NWAS colleagues and nurses in care homes to use this service from 1st April 2020 so we can collectively work to optimise our acute bed capacity for those who need them.

What we need from you…

You can help now by being prepared before you call the **Over 65s Out of Hospital Triage & Referral Service:**

- **Ask if there is an anticipatory care plan already in place** which expresses the patient's wishes if they have COVID-19?
- **Check their NEWS2 score**
- **Check the Rockwood Score** circulated in this pack
- **Use the COVID-19 clinical triage protocol** in this pack and reflect on whether admittance is in the best interests of the patient before calling to optimise patient care including in the community (where appropriate)

If you do decide they may be suitable for admittance…

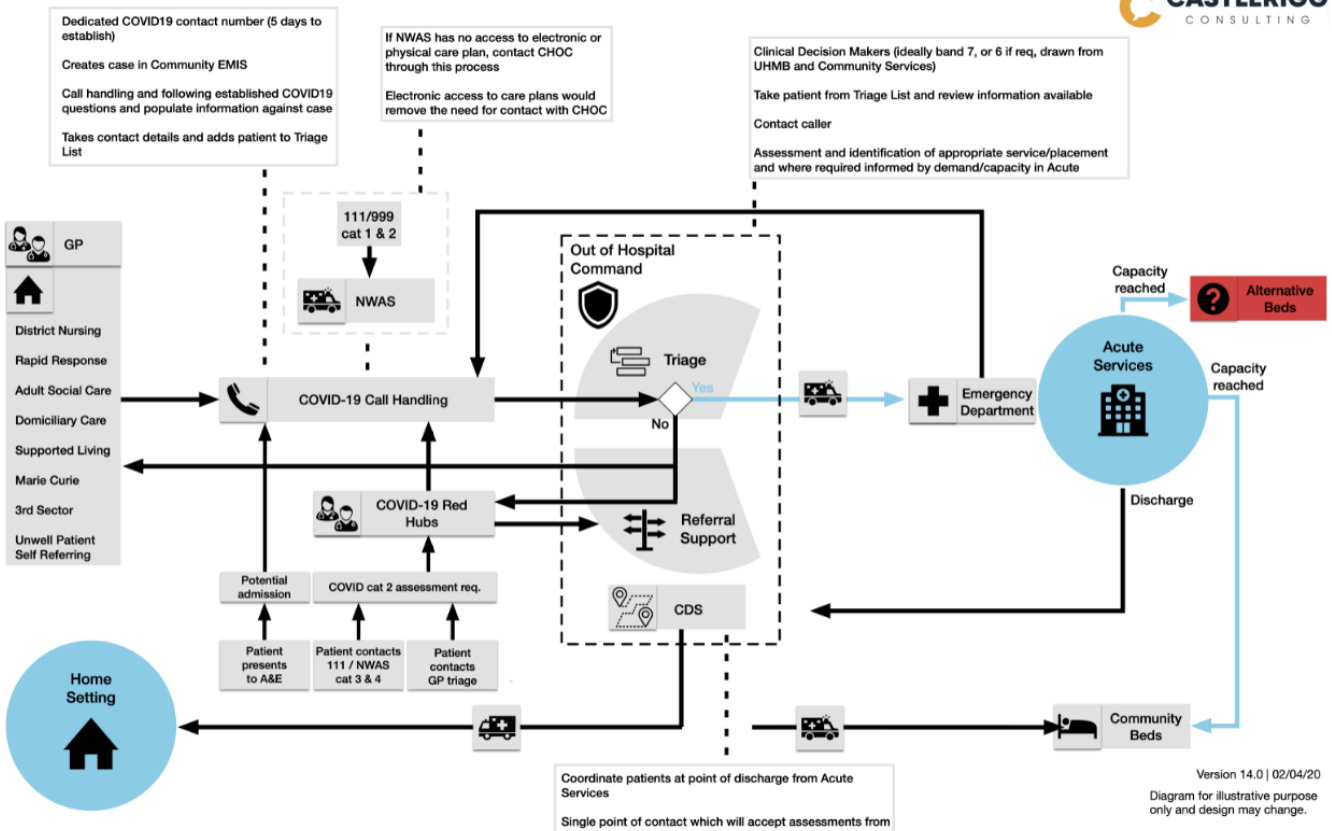
- **Review the initial call handler questions** provided in this pack we will ask you and be prepared with enough information to support triage
- **You will be contacted back if the patient is appropriate for admittance.** If admission is not appropriate (following the agreed BH&CP clinical protocol (below) you will be contacted to discuss the best community care options

We need to work together, across the health economy to optimise the Hospital and protect our patients' interests. Thank you in advance for your support.

For more information

Contact:

Proposed Out of Hospital Command Flow



Version 14.0 | 02/04/20

Diagram for illustrative purpose only and design may change.

2. Out of Hospital COVID-19 Triage & Referral Centre:

Questions for Call Handlers

1) What is the person's residence?

Independent in the Home 0, Home with Care 1, Sheltered 2, Residential Home 3, Nursing Home 4

2) What is the (Rockwood) Frailty Score 1-9 (mild/moderate/severe)?

Add Rockwood score to the above score

3) Is there an advanced care plan (available as hard copy or through electronic record sharing)? If yes then what are expressed wishes?

Yes or No and then a brief description of the wishes to be recorded

4) If Rockwood severe (7, 8 or 9) is this the final illness?

Yes or No Record

5) NEWS score 0-11

Record the Answer

6) Does the individual have capacity? If yes then what is **their** decision (need to promote choice and empower the individual?

Yes or No Must record the answer.

7) What is your assessment of stay at home (with appropriate safety net) vs ED transfer (consider safeguarding)?

Record the answer

8) What is your rationale for the decision taken and subsequent actions? Is there any additional information you need to share?

Record the answer

1 – COVID19 Community Triage Protocol – Part I (Page 7)

Aims of this protocol are to:

- Provide the high-level outline of the standardised triage protocol for suspected COVID19 patients in MB CCG
- Reduce pressure on Secondary Care capacity and decision-making by rapid identification of those patients who require, and are suitable for assessment at UHMB
- Support Community and Primary Care teams to identify cohorts of patients for whom admission would not be not required or inappropriate

Initial Telephone Triage
(GP Surgery/111/Command Centre)

Category 3 – COVID Possible, Mild Symptoms

Action

- Self-Isolate in line with current Government guidelines
- Stay at home & Self Care, utilise local volunteers/family or friends for support
- Call 111 if worsening

Category 2 – COVID Possible, Needs Assessment

Examples:

- Unlikely COVID19 Respiratory Symptoms requiring examination
- Likely COVID where assessment required to determine suitability for admission

Action

- GP Surgery book Red Hub appointment or Red Home Visit as required
- To be seen in locality 'Red Site'

Decision by Assessing Clinician

Either

1. Patient to be kept at home +/- support from community services
2. Patient to be considered for admission to hospital

NEXT PAGE FOR GUIDANCE

Box 1: Category 1 – COVID Possible and Severe Illness

Community Clinical Criteria

Any of:

- Significant NEW Dyspnoea, RR >25
- Cardiovascular instability
  - Dehydration requiring IV therapy
  - Hypotensive
- New confusion
- Pulse Rate >130
- New Hypoxaemia
  - <92%, or,
  - <88% (if usual target 88-92%)

If any of above, contact Command Centre

2 – COVID19 Community Triage Protocol – Part II (Page 8)

Command Centre

Cohort 1 - Keep at home

- Patients for whom admission is not in best interests
- Patients who are unlikely to benefit from, or do not require critical care interventions
- Patient preference

Cohort 1 – Example Criteria

Clinical Judgement based on combination of

- Category 1 clinical criteria **NOT MET (see Box 1)**
- Rockwood Frailty Scale 7, 8 or 9
- Multi-morbidities
- Care home resident **EXCLUDING** those with Chronic Mental Health & Learning Disability
- ACP in place to avoid admission
- Clinician feels not appropriate to admit

Assessment outcome:

1. Clinician would like to discuss case with Primary Care Hub
2. Patient will stay at home and need support package

GP Contacts Command Centre for referral management (or via EMIS X Org Appt)

NB – Patients who would be suitable for admission but do not meet clinical criteria (Box 1):

- 24-48 hour review assessment
- Patient may go on to meet admission criteria given natural course of COVID infection

Cohort 2 - Suitable for Admission

- Patients who require critical care interventions
- Should be considered for assessment by ITU & Respiratory teams for critical care intervention
- Clinical judgement may override NEWS2 score

Cohort 2 – Example Criteria

- Category 1 clinical criteria **MET (see Box 1)**
- Rockwood Frailty Scale 1-6
- No ACP in place to avoid admission
- Clinician feels appropriate to admit normal circumstances

Assessment Outcome:

1. Clinician feels that the patient is suitable for admission

Decision

Go/No-go for admission

Joint decision between assessing clinician and Command Centre
ONLY override if no hospital capacity

Non-Patient Factors to consider:

- Current ventilation criteria (from UHMB 9:30 meeting)
- Community services status
- Other

For admission

– Command centre to arrange Ambulance transport

Not for admission

– Command centre to co-ordinate care package with GP

3 – COVID19 Patient Initial Assessment (Page 9)

Summary

- This protocol provides some guidance and support for the assessing clinician
- It applies once a patient has been deemed to need face to face assessment at home or in a hub
- There are **three possible outcomes** – urgent admission, discharge with advice or discharge with planned review

COVID19, clinical course key points

- Three broad stages
  - Viral response phase with mild symptoms
  - Pneumonia in some patients, may need oxygen support
  - ARDS – host Immune response, ventilation required
- Average time from symptoms
  - Hospitalisation – **7 days**
  - ARDS – **8 days**
  - ITU admission – **10 days**
- Can decline rapidly
- **Status on day 1-5 does not predict clinical course**

Severe illness criteria. Any of:

- Significant NEW Dyspnoea, RR >25
- Cardiovascular instability
  - Dehydration requiring IV therapy
  - Hypotensive
- New confusion
- Pulse Rate >130
- New Hypoxaemia
  - <92%, or,
  - <88% (if usual target 88-92%)

Following triage Patient is Category 2 and requires face to face assessment

Assess:

- Patient age, pre-morbid status
- Advanced care plan status
- Social support/care package
- Current symptomatology & observations
- ?Signs of consolidation

Outcome – Discharge with Advice

- Mild or Non-COVID19 illness
- Patient and household to self-isolate
- Advice on self-care, 111 if deteriorates

Outcome – Palliation or Discharge with planned review

Either

1. Patients who would be for admission but currently don't meet the criteria
2. Patients for whom admission is NOT appropriate

Outcome - Admission

- Severe illness criteria met
- Clinician feels admission appropriate
- Rockwood Frailty score 1-6
- No ACP for care at home
- Depending on level of oxygen required/hospital capacity some frail patients may well benefit from admission e.g. for Nasal Cannula

Admission Protocol

- Clinician to contact Command Centre
- Call **0300 xxx xxxx**
- Patient conveyed to Emergency Department

1. Discharge with planned review – Next Steps

- Empirical Abx if signs of consolidation (Amox/Doxy)
- **Review at 24-48 hours - ?needs admission**
- Review via GP Red Hub – **Cross-Org appt. in EMIS**
- Refer from GP Red Hub – If Rapid Response or Social Care input required

2. Palliation – Next Steps

- Empirical Abx if signs of consolidation (Amox/Doxy)
- GP Red Hub referral to District Nurse/Palliative Care & Rapid Response via Strata Pathways
- Palliative medications **as per guidelines**

4 – Rockwood Frailty Score (Page 10)

1 Very Fit – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 Well – People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally, e.g. seasonally.

3 Managing Well – People whose medical problems are well controlled, but are not regularly active beyond routine walking.

4 Vulnerable – While not dependent on others for daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.

5 Mildly Frail – These people often have more evident slowing, and need help in high order IADLs (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 Moderately Frail – People need help with all outside activities and with keeping house. Inside, they often have problems with stairs and need help with bathing and might need minimal assistance (cuing, standby) with dressing.

7 Severely Frail – Completely dependent for personal care, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 Very Severely Frail – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. Terminally Ill – Approaching the end of life. This category applies to people with a life expectancy<6 months, who are not otherwise evidently frail.

<u>Scoring frailty in people with dementia</u>

- The degree of frailty corresponds to the degree of dementia. Common symptoms in **mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.
- In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.
- In **severe dementia**, they cannot do personal care without help.

5 – Oxygen Assessment (Page 11)

Summary

- Patients requiring supportive care in the community may require oxygen therapy as part of their overall management
- Currently we are expecting a high number of patients with possible or confirmed COVID 19 infection for whom admission is inappropriate and some of these may be hypoxic
- This temporary guidance is for primary and community teams to direct queries around oxygen therapy
- This applies to all community, palliative and primary care teams

Chronic Respiratory Disease + New Hypoxaemia (non-palliative)

O_2 Sats **<92%** on two occasions

- These patients would normally get an oxygen assessment for Long Term Oxygen Therapy
- Access may be limited given current situation

Palliative Oxygen Therapy

Consider Oxygen if:

O_2 Sats **<88%** in Palliative patient GSF Red

- Oxygen will likely only have limited role in symptom management
- Aim is symptom improvement and **not** normal oxygen saturations
- To be discussed with Primary Care Hub initially

Clinician contacts Primary Care Hub

- Need to know - smoking status of household

Patient Suitable for Palliative Oxygen Therapy

- Hub to contact Respiratory CNS direct line to discuss
- 7 Days a week, 8am – 6pm
- Ideally morning referrals to help with demand

Patient Established on Oxygen

- Ongoing clinical queries to same phone number
- Limited home visiting capacity during COVID 19 pandemic

Regular Review

- Palliative patients to be reviewed at 48-72 hours
- If no symptomatic benefit then consider removal of oxygen therapy
- Focus on alternative dyspnoea management strategies

6 – COVID19 Initial Post-Discharge Assessment (page 12)

Summary
- This page provides some guidance and information for the assessing clinician
- It applies once a patient has been discharged following **COVID19 admission**
- Patient should have initial review within the week post-discharge
- Patient requires a chest X-Ray at 6 weeks

Key issued to be reviewed/considered

- Should the patient deteriorate would they be suitable for admission?
- What are the baseline observations post-admission
- Short and long-term complications of ARDS (i.e. in patients who were ventilated)
- Mental health
- Social support/care package
- Palliative care

Accessing Support

– Community Teams – GP Red Hub Referral via Strata Pathways
- Rapid Response
- Social Care

– Clinical advice
- Via GP Red Hub and Strata Pathways- SMS text to duty respiratory advice
- They have access to respiratory consultant guidance

– Palliative Care
- Via GP Red Hub and Strata Pathways
- Clinical guidelines available

Complications of ARDS

Ventilation on ITU is most likely due to the development of Acute Respiratory Distress Syndrome (ARDS) which is a overwhelming immune response (cytokine storm) affecting the lung and provoked in this situation by COVID19 infection.

– Short Term (usually during admission)
- Hospital acquired pneumonia
- Breathlessness, crackles on auscultation
- Speech problems, sore throat
- Emotional
- Deconditioning/muscle weakness

– Longer term (up to five years)
- PTSD/Depression/Anxiety ~66%
- Lung function (obstruction or restriction) normalises usually by 6 months
- Cognitive impairment ~30-55%
- Muscle weakness, difficulties with ADL's
- Lung fibrosis