Treatment Escalation Plan and Frailty Assessment

The main complication of COVID-19 disease is hypoxaemic respiratory failure and it is likely that there will be many patients requiring oxygen some of whom maybe considered for increased support such as CPAP or intubation with mechanical ventilation. Due to the sheer numbers expected, the aim is to establish which patients are for further escalation or not at an early stage of their admission, ideally on admission. The **Treatment Escalation Plan** (TEP) is used to record this decision so that if the patient deteriorates it is easy to act appropriately. An initial escalation plan is documented in the Admission proforma. This should be reviewed on arrival to the ward and a TEP filled and placed at the front of the notes, scoring through the ED escalation note if necessary to avoid any confusion. Patient and family (by phone if necessary) should be informed of the decision wherever possible. To aid decision-making the functional status including an objective assessment of their overall frailty should be made.

These discussions can be difficult especially when the family are not present due to isolation measures. The RED-MAP structure is a suggested framework to help these discussions with patients and family.

TEP and Frailty Score

RED-MAP guide

TEP and Frailty Score: check for updates here under 'GRI COVID Source Documents'

RED-MAP guide: check for updates here

Return to Contents

GRI ED SUSPECTED COVID 19 TREATMENT PROFORMA

NHS Greater Glasgow and Clyde

Should be completed for **all patients with suspected COVID 19**

Affix patient ID label

Surname

First name

Address

CHI No.

Clinician completing form (name/ grade):

.....

Date/ time.....

Signature.....

Senior clinician approving escalation decision if required:

.....

Any additional medical notes: □ YES □ NO

Place a surgical face mask/oxygen mask on patient +/- companion on arrival

Ensure assessing patient in correct PPE

COVID criteria – extrapolated from HPS case definition 27/3/20 for patients requiring admission:

New respiratory symptoms: □ New persistent cough
□ New dyspnoea

OR Flu-like symptoms:
□ Fever (>37.8) AND acute onset ≥1 of

□ Coryza □ Anosmia
□ Hoarse voice □ Pharyngitis
□ Wheezing □ Sneezing

COVID also possible & should be considered:

□ Undifferentiated pyrexia with no other clear cause
□ Minor trauma + new resp symptoms
□ Abdominal pain + new resp symptoms
□ Diarrhoea or vomiting (no other obvious cause)
□ Elderly (70yrs) or immunosuppressed with Delirium/acute decline (& no other obvious cause)

Date of first symptom onset:

.....

- *BEWARE diagnostic anchoring; consider alternative pathologies with similar presentations*
- *Clarify recent Travel History (e.g. MERS)*
- *CONSIDER COVID-19 in recently hospitalised patients with relevant features without alternative cause*

HISTORY OF PRESENTING COMPLAINT:

LIST RELEVANT SIGNIFICANT COMORBIDITIES & PRE-MORBID STATUS:

□ Diabetes □ Cardiovascular disease

□ Obstructive Sleep apnoea □ COPD (□ Home O2 □ Home Nebulisers) □ Smoker

□ Other significant Respiratory history (list):

COVID Treatment Escalation Plan - Emergency Department decision:

1. **Level of suitable escalation**

□ **ITU referral** (i.e. consideration of mechanical ventilation)

□ **HDU referral** (i.e. consideration of NIV/CPAP/ inotropes but not intubation)

Clarify if NIV / CPAP needs to / can be continued if admitted

□ **Active ward based care** (i.e. treatments like IV line, antibiotics as ceiling of care)

□ **Comfort care** aimed at relieving symptoms only.

X2 SDM to agree Comfort Care. See palliative tab on StaffNet homepage for further guidance

2. **Is this patient for CPR** (complete DNACPR form if appropriate)

□ **YES** □ **NO** *Review this care plan if the patient's condition deteriorates.*

Communication:

Plan discussed with Patient: □ **YES** □ **NO**

Plan discussed with family: □ **YES** □ **NO**

Relevant other/dependants: □ **YES** □ **NO**

NOK contact number:

NOK Relationship:

Adults with incapacity form: □ **Completed** □ **Not applicable**

Please add further **useful free text** here

COVID 19 TREATMENT ESCALATION PLAN

ECMS North Sector

NHS Greater Glasgow and Clyde

TEP should be completed for **all patients with suspected COVID 19**

Affix patient ID label

Surname

First name

Address

CHI No.

Dr completing form..... Cons approving form .....

Name/ grade ..... Name.....

Date/ time..... Date/ Time.....

Signature..... Signature if in attendance.....

Note TEP must be filled out as soon as possible after patient is admitted

COVID classification and escalation plan:

Review Emergency Dept TEP if exists and score through after completing this form

For escalation, including Diagnostic/prognostic uncertainty: review escalation decision daily over first phase of episode ☐

Ward-level ceiling of care ☐

Is this patient for CPR? Yes/no DNACPR form completed if appropriate Yes/No

Target Oxygen Saturations by COVID classification

For escalation	**Diagnostic / Prognostic Uncertainty**	**Ward level ceiling of care**
Target SpO2 88-92%	**Target SpO2 88-92%**	**Target SpO2 88-92%**

Current clinical problems/Significant co-morbidities

COMMUNICATION:

Plan discussed with Patient **YES / NO**

Plan discussed with family **YES / NO**

Adults with incapacity form applicable **Completed / Not applicable**

Please add further **useful free text** here

.....

.....

.....

REVIEW Date of planned review

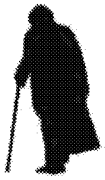
Date of period of suspension

Clinical Frailty Scale

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

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

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



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

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

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

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

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

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

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia,** recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia,** they cannot do personal care without help.

Guide for Professionals: 30/3/20

Talking with people and families about planning care, death and dying

During this emergency, we need to talk with people who are deteriorating due to underlying health problems and/ or infection with Coronavirus and their families using clear, sensitive and effective language.

RED-MAP is a 6-step approach to conversations about deteriorating health and dying developed in Scotland and with SPICT partners in the UK and internationally. It is suitable for use in all care settings.
- Each step is adapted to the individual person/ family, place of care and circumstances of the discussion.
- If talking with people by phone; check you have the right people, speak slower in shorter sentences

Seek advice and support from colleagues, a senior team member or a second opinion if needed.

	RED-MAP
Ready	Try to build a relationship with people. Eye contact, touch and tone help when wearing mask. *Hello Mr X, I am (your title and name) and my role in the team looking after you is….* Outline reason for discussion and check who should be involved. **We need to talk about your (person's name) treatment and care. Who needs to be involved?* **I'm sorry we are having to speak on the phone not in person at this difficult time.* **We are doing our best to look after you, but we are worried about your/ their condition.*
Expect	Find out what the person/family know and expect. Explore initial questions or worries. **I'll explain what is happening but do you have any important questions or worries for now?* **Can I ask, what you know about your (person's name) health problems?* **Do you know what an infection like Coronavirus might mean for you (person's name)?*
Diagnosis	Share information tailored to current understanding of the person/ family and their situation. Explain what we know in short chunks with pauses to check their response. Avoid jargon. Acknowledge and share uncertainty. Showing kindness makes a big difference to people. **You (person's name) are/is less well because…. Yes, you/they are very unwell now because….* **We hope you (person's name) will improve, but it's possible you/ they will not get better.* **We are doing our best to treat you (person's name) but you/ they are not improving.* **I'm so sorry but you (person's name) are/is very unwell now, …. We think you/they may die….*
Matters	Pause to let people take in information. Find out what's important to this person/ family. **Can we talk about what matters most to you now and what we can do to help?* **It is important for us to know about things you'd like and any things you do not want.*
Actions	Talk about realistic, available options for treatment, care and person/family support. Be clear about what will not work or help. Options depend on best place of care. **For people who already depend on others for most care needs at home or in a care home, it may be better to look after them well in a familiar place when they are very ill and dying.* **Intensive care with a breathing machine does not work for people in poor health.* **Has anyone spoken about cardiopulmonary resuscitation or CPR? CPR does not work for people with these health problems so we make a plan for good care and record that decision.* **We will focus on treatment and care to manage symptoms like breathlessness, pain or distress and do our best to look after people in hospital wards, at home and in care homes.*
Plan	Use available forms and online systems to record and share care plans and DNACPR decisions *We will record the plans we have made for your (person's care) and share it with other professionals and teams who may be looking after you/ them.*

Patients and families are already anxious and afraid of what will happen. Avoid words and phrases that can make them feel abandoned or deprived of treatment and care. (ANZICS 2014)

There is nothing more we can do. *Ceiling of treatment or treatment limits for a person.*
We are withdrawing treatment. *Further treatment is futile.*

Talking too early about how drugs or palliative care can help people die comfortably causes distress. This step comes after we have shared information and bad news so that the patient/ family know this person is very unwell and at high risk of dying.