Community Frailty COVID 19 Guidance

Patient: **Frail person** (CFS 5 and above) with suspected or known COVID 19
Social circumstances: **At home or in a care home**
Review and update ReSPECT form or complete one given new circumstances (see advice over)

Clinical assessment and CRB 65 scoring (see over)

Clinically stable (eg no sepsis red flags) / CRB 65 = 0-1 or low risk ISCARIC 4C score

Treatments as below as clinically appropriate

Clinically unstable (eg sepsis red flags) / CRB 65 = >/2 or intermediate / high ISCARIC 4C score

Preferred place of care and death is community

Treatments as below as clinically appropriate

If requiring new or increasing care or step up bed call trusted assessor team (via 01482 247111) or if clinical advice ICC frailty support team (via 01482 450078)

Preferred place of care is hospital

Arrange hospital admission

Treatments

1. **Antipyretics** as needed
2. Aim for oxygen saturation of 94-98%, or 88-92% if COPD / chronic CO2 retention
   If supplemental oxygen required **Oral dexamethasone** (6mg od for 10days**)**
   Consider **pulse oximetry at home**.
3. Consider antibiotics for 5 days if clear evidence LRTI (Doxycycline 100mg bd)
4. Consider **neutralising monoclonal antibodies** if the person has not been contacted by the national team as meeting inclusion criteria (as per national guidance see below– for advice call Covid Medicine Delivery Group on 01482 468095)
5. If unstable / high mortality risk **End of life care just in case medications and referral to District Nurses**
6. **Consider VTE prophylaxis** for those with reduced mobility if clinically appropriate and not already receiving anticoagulant treatment

Severity risk

CRB-65 = 1 point for each of:

- New Confusion
- RR≥30/min
- sBP <90mmHg or dBP <65mmHg,
- age > 65 years

3 or more is a predictor of poor outcome.

Frailty is also a marker for poor outcome.

ISARIC 4C score can also be used: https://isaric4c.net/risk/

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.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

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Inspiring Minds

Sepsis Red Flags

New altered mental state

RR > 25 or new need for 40% O2

HR > 130/min

sBP <90mmHg

No urine in last 12hrs

Purpura, mottled, ashen, cyanotic

The use of the CFS scale has not been widely validated in those below 65 years of age, or in those with a learning disability or stable single-system disabilities. The scale is never used as a judgement about someone's Quality of Life. It is used as one part of an assessment process to help ensure that decisions about healthcare interventions are appropriate in the context of an individual's healthcare needs. If the person is acutely unwell, score how they were 2 weeks ago, not how they are today.

Advance care planning considerations

Below is a guide in approaching conversations to guide patients/families through decision making around treatment options for COVID 19. It may be that these plans are never required but will help people feel reassured if prepared, and can lessen the burden of future difficult decision making.

If a ReSPECT form is in place, this should be reviewed in the current circumstances and in the context of information below. COVID19 does not specifically need to be mentioned on the ReSPECT form. To understand the patient's wishes during treatment of an acute illness review sections 3 and 4 of the ReSPECT form. If the patient does not wish to be taken or admitted to hospital and / or receive life support, the fact that they have confirmed or suspected COVIDC-19 should not supersede their wishes.

The following provides additional context to aid decision making:

Mortality from COVID 19 is much higher in the older age group, and with comorbidities. Outcomes for frail older patients in ICU and ventilation are already very poor.

If preferred place of care and death is unknown use clinical judgement, previous known wishes and discussion with patient, available next of kin or care staff. If decision support is needed call the ICC frailty support team available Monday to Friday 8am to 6pm on 01482 450078

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If clinical deterioration consider: Pulmonary embolism, vascular event, pneumothorax, secondary bacterial infection, delirium, clostridium difficile

If antibiotic advice required speak to HUTH ID / microbiology team via 01482 875875 extension 4991

Follow up – to be determined on individual basis based on symptom burden, and acceptability and appropriateness of further investigations.

If unvaccinated can have vaccine from 1 month after contracting Covid-19

Further information on treatments:

Neutralising Monoclonal Antibodies or antivirals

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2021/12/interim-clinical-comm-policy-neutralising-monoclonal-antibodies-or-antivirals-for-non-hospitalised-patients-v2.pdf see appendix 1 for inclusion / exclusion criteria. **Referral to CMDU via eRS using Infectious Diseases Covid Medicine Delivery Unit (CMDU) HUTH (site to be confirmed) – RWA Service ID no – 7980228** for further information see document below

Information for General Practices - Ne

Clinical guidelines for the control of symptoms in the COVID-19 patient in a community setting

This guidance has been created for the specific pattern of symptoms reported in those with severe COVID-19 infection, to supplement existing regional symptom control guidance https://www.hey.nhs.uk/wp/wp-content/uploads/2020/04/COVIDsymptomControlHERPC.pdf

Pulse oximetry at home information available at:

https://www.england.nhs.uk/coronavirus/publication/novel-coronavirus-covid-19-standard-operating-procedure-covid-oximetry-home/https://www.england.nhs.uk/coronavirus/publication/pulse-oximetry-to-detect-early-deterioration-of-patients-with-covid-19-in-primary-and-community-care-settings/

https://careprovideralliance.org.uk/coronavirus-oximetry-at-home-guidance-for-care-homes

Community Covid-19 Frailty guidance v6

These guidelines were developed by the community frailty team in collaboration with Hull University Teaching Hospitals Departments of Infectious Diseases, Respiratory, Elderly Medicine and ICU based on evidence at time of writing, UKHSA, NHS England, NICE and WHO guidance.

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