COVID-19: Clinical Advice
### Version History

<table>
<thead>
<tr>
<th>Version</th>
<th>Date</th>
<th>Summary of changes</th>
</tr>
</thead>
</table>
| V 2.3   | 03/04/2020 | - Addition of the following recommendation to ‘Key Recommendations’: It is vital that no arbitrary clinical decisions should be made on the basis of any characteristic(s) of a patient, such as age, disability or the presence of existing health conditions or impairments that are unrelated to their chance of benefiting from critical care.  
- Expansion of section 5 ‘Anticipatory Care Plans in COVID-19’  
- Inclusion of guide for ‘Management of Adult patients in the ED’  
- Expansion of section 7 ‘Critical Care’ to include more information on decision making in the ICU  
- Hyperlink to Scottish Palliative Care Guidelines updated in section 9 ‘End of Life Care’  
- Addition of section 9.1 on ‘Visiting’  
- Addition of note in Table 1: Management of symptoms when delivering end of life care in COVID-19 to seek advice or review if more than 100mg of Levomepromazine used in 24 hours  
- Section 10 ‘Ethical Considerations’ expanded to reflect the updated version of the Ethical advice and support guidance  
- Section 11 ‘Workforce Considerations’ expanded to note that regulatory bodies have recognised that professionals may need to depart from established procedures in these challenging times  
- Addition of two references to section ‘Useful Resources’  
- Appendix 2 updated to include the introductory page of the Healthcare Improvement Scotland Anticipatory Care Planning Template  
- Appendix 3 updated to acknowledge the template ‘Treatment Escalation and Limitation Plan’ was reproduced with permission from NHS Lanarkshire |
| V 2.5   | 20/04/2020 | - Addition of clarification of the limitations to Clinical Frailty Score use and ensuring consistency of wording throughout the document  
- Primary care infographic in appendix 1 updated  
- Addition of section 6.8 on ‘Discharge’ to reflect HPS ‘Stepdown Guidance’  
- Addition of acknowledgements section |
| V 2.6   | 22/04/2020 | - Update to visiting section 9.1  
- Updated ED flow chart  
- TELP removed due to inconsistencies in messaging |
| V 2.7   | 24/04/2020 | - Updated wording on use of Clinical Frailty Scale (CFS) and addition of Appendix 3 providing further guidance on the use of the CFS  
- Updated wording on clinical decision making following feedback from a range of stakeholders  
- Removal of text on patient stepdown from infection control measures and discharge from hospitals. This has been replaced with links to the relevant HPS guidance to ensure clinicians have access to the most up-to-date guidance on these topics |
| V 2.8   | 27/05/2020 | - Addition of web link to discharge leaflets for adults, children and pregnant women with possible or confirmed COVID-19 to section 6.3  
- Updated wording around Scope of the guidance in section 2 |
| V 2.9   | 05/06/2020 | - updated to reflect situation has changed since guidance first published  
- updated to incorporate comments from stakeholders following the Equality Impact Assessment  
- Sections 6.3 and 6.4 of the critical care section have been removed. A critical care guidance is currently being developed and will be published on the SIGN website when available  
- Web link to Scottish Government’s staged approach to reintroducing visiting added |
| V3.0    | 10/07/2020 | Further Information  
For more information on COVID-19, please see the COVID-19 guidance section of our website  
# Table of Contents

Key Recommendations 3

1. Introduction 5

2. Scope 7

3. Community Assessment & Referral to Secondary Care 7

4. Anticipatory Care Plans in COVID 19 9

5. Hospital Admission and Management 11
   - 5.1 Management of Adults in Emergency Departments 11
   - 5.2 Assessment for Admission 13
   - 5.3 Clinical Management and Investigation 13

6. Critical Care 15
   - 6.1 Delivery of Critical Care during Surge Conditions 15
   - 6.2 Critical Care Admission 16

7. Special Considerations 19
   - 7.1 Paediatrics 19
   - 7.2 Obstetrics 21

8. End of Life Care 23
   - 8.1 Visiting 23

9. Ethical Considerations 27

10. Workforce Considerations 28

Useful Resources 29
Authors 30

Appendix 1. Assessment tool for hospital or community management 31
Appendix 2. Anticipatory Care Planning template for use in COVID 19 Pandemic 33
Appendix 3. Guidance for Clinicians on the use of the Clinical Frailty Score (CFS) 35
Key Recommendations

- The impact of the COVID-19 pandemic has placed health and social care services across Scotland under additional pressure requiring an increase in the overall capability and capacity of NHSScotland.

- Scotland’s Community Hubs and Assessment Centres must continue to triage patients presenting with suspected COVID-19 to ensure that the best possible location of care is identified.

- Anticipatory care planning conversations should take place with those who are at higher risk of severe illness from COVID-19. Guidance is provided at appendix 2.

- On admission to hospital all patients over the age of 65 should be assessed for frailty, using the Clinical Frailty Score (CFS) where appropriate, irrespective of COVID-19 status. The CFS must be based on functional status 2 weeks before illness onset. The CFS must not be used in:
  - anyone under the age of 65 or,
  - anyone over the age of 65 with long-term disabilities (for example cerebral palsy), learning disability or autism.

- For those in whom a CFS assessment is not appropriate, a personalised, holistic and non-discriminatory assessment of their frailty status should be carried out.

- Even where it is appropriate to use the CFS, it should not be used in isolation to direct clinical decision making. While it will sensitise clinicians to the likely outcomes in groups of patients, clinical decision making with individual patients should be carried out through a holistic assessment, using the principles of shared decision making and non-discrimination.

- Factors such as age, frailty or the existence of co-morbidities should only be considered when included as part of a non-discriminatory personalised assessment which will assess a patient’s overall potential to benefit from interventions such as critical care admission, alongside their ability to return to a quality of life that is acceptable to them.

- It is vital that no clinical decisions are made on the basis of any characteristic(s) of a patient, such as age, disability or the presence of existing health conditions or impairments that are not clinically relevant to the potential benefits of a course of treatment. The healthcare response is crucial to ensuring that the rights to life and to health continue to be respected, without discrimination, and that resources reach those who are most likely to clinically benefit.

- Staff caring for people with suspected or confirmed COVID 19 should use Personal Protective Equipment (PPE) according to the most up-to-date Health Protection Scotland (HPS) advice.

- When people with suspected COVID-19 are admitted to hospital, throat and nose swabs should be sent for polymerase chain reaction (PCR) testing.

- If there is a high clinical suspicion of COVID-19, and negative initial tests, repeat sampling is required. If a patient has a productive cough then sputum should be sent for COVID-19 testing. Under no circumstances should an induced sputum be performed.
• Speciality teams should discuss treatment escalation and limitation plans (TELPS) with patients and those closest to them, at the earliest opportunity. Those identified as being likely to benefit from treatment escalation should be assessed by a member of the critical care team, if their condition deteriorates.

• Pregnant women with suspected COVID-19 will require specialised advice and care in relation to coronavirus. NHS 24 will use the maternity pathway to triage pregnant women.

• Specific guidance has been developed to help deliver the best possible care for patients with COVID-19 who are approaching the end of life which can be found here.

• The human rights and equality based principles and structures of the ethical advice and support framework must be taken together with the most current national decision-making and escalation guidance when making complex decisions.

• Preserving and protecting the wellbeing of health and social care staff is of vital importance as they respond to the COVID-19 pandemic. The Scottish Government has, together with a range of partner organisations, developed resources aimed at providing staff with advice, information and practical support that supports their mental and physical wellbeing. Further resources to support the wellbeing of health and social care staff are available through the National Wellbeing Hub.

• It is important that given the rapidly evolving and unpredictable nature of the COVID-19 pandemic, that this clinical guidance is reviewed in the current clinical and healthcare context. Clinical teams should ensure to keep up-to-date with the most recent national guidance.
1. Introduction

It is important that given the rapidly evolving nature of the COVID-19 pandemic, that this clinical guidance is viewed in the current clinical and healthcare context. Scottish Government will aim to keep this guidance up to date, but it should be noted that the most up to date guidance on a range of COVID-19 related topics will in future, be found elsewhere. For example, a range of infection prevention and control guidance has been produced by Health Protection Scotland and is available here: Health Protection Scotland (HPS) advice.

The impact of the COVID-19 pandemic has placed health and social care services across Scotland under additional strain. While the pandemic has not overwhelmed services, Scottish Government and Health Boards continue to work hard to maintain capacity to deal with it, while safely and incrementally resuming services that have been paused. The Scientific Advisory Group on Emergencies (SAGE) agrees that pandemic suppression should continue to be our goal to ensure we maintain the capacity to do this.

There is currently no preventative or curative treatment, beyond evidence based good clinical care, that has been proven effective for COVID-19. Research continues across the UK and rest of the world. As new evidence emerges, the approach to management of COVID-19 at the individual, local and national level continues to be reviewed to ensure that it remains proportionate to the health and wellbeing risks faced by the population, and that any guidance remains useful, appropriate and grounded in ethics, including principles of equality and human rights.

Having a robust community response to COVID-19 is vital to protect acute services. Health Boards, in partnership with Community Services and Integration Authorities, have set up and resourced Community Hubs and assessment centres to manage patients presenting in the community. The effective resourcing and functioning of our community hubs has been essential in our efforts to ensure that people are being treated in the right setting at the right time.

There are two parts to these new pathways: COVID-19 Hubs for telephone triage accessed through NHS24-111, and local COVID-19 Assessment Centres, where unwell patients needing to be seen are offered a face-to-face assessment to assess the need for treatment and/or admission to hospital.

1.1 Surge conditions

Surge capacity is the ability to manage a sudden influx of patients while surge capability is the ability to manage patients requiring very specialised medical care. When capacity and capability are outstripped by
demand, an “extreme surge” situation arises and an alternative model of healthcare delivery is required, which requires thoughtful stewardship of available resources.

While this pandemic has not resulted in “extreme surge” situation to date, it is vital that our health and care systems maintain flexibility, capacity and resource to respond to a resurgence of COVID-19 in future.

In the unlikely event that resources become scarce during any future COVID-19 outbreak, healthcare resources should be distributed equitably and prudently to minimise loss of life, in a manner consistent with equality and human rights obligations and with due regard to the need to eliminate discrimination and advance equality of opportunity. The healthcare response is crucial to ensuring that the rights to life and to health continue to be respected, without discrimination, and that resources reach those who are most likely to clinically benefit.

Plans have been put in place to help ensure that we do not reach this point. However, should such circumstances arise, further national guidance to aid clinical decision making, will be published by the Chief Medical Officer’s Professional Advisory Group. This national guidance will aim to support the provision of treatment and care that:

- complies with the principles set out in human rights and equality legislation;
- respects broader human rights and equality principles including those of human dignity, the inherent value of every individual and non-discrimination;
- respects the principles of Good Medical Practice as set out by the General Medical Council;
- is fair, equitable and transparent; and,
- is based on the best available scientific evidence.

**Should the need to produce national guidance arise, it will be subject to review as new evidence emerges and our experience of treating people with COVID-19 evolves.**

Focus on best practice, aligned with the principles of Realistic Medicine should also continue. This means ensuring that each person receives the right care for them, at the right time. This includes:

- Identification of those who will benefit from medical interventions;
- Provision of supportive or end of life care for all acutely ill patients, in whom extensive medical interventions are futile;
• Discussions with patients and those closest to them, with support for decision-making where needed, about their preferences in the event of becoming acutely unwell with COVID-19 or other illnesses;
• Ensuring cohesive working across health and social care in Scotland to reduce unwarranted variation in care.

2. Scope

This guidance is intended to guide delivery of primary and secondary care in Scotland during this COVID-19 pandemic. It is intended to be helpful to all staff working in these areas.

This clinical advice will be continuously monitored and updated as needed, as the trajectory of the pandemic in Scotland develops, and as new evidence and experience emerges. Healthcare services should ensure that they refer to the most up-to-date version of this guidance, which will be available on the Scottish Government website.

Every effort will be made to communicate changes to this clinical advice to all stakeholders in Scotland, and where necessary, complementary public information will be provided.

This clinical advice forms part of a suite of guidance intended to help support the delivery of healthcare in Scotland. It includes this Clinical Advice and the Ethical Advice and Support Framework Guidance. This guidance has been issued by the Scottish Government and applies to the Scottish healthcare context, with consideration of the approach taken across the UK.

3. Community Assessment & Referral to Secondary Care

A clinical assessment tool has been developed to support clinicians in selecting patients for assessment at hospital or management in the community. This can be printed off for use separately (Appendix 1).

Health boards have established a network of COVID-19 Community Hubs and Assessment Centres across Scotland, which aim to provide a comprehensive and expansive frontline community response to enable rapid pathways for those affected by COVID-19. The Hubs are not for direct face-to-face care, instead accepting calls from NHS 24 and other primary care providers. They are staffed by senior clinical decision makers who can triage incoming enquiries and work with patients and those that they care about to decide
on appropriate onward management. Some people will require clinical assessment at COVID-19 assessment centres. These are staffed by nurses and a senior clinical decision maker. They are able to take context-appropriate clinical observations, and then can refer on to secondary care or discharge patients back into the community. Patients and those that they chose to involve should be supported in making shared decisions about their health and wellbeing, helped to understand the treatment options available to them, and their views and wishes must be respected. It is important that healthcare professionals are aware of and are able to signpost patients with protected characteristics to community organisations that will be able to provide them with further, advice, and support should they require it.

The Community Hubs and Assessment Centres will continue to triage patients presenting with suspected COVID-19 in the community to ensure that the best possible location of care is identified for and with these patients. In addition, the Hubs and Assessment centres will continue to work collaboratively to ensure that where appropriate, people are well cared for in the community.

It is recommended that all patients over the age of 65 be assessed for frailty, using the CFS where appropriate, during the triage process by the Community Hubs and Assessment Centres. The CFS must not be used in:

- anyone under the age of 65 or,
- anyone over the age of 65 with long-term disabilities (for example cerebral palsy), learning disability or autism.

For those in whom a CFS assessment is not appropriate, a personalised, holistic and non-discriminatory assessment of their frailty status should be carried out.

The CFS must be based on functional status 2 weeks before illness onset. Even where it is appropriate to use the CFS, it should not be used in isolation to direct clinical decision making. While it will sensitise clinicians to the likely outcomes in groups of patients, clinical decision making with individual patients should be carried out through a holistic assessment, using the principles of shared decision making and non-discrimination. For more information on the use of CFS, please see Appendix 3.

Older adults and those living with pre-existing health conditions, such as diabetes, heart and lung disease, and severe frailty (e.g. CFS>7) are at higher risk of dying from infections and are particularly vulnerable to becoming seriously unwell from COVID-19. Therefore, if an individual is assessed to have severe frailty (using the CFS, where the CFS is >7, or an individualised assessment of frailty) it may be best to assess them in their own environment, if possible.
4. Anticipatory Care Plans in COVID-19

Anticipatory Care Planning (ACP) conversations should take place in a person-centred way respecting the needs and rights of individuals and this has been made clear to health professionals in updated guidance prepared by Healthcare Improvement Scotland. This guidance has been shared with GP surgeries and reinforces existing approaches to ensure that good ACP conversations are as widespread as possible. A letter was sent by the Chief Medical Officer to GPs and other health professionals on the 10\textsuperscript{th} April 2020, providing support in the context of ACP conversations.

Where anticipatory care plans have already been made these should be followed. People may choose to discuss how they wish to be treated with those closest to them in advance of admission to hospital, or before becoming unwell. This may be particularly important during the COVID-19 pandemic, due to visiting restrictions in hospital for patients diagnosed with COVID-19 and reduced contact with those people care about. These conversations may not be possible if their clinical condition were to deteriorate rapidly.

Older adults and those living with some pre-existing health conditions, such as diabetes, heart and lung disease, and severe frailty are at higher risk of dying from infections and are particularly vulnerable to becoming seriously unwell from COVID-19.

We know that treatments for COVID-19 focus on supportive measures, and specific care options such as ventilation offer low chance of benefit, and may carry a risk of harm to people who are already in poor health. However not receiving critical care does not mean a patient will no longer be well cared for, and conversations between patients, those patients choose to involve, and health and care professionals can help ensure that patients receive the best possible care for them as an individual. People may be worried about the future and so there is an opportunity to have a helpful conversation about their wishes, values and preferences about the care they would choose to receive should they become seriously unwell.

These conversations can be extremely difficult to initiate for everyone involved; however, they are important and can be immensely helpful to patients and those closest to them. The aim is to have an open and honest, and sensitive conversation with patients and those closest to them, so that future care can be planned in line with the patient’s wishes. Depending on how the conversation progresses, consideration can be given to exploring other relevant aspects of anticipatory care planning (ACP). Where it is necessary to have difficult conversations with people and those closest to them regarding their care wishes, they should always be handled with care and tact. The updated guidance to GP surgeries makes clear that there
is no requirement to have a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) discussion as part of an ACP conversation, unless the patient raises this and wishes to discuss it, or the clinician feels strongly that they need to discuss it.

In the instances where healthcare teams are sure that Cardiopulmonary Resuscitation (CPR) will not work for the patient, then they can decide in advance that it should not be tried. That decision is made on a case-by-case basis in close consultation with the individual and their family. This was the situation before COVID-19 and remains the position now.

These anticipatory care planning discussions can be initiated by the patient, or health and care staff, but efforts should be made where appropriate to communicate these discussions to the wider health and social care team involved in the care of the individual. It should be noted that these anticipatory care plans can be updated at any time by the patient and those closest to them to reflect changes in thinking or circumstances.

Decisions need to be documented and communicated to the relevant GP practice so that they can be recorded in the patient’s Key Information Summary (KIS), which is maintained by the GP. Some people may not be ready for this conversation, and it may be more appropriate to re-approach the discussion at another time.

Updated information for the public about ACP in the context of COVID-19 has been published on NHS Inform and a video has been created to highlight the need for these conversations to take place. Guidance and advice on anticipatory care planning can also be accessed via the Health Improvement Scotland iHub. Some people may also require support to have these discussions and to make decisions. In particular, people whose decision-making ability is affected by mental illness, learning disability, dementia or related conditions may require tailored support, which must be provided. Guidance on good practice in supported decision-making is provided by the Mental Welfare Commission for Scotland here. Patients should have access to communication support including professional interpreting service within hospital/social care settings to support them to make informed decisions about their care, this may have to be provided through virtual platforms due to infection control measures.

A template to guide and document significant conversations for those most vulnerable to COVID-19 can be found in Appendix 2.
5. Hospital Admission and Management

The majority of patients with COVID-19 will be able to be cared for at home. However, patients with suspected or confirmed COVID-19 may require admission to hospital either for management of respiratory failure because of infection, or because of another illness.

5.1 Management of Adults in Emergency Departments

Specific guidance providing targeted clinical advice to support those working in Emergency Departments (ED) has been developed by the COVID-19 Clinical Cell (Figure 1). This Guidance has two primary objectives:

1. To provide a standard for the care provided by Emergency Departments in the case of suspected or proven COVID-19 infection in Adults
2. To ensure patients spend the minimum appropriate time within the Emergency Department setting

To ensure this is achieved, this guidance is written to provide the essential components of care as required for the majority of patients attending with this condition, but does not detract from the importance of clinical judgement in individual cases.

This guidance is intended to guide delivery of Emergency Care in hospitals during this COVID-19 pandemic. It is intended to be helpful to clinical staff working in these areas. This guidance will be continuously monitored and updated as needed, as the trajectory of the pandemic in Scotland develops, and as new evidence and experience emerges. Healthcare services should ensure that they refer to the most up-to-date version of this guidance, which will be available on the Scottish Government Website.
## COVID-19 Emergency Department Guide

### Identify

**Common Symptoms**
- Fever, Persistent Cough, Dyspnoea, features of Pneumonia
- GI symptoms
- Non-specific presentations are common in the elderly
- Always consider potential alternative diagnoses

### Observe

- Check Temp., P, BP, RR, SpO₂
- Continue observations during ED stay
- Use NEWS chart if available or MEWS chart in Pregnant women

### Investigate

- CXR, FBC + differential WCC, U&Es, CRP, Ambulatory SpO₂ if borderline (may unmask exertional hypoxia)
- Throat/nose swabs if for admission

### Immediate Management

- Give O₂ via nasal cannulae/mask. Use SpO₂ and RR to guide O₂ therapy.
- Aim for SpO₂ ≥ 92% and RR ≤ 24/min (88-90% if Hx Type II resp failure)
- In Pregnancy: aim for SpO₂ ≥ 95%, RR <20/min and contact obstetrics for MDT management
- ABGs/arterial lines are not indicated routinely
- Give IV fluids only for immediate Rx of hypotension or dehydration
- Aim for Euvolaemia and avoid over-resuscitation with IV fluid

### Further Care

- If poor response to standard O₂ therapy (SpO₂ ≤ 92% or ≤ 88-90% if Type II respiratory failure), consult ICU as to need for CPAP or tracheal intubation/IPPV
- Use standard vasopressor therapy e.g. norepinephrine if required
- Do not give antibiotic or steroid therapy routinely
- Consider VTE Prophylaxis if for admission (as per local guidelines)
- Consider if the patient has an Anticipatory Care Plan
- Consider completion of Treatment Escalation Plan (as per local guidelines)

#### For patients with pre-existing advanced illness

- Consider Clinical Frailty Score if over 65
- Does patient have an Anticipatory Care Plan and/or are they for end of life care?

### Admit

- Subject to local guidelines:
  - ICU
  - HDU/Cohorted ward

### Discharge

**Patients suitable for discharge should normally have:**
- mild symptoms,
- no/minimal CXR changes,
- SpO₂ ≥ 92% & RR ≤ 24/min on air

**Ensure written discharge advice is given**

### Notes:

1. Fever is usually > 37.8°C but is NOT invariably present. Other respiratory symptoms e.g. sore throat, hoarseness, nasal discharge etc. may be present. Non-specific ‘viral’ symptoms are often present e.g. lethargy, headache, malaise, myalgia, arthralgia
2. Anorexia, nausea, vomiting, diarrhoea, abdo pain, loss of smell/taste
3. Standard NEWS ‘Trigger scores’ may not be applicable
4. Provided SpO₂ readings are considered representative of respiratory status – Type II respiratory failure patients will be a likely exception to this
5. For antibiotic therapy, refer to National Guidelines
6. Continue steroid therapy in patients already on steroids e.g. for asthma, COPD, etc. For patients taking steroid replacement therapy give an appropriately increased dose
7. The CFS must not be used in anyone under the age of 65 or anyone over the age of 65 with long-term disabilities (for example cerebral palsy), learning disability or autism. For those in whom a CFS assessment is not appropriate, a personalised, holistic and non-discriminatory assessment of their frailty status should be carried out. The CFS must be based on functional status 2 weeks before illness onset. Even where it is appropriate to use the CFS, it should not be used in isolation to direct clinical decision making. Clinical decision making with individual patients should be carried out through a holistic assessment, using the principles of shared decision making and non-discrimination. For more information on the use of CFS, please see Appendix 3
8. Links for guidance for patients requiring Palliative Care Advice and/or Anticipatory Care Planning
5.2 Assessment for Admission

On admission to hospital, adults over the age of 65 should be assessed for frailty using the CFS where appropriate, irrespective of COVID-19 status.

The CFS must not be used in:

- anyone under the age of 65 or,
- anyone over the age of 65 with long-term disabilities (for example cerebral palsy), learning disability or autism.

For those in whom a CFS assessment is not appropriate, a personalised, holistic and non-discriminatory assessment of their frailty status should be carried out.

The CFS must be based on functional status 2 weeks before illness onset. Even where it is appropriate to use the CFS, it should not be used in isolation to direct clinical decision making. While it will sensitise clinicians to the likely outcomes in groups of patients, clinical decision making with individual patients should be carried out through a holistic assessment, using the principles of shared decision making and non-discrimination.

For more information on the use of CFS, please see Appendix 3.

Underlying comorbidities and health conditions should be assessed for all patients. Clear documentation of all assessments must be noted in the clinical record.

5.3 Clinical Management and Investigation

The common clinical features of COVID-19 include:

- fever (temperature greater than 37.8°C);
- coughing;
- shortness of breath or myalgia.
- Loss of/ change in sense of taste or smell (anosmia)

A small number of patients may present with gastrointestinal symptoms.
Clinicians should be alert to the possibility of atypical presentations of COVID-19, especially in patients who are immunocompromised. Please refer to the [Health Protection Scotland website](https://www.healthprotection.scot) for the most current guidance on management of possible/confirmed COVID-19 patients presenting to secondary care.

Clinicians must also remain alert to patients with acute medical problems that are not COVID-19, but whose presentation might be confused with this infection. This could lead to inappropriate management and deny patients best standard of care.

Investigations may demonstrate bilateral infiltrates on chest x-ray, or lymphopenia on full blood count. Biomarkers of severe infection that might indicate a worse prognosis are under intense investigation but no such marker is available at this time. It is important to note that troponins are commonly elevated in COVID-19, but in the absence of typical chest pain and ECG changes, are not on their own an indication of an acute coronary event, in this context.

Patients admitted to hospital where COVID-19 is suspected should have throat and nose swabs sent for PCR testing. The throat is swabbed first and then the nose. Swabs must be either the Virocult or Copan swabs for virology testing. Note that false negatives can occur with the PCR test, if swabs have been inappropriately or poorly taken. A video of how to obtain throat/nose swabs can be viewed [here](https://www.healthprotection.scot).

If there is a high clinical suspicion of COVID-19, and negative initial tests, repeat sampling is required. Deep respiratory samples (sputum/tracheal aspirate) have a higher sensitivity than nose/throat swabs, so if a patient has a productive cough then sputum should also be sent for COVID-19 testing. **Under no circumstances should an induced sputum be performed.**

All repeat tests should be discussed with virology and should be done at 48 hours post initial swab. If patients have convincing clinical features of COVID-19, but throat/nose swabs have tested negative by PCR, then it is appropriate to repeat the throat/nose swabs and re-test. Advice from virology and infectious diseases may be useful at this stage.

Patients may require management with supplemental oxygen. Antibiotics are not usually required unless there is evidence of a secondary bacterial infection. Focal chest x-ray changes, neutrophilia or persistent fever may be signs of this, and if suspected, appropriate cultures should be sent.

Speciality teams should discuss treatment escalation and limitation plans (TELPS) with patients and those patients chose to involve, at the earliest opportunity in case of an unexpected deterioration. This should
include treatment plans for patients who would not wish or benefit from critical care admission and, where this is appropriate, documenting DNACPR decisions.

At the earliest opportunity, a patient TELP should be put in place to establish the appropriate future pathway of care including whether referral to critical care will be of benefit. This should be recorded in the patient’s medical record. All patients should have National Early Warning Score (NEWS) observations regularly documented. If patients who are for full escalation are deteriorating, then early referral to critical care should be made. Use of Continuous Positive Airways Pressure (CPAP) in a ward setting should only be initiated following discussion with critical care or a senior doctor.

Please refer to the Health Protection Scotland ‘Guidance for Stepdown’ for the most up-to-date and detailed information on the discontinuation of COVID-19 Infection Prevention and Control (IPC) measures for inpatients, and the discharge of COVID-19 patients from hospital settings.

For detailed patient transport guidance please see Appendix 1 of COVID-19: Guidance for Secondary Care.

Discharge leaflets for adults, children and pregnant women with possible or confirmed COVID-19, on their discharge from hospital can be found here.

6. Critical Care

Hospital and critical care facilities have been expanded to meet increased demand during this pandemic and will be again, in the event of any resurgence of COVID-19.

It should be clear that even in non-pandemic circumstances, it is not ethically appropriate to offer intensive care to patients who will not benefit from it. This includes patients with untreatable disease, who have no prospect of recovery, or those who are dying.

6.1 Delivery of Critical Care during Surge Conditions

While, Scotland has not experienced surge conditions, it is important to have protocols in place to maintain capacity and flexibility within the healthcare system to deal with any eventuality in the future. Depending on the circumstances and magnitude of increased demand, the response may vary from a conventional
response - where patients can be managed without significant alterations in usual processes, to a crisis response - where resource limitations require significant alterations in standards and processes to provide the best possible care for the maximum number of patients. In the unlikely event that a crisis response is required during any future COVID-19 outbreak, appropriate guidance that includes a national triage protocol will be published.

6.2 Critical Care Admission

Patients who have been identified as suitable for admission to critical care should be assessed by a member of the critical care team if their condition deteriorates. This should involve a holistic, personalised and non-discriminatory assessment including of frailty, comorbidities, severity of acute illness, and the likelihood of critical care provision leading to survival with a quality of life acceptable to the patient. Where possible, quality of life discussions will always be carried out together with patients, considering their individual circumstance, and asking them about their wishes, values and goals. If a holistic assessment of the patient indicates that the patient is unlikely to respond to certain treatment and/or unlikely to go back to a quality of life acceptable to them, clinicians will be honest with their patients empowering them to make decisions that are right for them.

In patients with COVID-19 who require critical care admission, international data suggests that COVID-19 affects older people more severely. Significant cardiovascular, respiratory or other comorbidities also increase the likelihood of death, even with intensive care support. In all patients, if clinical assessment suggests the person has an increased degree of frailty (e.g. a CFS score of 5 or more, where the use of the scale is appropriate), there is strong evidence regarding the limited benefit of critical care organ support.

It is recommended that all patients are assessed for frailty as part of an individual and holistic assessment of suitability for critical care admission. For patients over the age of 65 the Clinical Frailty Score (CFS) should be used where appropriate.

The CFS must not be used in:

- anyone under the age of 65 or,
- anyone over the age of 65 with long-term disabilities (for example cerebral palsy), learning disability or autism.
For those in whom a CFS assessment is not appropriate, a personalised, holistic and non-discriminatory assessment of their frailty status should be carried out.

The CFS must be based on functional status 2 weeks before illness onset. Even where it is appropriate to use the CFS, it should not be used in isolation to direct clinical decision making. While it will sensitise clinicians to the likely outcomes in groups of patients, clinical decision making with individual patients should be carried out through a holistic assessment, using the principles of shared decision making and non-discrimination.

For more information on the use of CFS, please see Appendix 3

Clinicians and decision makers must be mindful of the principle of non-discrimination and equity of access for people who could benefit from treatment escalation, and the principle of support for autonomy for people who want to be involved in decisions. Normal practice of shared decision-making informed by experience, evidence, available resources and patient views should be maintained where possible. Some people may require support to have these discussions and to make decisions. In particular, people whose decision-making ability is affected by mental illness, learning disability, dementia or related conditions may require tailored support, which must be provided. Guidance on good practice in supported decision-making is provided by the Mental Welfare Commission for Scotland here. Decision-making should not be disease specific, i.e. the presence or absence of COVID-19 should not in itself be a limiting factor in treatment decisions.

It is vital that no clinical decisions are made on the basis of any characteristic(s) of a patient, such as age, disability or the presence of existing health conditions or impairments that are not clinically relevant to the potential benefits of a course of treatment. Factors such as age, frailty or the existence of co-morbidities should only be considered as part of a holistic individualised and non-discriminatory assessment which will assess any patient’s potential to benefit from an ICU admission alongside their ability to return to a quality of life that is acceptable to them. Decision support tools may be useful to inform both patients and clinicians.

Every patient should have an individualised assessment of suitability for critical care admission which includes:
• nature and severity of the patient’s illness
• the presence of comorbidities and frailty
• the presence of organ failure and whether it can be reversed
• the patient’s capacity to survive critical care interventions
• the likely duration of critical care treatment
• the likelihood of survival with a quality of life acceptable to the patient
• if possible, an informed decision on whether they would wish to receive critical care therapies (e.g. ventilation)

To ensure that patients are not subjected to potentially traumatic and futile interventions of no benefit, a realistic assessment of outcomes for different treatment options must be communicated accessibly to patients and those closest to them, in order to facilitate shared decision-making. In all cases, it is important that all healthcare professionals involved in the decision-making process document the shared decisions they have made together with the patient, alongside the rationale for these decisions. Healthcare professionals should ensure that they communicate regularly with their patients and those closest to them.

Speciality teams should be encouraged to discuss treatment escalation and limitation plans (TELPS) with patients and those they chose to involve [see section 6.7].

All critical care patients should be reviewed daily by appropriately trained medical staff and clear management plans made for the next 24 hours.

Critical care clinical guidance for managing patients with COVID-19 is currently being developed. When available, it will be published on the Scottish Intercollegiate Guideline Network (SIGN) and a link to this guidance will be signposted here.
7. Special Considerations

7.1 Paediatrics

Current understanding of COVID-19 in the paediatric population is that it is almost always a very mild disease. Nevertheless, it is important that when cases do arise, they are managed appropriately. This guidance is not intended to supplant individual decisions by responsible clinicians in paediatric practice. It is suggested that children with symptoms suggestive of COVID-19 follow standard referral pathways and are assessed as outlined in Figure 2 below.
Figure 2. Referral Guideline for Children and Young People
7.2 Obstetrics

Pregnant women are at risk of contracting COVID-19 in the same way as the rest of the population. Most pregnant women will already be under the care of maternity professionals. Maternity care operates at both community and acute levels, and occupies a distinct place in the healthcare landscape. Pregnant women will require specialised advice and care in relation to coronavirus because of the unique physiological changes of pregnancy.

NHS 24 will provide a single point of entry for all adults, including pregnant women, with respiratory symptoms via the national 111 phone line. NHS 24 will use the maternity pathway thereafter to triage pregnant women. The pathway depicted in figure 3 describes how to assess pregnant women to determine their route into care. In all cases, pregnant women experiencing symptoms indicative of COVID-19 should additionally be advised to inform their midwife as soon as possible, ahead of their next scheduled antenatal appointment. In all cases where symptomatic women are in labour or have an additional obstetric problem e.g. vaginal bleeding, they should be referred to their local maternity unit for combined assessment by an obstetrician and a physician, in an obstetric unit with isolation facilities.

Those with no obstetric issues but worsening respiratory symptoms, breathlessness or risk factors for deterioration (those who are shielding, have underlying health conditions or are of BAME background) should be assessed in person and in consultation with an obstetrician. They should NOT be referred to the local COVID Hub. Their point of assessment will be a secondary care setting and will be Board specific, either through a COVID-19 assessment centre or the local Maternity Triage unit. In either location, obstetric input must be available.

There are pregnancy specific respiratory symptom criteria for admission to secondary care, which reflect the differing physiology of pregnancy. All pregnant women assessed and/or admitted with respiratory symptoms must be seen or discussed with an obstetrician and have daily physician and obstetric review irrespective of location of their secondary care.

Further information on managing maternity care can be found at the RCOG website.
Figure 3. Assessment of pregnant patients with possible COVID-19

Central COVID-19 NHS 111 hotline
For pregnant with respiratory symptoms at any stage of pregnancy

Cough/fever; no risk factors for deterioration?

Shortness of breath, worsening respiratory symptoms or risk factors for deterioration

No Breathsness

Refer for face to face assessment as per local health board policy. This should include contact with Maternity Triage, who will then advise according to:

Advice:
Self isolate 7 days and inform primary midwife
Call back if worsening symptoms or develop breathlessness

Additional obstetric complications - assessment in obstetric unit

No additional obstetric complications - Follow local health board policy
Pregnancy specific criteria for admission:
Sats <95%
RR >20

*Risk Factors for Deterioration
- Respiratory or cardiac comorbidities
- Immunosuppression
- Diabetes (type 1 & 2 not gestational diabetes)
8. End of Life Care

The focus of this section on end of life care is to reduce suffering for those rapidly dying from COVID-19 specifically. It is intended to be used to support professionals managing patients approaching the end of life in this context. It does not replace existing local and Scottish guidelines for symptom management, and advice should be sought from your local palliative care team should this be deemed necessary.

The clinical profile of dying from COVID-19 has been described as high breathlessness, high distress and delirium, high fever and rapid cessation of life over a short number of hours. In this context, specific guidance has been drawn up to enable confidence in higher starting doses and broader prescribing ranges in professionals caring for them in any setting.

The management options detailed in table 1 are indicated to reduce distress at point of imminent death and should only be used when reversible causes for deterioration have been addressed and there is consensus that the patient is dying.

Note that any syringe pump prescription should be reviewed regularly and may need titrated more than once in 24 hours to manage symptoms. Syringe pumps take at least 4 hours to reach full effect and this should be considered when initiating or changing doses. Early commencement of syringe pump, if available, is strongly recommended.

Route of delivery will depend on the individual clinical setting. Subcutaneous dosing is interchangeable with intravenous dosing where that route is available and more familiar.

8.1 Visiting

As per the guidance issued to NHS Boards on 25 March 2020 by the Chief Nursing Officer and the National Clinical Director, visiting must be restricted to essential visitors only. The following visitors have been deemed essential:

- birth partners during childbirth
- those visiting a person receiving end-of-life care
• those visiting to support someone with a mental health issue such as dementia, a learning disability or autism where not being present would cause the patient to be distressed
• those accompanying a child in hospital

Visitors should always consider whether a visit is essential even in these circumstances.

It must be recognised that visiting will carry a risk to visitors, particularly in high-risk areas such as critical care wards. Appropriate risk assessment should be carried out and PPE issued where necessary.

Non-essential visitors should be encouraged to consider alternative ways of maintaining contact with relatives and loved ones in hospital such as phones and video calling technology. Any visitor who is unwell and/or exhibiting symptoms of COVID-19 should not visit a hospital. The current guidance in relation to visiting will be reviewed regularly and relaxed when it is safe to do so. Scottish Government has set out a staged approach to the reintroduction of visiting in hospitals in a safe and planned way.

**These guiding principles produced by the Royal College of Physicians Edinburgh, the Scottish Academy of Medical Royal Colleges, Marie Curie & Scottish Care** on visiting at end of life are considered particularly helpful.

**Table 1: Management of symptoms when delivering end of life care in COVID-19**

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Route</th>
<th>Dose</th>
<th>Administration/comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine sulphate</td>
<td>Subcutaneous or slow intravenous injection</td>
<td>Start with 5 to 10mg every hour as required.</td>
<td>Consider using the higher dose if the patient is very distressed with breathlessness. Consider using lower doses in elderly patients. In patients who are already receiving regular opioid, use 1/6 of total daily subcutaneous opioid dose for as required dose.</td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>Start with 10 to 20mg over 24h.</td>
<td></td>
</tr>
</tbody>
</table>

Non-pharmacological measures to manage breathlessness should also be considered, these include positioning, relaxation techniques, wiping the face with cool wipes and menthol. **The use of fans is not recommended in the context of COVID-19**
If the patient has known renal impairment (eGFR <30), consider using equivalent doses of oxycodone/alfentanil as required and alfentanil/oxycodone in an infusion. See [Scottish Palliative Care Guidelines](#) for conversions.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dosage Details</th>
<th>Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Midazolam</strong></td>
<td>Subcutaneous or slow intravenous injection</td>
<td>Start with 5 to 10mg every hour as required.</td>
<td>Consider using the higher dose if the patient is very distressed with breathlessness. Consider using lower doses in elderly patients. Maximum dose 80mg over 24h.</td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>Start with 10 to 20mg over 24h.</td>
<td></td>
</tr>
</tbody>
</table>

Patients who are receiving medication via nebulisers may continue to do so in the context of COVID-19. Corticosteroids are not thought to be helpful in managing breathlessness due to COVID-19 at end of life.

Consider whether the patient is benefiting symptomatically from any oxygen prescribed, or if medications alone can provide sufficient symptom control. Consider discontinuing oxygen where possible and appropriate.

<table>
<thead>
<tr>
<th><strong>Cough</strong></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Codeine linctus</strong></td>
<td>Oral</td>
<td>30 to 60mg every 6 hours as required</td>
<td></td>
</tr>
<tr>
<td><strong>Morphine sulphate</strong></td>
<td>Oral</td>
<td>5 to 10mg every hour as required</td>
<td>Consider using the higher dose if the patient is very distressed with cough. Consider using lower doses in elderly patients. In patients who are already receiving regular opioid, use 1/6 of total daily opioid dose for as required dose.</td>
</tr>
<tr>
<td></td>
<td>Subcutaneous injection</td>
<td>5mg every hour as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>15 to 20mg over 24h</td>
<td></td>
</tr>
</tbody>
</table>

If the patient has known renal impairment (eGFR <30), consider using equivalent doses of oxycodone/alfentanil as required and alfentanil/oxycodone in an infusion. See [Scottish Palliative Care Guidelines](#) for conversions.

<table>
<thead>
<tr>
<th><strong>Respiratory Secretions</strong></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hyoscine Butylbromide</strong></td>
<td>Subcutaneous injection</td>
<td>20mg every hour as required</td>
<td>Remember alternative antisecretory drugs are available – see <a href="#">Scottish Palliative Care Guidelines</a></td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>Up to 180mg over 24h</td>
<td>Alternative routes of administration are also available – see <a href="#">Scottish Palliative Care Guidelines</a></td>
</tr>
</tbody>
</table>

**Suction is not recommended** in the context of COVID-19 as this is an aerosol generating procedure and requires full PPE including FFP3 mask.
<table>
<thead>
<tr>
<th>Delirium / Terminal agitation / Terminal restlessness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Midazolam</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Levomepromazine</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Haloperidol</strong></td>
</tr>
</tbody>
</table>

Remember to consider non-pharmacological interventions for delirium in addition to using drugs where required. If the patient remains agitated, please contact your local palliative care team for further advice.

<table>
<thead>
<tr>
<th>Pyrexia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Paracetamol</strong></td>
</tr>
<tr>
<td><strong>Diclofenac</strong></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td><strong>Ketorolac</strong></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>
NSAIDs should be used with caution in patients who may have COVID-19, however if the patient is in the last days of life their use may be appropriate. [https://www.gov.uk/government/news/ibuprofen-use-and-covid19coronavirus](https://www.gov.uk/government/news/ibuprofen-use-and-covid19coronavirus)

Remember non-pharmacological measures such as reducing room temperature, removing excess bedding, and cooling forehead with tepid sponging.

<table>
<thead>
<tr>
<th>Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain is not a prominent feature of COVID-19. Paracetamol (as above) may be adequate analgesia in addition to the above medications for other symptoms. If this is not the case, refer to <a href="https://www.gov.uk/government/news/ibuprofen-use-and-covid19coronavirus">Scottish Palliative Care Guidelines</a> for advice.</td>
</tr>
</tbody>
</table>

## 9. Ethical Considerations

Even when experiencing increased demand for healthcare, ethical advice and support will not be needed in most cases as clinicians will continue to make decisions by utilising their knowledge and experience, together with current scientific evidence, the wishes of patients and those closest to them, and in accordance with national guidance.

The COVID-19 pandemic may however result in changes to healthcare scope and delivery across the UK, for all patients. It is important that if this happens, decisions are made fairly and equitably and all individuals should be treated with care, compassion and respect.

**Clinicians should be assured that decisions taken in good faith, in accordance with national actions to counter COVID-19, will not be held against them.**

[Ethical advice and support framework guidance](https://www.gov.uk/government/news/ibuprofen-use-and-covid19coronavirus) has been developed by the Chief Medical Officer Directorate. It outlines the structures and principles for ensuring ethical advice and decision-making support is available for complex or challenging decisions, beyond the normal experience of clinical teams. This guidance complements professional guidance provided by the General Medical Council.

Ethical advice and support groups will be established in each Health Board in Scotland to provide useful, timely and pragmatic ethical support for complex or difficult cases. Mutual aid agreements will offer access to immediate support, where the Health Board ethical advice and support group is unable to offer advice in a clinically useful timeframe. In addition, a national ethical advice and support group will be established to provide advice and support to local Health Board ethical support groups.
9 Workforce Considerations

There must be flexibility and capacity within the workforce to be able to respond effectively to any future resurgence of COVID-19. If this were to happen and capacity and capability are outstripped by demand, staff should be supported to work within their frame of competence and experience, but may have to work outside their usual specialties, environments, teams and hierarchies. **Staff should be reassured that regulators such as the General Medical Council and the Nursing and Midwifery Council have recognised that in highly challenging circumstances, professionals may need to depart from established procedures in order to care for patients in health and social care services, while continuing to adhere to guidance and legal duties.** Additional pressures on healthcare resource, staff and systems may necessitate a change in the way that we deliver care to patients across Scotland and result in a change to normal practice. However, clinicians **must** continue to act within the law during the COVID-19 pandemic and should ensure that they are continuing to meet their obligation to uphold it.

The wellbeing of the workforce has been recognised as a priority during this COVID-19 pandemic, and this must be maintained during the remobilisation of services and beyond. A National Wellbeing Hub for those working in health and social care has been created to support the emotional and psychological wellbeing needs of staff.

Leaders across all health and social care sectors should aspire to lead with compassion and kindness during recovery from this unprecedented crisis.
Useful Resources

1. NHS England Extreme Surge Guidance, NHS England and Improvement, UK (publication pending)
7. COVID-19 Guidance: Ethical Advice and Support Framework, UK (publication pending)

This Guidance has been produced on behalf of the Scottish Government’s Chief Medical Officer
Authors

Dr Gregor Smith, Interim Chief Medical Officer for Scotland, Scottish Government

Dr Michael Gillies, Consultant in Critical Care & Associate Medical Director, NHS Lothian

Professor Thomas Evans, Professor of Molecular Microbiology at the University of Glasgow & Consultant in Infectious Disease and General Medicine

Dr Corinne Love, Consultant Obstetrician & Senior Medical Officer, Scottish Government

Dr Deans Buchanan, Consultant in Palliative Care & Medical Advisor, Scottish Government

Dr Dan Beckett, Consultant Acute Physician & Unscheduled Care Clinical Lead, NHS Forth Valley

Professor Graham Ellis, National Clinical Lead for Older People & Medical Advisor, Scottish Government

Dr John Harden, Consultant in Emergency Medicine & National Clinical Lead for Quality and Safety at The Scottish Government

Dr Rosie Hague, Consultant Paediatrician & Medical Advisor, Scottish Government

Dr Michelle Watts, Associate Medical Director NHS Tayside & Medical Adviser, Scottish Government

Dr Sian Tucker, Clinical Director, Lothian Urgent Care Services & Medical Advisor, Scottish Government

Dr Dave Caesar, Consultant in Emergency Medicine & Head of Health Leadership & Talent Management Scottish Government.

Mr Jacques Kerr, Consultant in Emergency Medicine and Unscheduled Care Clinical Lead, Scottish Government

Craig Bell – Chief Medical Officer’s Directorate, Scottish Government

Dr Savita Brito-Mutunayagam, Scottish Clinical Leadership Fellow & Specialist Registrar in Sexual and Reproductive Health

Acknowledgements

Professor Colin Robertson
Dr Erica Peters
Dr Stefanie Lip
Dr Beth White
Appendix 1: Clinical assessment tool for assessment at hospital or community management (two pages)

Note: A downloadable version with working hyperlinks is available at the [Scottish Government Website](https://www.gov.scot/).
Note: The CFS must not be used in:
- anyone under the age of 65 or,
- anyone over the age of 65 with long-term disabilities (for example cerebral palsy), learning disability or autism.
For those in whom a CFS assessment is not appropriate, a personalised, holistic and non-discriminatory assessment of their frailty status should be carried out. The CFS must be based on functional status 2 weeks before illness onset. Even where it is appropriate to use the CFS, it should not be used in isolation to direct clinical decision making. While it will sensitise clinicians to the likely outcomes in groups of patients, clinical decision making with individual patients should be carried out through a holistic assessment, using the principles of shared decision making and non-discrimination. For more information on the use of CFS, please see Appendix 3.
Appendix 2: Anticipatory Care Planning Template for Use in COVID-19 Pandemic

Having significant conversations to support those most vulnerable to coronavirus

There are particular groups of individuals who are at increased risk of severe illness from coronavirus. These people would benefit from having a 'Key Information Summary' created or updated. Many will also benefit from Anticipatory Care Planning.

There is a second group of people who are at much higher risk of becoming seriously unwell from coronavirus, and are already at greater risk of dying from infections and other health problems. This group should be prioritised for Anticipatory Care Planning. This template can be used to document these discussions and shared on the Key Information Summary.

This is an important opportunity for people to have conversations with carers and loved ones about the type of care that they would like to receive should they become unwell.

We know that treatments for coronavirus focus on supportive measures, and specific care options like ventilation are of low benefit or do not help people who are already in poor health. However, there are many other aspects of care that can be discussed and planned. People may well be worried about the future, and so there is an opportunity to have a helpful conversation about what matters to them if they become very unwell and die.

These discussions can be extremely difficult to start, but they are important and helpful. The aim is to have an open and honest conversation with people and their families and carers so that we can plan future care as well as possible.

The RED-MAP framework can be helpful to guide discussions about ACP

https://www.ec4h.org.uk/covid-19-effective-communication-for-professionals/

R eady: Can we talk about how coronavirus might affect you?
E xpect: What do you know? What do you want to ask?
D iagnosis: We know that coronavirus.... We don’t know....
M atters: What matters to you if you were to become unwell?
A ctions: What we can do to help is....
P lan: Let’s plan ahead for ‘just in case’

Depending on how the conversation goes, you may consider exploring other relevant aspects of Anticipatory Care Planning. Some people may not be ready for this conversation and it may be necessary to revisit it at another time. Focus on the benefits of having a plan for each person and, if possible, offer another opportunity with you or a colleague.
An essential ACP for those most vulnerable to coronavirus

<table>
<thead>
<tr>
<th>Name</th>
<th>Preferred name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHI or DoB</td>
<td>Phone number</td>
</tr>
<tr>
<td>Address</td>
<td></td>
</tr>
</tbody>
</table>

Ask: ‘If you were to become seriously unwell due to an infection such as the coronavirus, how would you like to be cared for?
Ask: ‘Is there anyone that you would like to be involved in future decisions about your care, if you were to become unwell (e.g. a friend, family member or carer)?

Note: Specific care options e.g. ventilation in intensive care may not be available or appropriate. It may help to explore this further and consider whether comfort options such as symptom control would be a priority.

The things you would like:

The things you do not want:

Any other information around preferences for care:

Discussions about cardiopulmonary resuscitation:

Is this person to have cardiopulmonary resuscitation? Yes ☐ No ☐
If NO, Is a DNACPR form completed? Yes ☐ No ☐

The people you would like to be involved in decisions about your care. (List names and contact info.)

Do any of these people have power of attorney or welfare guardianship? Yes ☐ No ☐
If so, what are their names?

Other important contacts (next of kin / carer / neighbour):

Key worker (social / health care worker/ mental health support/ others )

Name and contact details of Responsible Clinician (Consultant/ GP/ Other)

Name and designation of person who has led this ACP discussion | Date completed:

Consent obtained to share in Key Information Summary (good practice but not mandatory) Yes ☐ No ☐

Please send this completed electronic word document to the GP practice so that the above information can be copied and pasted into the special notes section of the Key Information Summary
Appendix 3: – Guidance for Clinicians on the use of the Clinical Frailty Score (CFS)

Frailty is a distinctive health state often but not exclusively, related to the ageing process in which multiple body systems gradually lose their in-built reserves. Increased frailty can have a marked impact on an individual’s quality and length of life and is recognised to have strong predictive value for adverse health outcomes in older adults, both in the community as well as in hospital. It is therefore very important to consider frailty as part of a holistic and personalised health and care assessment.

The CFS is a validated tool that can:
- reliably identify and measure frailty and,
- be a predictor of health outcomes in the acute and critical care context, when used as part of a holistic and personalised assessment of an individual.

It is important to note that the CFS has only been validated in older people and it has not been widely validated in younger populations (below 65 year of age), or in those with learning disability or long term disability such as cerebral palsy.

Therefore, the CFS **must not** be used in:
- anyone under the age of 65 or,
- anyone over the age of 65 if they have long term disabilities (for example cerebral palsy), learning disability or autism. *This includes people with physical disabilities that may affect their ability to do things independently.*

It is important to note that the CFS is a measure of frailty and is **not** a tool for assessing disability. Frailty and disability are two distinct entities, although there can be an overlap. When assessing for frailty it is very important to make the distinction between those whose independence is affected by a disability from those whose frailty is causing progressive disability.

Even where it is appropriate to use the CFS, it **should not** be used in isolation to direct clinical decision making and should be part of a personalised, holistic and non-discriminatory assessment. A vital component of this assessment is the views of the individual, and those they choose to involve. Clinicians should provide people with the information they need to be able to make an informed choice about their treatment and care.