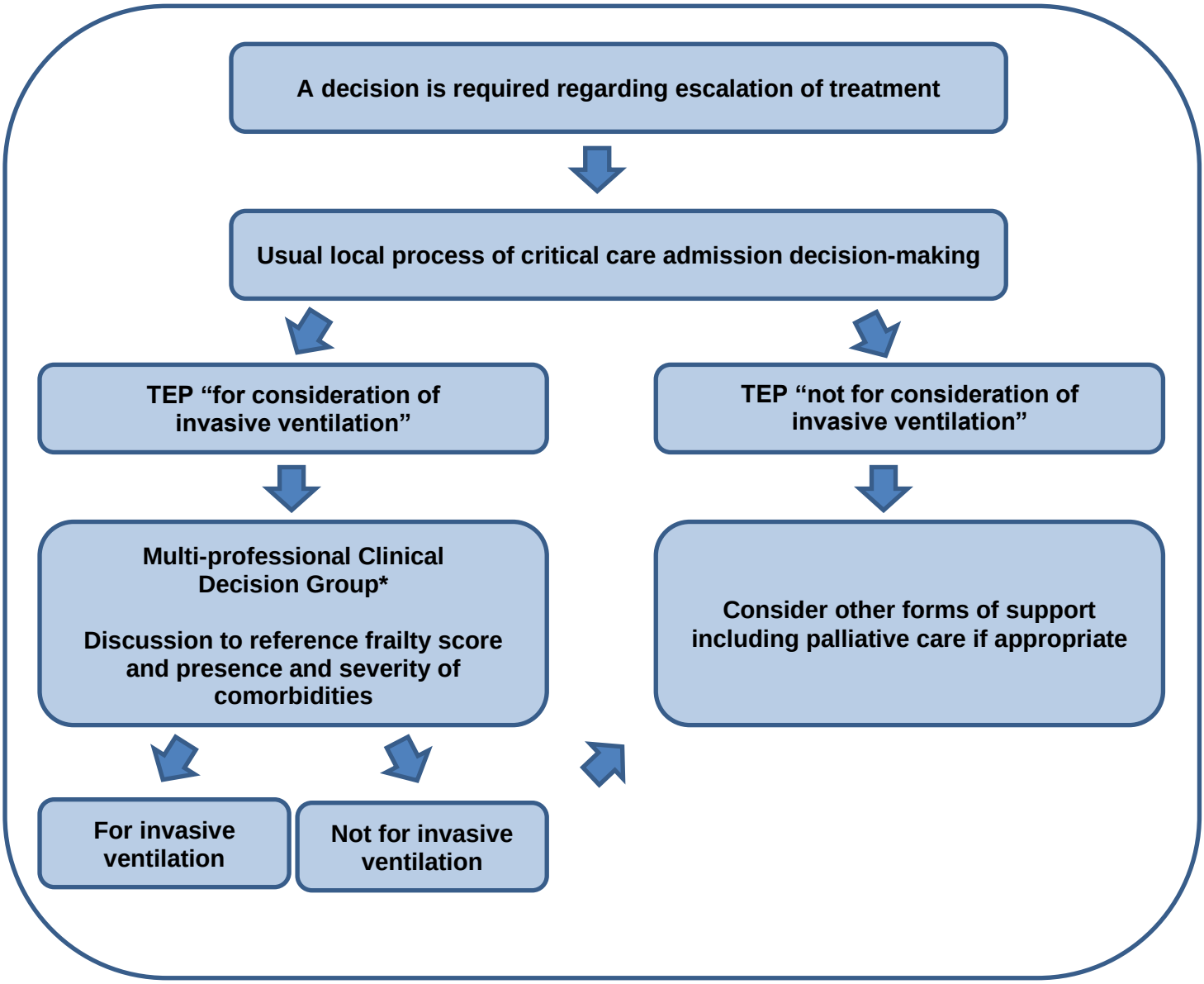
Clinical decision-making in respiratory failure COVID-19 Outbreak

All emergency COVID positive and negative medical admissions to have Treatment Escalation Plan (TEP) including decision regarding invasive ventilation discussed and recorded.

Refer to Lasting Power of Attorney, Advance Decision to Refuse treatment, Statement of Wishes or Electronic Palliative Care Coordination system record if available and patient lacks capacity.



The National Institute for Health and Care Excellence (NICE) has produced a more comprehensive rapid guideline for critical care, published on 20 March 2020. It is available on their website at https://www.nice.org.uk/guidance/ng159.

Chaplaincy / Spiritual Care Teams

Spiritual care is a core element of palliative care (Weissman and Meier, 2009) and routinely provides emotional and spiritual support to patients and those close to them (Vanderwerker *et al*, 2008; Handzo *et al*, 2008; Flannelly *et al*, 2003; Fogg *et al*, 2004; Galek *et al*, 2009). Chaplains will regularly be involved in the support of patients' families pre-bereavement and in many instances will play a significant role in bereavement care, including the conduct of patients' funerals and the organisation and conduct of memorial services and related events. As members of the multi-disciplinary team chaplains will often be responsible for supporting staff, especially in difficult circumstances.

The individual needs of the patients, relatives, carers and members of staff should be fully assessed as part of a Spiritual Needs Assessment to take into consideration their religious, spiritual and cultural requirements. This will ensure that the safety of staff and patients is maintained and will enable a full risk assessment to be undertaken before each visit.

Chaplaincy teams should continue to work alongside relevant clinical staff, Specialist Bereavement Nurses, Equality and Inclusion Leads and to liaise with community partners to provide faith-related advice and resources around end of life issues, death and bereavement.

Northern Care Alliance NHS Group

Chaplaincy & Spiritual Care (Hospital Services) COVID-19 Outbreak

Space for local contact details:

All routine and intentional visits suspended

Religious, spiritual, cultural need identified response required from Chaplaincy Teams

Chaplaincy & Spiritual Care support accessed through normal routes
Urgent / out of hours – Switchboard ** Add local contact details
Non urgent – telephone or other local contact details

Chaplain to contact clinical staff to confirm COVID-19 status and response required

No COVID-19 suspected

New / Ongoing / Urgent Support

Triaged & reviewed in partnership with ward / unit / IC staff

Spiritual Needs Assessment completed

Consider appropriate and safe response:

- Is telephone / Skype response possible?
- What infection control measures are necessary?
- Is generic or faith specific response required?
- Is an urgent response required?

Urgent / EoL

Visit and respond as agreed with clinical staff

Non urgent

Arrange appropriate response and consider telephone contact

Confirmed/Suspected COVID-19

New / Ongoing / Urgent Support

Triaged, reviewed in partnership with ward / unit / IC staff

Spiritual Needs Assessment completed

Consider appropriate and safe response:

- Is telephone / Skype response possible?
- Discuss infection control measures and requirements?
- Is generic or faith specific response required?
- Is an urgent response required?

Urgent /EoL

If visit agreed as urgent and necessary, appropriately trained staff utilise PPE

Non urgent

Visit not appropriate unless urgent. Utilise remote support options

- The individual needs of the patients, relatives, carers and members of staff will be appropriately assessed as part of a Spiritual Needs Assessment to take into consideration their religious, spiritual and cultural wishes.
- An initial risk assessment will be undertaken with a review before each subsequent visit.
- Chaplaincy teams to work alongside relevant clinical staff, Specialist Bereavement Nurses, Equality and Inclusion Leads and to liaise with community partners to provide faith related advice and resources around end of life issues, death and bereavement.

Northern Care Alliance NHS Group

Visiting palliative care / end of life patients COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

The public should be asked to limit visiting patients in hospital and to consider other ways of keeping in touch with those close to them, through phone calls and using facilities such as FaceTime, WhatsApp and Skype.

Visitors in clinical areas must be immediate family members or carers.

General principles

Members of the public should not attend any health or care setting if they:

- are unwell, especially with a high temperature or a new persistent cough
- vulnerable as a result of medication, have a chronic illness or are over 70 years of age
- all visitors should be advised of, and adhere to, local and national guidance regarding handwashing and use of alcohol hand gel when visiting patients

COVID-19 patients: negative

- end of life visiting and care continues as normal practice, this includes the performance of mementos in care after death)
- consideration regarding the number of visitors at the bedside at any one time should be guided by the individual situation, the facility and appropriate risk assessments
- no children under the age of 12 should be visiting without the nurse in charge's prior permission, but considerate, informed decision-making should be the rule of thumb

COVID-19 patients: suspected or positive

- visitors will wear PPE in the same way as the staff caring for the patient
- there should be no time limit on how long visitors can stay with a patient and relatives can, if they wish to do so, be involved in providing care
- mementoes in care after death can be provided, on the ward
  - mementoes should be placed in a sealed bag and the relatives must not open these 7 days
  - for all other care after death guidance please refer to the appropriate flowchart

Visitors should be restricted to essential visitors only, such as parents or carers of a paediatric patient or an affected patient's main carer. Visiting should also be restricted to those assessed as able to wear PPE (see risk assessment below). Visitors should be permitted only after completion of a local risk assessment which includes safeguarding criteria as well as the infection risks.

Visitors should be advised not to go to any other departments or locations within the hospital or healthcare facility after visiting.

The risk assessment must assess the risk of onward infection from the visitor to healthcare staff, or from the patient to the visitors. The risk assessment should include whether it would be feasible for the visitor to learn the correct usage of PPE (donning and doffing under supervision) and should determine whether a visitor, even if asymptomatic, may themselves be a potential infection risk when entering or exiting the unit. This must be clear, documented and reviewed.

Northern Care Alliance NHS Group

Important considerations for care immediately before and after death COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

This advice is for cases where a COVID-19 is suspected or confirmed.

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times. The Swan Bereavement team, site Bereavement Offices, mortuary teams and Coroners Offices can be contacted for additional support and guidance.

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased' s family / significant others

Before death

Decisions regarding escalation of treatment made on a case by case basis

If death is imminent and family wish to stay with their loved one staff must advise them that they should wear full PPE

Faith deaths – AWAITING CLARIFICATION

At the time of death

Inform and support family and /or Next of Kin

Appropriately trained professional completes Verification of Death process wearing required PPE and maintaining infection control measures

Appropriate Doctor completes MCCD as soon as possible

- COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death
- COVID-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009
- that COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status

If the deceased is to be cremated, doctors will not be able to physically see the deceased due to risk. AWAITING OF CONFIRMATION OF CREMATORIUM ACCEPTABLE RECOGNISED IDENTIFIERS

Where next of kin / possible informant are following self-isolation procedures, arrangements should be made for an alternative informant who has not been in contact with the patient to collect the MCCD and attend to give the information for the registration

If referral to HM Coroner is required **for another reason**, a telephone conversation should take place as soon as possible with HM Coroner's Office and guidelines within Care after Death policy should be followed alongside this guidance

Consideration of emotional/spiritual/religious needs of the deceased & their family/significant others

SWAN Model of Care

Northern Care Alliance NHS Group

Care after death
COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased' s family / significant others

This advice is for cases where a COVID-19 is suspected or confirmed. If tested and no results, treat as high risk during care after death.

Mementoes / keepsakes (e.g. locks of hair, handprints, etc) should be offered and taken at the time of care after death. These cannot be offered or undertaken at a later date

- mementoes in care after death can be provided, on the ward
  - mementoes should be placed in a sealed bag and the relatives must not open these before 7 days

Full PPE should be worn for performing physical care after death.
PPE Guidance

Moving a recently deceased patient onto a hospital trolley for transportation to the mortuary might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk - a body bag should be used for transferring the body and those handling the body at this point should use full PPE (see above)

The outer surface of the body bag should be decontaminated immediately before the body bag leaves the anteroom area. This may require at least 2 individuals wearing PPE as above
decontamination guidance

Registered nurses on ward to complete Notification of Death forms fully including details of COVID-19 status and place in pocket on body bag along with body bag form, ID band with patient demographics placed through loops in body bag zip, body bag wiped over with, for example, Chlorclean & porters contacted to transfer to mortuary

- the deceased's property should be handled with care as per policy by staff using PPE and items that can be safely wiped down such as jewellery should be cleaned with, for example, Chlorclean
- clothing, blankets, etc., should ideally be disposed of. If they must be returned to families they should be double bagged and securely tied and families informed of the risks
- any hospital linen should be treated as Category B laundry

Property bags should still be used for property that has been properly cleaned / bagged

Refer all suspected / confirmed COVID-19 deaths to the Swan Bereavement team

Organ / tissue donation is highly unlikely to be an option as per any other active systemic viral infection

Consideration of emotional / spiritual / religious needs of the deceased and their family / significant others

SWAN Model of Care