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**SHIELDING PATIENTS v1 April 2020**

**CLINICAL RISK and THRESHOLDS FOR INTERVENTION**

**Those on the shielding list are at high risk of COVID COMPLICATIONS** but that doesnot necessarily mean either palliative or unsuitable for ITU. It is helpful to distinguish:

* Shielding – reducing risk of vulnerable patients contracting COVID
* Anticipatory Care Planning – what happens if they do become infected.

The letter patients received was not primarily to discuss ventilation / ceilings of care – but there are opportunities with some patients to explore these and address unwarranted fears. There are very varied levels of need and disability within the list and therefore individual assessment will be required for specific decisions around anticipatory care.

**THRESHOLDS – main decisions in those ill with COVID positive are:**

1. Appropriate for admission?
* Sufficiently ill
* Best for that patient (some very ill and frail / poor life expectancy palliative care at home more humane).
1. Appropriate for ITU? – considering this in terms of suitable for ventilation rather than ITU care makes options more explicit (and binary)
2. CPR – essentially very helpful for those who would have a DNACPR under normal circumstances to have one and they would generally not be suitable for ICU either. But CPR will not work in those with cardiac arrest due to advanced COVID respiratory failure WHATEVER the pre-morbid condition.

***In ALL the above, frailty is a huge consideration whatever the age or co-morbidity. And most of those decisions will be made at the time of severe illness – most will never reach that point. A*** [***Frailty Score***](https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf) ***of 5 often seems to represent the cut-off for intensive ventilatory treatment.***

**PRIMARY / SECONDARY CARE INTERFACE:**

* THERE IS A RISK OF MIXED MESSAGES – potentially causing confusion and distress – if specialist teams and GPs are saying different things. *Always ask first if anyone else has been in touch and what they have said.*
* Where the GP has updated the ACP – indicate SHIELDING CONVERSATION.
* Where the specialist team has done so, please send ACP / brief email to the practice / clinical email boxes. GPs can COPY AND PASTE INTO A KIS-ACP from an email, but not a letter.
* GP Practice clinical email boxes are checked regularly and can be found on the NHS Lothian intranet directory under [GP Clinical Email Addresses](http://intranet.lothian.scot.nhs.uk/Directory/Pages/default.aspx).

**In Lothian the recommendation is that those with the following are contacted by their specialist**:

1. Solid organ transplant recipients – *some are managed by teams elsewhere in the UK*
2. Chemotherapy / active cancer treatment / haematological malignancies[[1]](#footnote-1)
3. Cystic fibrosis
4. Sickle cell disease and rare metabolic conditions
5. Where treatments PRESCRIBED / MONITORED by specialist (many immunosuppressants)
6. People who are pregnant with significant heart disease, congenital or acquired.
7. Others felt by the specialist to need shielding (new category 7, CMO letter) – a varied group.

**And the following by Practices**

1. Those on palliative care register
2. Severe respiratory conditions (other than Cystic Fibrosis)
3. People on immunosuppressant therapies sufficient to significantly increase risk of infection – UNLESS prescribed for / monitored by secondary care (or solid organ transplant)
4. The large workload of supporting frail and care home patients who may not appear on shielding lists, some being ‘category’ 7 in the CMO’s updated letter.

**There are national templates for ACP calls, but in addition please consider for all:**

1. Inform DN team if CLEAR NEED for housebound nursing care
2. Add a clinical frailty code wherever possible - the [Rockford Frailty Score](https://www.bgs.org.uk/sites/default/files/content/attachment/2018-07-05/rockwood_cfs.pdf) is recommended
3. Any issues where specialist teams need to be informed.

**There are a range of approaches. We suggest:**

* For all – check patient’s understanding, that care and medication needs met, that know how to get help, have rescue medications where appropriate, issues for ACP. HIGHLIGHT that General Practice is still there for care, and open at the usual times….
* *Wherever possible check frailty status and add to ACP – hugely helpful for specialist colleagues AND our GP colleagues triaging in COVID Hubs. Baseline function and oxygen sats greatly aid decision-making.*
* We cannot always know in advance whether or not someone might be suitable for ventilation (and decisions may in part relate to availability at the time) – so be cautious, don’t feel that these decisions have to be made in advance. All patients have an [COVID ACP form](http://intranet.lothian.scot.nhs.uk/COVID-19/PatientManagement/Documents/Hospital%20Anticipatory%20Care%20Plan%20-%20for%20use%20in%20ALL%20admissions%20during%20COVID%2019%20Pandemic%2024%20%20March%202020.pdf) completed on admission.
* DNACPRs are not always the right thing, even in these difficult times. Alternative dialogues are possible and help our specialist colleagues if the person is admitted. An ACP example – “XX would normally be resuscitated but is aware that CPR in advanced COVID disease is ineffective”.
* BUT for those who do have limited life spans, or where ventilation is clearly not an option, then DNACPRs and ceiling discussions are hugely helpful.
* If ventilation will not work, then ‘doing no harm’ means – not exposing that patient to unnecessary interventions, or false expectations.
* All these conversations can help future discussions and decision making, even if they do not result in formal statements round limits of intervention.

**During the pandemic, patient expectations may be very different, and many will be realistic too:**

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| **Normal situation** | **COVID pandemic** |
| Hospitals treat ill patients and make them better | Hospitals are for the very ill, there is no COVID treatment, death is likely |
| Everyone likes a phonecall from their GP | Cold calls are frightening – patients aware but don’t want to know more (already reported) |
| People go to ITU to get better | People go to ITU to die |
| Everyone goes to ITU if they are sufficiently ill | There are not enough ITU spaces for everyone |
| Hospitals provide comforting end of life care | Families and friends cannot visit; wards are more stressful and busier. There may be fewer staff than usual to provide everyday care due to staff illness / self-isolation |
| My surgery is open during the week | My surgery is closed *(not the case!)* |
| Patients with symptoms will phone their GP | Patients may not phone even if their symptoms are significant  |

1. People with specific cancers:

People with cancer who are undergoing active chemotherapy or radical radiotherapy for lung cancer

People with cancers of the blood or bone marrow such as leukaemia, lymphoma or myeloma who are at any stage of treatment

People having immunotherapy or other continuing antibody treatments for cancer

People having other targeted cancer treatments which can affect the immune system, such as protein kinase inhibitors or PARP inhibitors.

People who have had bone marrow or stem cell transplants in the last 6 months, or who are still taking immunosuppression drugs. [↑](#footnote-ref-1)