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Devon Partnership NHS Trust

Clinical guide for the management of coronavirus and palliative (end of life) care in hospital during the pandemic

The existing legislative framework, staffing, equipment, training, experience for the management of those with mental disorder or impaired capacity is not developed to cope with the circumstances of a pandemic. Devon Partnership Trust will support clinicians who make defensible principle led decisions which follow recognised guidance and principles of good medical practice.

This guidance is only intended to support clinicians already trained (even if not recently) which may include training given by another competent professional and only intended for the duration of the pandemic where access to higher skilled or experienced clinicians is not possible e.g. in Emergency Departments.

Document Control	
Title and Version Number:	Clinical guide for the management of coronavirus and palliative (end of life) care in hospital during the pandemic v. 1.5
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Approval Committee:	Gold Command
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Contents

This guidance draws upon two main sources:

- ***Clinical guide for the management of palliative care in hospital during the coronavirus pandemic*** produced by NHS England and NHS Improvement
- ***COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care*** collated for the Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland. https://apmonline.org/ v3.0 (April 2020)

Devon Partnership NHS Trust thanks Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland for sharing their guidance and specifically acknowledge the writers:

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Section One – Palliative Care during the Pandemic

Introduction

It will not be possible for local palliative care services to provide direct care to everybody who needs it, especially as the pandemic progresses.

This guidance is therefore aimed at all staff looking after patients with coronavirus in the hospital setting. It does not replace evidence based local guidelines for palliative care. It is intended to support practice where local guidance does not already exist and palliative care services may not be able to respond.

As clinicians, we all have responsibilities in relation to coronavirus and we should seek and act on national and local guidelines. We have a specific responsibility to institute best practice palliative care for all patients who require this, either with pre-existing palliative care needs or because of coronavirus infection. We may need to work outside our specific areas of training and expertise, and the General Medical Council (GMC) has already indicated its support for this in the exceptional circumstances we may face.

All Trust units have support from specialist palliative care teams, whether as on-site hospital palliative care teams or in-reach teams from local palliative care services. These teams will be able to provide advice and support.

Potential triggers for contacting specialist palliative care

- Patient already known to specialist palliative care.
- Symptoms not responding to clinical guidelines, including when a patient is imminently dying.
- Complex symptoms that require specialist advice.
- Decision not to escalate treatment in the face of deterioration or uncertain prognosis.
- Other complexities, for example, young children or other dependents who rely on the patient.

Role of Supportive and Palliative Care teams

Supportive and Palliative care teams can provide:

- Advice, guidance and support to health care teams.
- Remote assessment, via window, if indicated and possible.
- Face-to-face assessment, if it is not possible to help remotely, for example, due to complexity, refractory symptoms or severe distress.
- Additional support for family and those close to the patient.
- Training and support for ward staff, for example, prescribing, conversations to plan treatment escalation.
- Help to facilitate rapid discharge out of hospital using established connections with hospices, community palliative care teams and primary and community health care services.

Goals of care

The treatment of patients suffering from coronavirus may be orientated towards three areas:

1) **Supportive measures** – for example, provision of fluids and/or oxygen.

2) **Targeted treatment** – for example, provision of antibiotics to treat pneumonia.

3) **Organ support** – for example, ventilator support, renal replacement therapy, etc.

These are aimed at preserving and prolonging life. **It is important to remember that most people with coronavirus will survive and recover**.

For those who are dying as a consequence of coronavirus and/or who do not wish to have active or invasive treatments, the switch in focus to high quality, compassionate, palliative care provided by the Trust at the end of their life is equally important.

Treatment escalation planning

In End of Life care… "A **Treatment Escalation Plan** (TEP) is a document and guide to clinical care to help improve and aid communication between medical staff, patients and families and facilitate 'difficult conversations' by broadening the issues covered."

C37 – End of Life Policy. September 2018

In the context of the coronavirus pandemic, decisions about further treatment escalation or shifting the focus to palliative care will need to take place rapidly. It may not be possible to have joint discussions involving the patient, those close to them and the clinicians because:

- the patient may have become ill and deteriorated very quickly, so they may not be able to fully participate in the decision-making.

- the patient's family and those closest to them may not be able to be present because of hospital infection control procedures, or they may be in self-isolation or looking after family members who are ill.

Conversations with the patient's family may well have to take place remotely. They are likely to be anxious and shocked by what has happened. These are not easy conversations to have but it is important that honest and timely conversations do take place. Senior clinicians

should role model these conversations and support their teams to do so. Palliative care teams are skilled at these conversations and will do their best to support colleagues in doing so, but there will not be enough capacity for palliative care teams to undertake all conversations themselves. See Appendix 3 for 'three talk' model for shared decision making.

Consultants / RCs should consider having treatment escalation discussions with their patients, particularly if over the age of 65, with relevant physical health comorbidities or being advised to shield.

Documentation required in DPT for End of Life decision documentation

1. **What:** Follow guidance documentation (appendix seven) to develop an accurate record of a personalised discussion with a patient regarding their Treatment Escalation Plan
   Where: record in care notes entry

2. **What:** record of Capacity to make the relevant decision and where lacking – a relevant Best Interests Decision Outcome
3. **Where:** MCA Form in carenotes

4. **What**: Complete Treatment Escalation Plan (TEP) and Resuscitation Decision Record (appendix six). This document details the outcome of the treatment escalation discussion in a form that is used by acute hospitals.
   Where: It should be included in the patient correspondence section.

5. **What**: Create Alert in Carenotes
   Where: Create Alert, category: OTHER, title: TEP IN PLACE

6. **What**: Inform wider MDT
   Where: Ensure evidenced in MDT handover and Inpatient Careplan and Review

7. **What**: Nursing Checklist
   Where: Nursing checklist form uploaded to carenotes clinical documentation

Other Relevant Trust Documents

- Guidance for completing Treatment Escalation Plan and Resuscitation Decisions
- Treatment Escalation Plans – Checklist for nursing team
- Twelve things a doctor should know about the Treatment Escalation Plan/ Resuscitation Decision Record (TEP/RDR)
- COVID 19 Treatment Escalation Plan (carenotes form)

Chaplaincy & Spiritual Care

Routine visits suspended, but we might be able to visit those who are facing the end of life.

In the event that a pastoral, religious, spiritual, or cultural need is identified, **staff** may ring:

- Jez Brown (Lead Chaplain) - 07989 227018 **Number not available to patients**
- Malc Reddaway (Senior Chaplain) 07870 364327 **Number not available to patients**

Alternatively, support can be accessed **directly by patients** on two hotlines available across all Trust wards. **Patients** may ring:

- Jez Brown on 07934 727016
- Malc Reddaway 07864 723362

Urgent / out of hours: Staff only to call Jez Brown on 07989 227038

Staff may have to do the work of Chaplains

Because we might not be able to attend a patient at the end of their life, you may be required to perform some of the duties of Chaplains. We are moving into a time of enormous stress and many people find that their religion helpful and comforting. Chaplains in the Trust understand that you may not share the faith of your patient but at these exceptional days, we believe it is perfectly acceptable for people who do not share a patient's faith, to pray with them if they request it.

End of Life prayers – for patients holding to particular faiths prayers will be available on laminated cards found on each ward where End of Life care is being administered and also in this guidance:

- **Christian Prayers and Readings**
  - The Lord's Prayer
  - The Hail Mary
  - Psalm 23
  - The commendation

- **For Muslim patients (in order of preference: a, b, c, d)**

  a) Ask a relative to speak End of Life prayers over phone within patient's hearing
  b) Ring Malc Reddaway for recorded Arabic prayers to be played to patient
  c) Is there a Muslim staff member available on the ward to recite the EoL prayers?
  d) Any staff member to pray from the prayers on the laminated card

- **For all other patients of faith -** A staff member should be asked to read the relevant prayers from the laminated card:
  - Supporting Sikh patients
  - Supporting Buddhist Patients
  - Supporting Jewish Patients

- **For all other patients who profess no particular faith**
  A staff member should be asked to read an End of Life Reflection from the laminated card

Emotional Support for Staff

It is natural that you, your colleagues and your family may experience increased feelings of anxiety, stress and worry. Managing our own stress and psychological wellbeing and supporting our colleagues to do the same is as important as managing our physical health

Additional Workplace Support service

We have set up a new Additional Workplace Support service which is for additional targeted support or clinical intervention which may be necessary to support a return to sustained health and wellbeing, as quickly as possible. This can be accessed by phone on 01392 677076

24/7 advice and support in relation to stress, anxiety and health

Our usual 24/7 advice and support line continues to be available for staff and their families Call CIC on 0800 085 1376 www.well-online.co.uk (Username: dnlogin Password: wellbeing)

24/7 financial advice and support

CiC also provides financial advice and support and again, this is available for staff and their families Call CIC - 0800 085 1376
www.well-online.co.uk (Username: dnlogin Password: wellbeing)

TALKWORKS

If you are struggling to cope, feel overwhelmed, anxious or stressed, you can self-refer to our TALKWORKS service through their website - www.talkworks.dpt.nhs.uk or by phone on 0300 555 3344. Please note that following national guidance, the TALKWORKS service is now offering appointments and sessions on the phone or through digital platforms.

Pastoral, religious and spiritual support

Our chaplains are available to all staff members – regardless of whether you consider yourself to be a person of a particular faith, or not. The team have access to Faith Leaders of all major religions who are available to support you. They offer support in three areas, pastoral care (offering you a listening ear when you are facing any sort of problem or just feeling the needs to be supported), religious care and spiritual care. Please contact Jez Brown on 07989 227018 to request assistance in the first instance.

Mindfulness and online tools

Workplace wellness platform Unmind has announced it will offer free access to its digital resources for all NHS staff to help to deal with the pressures and demand on their mental health during the crisis. www.nhs.unmind.com Find tools and resources to help yourself and others tackle stress, anxiety, and sleep deprivation. Supported by NHS England and Public Health England at https://www.goodthinking.uk/

Please also see resources available on the dedicated COVID-19 section on DAISY.

Symptom management

Even though many patients will survive and recover from coronavirus, managing their symptoms during this period remains important. This guidance assumes that a patient has received all appropriate supportive treatments and management of their comorbidities has been optimised.

The good practice approach to symptom management is as follows:
- Correct the correctable, for example, give the patient antibiotics for a bacterial infection.
- Non-drug approaches, especially in mild to moderate disease – see Section Two.
- Drug approaches – see Section Two.

The most common symptoms of coronavirus that require attention are:
- breathlessness
- cough
- fever
- delirium

A synopsis of the approach to these symptoms is set out in Section Two. Local guidelines may be used instead, provided these have been ratified appropriately within local governance structures.

Management of other symptoms, including pain, should be treated in accordance with local guidelines and policies.

Generally, non-drug approaches are preferred, particularly in mild to moderate disease. Drug approaches may become necessary for severe distressing symptoms, particularly in severe disease.

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. See also CP29 Protocol for Prescribing & Administering Medicines in the Last Days of Life on DPT Inpatient Units that do not have End of Life Support on Site via DAISY

Care of the dying patient

Despite the challenging circumstances of the coronavirus pandemic, it is important not to lose sight of the important elements of holistic care of the dying person. This includes:

- Effective communication including clear decision-making.
- Adequate pain and symptom management.
- Opportunity to prepare for death, including emotional and spiritual support (chaplains and faith leaders may play an important role here).
- Support for those close to the dying person, including the ability to keep in touch via phone or virtual communication such as NHS Attend Anywhere, Skype or WhatsApp.

Equipment for Subcutaneous fluids and other treatments	
• Drip stand Fam10805 • Giving sets FSB2299 • Saf-T-Intima integrated system • Butterfly needles Green FSB1119	• Butterfly Needles Blue FSB1120 • 0.9% sodium chloride 1L order from Pharmacy • Oxygen Masks FDD954

Visits during the palliative care period to the ward

End of life care is a fundamental pillar of nursing care and relates to both the care of the person at the end of life and their family. The current COVID-19 epidemic has resulted in all normal hospital/ hospice and care home visiting being suspended except for special circumstances. The End of Life period (defined in DPT as death expected within 48 hrs) is considered a special circumstance and visits may occur.

Principles:

- Limit the number of next of kin/ significant others to one or two immediate household or close family contacts.
- Provide a detailed description of the setting and what to expect when they see their loved one and instructions related to wearing personal protective equipment and cleaning their hands.
- The next of kin/ significant other should be able to drive or be driven to the hospital/ hospice/ care home. This minimises the risk of exposure to others, particularly if the household is self-isolating as contacts of the dying person.
- The next of kin/ significant other should be asked to minimise the number of personal belongings that they bring with them e.g., bags, handbags, electronic devices.
- On arrival the next of kin/ significant other should call the ward/unit so that someone can be sent to meet them at an agreed meeting point, escort them to the care setting and provide them with PPE.

Process:

1) Follow usual Infection Control Processes in place in the context the patient is in
2) The member of staff meeting the next of kin/ significant other should take with them Fluid Resistant Surgical mask, plastic aprons and alcohol hand gel
3) The member of staff should escort the next of kin/ significant other to the care setting by the shortest possible route.
4) The next of kin/ significant other should remove outer clothing e.g., coat or jacket, roll up their sleeves and clean their hands before putting on the appropriate PPE to enter the care setting. They should understand that the front of the surgical mask must not be touched or removed while they are with their relative.
5) Gloves are not necessary for the next of kin / significant others contact and hands must be washed prior to leaving the care setting. This level of protection will minimise the risk to the visitor and allow him/her to hold the hand of their loved one.
6) The next of kin / significant other can be left with their loved one
7) Reassure the relative/ significant other that self-isolation is not required following the visit as they have been protected from the risk of transmission by using PPE and performing hand hygiene.
8) Help the person to remove their PPE in a safe way and dispose of it in an orange bag.

NB If the visitor is self-isolating or COVID19 positive they should continue to wear the surgical facemask until they leave the premises and dispose of it in the household rubbish when they get home.

Visits during the palliative care period from the ward

If a DPT patient's relative is in the palliative phase then visits may occur subject to the usual risk assessment and considerations by the RC / Lead clinician and the wider MDT in discussion with the care providers for the dying person.
If the dying person is in another hospital health care setting – follow the guidance provided by that hospital health care setting.

If the dying person is in another health care setting e.g. residential or nursing home:

The DPT patient other should be asked to minimise the number of personal belongings that they take with them e.g., bags, handbags, electronic devices.

The escorting staff should take Fluid Resistant Surgical Mask, Gloves, Plastic Apron for themselves and the DPT patient and suitable hand cleaning solution and disposal bags.

The DPT patient should remove outer clothing e.g., coat or jacket, roll up their sleeves and clean their hands before putting on the appropriate PPE to enter the home following the PPE donning guidance. They should understand that the front of the surgical mask must not be touched or removed while they are with their relative.

Gloves are necessary for the DPT patient.

The DPT patient may be left with their loved one.

Help the person to remove their PPE in a safe way and dispose of it in an orange bag following PPE doffing guidance.

If there is an opportunity to leave the clinical bag there for disposal in the domestic waste 72 hrs after the bag closed then do so. If not seal and transport back to ward away from travelling staff e.g. in car boot.

Section Two – Managing Symptoms

COVID-19 symptom management, and the management of end of life symptoms may be necessary where there is **no access to a syringe driver**. Pharmacological measures must be read in conjunction with the BNF and relevant product literature. Advice must still be sought from the local palliative care team. Be mindful of the risks of respiratory depression with benzodiazepines and opioids. In cases with renal impairment consider choice of opioid, hyoscine butylbromide rather than hydrobromide, and lower midazolam dose.

Not all medicines referenced in the associated online training are available for use within DPT wards. Please refer to this COVID End of Life guidance for details of medicines recommended for use in Devon during the pandemic which are available locally.

Management of Mild to Moderate Breathlessness

Breathlessness is the subjective sensation of discomfort with breathing and is a common cause of major suffering in people with acute, advanced and terminal disease. Treatment of underlying causes of dyspnoea should be considered and optimised where possible.

Reversible causes

- both COVID-19 and non-COVID-19 conditions (advanced lung cancer, SVCO, lymphangitis carcinomatosis, etc) may cause severe distress / breathlessness toward end of life

Non-pharmacological measures

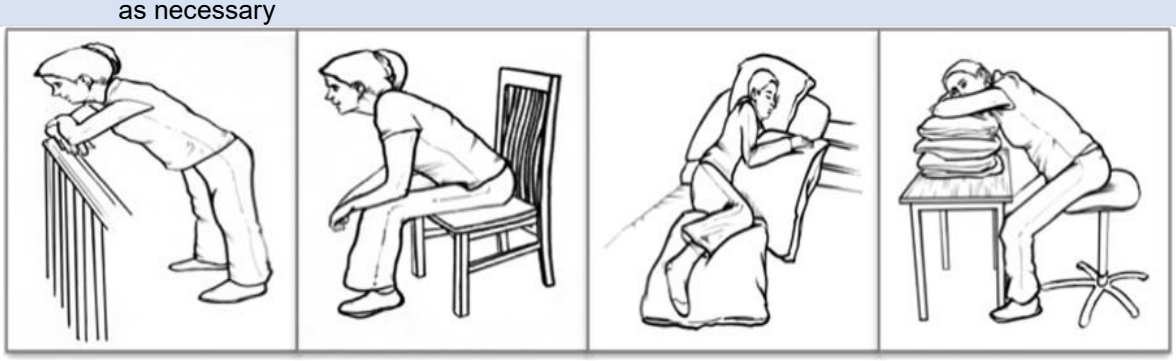
- positioning (various advice depending on position: sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward)
- relaxation techniques
- reduce room temperature
- cooling the face by using a cool flannel or cloth
- portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
- portable fans are ***not*** recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

Pharmacological measures

For distressing breathlessness consider a combination of a regular opioid and an anxiolytic. Consider oxygen as appropriate and if available.

Please note that morphine can accumulate in severe renal impairment and an alternative, e.g. oxycodone, should be used in those with GFR<30ml/min. Speak to local palliative care team for advice. See Flow Charts in Appendix One

- **Able to swallow and opioid naive** (not currently taking opioids)
  - **Oramorph** liquid 2mg to 5mg every 2 to 4 hours as required
    or
  - **Morphine sulfate M/R** tablets 5mg twice a day, increased as necessary (maximum 30 mg daily)
- **Able to swallow and already taking regular opioids** for other reasons (for example, pain relief)
  - **Morphine sulfate** immediate-release 5mg to 10mg every 2 to 4 hours as required or one twelfth of the 24-hour dose for pain, whichever is greater
- **Unable to swallow**
  - **Morphine sulfate** 2.5mg to 5mg S/C every 2 to 4 hours as required, increasing the dose as necessary



Forward lean 1 | Forward lean 2 | Adapted forward lean for lying | Adapted forward lean for sitting

Management of Coughing

Cough is a protective reflex response to airway irritation and is triggered by stimulation of airway cough receptors by either irritants or by conditions that cause airway distortion.

Cough hygiene

To minimise the risk of cross-transmission, patients should:

- cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping & blowing the nose
- dispose of used tissues promptly into clinical waste bin used for infectious or contaminated waste
- clean hands with soap and water, alcohol hand rub or hand wipes after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions

Non-pharmacological measures

- humidify room air
- oral fluids
- honey & lemon in warm water
- suck cough drops / hard sweets
- elevate the head when sleeping
- avoid smoking

Pharmacological measures

- **Able to swallow**
  - simple linctus 5-10mg PO QDS

If not tolerated:

- Oramorph 2mg-5mg PO every 4 hours PRN (can be increased to 5-10mg)
  If already taking regular morphine, increase the regular dose by one third

Management of Delirium

Delirium is an acute confusional state that can happen when someone is ill. It is a SUDDEN change over a few hours or days, and tends to vary at different times of day. People may be confused at some times and then seem their normal selves at other times. People who become delirious may start behaving in ways that are unusual for them- they may become more agitated than normal or feel more sleepy and withdrawn.

Non-pharmacological measures

- identify and manage the possible underlying cause or combination of causes
- ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- consider involving family, friends and carers to help with this
- ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk
- avoid moving people within and between wards or rooms unless absolutely necessary
- ensure adequate lighting

Pharmacological measures:

- **Able to swallow**
  - Agitation may respond to lorazepam 0.5-1mg PO
  - Haloperidol 500mcg-1.5mg 2 hourly prn (max 5mg daily)
  - Olanzapine 2.5-5mg OD (start with 2.5mg if frail of over 75yrs) titrate cautiously upward according to symptoms
- **Unable to swallow**
  - Olanzapine 2.5-5mg OD orodispersible tab S/L (start with 2.5mg if frail of over 75yrs) titrate cautiously upward according to symptoms
  - Agitation may respond to lorazepam 0.5-1mg S/L or Midazolam 2.5-5mg s/c 1 - 2 hourly prn
  - Levomepromazine:

    6.25-12.5mg s/c 2 – 4 hourly prn for mild/moderate agitation/delirium and/or nausea (also frail/elderly)

    12.5-25mg s/c 2 – 4 hourly prn for severe agitation/delirium

Management of Fever

Fever is when a human's body temperature goes above the normal range of 36–37° Centigrade (98–100° Fahrenheit). It is a common medical sign. Other terms for a fever include pyrexia and controlled hyperthermia. As the body temperature goes up, the person may feel cold until it levels off and stops rising.

Is it fever?	
Significant fever is defined as a body temperature of:	
○ 37.5ºC or greater (oral) ○ 37.2ºC or greater (axillary)	○ 37.8ºC or greater (tympanic) ○
Associated signs & symptoms:	
○ shivering ○ shaking ○ chills	○ aching muscles and joints ○ other body aches

Non-pharmacological measures

- reduce room temperature
- wear loose clothing
- cooling the face by using a cool flannel or cloth
- oral fluids
- avoid alcohol
- portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
- portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

Pharmacological measures

- Able to Swallow
  - Paracetamol 0.5-1g PO every 4-6 hours, max QDS
- Unable to Swallow
  - Paracetamol suppositories 0.5-1g PR every 4-6 hours, max QDS

Normal Body temperature
37.0 °C

Body Fever temperature
37.7 °C

Management of pain

Patients may experience pain due to existing co-morbidities, but may also develop pain as a result of excessive coughing or immobility. Such symptoms should be addressed using existing approaches to pain management.

Please note that morphine can accumulate in severe renal impairment and an alternative, e.g. oxycodone, should be used in those with GFR<30ml/min. Speak to local palliative care team for advice - see Appendix One.

Able to swallow		**Paracetamol** 0.5-1g PO every 4-6 hours, max QDS If needs opioid –
	Opioid naive	**MST** 10mg BD PO (If elderly/frail 5mg BD) and PRN **Oramorph** 2.5-5mg every 1-4 hours PO
	Currently taking opioid	Continue current regime and titrate as necessary
Unable to swallow		**Paracetamol suppositories** 0.5-1g PR every 4-6 hours, max QDS If needs opioid
	Opioid naive	*Please see opioid conversion table for dosing* **Buprenorphine** transdermal patch changed every 7 days (BuTrans) or **Fentanyl** transdermal patch changed every 72 hours (Matrifen) and PRN SC medication for breakthrough pain as advised by palliative care team
	Currently taking opioid	Switch to equivalent patch strength

Please note that patches will take 12-24 hours to reach effective blood levels and PRN pain relief may be required. Speak to the local palliative care team for guidance.
Consider prescription of laxatives alongside strong opioids.

Management of Secretions, Anxiety & Nausea

Possible Pharmacological Management of Secretions

Able to swallow	**Hyoscine hydrobromide** tablets 300mcg 8 hourly PO
Unable to swallow	**Hyoscine hydrobromide** tablets 300mcg 8 hourly S/L or **Hyoscine hydrobromide** patch 1mg/72hr or **Hyoscine hydrobromide** 400mcg s/c 4 – 6 hourly prn (maximum 2.4mg/24 hours)

Please note that hyoscine has a high anticholinergic burden and may cause confusion, particularly in those with cognitive impairment or dementia

Possible Pharmacological Management of Anxiety

Able to swallow	**Lorazepam** 0.5-2mg PRN, max 4mg in 24 hours **Diazepam** 2-10mg PO PRN, max TDS (slower onset of action, but longer acting. Accumulates in those with renal impairment)
Unable to swallow	**Lorazepam** 0.5-2mg S/L PRN, max 4mg in 24 hours **Diazepam** 5-10mg PR PRN

Possible Pharmacological Management of Nausea

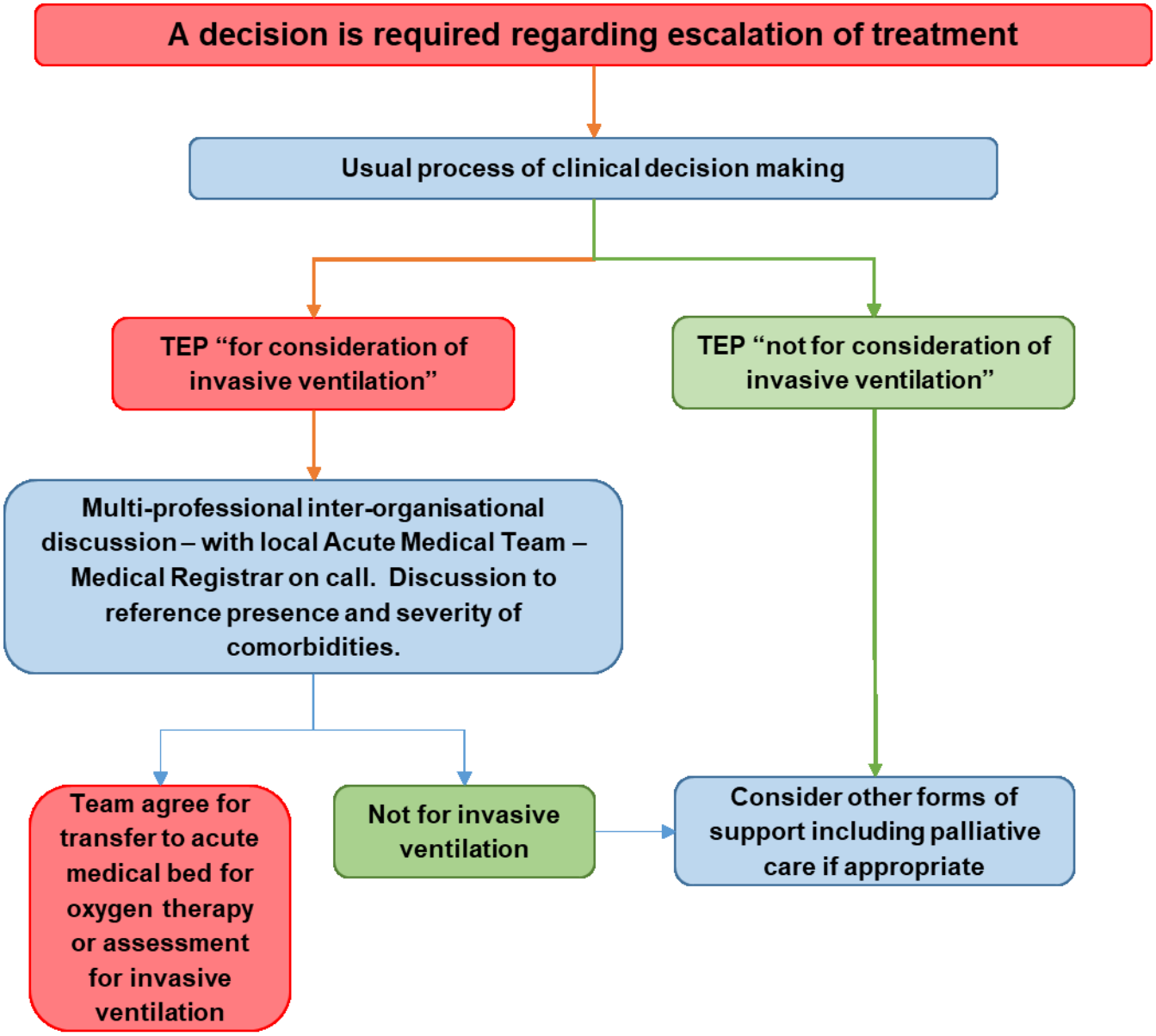
Able to swallow	**Haloperidol** 0.5-1.5mg OD/BD PO **Hyoscine hydrobromide** tablets 300mcg PO every 8 hours
Unable to swallow	**Buccal Prochlorperazine** 3-6mg BD **Hyoscine hydrobromide** tablets 300mcg SL every 8 hours **Hyoscine hydrobromide** patch 1mg/72hr

Please note that hyoscine has a high anticholinergic burden and may cause confusion, particularly in those with cognitive impairment or dementia.

Clinical Decision making in for Trust inpatients with symptoms of respiratory illness (ie CoVid 19)

All OPMH and 'Shielded' status service users to have Treatment Escalation Plan (TEP) including decision regarding invasive ventilation discussed and recorded (Coronavirus Discussion Tool).

Refer to Lasting Power of Attorney, Advance Decision to Refuse Treatment, or Statement of Wishes 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

Important considerations for care immediately before and after death

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 Infection Control team can be contacted for additional support and guidance.

Before death
• Decisions regarding escalation of treatment made on a case by case basis
• Establish any specific death / burial requirements and contact Chaplain for support. • Consider exceptional circumstances for carers / family to visit • Consider discharge Section of the Mental Health Act or end DOLS authorisation
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
• Use established Bereavement Services unless otherwise notified.
• An appropriate Doctor via Bereavement Services completes MCCD as soon as possible (certificates are available at Secure Services, Franklyn Site, Wonford Site if needed).
• 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
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
All patient deaths should be reported using the RMS system. Where a patient has died whilst formally detained under the provisions of the Mental Health Act, the Experience, Safety and Risk Team will undertake liaison with HM Coroner's office and the guidelines within Care after Death policy should be followed alongside this guidance. Where a patient has died whilst subject to a DoLS Authorisation, the Coroner's Office does not require notification unless there are concerns about the death - *such as a concern about care or treatment before death, or where the medical cause of death is uncertain, the coroner will investigate thoroughly in the usual way. There will always be a public interest in the careful scrutiny of any death in circumstances akin to state detention. As in all cases there must be sufficiency of coroner inquiry*.
Death of Detained Patients
Notification of death to the police as a 'death in custody' should take place and room sealed until police have attended or provided instruction.

Section Three – Care after death

In this sad and difficult time it is important to remember:

- Keep clear and complete documentation
- Be open, honest and clear communication with colleagues and the family of the deceased or significant others
- Consideration of emotional / spiritual / religious needs of the deceased and their family / significant others
- 'Rest' the room to allow Aerosols and droplets to settle for one hour
- If there has been recent Aerosol Generating Procedures (within one hour) then use PPE as for Aerosol Generating Procedures if entering the room.
- If no recent Aerosol Generating Procedures then use PPE as for close contact with a confirmed or suspected covid case if entering the room. See Daisy for latest guidance PPE and Decontamination guidance

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, mementoes should be placed in a sealed bag and the relatives must not open these before 7 days
Moving a recently deceased patient 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 required PPE for close contact with a confirmed or suspected case of Covid.
The outer surface of the body bag should be decontaminated immediately before the body bag leaves the isolated room. This may require at least 2 individuals wearing PPE as above.
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 a chlorine based cleaning product, for example, Tristel & contact the local portering solution 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 chlorine based cleaning product, for example, Tristel • clothing, 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 and asked to leave items in the bag for 7 days • any hospital linen should be treated as infectious laundry
Property bags should still be used for property that has been properly cleaned / bagged.
Organ / tissue donation is highly unlikely to be an option as per any other active systemic viral infection

After death and after notification of the family/carers, the clinical team to promptly contact the local agreed process for transfer of a deceased person.

Decontamination of the environment to be undertaken as per Infection Prevention and Control Policy.

Registering a death / cremation

The person who registers the death is formally known as the 'the informant'. This is usually a relative of family of the person upon receipt of a Medical Certificate of the Cause of Death (MCCD) or can be a member of staff if no relatives are available within five working days.

As a result of the Coronavirus Act 2020, the procedure for registering a death has changed

Registering a Death

- a qualified informant (including a Funeral Director responsible for the arrangement of the funeral and authorised by a relative) who is required to give information about a death or still-birth to the Registrar may give the information to the Registrar by telephone, or by any other methods specified in guidance issued by the Registrar General
- a death can still be registered if an informant is unable to attend in person because it would be impractical for the person to do so, whether because of illness, need to care for others, risk of infection, staff shortages at the Registrar's office or any other reason
- it is still necessary for an original MCCD to be issued and fully completed and signed. This can be sent by electronic means (PDF) to the Registrar by a secure e-mail link provided by the Local Authority. The Informant, a relative or the doctor can send it to the Registrar
- the MCCD still has to have an acceptable medical cause of death and not be a mode of dying. Existing guidance on this still applies

Medical Certificate of the Cause of Death (MCCD)

- A doctor who has seen the deceased within 28 days before death can issue a MCCD but if it is impractical or that doctor is unable is issue a MCCD, another doctor who has not attended the deceased may do so if they are able to state the cause of death to the best of their knowledge and belief. They will still have to complete an original MCCD, complete it fully and sign it in the usual way
- if no doctor had attended the deceased within the 28 day period any doctor can still issue a MCCD if they are able to state the cause of death to the best of their knowledge and belief. There is still a requirement that the Doctor issuing the MCCD has seen the body after death
- a doctor seeing a patient within 28 days before death (but not afterwards) by video link or skype is acceptable

Cremation

- The Cremation Referee is still required to issue Form 10 giving permission for the cremation
- In order for a body to be cremated an application still has to be made – only Form 4 needs to be completed by the doctor issuing the MCCD and the body has still to be seen after death by the doctor issuing the MCCD
- There is no requirement for a confirmatory certificate – Form 5. However, there is still a requirement that no cremation can take place without the Cremation referee issuing Form 10
- The doctor who issues the MCCD and Form 4 still has to see the body after death
- The provisions relating to the issue of Form 6 by the Coroner still applies and a cremation take place if this is issued

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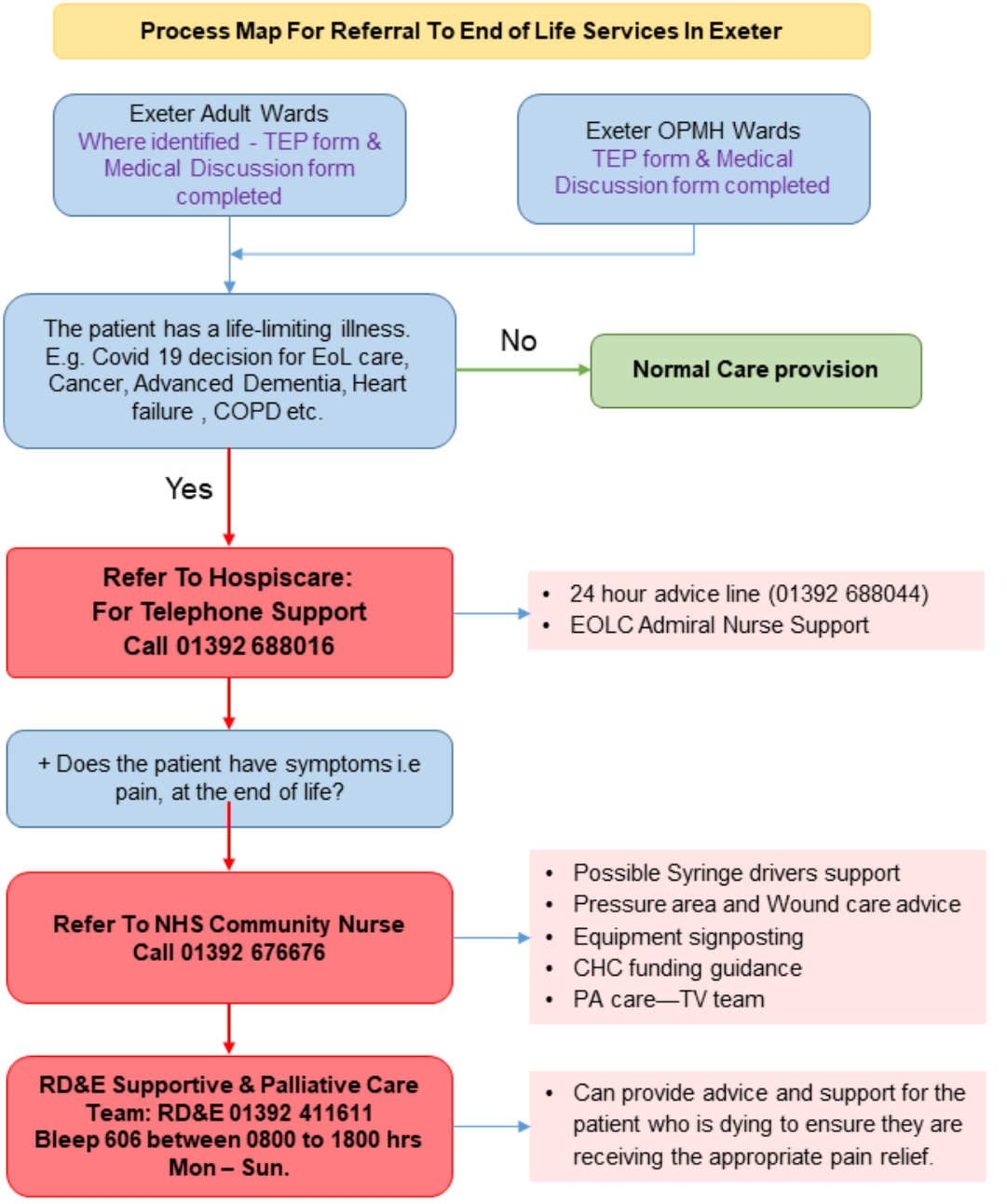
Appendix One – Palliative Care Support Flowcharts

For Exeter East and Mid Services

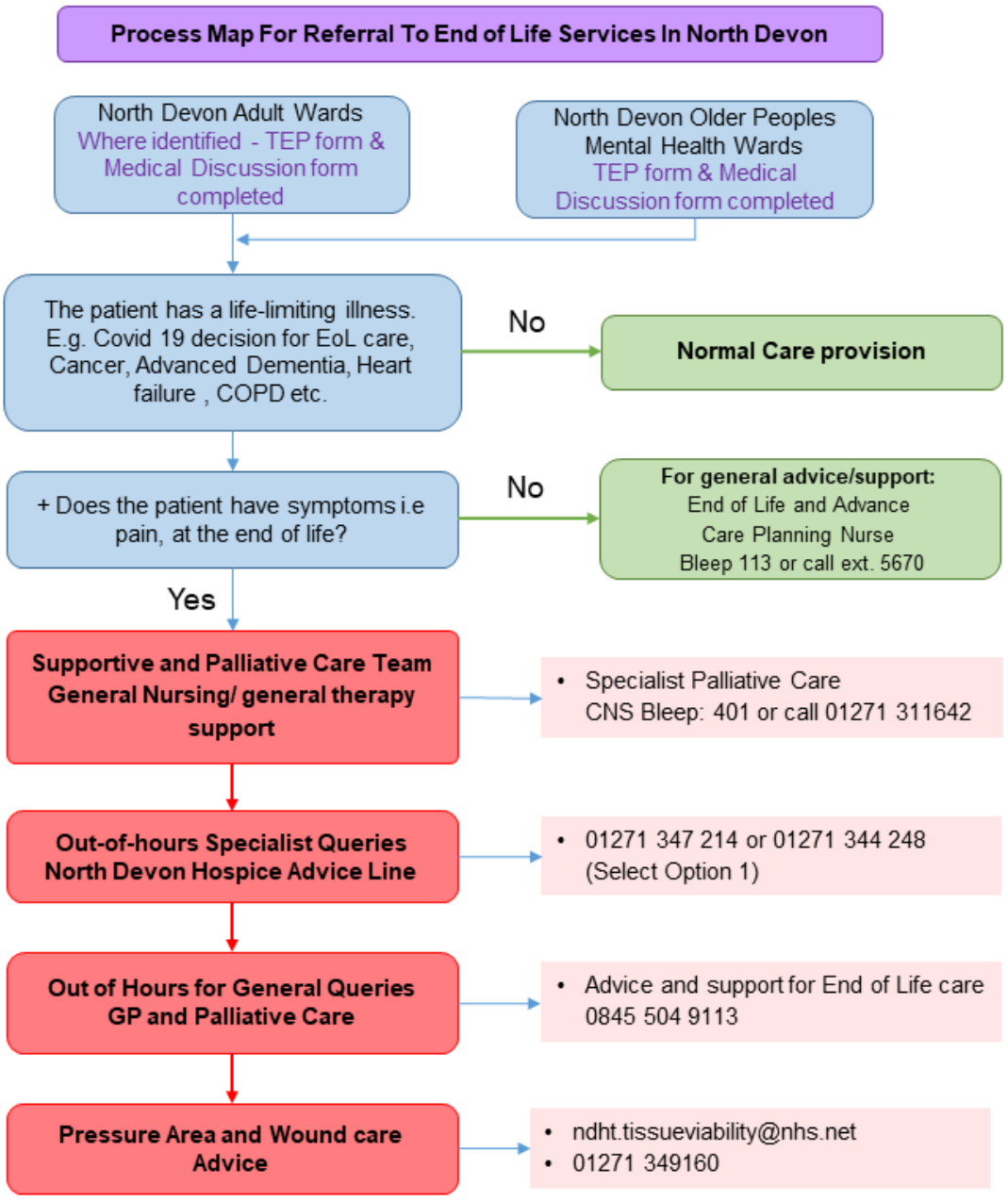
NHS
Devon Partnership
NHS Trust



- To be used in collaboration with the CoVid 19 EoL SOPS for care and pharmacological interventions guidance.
- For the clinical discussion with the Supportive and palliative Care teams and Hospice teams to be led by the Senior Medical Clinician or Consultant Psychiatrist.

For North Devon Services

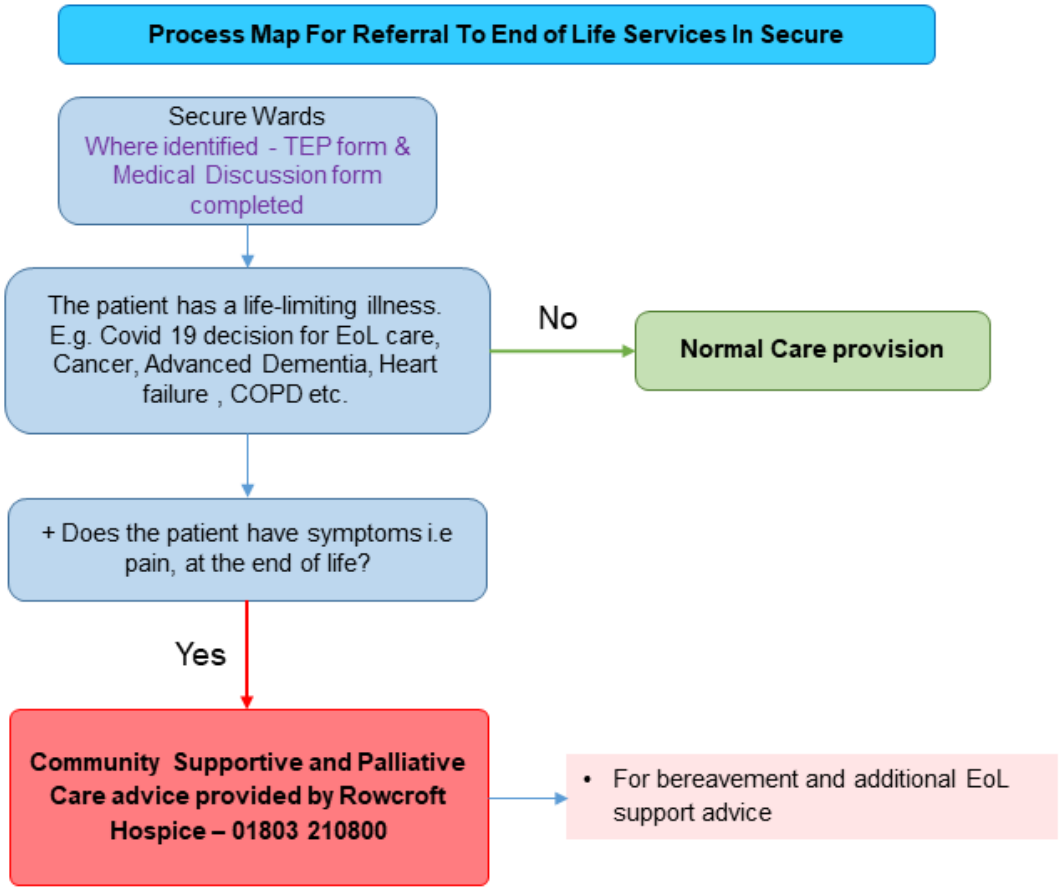
NHS
Devon Partnership
NHS Trust



- To be used in collaboration with the CoVid 19 EoL SOPS for care and pharmacological interventions guidance.
- For the clinical discussion with the Supportive and palliative Care teams and Hospice teams to be led by the Senior Medical Clinician or Consultant Psychiatrist.

For Secure Services

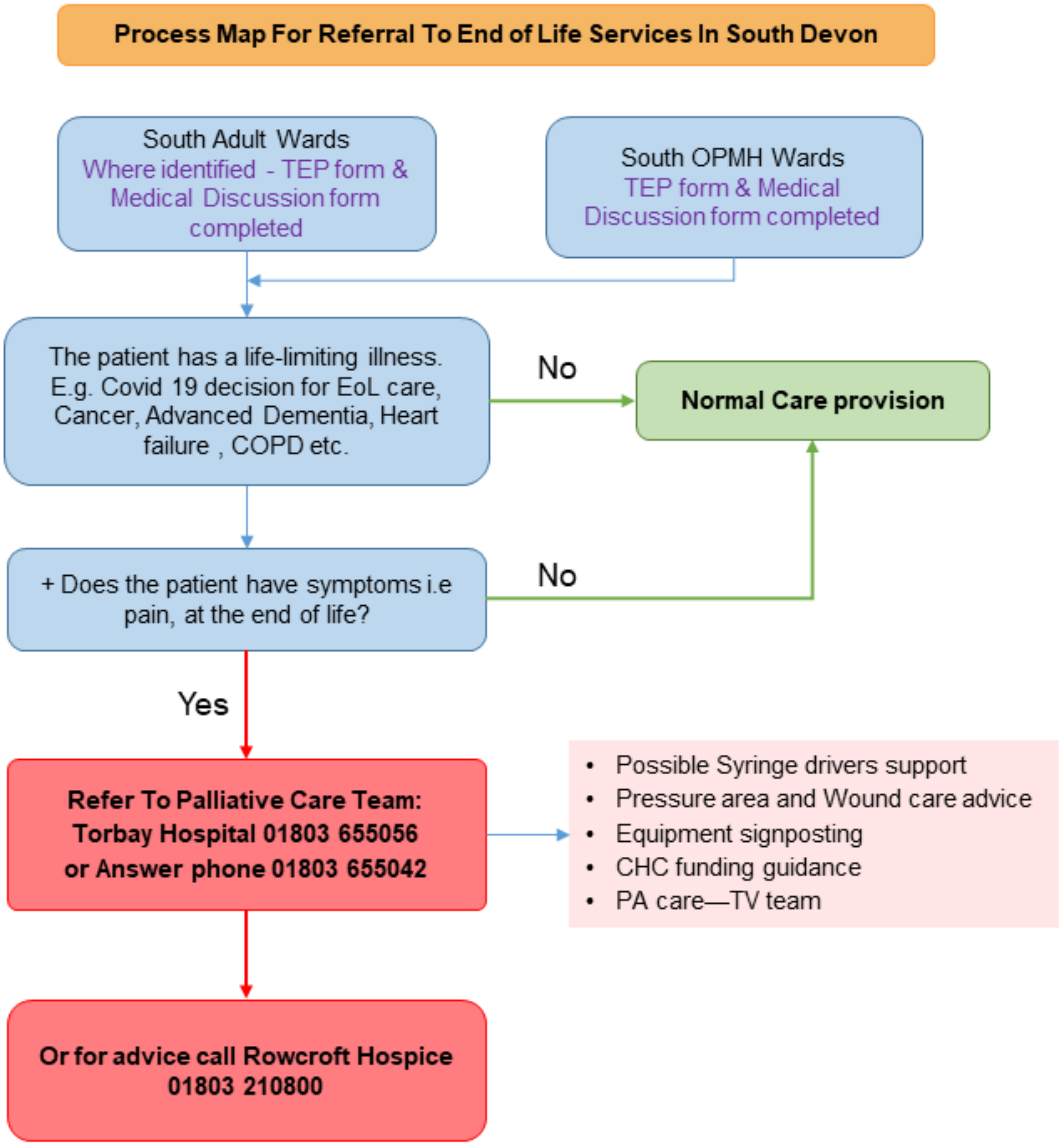
Devon Partnership NHS Trust



- To be used in collaboration with the CoVid 19 EoL SOPS for care and pharmacological interventions guidance.
- For the clinical discussion with the Supportive and palliative Care teams and Hospice teams to be led by the Senior Medical Clinician or Consultant Psychiatrist.

For South Devon Services

NHS
Devon Partnership
NHS Trust



- To be used in collaboration with the CoVid 19 EoL SOPS for care and pharmacological interventions guidance.
- For the clinical discussion with the Supportive and palliative Care teams and Hospice teams to be led by the Senior Medical Clinician or Consultant Psychiatrist.

Appendix Two – Prescribing In Palliative Care

This is to be used as **a guide** rather than a set of definitive equivalences. It is crucial to appreciate that conversion ratios are never more than an approximate guide (comprehensive data are lacking, inter-individual variation). The advice is always to calculate doses using morphine as standard and to adjust them to suit the patient and the situation. Some of these doses have by necessity been rounded up or down to fit in with the preparations available, including adjustment of doses for liquid and injectable medications in order to optimise ability to dispense accurately.

PLEASE SEEK SPECIALIST ADVICE IF YOU ARE UNCERTAIN ABOUT WHAT TO PRESCRIBE AND/OR PATIENT NEEDING ESCALATNG OPIOID DOSES

Oral Morphine			**Subcutaneous Morphine**		**Subcutaneous Diamorphine**		**Oral Oxycodone**			**Subcutaneous Oxycodone**		**Approximate TD Fentanyl patch micrograms/hr**	**Subcutaneous Alfentanil**		**Subcutaneous Fentanyl**	
4 hr dose (mg)	12hr SR dose (mg)	24hr Total dose (mg)	4 hr dose (mg)	24 hr total dose (mg)	4 hr dose (mg)	24 hr total dose (mg)	4hr dose (mg)	12hr SR dose (mg)	24hr total dose (mg)	4 hr dose (mg)	24 hr total dose (mg)	Please see additional chart below for dose conversion ranges	4 hr dose (mg)	24hr total dose (mg)	4 hr dose (mcg)	24hr total dose (mcg)
5	15	30	2.5	15	1	10	2.5	7.5	15	1	7.5	12mcg	0.1	1	25	200-250
10	30	60	5	30	2.5-5	20	5	15	30	2.5	15	25mcg	0.2	2	50	400-500
15	45	90	7.5	45	5	30	7.5	25	50	4	25	25-37mcg	0.5	3	100	600-750
20	60	120	10	60	7.5	40	10	30	60	5	30	37-50mcg	0.7	4	Syringe pump volume issues likely above 500 mcg / 24hours because fentanyl injection available as 50 micrograms/ml	
30	90	180	15	90	10	60	15	45	90	7.5	45	50-75mcg	1	6		
40	120	240	20	120	12.5	80	20	60	120	10	60	75-100mcg	1	8		
50	150	300	25	150	15	100	25	75	150	12.5	75	100-150mcg	1.5	10		
60	180	360	30	180	20	120	30	90	180	15	90	100-150mcg	2	12		
70	210	420	35	210	25	140	35	105	210	17.5	100	125-175mcg	2.5	14		
80	240	480	40	240	27.5	160	40	120	240	20	120	125-200mcg	2.5	16		

- Two thirds of palliative care patients need <180mg/24hrs of oral morphine
- The dose conversion ratio of morphine to oxycodone is approximately 1.5-2:1. For the purposes of this guidance we have adopted a 2:1 ratio
- The dose conversion ratio of SC diamorphine: SC alfentanil is from 6-10:1. It is prudent to use the more conservative ratio when switching from one to the other e.g. if switching from diamorphine to alfentanil, use dose conversion ratio 10:1 so that 10mg diamorphine = 1mg alfentanil. If switching from alfentanil to diamorphine use dose conversion ratio 6:1 so that 1mg alfentanil = 6mg diamorphine.
- The dose conversion ratio of SC Alfentanil: SC fentanyl is approximately 4-5:1

TRANSDERMAL (TD) OPIOID PATCHES

Fentanyl TD patch micrograms/hr	Approximate oral Morphine mg/24hours
12	30-45
25	60-90
37	90-135
50	120-180
62	150-225
75	180-270
100	240-360
125	300-450
150	360-540
175	420-630
200	480-720

Buprenorphine TD micrograms/hr	Approximate oral Morphine mg/24hrs
5	10-20
10	20-30
15	30-40
20	40-50
35.5	80-90
52.5	120-130
70	160-180
Maximum authorised dose is two 70micrograms/hr patches	

- A PO morphine:transdermal fentanyl dose conversion ratio of 100-150:1 is used (PCF6 & BNF 100:1, Public Health Education Opioids Aware Resource 150:1) resulting in a dose range of oral morphine per patch strength e.g. Fentanyl TD 25mcg/hr patch approximately= 60-90mg oral morphine/24hrs.

- It is suggested that for conversions from oral morphine to fentanyl patches, the lower doses of fentanyl should be used for patients who have been on oral opioids for just weeks and the higher doses for people who have been on a stable and well tolerated oral opioid regimen for a longer period.

- Transdermal fentanyl patches are changed every 3 days (72 hours).

- A PO morphine: transdermal buprenorphine dose conversion of 100:1 is used (PCF6)

- A variety of transdermal buprenorphine patches are available, changed either every 3, 4 days or 7 days. Check carefully before prescribing & instructing the patient.

Resources: Palliative Care Formulary 6th Edition (PCF6)
BNF
UK Medicines Information: How should conversion from oral morphine to fentanyl patches be carried out?
https://www.sps.nhs.uk/wp-content/uploads/2017/12/UKMI_QA_Conversion-from-oral-morphine-to-fentanyl-patches_November-2017_Final.docx.
Updated November 2018 / Review November 2021
Dr Sarah Human, Dr Jo Sykes and Dr George Walker, Consultants in Palliative Medicine, Rowcroft Hospice, South Devon in collaboration with Hospiscare, Exeter, St Luke's Hospice, Plymouth and North Devon Hospice, Barnstaple.

CCG COVID-19 Pandemic Medicines Optimisation Control Centre: Syringe driver medication prescribing at end of life for patients with COVID-19

The utilisation of drugs for symptom control is an important facet of the management of COVID-19 as patients approach the end of life. Although the majority of patients are managed currently within the hospital setting, for some patients, it is appropriate for them to be cared for in a non-hospital setting.

National guidance has been provided in the form of the following documents:

- *COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community (NICE; 3/4/2020),*
- *Community Palliative, End of Life and Bereavement Care in the COVID-19 pandemic (RCGP, March 2020).*

Some patients will need to have drugs for symptom control administered by a syringe driver in the last few days of their life. The documents listed above contain some information on the use of injectable drugs but they do not present this in a synthesised form, or focus on the doses that recently published evidence has shown are most commonly used. Furthermore they do not consider the lack of pharmaceutical stability data for the possible combinations and dose ranges that are described in the documents. The attached guidance draws upon the above documents to provide specific guidance for primary care on the use of end of life drugs administered via a syringe driver in the doses and combination commonly anticipated to be used. It has had input from palliative care specialists, and support from NHS Devon CCG medicines optimisation and clinical effectiveness team.

Medication administered orally or given as a subcutaneous bolus is outside the scope of this document.

The use of parenteral drugs for patients requiring Covid-19 end of life care is similar to prescribing for end of life symptoms in non-Covid-19 patients. Dose ranges may vary between the Covid-19 and non-Covid-19 settings and generalists seeking specialist advice are encouraged to seek support with prescribing decisions on an individual patient basis. Specialist advice phone line numbers are provided.

Syringe driver medication prescribing at end of life for patients with Covid-19 *(where available)*

The use of parenteral drugs for patients requiring Covid-19 end of life care is very much building on your existing knowledge of prescribing in similar end of life symptoms in non-Covid-19 patients. Each choice of drug and dose will need to be on an individual patient basis. Doses in the table overleaf are suggested starting doses based on RCGP and NICE guidance (links at bottom of page 4)

- Patients may deteriorate rapidly and will require regular review
- Ensure ‘as required’ SC doses are available whilst stabilising syringe driver medication
- Consider renal function. Seek specialist advice if eGFR <30ml/min
- Frail/elderly patients may require lower starting doses
- Higher doses may cause site reactions - seek advice from specialists on how to manage these should they occur
- Compatibility data is available for the following combinations of drugs in a syringe driver (diluent NaCl 0.9%) up to and including the maximum recommended doses in the table overleaf:

    - Morphine plus midazolam plus glycopyrronium
    - Morphine plus midazolam plus hyoscine hydrobromide
    - Morphine plus midazolam plus levomepromazine

Seek specialist advice for patients requiring more than three medications or doses above those in the table below

Prescribe according to clinical need of the patient and familiarity with use of drug

If the patient has poorly controlled symptoms and/or you are uncertain about dose ranges to use, please seek specialist advice from your palliative care 24-hour line:

North Devon - 01271 347214	**South Devon - 01803 210 800**
East Devon - 01392 688040 **(out of hours - 01392 688044)**	**West Devon - 01752 964200** **(out of hours - 01752 401172)**

Diluent NaCl 0.9%

Clinical Indication	Medication	Suggested starting dose	Maximum recommended dose*
Pain, cough or breathlessness	Morphine Sulfate 10mg/1ml ampoules	10mg/24hrs	30mg/24hrs
Nausea/vomiting	Levomepromazine 25mg/ml ampoules	6.25mg/24hrs	25mg/24hrs
Agitation/delirium	Levomepromazine 25mg/ml ampoules	25mg/24hrs (12.5-25mg/24hrs in frail/elderly)	25mg/24hrs
Anxiety, agitation, restlessness and breathlessness	Midazolam 10mg/2ml ampoules	10mg/24hrs	30mg/24hrs
Respiratory Secretions	Hyoscine Hydrobromide 400micrograms/ml ampoules • Sedating • Avoid if eGFR <30ml/min	1.2mg/24hrs	2.4mg/24hrs
OR	Glycopyrronium 200micrograms/ml ampoules • Non-sedating • Use if eGFR <30ml/min	600 micrograms /24hrs	600 micrograms /24hrs

*Seek specialist advice if considering use of higher doses (based on The Syringe Driver 4th ed.)

Community Palliative, End of Life and Bereavement Care in the COVID 19 pandemic. A guide to End of Life Care symptom control when a person is dying from COVID care for General Practice Teams, prepared by the Royal College of General Practitioners and the Association for Palliative Medicine. First Edition March 2020 Version 3. https://elearning.rcgp.org.uk/mod/page/view.php?id=10537

COVID-19 rapid guideline: managing symptoms (including at the end of life) in the community. NICE guidance (NG163). Published date: 03 April 2020 Last updated: 22 April 2020 https://www.nice.org.uk/guidance/ng163

NHS Devon Clinical Commissioning Group

Review date: 30th August 2020

Appendix Three – Three Talk Model of Decision Making

'Three talk' model for shared decision making can be used to guide the decision-making process:

1. **Team talk** - Clarify the diagnosis, establish that a decision needs to be made regarding the next steps and reinforce partnership

   For example, 'You have coronavirus infection that has severely affected your breathing. We need to decide on the next steps'

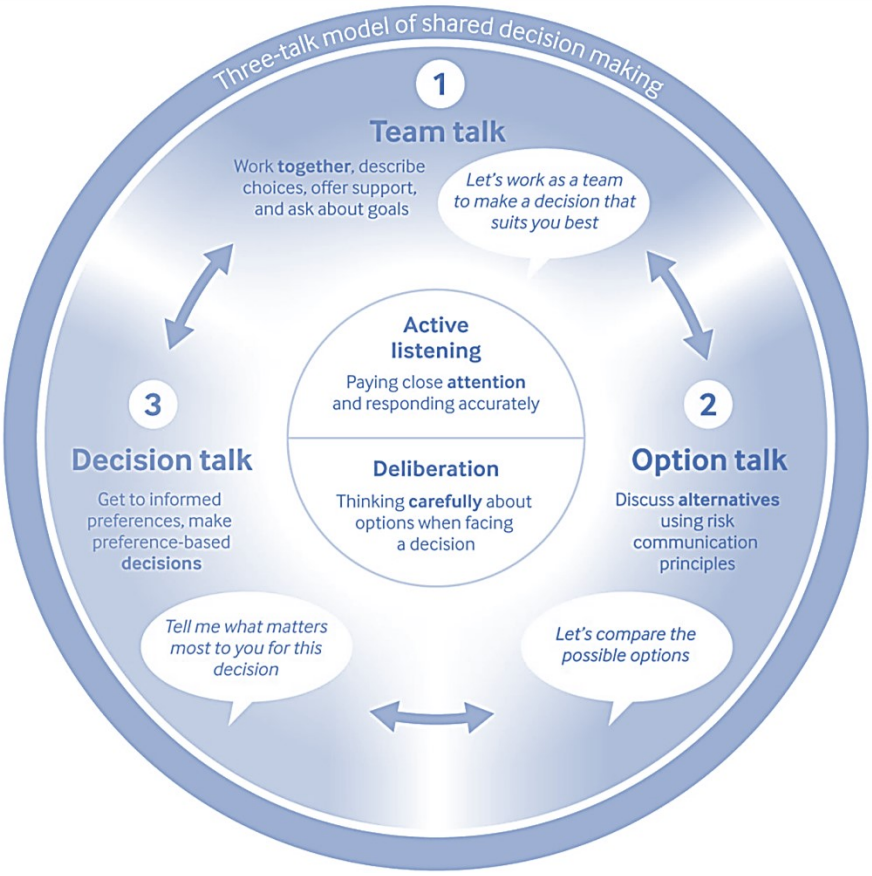
2. **Option talk** - Check prior knowledge, then outline options along with what is known of the pros and cons of the options, then check understanding

3. **Decision talk** - Further establish that a decision needs to be made, reinforce empathy and partnership, check for information gaps

   The decision

   - If possible, defer closure and give time for discussion with relatives, carers, advocates.
   - If not possible, 'What thoughts do you have about the best way forward?'
   - If low confidence/high anxiety, empathy

   'This is so difficult, but I am here…' What else can I do/tell you to help us come to the right decision?'



https://www.bmj.com/content/359/bmj.j4891

Appendix Four – Prayers and Readings

Christian Prayers and Readings

The Lord's Prayer. *This prayer is familiar to all Christians; saying it with a patient can be comforting. The patient may or may not join in if you say this. Please note that the last two lines (in italics) are not used by Roman Catholics*

Our Father, who art in heaven,
hallowed be thy name;
thy kingdom come;
thy will be done;
on earth as it is in heaven.
Give us this day our daily bread.
And forgive us our trespasses,
as we forgive those who trespass against us.
And lead us not into temptation;
but deliver us from evil.
For thine is the kingdom,
the power and the glory, for ever and ever. **Amen.**

The Hail Mary. *This is a prayer familiar to all Roman Catholics and saying it with them may be comforting. Once again they may or may not join you in saying this.*

Hail Mary, full of grace.
The Lord is with thee.
Blessed art thou amongst women,
and blessed is the fruit of thy womb, Jesus.
Holy Mary, Mother of God,
pray for us sinners,
now and at the hour of our death.
Amen.

Psalm 23. *This psalm is associated with difficult times as the words indicate. It can be used with any Christian or Jew. Patients who ask you for a prayer may be comforted if you simply say this.*

The Lord is my shepherd; therefore can I lack nothing.
He makes me lie down in green pastures and leads me beside still waters.
He shall refresh my soul and guide me in the paths of righteousness
for his name's sake.
Though I walk through the valley of the shadow of death, I will fear no evil;
For you are with me; your rod and your staff, they comfort me.
You spread a table before me in the presence of those who trouble me;
You have anointed my head with oil and my cup shall be full.
Surely goodness and loving mercy shall follow me all the days of my life,
And I will dwell in the house of the Lord for ever

The commendation
God our creator and redeemer,
by your power Christ conquered death and entered into glory.
Confident of his victory and claiming his promises,
we entrust N to your mercy in the name of Jesus our Lord,
who died and is alive and reigns with you,
now and for ever**.** **Amen.**

Supporting Muslim Patients

As sunrise and sunset change through the year so do times for Muslims to pray. If you need to support a Muslim wishing to pray the times can be found here https://www.salahtimes.com/uk/

Muslims pray in Arabic even if they do not speak Arabic because the Holy Koran was given to the Prophet Mohammad (Peace be upon him) in Arabic. However it is permissible to pray in your native tongue but better to do so in Arabic.

This prayer in English can be used with very sick or dying patients

O God, I ask of thee a perfect faith, a sincere assurance, a reverent heart, a remembering tongue, a good conduct of commendation, and a true repentance, repentance before death, rest at death, and forgiveness and mercy after death, clemency at the reckoning, victory in paradise and escape from the fire, by thy mercy, O Mighty One, O Forgiver, Lord increase me in knowledge and join me unto good.

There is a particular prayer in Arabic which Muslims who are ill would find comforting; There follows a transliteration which a member of staff can use followed by an English translation:

Allahuma rabban-nas adhhabal ba'sa, ashfi anta shafi, la shifa' illa shifa'uka shifa' la yughadiru saqama.

Oh Allah! The Sustainer of Mankind! Remove the illness, cure the disease. You are the One Who cures. There is no cure except Your cure. Grant us a cure that leaves no illness.

When a Muslim dies it is preferable that they are facing Makkah. If you have a compass that points in that direction that would be great, you can also download an app on your phone. Failing this, just point the patient's face south east. The following should be said:

Allah hummag fir le hayyena, wa mayyetena, wa shaaedena, wa gaaebena, wa sagheerena, wa kabirena ,wa zakarena ,wa unsana , Allah humma man aah yaiytahu , minna fa aah yehi alal Islam .Waman tawaf faiytahu minna fata waffahu alal Iman.

Oh Allah! Forgive those of us who are alive and those of us who have passed away; those of us who are present and those of us who are absent; those of us who are young and those of us who are old; our males and our females. O`Allah! Whomsoever You keep alive, let him live on Islam and whomsoever You cause to die, let him die with Iman (faith).

Supporting Sikh patients

You can use the following to encourage Sikhs to pray

Prayer is the medium, the way, that enables us to communicate with the unseen reality which is the ground of the universe. To a God awakened soul, forgetting God for an instant is a great affliction of the mind. The very act of prayer gives us a strange sense of peace and links us with something far greater than us.

Supporting Buddhist Patients

May I become a medicine for the sick and their physician, their support until sickness come not again.
May I become an unfailing store for the wretched, and be first to supply them with their needs.
My own self and my pleasures, my righteousness past, present, and future, may I sacrifice without regard, in order to achieve the welfare of beings.

Supporting Hindu Patients

We meditate upon that adorable effulgence of the resplendent Savitr, the life giver. May he stimulate our intellects. (A prayer to Savitr. Rig Veda II.62.10):

O Lord lead me, from untruth to Truth, from darkness to Light and death to Immortality. (Brihadaranyaka Upanishad)
May good thoughts come to us from every side, pure, unobstructed, overflowing. May we, O Devas, with our ears hear what is good. Holy ones, may we see with our eyes what is good. (Rig Veda)

Supporting Jewish Patients

Our God and God of our fathers, may our rest be pleasing to you. Make us holy by doing your commands and let us share in the work of your Torah. Make us content with your goodness and let our souls know the joy of your salvation. Purify our hearts to serve you in truth. In your love and goodwill let us inherit your holy Sabbath and may all Israel who seek holiness find it in their rest. Blessed are you Lord, who makes the Sabbath holy.

Blessed are you, Lord our God and God of our fathers. God of Abraham, God of Isaac, and God of Jacob. The great, the mighty and awesome God. God beyond, generous in love and kindness, and possessing all. He remembers the good deeds of our fathers, and therefore in love brings rescue to the generations, for such is his being. The King who helps and saves and shields. Blessed are you Lord, the shield of Abraham.

For the non-religious

Into the freedom of wind and sunshine
We let you go.
In to the dance of the stars and the planets
We let you go.
Into the arms of death that waits for us all
We let you go.
Think not that you are dying but remember that you lived.

Go gently on your voyage, beloved.
Let love call you home with the ebb tide.
May the moon light a way across the waters for you.
May the earth cradle you,
The breeze blow you swiftly
Until you reach the place where your weary vessel need labour no more,
Go gently, beloved, go.

Appendix Five – Digital Communications

Supporting Service User and Carer communication during periods of isolation due to clinical presentations such as CoVid 19 + EoL care.

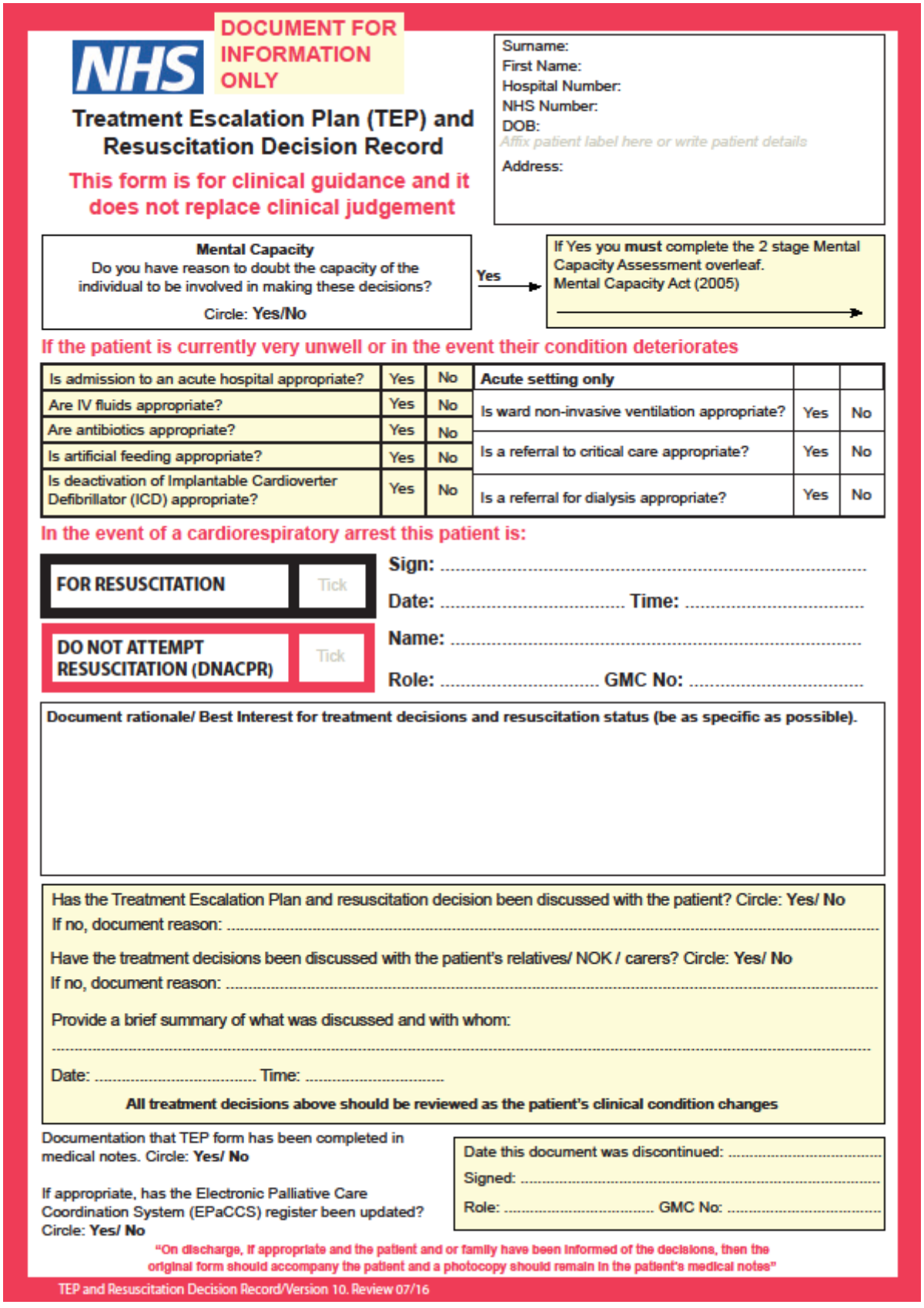
- The Trust is equipping each inpatient setting with an iPad or similar device and has installed NHS Attend Anywhere as a platform for video communication for use by service users.

- Service users and carers can use their own devices where these are available to use routine platforms such as messenger, WhatsApp and Facetime to support contact and communications.

- The decision to enable to the use of personal communication devices needs to be undertaken with the individual and in line with the person's risk assessment of that activity and the setting in which they are being cared in.

- All devices used must be cleaned in line with current Infection Prevention and Control procedures.

Appendix Six - Treatment Escalation Plan (TEP) and Resuscitation Decision Record



DOCUMENT FOR INFORMATION ONLY

NHS

Treatment Escalation Plan (TEP) and Resuscitation Decision Record

This form is for clinical guidance and it does not replace clinical judgement

Surname:
First Name:
Hospital Number:
NHS Number:
DOB:
Affix patient label here or write patient details
Address:

Mental Capacity
Do you have reason to doubt the capacity of the individual to be involved in making these decisions?
Circle: **Yes/No**

Yes →

If Yes you **must** complete the 2 stage Mental Capacity Assessment overleaf.
Mental Capacity Act (2005)

If the patient is currently very unwell or in the event their condition deteriorates

Is admission to an acute hospital appropriate?	Yes	No	**Acute setting only**		
Are IV fluids appropriate?	Yes	No	Is ward non-invasive ventilation appropriate?	Yes	No
Are antibiotics appropriate?	Yes	No	Is a referral to critical care appropriate?	Yes	No
Is artificial feeding appropriate?	Yes	No			
Is deactivation of Implantable Cardioverter Defibrillator (ICD) appropriate?	Yes	No	Is a referral for dialysis appropriate?	Yes	No

In the event of a cardiorespiratory arrest this patient is:

FOR RESUSCITATION	Tick
DO NOT ATTEMPT RESUSCITATION (DNACPR)	Tick

Sign: .....
Date: ..... **Time:** .....
Name: .....
Role: ..... **GMC No:** .....

Document rationale/ Best Interest for treatment decisions and resuscitation status (be as specific as possible).

Has the Treatment Escalation Plan and resuscitation decision been discussed with the patient? Circle: **Yes/ No**
If no, document reason: .....

Have the treatment decisions been discussed with the patient's relatives/ NOK / carers? Circle: **Yes/ No**
If no, document reason: .....

Provide a brief summary of what was discussed and with whom:
.....
Date: ..... Time: .....

All treatment decisions above should be reviewed as the patient's clinical condition changes

Documentation that TEP form has been completed in medical notes. Circle: **Yes/ No**

If appropriate, has the Electronic Palliative Care Coordination System (EPaCCS) register been updated? Circle: **Yes/ No**

Date this document was discontinued: .....
Signed: .....
Role: ..... GMC No: .....

"On discharge, if appropriate and the patient and or family have been informed of the decisions, then the original form should accompany the patient and a photocopy should remain in the patient's medical notes"

TEP and Resuscitation Decision Record/Version 10. Review 07/16

Appendix Seven - Guidance for completing Treatment Escalation Plan and Resuscitation Decisions

Guidance for completing Treatment Escalation Plan and Resuscitation Decisions

- This form should be completed legibly in black ball point pen
- Complete patient details (including address) or affix patient's identification sticker
- When completing this form it is important that the healthcare professional has knowledge of end of life procedures and documents. If in doubt refer to your organisation's End of Life Policy.

Healthcare professional making the Treatment Escalation Plan (TEP) and Resuscitation Decision
Ideally the TEP and Resuscitation Decision should be made by the most senior medical clinician looking after the patient. However, if a more junior member of staff is completing the form it must be in consultation with their registrar or consultant and documented in the medical notes.

TEP and Resuscitation Decision Review
A fixed review date is not recommended; the TEP is considered as 'indefinite' unless clearly cancelled. The form should be reviewed whenever clinically appropriate or whenever the patient is transferred from one healthcare setting to another and admitted from home or discharged home.

Capacity/advance decisions
If there is any reason to doubt capacity of the patient, a Mental Capacity Assessment must be completed. The 2 stage Mental Capacity Test is on the back of the form. The assessment of mental capacity is only in relation to the decisions made at the time of completing the form. If capacity changes, the form (including capacity) must be reviewed and documented. Clearly document any Best Interest Decision in relation to the Treatment Escalation Plan and Resuscitation Decision. For further information and guidance please refer to your local multiagency safeguarding policy and procedures and the 'Mental Capacity Act 2005 Code of Practice' (2007)

Summary of communication with patient
State clearly what was discussed and agreed. If this decision was not discussed with the patient state the reason why. It is good and recommended practice to discuss treatment decisions with every patient but if this would cause distress without any likelihood of benefit for the patient or if the patient lacks capacity this should be recorded.

Summary of communication with patient's relatives or friends
If the patient does not have capacity their relatives, friends or an IMCA must be consulted and may be able to help by indicating what the patient would decide if able to do so. If the patient has made a Lasting Power of Attorney (LPA) for health and welfare to make health-related decisions on their behalf, the doctor must ensure that the LPA is valid before consulting the Welfare Attorney (WA). A WA may be able to refuse life-sustaining treatment on behalf of the patient if this power is included in the original LPA. That person will make decisions as if they are the patient themselves. All their decisions must be in the patient's best interest. If it is felt the WA is not acting in the patient's best interest the Office of the Public Guardian must be informed along with the local Safeguarding Team. Ensure that discussion with others does not breach confidentiality. State the names and relationships of relatives or friends or other representatives with whom this decision has been discussed. A more detailed description of such discussion should be recorded in the clinical notes. For further guidance on Best Interests Principles see overleaf.

The multidisciplinary team
Ensure that the TEP decisions have been communicated to all relevant members of the multidisciplinary health and social care teams involved in caring for the patient.

Communication across other healthcare settings
For End of Life patients, the original of this form should accompany the patient on transfer if appropriate. This document remains valid until reviewed / endorsed by the receiving healthcare professional.

Discharge and TEP / Resuscitation Decision Record
Prior to discharge the content of the form should be reviewed and if the patient and / or family are informed about it's contents and it is relevant to the clinical situation the original form should accompany the patient. Ensure conversations with the patient and family regarding this are documented. Ensure a photocopy of the form remains in the medical notes and it is communicated to the GP in the discharge letter.

Ambulance and TEP
In the community the most recent TEP form should be placed at the front of the patients record.

Organ donation
Patient and family wishes regarding organ / tissue donation after death should be ascertained and documented. It is essential for staff to establish if the patient has previously expressed the wish to be a donor and if the patient is on the NHS Organ Donor register or carries a Donor Card. Please refer to your organisation's guidelines relating to organ donation.

If following clinical review treatment decisions are changed:
- Clearly score through this form, then sign & date the discontinuation
- File at the back of the patient's medical notes
- Document the change of decision in the patient's medical notes
- Complete a new form and insert in the patient's medical notes

Appendix Eight - Treatment Escalation Plans – Checklist for nursing team

Devon Partnership NHS Trust

Treatment Escalation Plans – Checklist for nursing team

Name of patient:_____ Ward: _____

Date of birth: _____ Consultant: _____

		Yes	No	N/A
1.	Are the person's details entered correctly and in full on the TEP form?			
2.	Have all sections of the TEP form been fully completed?			
3.	Has the patient's mental capacity status been recorded on the TEP form?			
4.	Is the mental capacity assessment on the back of the TEP form completed in full?			
5.	Is it recorded on the TEP form if the patient has an Advance Decision to Refuse Treatment and/or Lasting Power of Attorney for health and welfare?			
6.	Is the resuscitation decision clear? **If this is not clear please bring this to the Responsible Clinician's attention**			
7.	Are the following completed next to the resuscitation decision:			
	doctor's signature?			
	date?			
	time?			
	doctor's name (this must be legible)?			
	doctor's job title?			
	doctor's GMC number?			
	If these are not completed please bring this to the Responsible Clinician's attention			
8.	Have the decisions on treatment and resuscitation been discussed with the:			
	patient?			
	patient's relative(s), IMCA and/or carer(s)?			
	If the answer is no or its unclear discuss with the Responsible Clinician			

Please place a copy of the TEP form in the patient's file and send a copy to the MHA Office.

Appendix Nine - Twelve things a doctor should know about the Treatment Escalation Plan

Twelve things a doctor should know about the Treatment Escalation Plan/ Resuscitation Decision Record (TEP/RDR)

1. **Which of my patients should have a TEP/RDR?**
   Take a view. A guide is "would I be surprised if this patient were to die within the next 6 to 12 months?" Your patient may already have a TEP/RDR form from the community. In which case reconsider their resuscitation status and ceiling of care

2. **Who should make the decision/complete the form?**
   Ideally such decisions should be made by the most senior medical clinician looking after the patient. If a more junior member of staff is completing the form, it must be in consultation with their registrar or consultant.

3. **Do I discuss the decision with the patient?**
   It is clearly good practice to take account of the patient's wishes, though the courts recognise that on occasions the decision to consult is one of the utmost sensitivity and difficulty. However they also argue that there should be a presumption in favour of patient involvement and that there needs to be convincing reasons not to involve the patient; "D*octors should be wary of being too ready to exclude patients from the process on the grounds that their involvement is likely to distress them"*[1]. Discussion regarding treatment escalation in conjunction with resuscitation status may be less distressing for the patient. If your patient indicates they do not wish to discuss resuscitation, this should be respected and documented – take a 'best interests decision'. Record discussion or no discussion (and reasoning) on the form (in the third yellow box).

4. **Should I discuss the decision with the family?**
   If your patient has capacity and is happy for disclosure then do so, recording this on the form. If your patient lacks capacity, then discuss your patient's likely wishes, feelings, beliefs and values with those close to them, in order to help you make a 'best interests' decision. Sensitively explain to them that they are not the final decision makers. Record your discussion clearly on the TEP/RDR form.

5. **What should I do if my patient lacks capacity and has no one close?**
   For those patients who are 'unbefriended' discuss the merits/not of resuscitation with their advocate if they have one, or else consider appointing an Independent Mental Capacity Advocate. Discussion with and appointment of any advocate is deemed unnecessary if you feel resuscitation is clearly inappropriate, though informing is good practice[1].

6. **How do I indicate that my patient lacks capacity?**
   This should be clearly documented and is a focus of Care Quality Commission scrutiny. In the example given (Fig 1), complete the reverse side of the form. If the response is 'yes' to any of the four questions, then your patient lacks capacity. Of course this may be temporary. It is good clinical practice to review resuscitation status and ceiling of care if your patient recovers.

7. **What if my patient wants resuscitation that I think will be ineffectual?**
   You are not required to provide treatment you consider to be inappropriate. The R(Tracey) v Cambridge University Hospitals NHS Trust case emphasises the patient's (or relatives') potential access to a second opinion. If communicating the endorsement of a do not resuscitate decision by all members of the multidisciplinary team is not accepted, then consider offering a second opinion. This is not a legal obligation.

8. **What if my patient declines resuscitation that I believe will be effectual?**
   If a patient with capacity refuses resuscitation, or a patient lacking capacity has a valid and applicable advance decision refusing treatment (ADRT), specifically refusing resuscitation, this must be respected.

9. **When should my patient's TEP/RDR form be reviewed?**
   It is good clinical practice if potential TEP/RDR patients routinely discussed, and those with existing ones reviewed at each ward/board round; particularly when the patient's condition has changed (either for better or worse). Relocation of a patient within the hospital (for example from intensive care or high dependency unit to a ward) should also trigger review. Senior medical and nursing staff should consider adopting a culture where any member of the care team prompting a TEP/RDR decision/review is applauded.

10. **What I do with the TEP/RDR form on patient discharge?**
    Review the TEP/RDR form decision and/or ask the patient's GP to do the same. Communicate this decision within the discharge summary. Ensure the TEP/RDR form is photocopied for the trust medical records and that the original travels with the patient. Your patient, or those close to them may request a review at any stage.

11. **The existence of a TEP/RDR form ≠ not for resuscitation**
    Should your trust combine a DNAR record with a treatment escalation plan, beware staff misinterpreting the existence of a patient's form as "not for resuscitation", even though the form may indicate "for resuscitation". Good education throughout such a significant change in practice is required.

12. **Choking, tracheostomy tube problems and temporary 'do not resuscitate' suspensions**
    A TEP/RDR form indicating "not for resuscitation" does not override clinical judgement in the unlikely event of a reversible cause of the patient's respiratory or cardiac arrest that does not match the circumstances envisaged. Choking, a displaced or blocked tracheostomy tube are good examples. Apply common sense. Similarly, it may be appropriate to suspend a do not resuscitate decision temporarily during some procedures e.g. cardiac catheterisation, pacemaker insertion or surgical operations.

Appendix Ten – Guidance for TEP decision discussions

Evidence Consideration of Factors in the Patients Acute Condition and Long Term Health Conditions
Current clinical status Age Recent cardiac arrest any cause Congestive heart failure with symptoms at rest or on minimal exertion Hypertension Severe and irreversible neurological condition including dementia Chronic pulmonary disease (symptoms at rest/minimal exertion or pulmonary hypertension) Chronic Liver Disease End stage chronic renal failure requiring renal replacement therapy Diabetes mellitus with end organ dysfunction Uncontrolled malignancy AIDS/ immunosuppression Solid organ or bone marrow transplant Inflammatory bowel disease, rheumatoid arthritis and other collagen vascular diseases requiring advanced therapies Current significant alcohol dependence
Evidence Consideration of Ability to Recover From This Episode of Physical Illness
Frailty Score or Assessment of Metabolic Equivalent Task or similar assessment of tolerance of demands of ITU admission Self reported Quality of Life Level of Dependence Trajectory of this Illness
Evidence Considerations of Balancing Benefits and Disbenefits of Escalating Treatment
What good may be achieved for this patient (including the likelihood of this) and what Disbenefits may be achieved for this patient (including the likelihood of this)
Evidence Considerations of Patient Past Wishes and Relevant Statements and Beliefs
Is there a valid advance decision to refuse treatment that must be adhered to? Is there an advanced directive or advanced plan that needs to be taken into account? If relevant are there appropriate relevant others e.g. family, IMCA etc that should be considered?