Interim Advice for Clinicians Regarding a Shared Ethical Approach to Treatment and Referral Decisions During COVID-19 Pandemic

7 April 2020

This advice note is intended to support clinicians in making ethical decisions with patients and families regarding treatment for Covid-19. It will be subjected to wider consultation and agreement and will be updated accordingly. The most up to date version will be held centrally on the South West Operational Delivery Network NHS Future Collaboration workspace.

As the COVID pandemic moves into different phases patients and caregivers will be faced with challenging decisions daily that balance the need to shield vulnerable patients from the impact of coronavirus with the needs of individual patients who present with potentially serious health conditions. These decisions, whilst difficult, are the same decisions we make daily and the principles of decision making remain the same. Each patient must be considered on an individual basis and decisions should be made based on their capacity to benefit from the treatment offered, whether that is admission to hospital for oxygen or admission to intensive care for respiratory support or palliative care at home. Wherever possible, the views of the patient and their family should be taken into consideration and due attention paid to any previously expressed wishes. Treating clinicians are responsible for the decisions they make and provider boards have responsibility for ensuring an ethical approach is taken to clinical practice throughout their services. This advice will not remove these accountabilities.

There are current uncertainties and we will gain knowledge and experience as the pandemic progresses. In order to improve decision making, we aim to ensure that all clinicians remain abreast of new scientific evidence and current system pressures. This will not substitute guidance but enhance it.

A collaborative system-wide approach with shared responsibility for difficult decisions is more important than ever. This guidance offers a framework for decision making to support clinicians assessing patients in the community to come to the right decision regarding admission to hospital.

1) Understanding of current systemwide intelligence

Background to current knowledge about COVID 19 and Admission to Hospital. This may change as we learn more about the disease. This knowledge comes from medical publications, national datasets and experience from the ITU Follow Up Clinic.

- Overall mortality from Covid-19 is 1-5%. Probably closer to 1%
- Mortality in patients over 80 years of age is 15-20%
- The move from increasing breathlessness to a sepsis-like syndrome can be potentially rapid over several hours.
- Time from onset of symptoms to need for ventilation 7 days (range 2-10 days)
- The average duration of ventilation is 7-10 days (longer in older and comorbid patients)
- Recovery from 7-10 days of ventilation in a young and fit patient is 3-6 months. Full recovery may not happen.
- Mortality in patients over age 70 who require ventilation may be as high as 75%
- Some patients may develop hypoxemia and respiratory failure without dyspnea – 'Silent Hypoxia'
- Hospitals have adapted their acute pathways and criteria for admission for non-covid conditions have changed.

Be aware of the current system-wide pressures and latest knowledge on coronavirus presentation and trajectory. During the pandemic, systemwide leaders of critical care / A&E / IUC / SWAST and primary care will meet regularly and share intelligence on current system pressures, and experience of disease presentation and progression. This information will be made available on the NHS futures website in the form of a '30 second brief', which will be regularly updated. Taking this information into account will help inform difficult decisions by refining the assessment of the likely risks and benefits to the patient, of the various clinical options.

We recognise that there may come a situation where resources are limited and decisions may need to be made based on assessing and prioritising patients for treatment. These decisions will be made by multiple intensive care physicians with assistance from colleagues and will be documented. By making decisions as a system that take the evolving pandemic into account, we hope to mitigate this situation and possibly avoid it altogether. The steps being taken to respond to the pandemic such as increased capacity and social distancing are intended to avoid this situation arising.

2) Assessment of respiratory distress

All patients should be considered for hospital transfer in particular:

- Patients with signs of increasing respiratory distress
- Patients whose symptoms cannot be satisfactorily controlled

Physical examination is generally non-specific. For many patients, a decision on further treatment will be possible with video/telephone assessment. Face to face assessment should be offered if there is a clear rationale that it will influence decision making.

Patients with signs of respiratory distress could benefit from hospital admission for oxygen therapy without needing ventilation. The parameters below are a guide and should be interpreted in the context of the situation and comparing any knowledge from the patient or medical record of baseline parameters. Trust your clinical judgement.

- Unable to complete full sentences
- Sitting up, leaning forwards with arms on legs, not able to lie flat
- Breathing differently: flared nostrils, pursed lips.
- Restlessness or anxiety can be a sign of early hypoxia
- Changes in skin colour to bluish or grey
- Respiratory rate >24 at rest
- Saturations <93% if available
- Tachycardia at rest*
- Excessive sweating
- Significant deterioration of SOB over the last 2-6 hours
- Alteration of consciousness or new delirium

* Patients may know their pre-morbid resting heart rate or an estimation of their baseline can be based on physical activity/medication such as beta-blockers etc.

3) Supporting patients at home

For patients with no signs of respiratory distress advise on self-care and safety-netting.

https://www.nhs.uk/conditions/coronavirus-covid-19/self-isolation-advice/

4) Safety Netting

For people with some respiratory distress where admission is not felt necessary it will be important to provide specific advice on the deterioration of breathlessness that would warrant re-contacting health care professionals. Including deterioration in symptoms and symptoms that have not resolved within 7-10 days.

If patients are not well supported and/or not able to comply with safety-netting advice, or you are concerned about the potential for rapid deterioration, consider a planned follow-up.

5) Assessment of co-morbidity

Patients with any of the following conditions are unlikely to survive and return home from admission to ITU. Note that such scoring is intended as a prompt for discussion and consideration; rather than determinative.	
Rockwood Frailty score of 5 and above or Charlson index	Chronic Lung disease on home oxygen or secondary pulmonary hypertension
Advance and irreversible immunocompromised state	COPD with FEV1 <25% predicted or symptoms on mild exertion
Widespread life-limiting metastatic malignant disease	Heart failure with symptoms at rest or on mild exertion
Unwitnessed cardiac arrest	Severe and irreversible neurological disease
Elective Palliative Surgery	Chronic Liver disease with Child-Pugh score ≥ 7
Primary pulmonary hypertension with symptoms at rest or on mild exertion Or mean pulmonary artery pressure > 50 mmHg	

6) Discussion with patient and/or family

Acknowledge where the care you can offer deviates from your usual high standard of care.

Depending on co-morbidities supplemental oxygen may offer benefit whilst mechanical ventilation may be recognised as causing suffering without an expected benefit.

- Decision making on admission to ITU has not changed. If patients will benefit from ITU and they want to be ventilated the treatment is available.
- Patients should be treated fairly; all patients (Covid and Non Covid) should be offered intensive care admission and ventilation based on the likelihood of a successful outcome for them as an individual.
- The expected benefit for patients is a return to health and to resume their lifestyle in the community with a quality of life that is acceptable to the patient.
- Patients who are frail or have serious comorbidities may have their death prolonged but not prevented by ventilation in ITU.
- Ventilation in ITU comes with a burden of suffering, pain and distress. Psychological and physical morbidity is significant.
- Hospitals are operating a policy of no visitors for reasons of infection control. This may be distressing for dying patients and their family and may influence a decision to stay at home, where supportive care can be offered, including non-injectable, just in case medication.

Checklist for complex escalation decision making.

1. Assess the patient's capacity to benefit from proposed treatment.
2. Assess patient's wishes in the context of (1)
    a. Clear cut decision? Discuss with patient and document
    b. Borderline decision? Discuss with the patient and named colleague and document.
    c. "V
    d. ery" difficult decision or conflict with patient and family and bed capacity does not enable you to err on caution.
        i. Discuss with at least 2 colleagues
        ii. Formal second opinion from a senior clinican in a relevant but different specialty.
        iii. An ethical opinion if possible
        iv. Document your decision process, logical argument and specific input from each colleague
    e. Concerns relating to Mental Capacity, Safeguarding – document your assessment of Mental Capacity, consider discussion with a colleague or with your safeguarding lead as appropriate. Follow steps i. – iv. as above.
3. The patient likely to benefit in your view and patient agrees: refer
4. Patient not likely to benefit: Assess current need - continue current active treatment or palliate

7) Record Keeping

Document the decision you have made, parameters contributing to decision and communication with patient/family.

Make it clear in the notes when your preferred options are not available.
Keep records that demonstrate the circumstances at that moment including information from the '30 second brief'.

8) Multi-professional Decision making

If after considering the above, you are not clear on the best course of action or you and the patient/ family are not agreed– i.e. patient declining admission when you think they may benefit, or patient seeking admission that you do not agree is clinically appropriate or necessary;

- Discuss with colleagues / senior member of your team
- Discuss with hospital acute care team

Most importantly, get up each morning knowing that you are human, and can only do your best. This guide has been designed to help support you. Please document your rationale and decision-making process. It is important to retain a record should there be a future review or challenge.

And finally….

Please send back any comments, suggestions or reflections you have regarding this guidance to england.swcovid19-clinical@nhs.net

Resources

Signs and Symptoms of Hypoxia

Covid 19 Rapid Guideline Critical care in Adults NICE

Charlson Comorbidity Index

Rockwood Clinical Frailty Scale

Community Palliative, End of Life and Bereavement Care in the COVID-19 pandemic RCGP COVID-19 End of Life Care Advisory Group

Ethical guidance published for frontline staff dealing with pandemic Royal College of Physicians

BNSSG Remote assessment summary for ALL patients including those with suspected Covid-19

Safety netting follow-up in Covid-19 Review Protocol

Clinical Guide for Palliative Care

Contributors

Dr Liz Mearns Medical Director NHSE/

Dr Sam Waddy Medical Lead, South West Critical Care Network

Dr Lisa Gibbons Clinical Governance Lead Integrated Urgent Care Services, NHS Devon CCG

Dr Amelia Randle Urgent and Emergency Care Clinical Advisor NHSE SW

Dr Simon Scott-Hayward Medical Director SWAST

Dr Simon Horne Emergency Department Consultant University Hospitals Plymouth

Dr Tim Nutbeam Emergency Consultant University Hospitals Plymouth

Dr Byran Macleod Consultant in Emergency Medicine Portsmouth Hospital

Dr Anthony Hudson Emergency Consultant Royal Devon and Exeter Hospital

Dr Scott Grier Consultant Anaesthetist North Britstol Trust

Dr David Wynick University Hospital Bristol

Professor David Lockey Anaethetics North Bristol Trust

Dr Rob White Clinical Lead for Elective Care NHS Kernow

Dr Mark Sanford-Wood LMC

Mr Scott Adams Consultant Orthopaedic Surgeon University Hospitals Plymouth

Dr Simon Rash

Dr Helen Thomas Urgent Care Lead Somerset CCG

Dr Phillip Cowburn Acute Care Medical Director SWAST

Dr Andy Smith Executive Medical Director SWAST

Wayne Darch EPRR Manager SWAST

Katharine Young Specialised Commissioning South West

Dr Jaime-ann Tweedie Care UK

Dr Malcolm Gerald Gloucestershire CCG

Dr Steve Holmes Clinical Respiratory Lead, Somerset CCG

Dr Alison Wint Clinical Lead Specialised Care BNSSG CCG

Debbie Rigby Programme Lead Joint Commissioning Somerset Clinical Commissioning Group

Adam Carrick Head of Planned Care Devon CCG

Dr Lesley Ward Clinical Lead for Planned Care BNSSG CCG