St Helens and Knowsley Teaching Hospitals NHS Trust

Department of Respiratory Medicine

Covid.19 Standard Operating Procedure

Document Name:	Covid.19
SOP Written by:	A. McIntosh, N. Brownbill, N. McStein, O.Seddon
Signature:	
Contributors:	Respiratory Consultant Team, Palliative Care, Infection Control, Resuscitation Officer, Purchasing and Supplies, Discharge team, Cardio- Respiratory Team
SOP authorised by:	COVID council
Signature:	
Version control	1.6

This SOP – version 1.5 is accurate as at 12th June 2020 - please be aware guidance can be updated at a national level and an updated version of this SOP

Contents

1 Purpose

To ensure processes are followed to ensure correct treatment of COVID19 positive patients within the ward environment.

Offer staff some practical guidance when nursing COVID19 positive patients when an inpatient.

2 Scope

Staff have guidance for nursing COVID19 positive patients whilst an inpatient

3 Responsibility

All staff are responsible for ensuring patients are being nursed in the most effective, safe and practical manner.

4 Validation

Standard operating procedure has been reviewed by Dr P Stockton.

5 References

None

6 Related Documents

See attached appendices

7 Procedure

7.1 Receiving COVID19 positive patients

Ensure the referring ward/department have discussed with the bed manager.

The referring ward must then ring to speak to the ward co-ordinator, the receiving ward must ensure they ask if the patient is confirmed COVID19 positive, receive a handover and ask if there is any Aerosol Generated Procedures (AGP) being performed so receiving staff can don correct PPE.

A standard full care plan is available as Appendix 1 to be used for all COVID19 patients

7.2 Staff uniform

All staff caring for COVID19 positive patients on cohort wards should wear scrubs whilst in their clinical role. All staff are advised to travel to and from work in their own clothing (as per Trust uniform policy) and use staff changing facilities to change into scrubs provided either on their own ward area or the central changing area. A temporary central changing room has been set up in the Therapy Suite, Level One at Whiston hospital. Staff need to remove scrubs at the end of shift and place in a red linen bag, they must secure this bag and then place in a standard white linen bag. Staff who transiently visit a ward e.g. to see a ward referral etc. and staff who do not spend a majority of their shift on a cohort ward do not need to wear scrubs but should adhere to general PPE guidance.

Surgical masks must be worn at all times whilst on the main ward area including corridors in line with standard Trust PPE advice

7.3 Personal protective equipment (PPE)

Follow signage outside of ward cubicles as PPE guidance can change based on each individual patient's need.

All persons must wear a surgical face mask whilst in any clinical area

Prior to entering a patient's room staff must don an apron, goggles and gloves in addition to a surgical face mask that must be worn at all times whilst in the clinical area. Surgical face masks can be worn for 3 hours provided they do not become contaminated/soiled.

When there is a risk of splashing, staff must wear goggles/visor (appendix 2).
For patients undergoing any AGPs staff must don a visor, FFP3 mask, long sleeve fluid repellent disposable gown and long gloves that are pulled over the cuffs of the gown (appendix 3).

AGP include:

- Intubation
- Tracheostomy
- Manual ventilation
- Open suctioning
- Bronchoscopy
- NIV, CPAP and high flow oxygen
- Induction of sputum (chest physio)

PPE equipment must be removed carefully, and hands decontaminated as per standard procedure i.e. doffing, (appendix 4 and appendix 5)

Reapply surgical mask if mask becomes contaminated. Masks must be removed on leaving a clinical area.. Masks need to be changed every three hours.

PPE stock should be ordered using standard Trust procedure. Staff must ensure they are completing stock checks of PPE at least three times a week (appendix 6).

Urgent PPE can be obtained from the pandemic store, but staff are encouraged to ensure the ward stock levels are maintained to the relevant volume. Urgent PPE must be requested using the standard Trust documentation and signed by the ward manager (appendix 7).

7.4 Patient observations

On ward areas with small numbers of COVID19 positive patients it is recommended that an allocated observation machine is left in the isolation room with the positive patient. Where this is not possible, all equipment should be Chlorcleaned prior to leaving the room and a disposable blood pressure cuff for single patient use must be used and discarded once the patient has been discharged.

In areas with multiple positive patients, observation machines can be used for multiple patients, but staff must ensure they clean the equipment between each isolation room and patient use. Disposable blood pressure cuffs should be used.

7.5 Medical protocols

Several useful protocols have been developed to help manage patients with COVID19 including the following:
MET call protocol (appendix 8)
Pyrexia management (appendix 9)
Oxygen management (appendix 10)
Conscious Proning of patients (appendix 11)
Diarrhoea and COVID (appendix 12)
In-patient Echocardiography British Society of Echocardiography (appendix 13)

7.6 Cardiac arrest

There are **"RESUSCITATION GRAB BAGS"** in the clean clinical room on every ward and at the bottom of the arrest trolleys. These must be taken to **ANY** patient in cardiac arrest irrespective of their COVID19 status (appendix 14 for latest resuscitation council algorithm). Full PPE must be donned prior to any chest compressions or airway manoeuvres. An appropriately trained person can enter the patient area without enhanced PPE provided they are wearing basic PPE to deliver 3 stacked shocks in patients who have a shockable rhythm. A member of staff should

act as a Gatekeeper to ensure that staff do not enter the patient area without enhanced PPE in place.

Trust guidance, based on Resuscitation Council guidelines must be followed. (Appendix 12). The resuscitation trolley must always remain outside the room/bay

7.7 Deteriorating patients

It is essential to ensure there is a clearly documented medical plan regarding a patient's ceiling of care, resuscitation status, and suitability for MET/Tier1 calls. Anticipatory medications should be prescribed at the earliest opportunity to ensure symptoms can be managed without delays in the event of deterioration. It is important to use the support and guidance from palliative care and ensure that patient's symptoms are being actively managed. Palliative Care have produced guidance regarding use of anticipatory medication (appendix 15)

Any difficult conversations held with relatives/carers need to be documented in the patient's case notes, these conversations will more than likely be held via telephone so it is vital to clarify the name of the person that has been in discussion and confirm their relationship to the patient. The palliative care team has produced guidance related to difficult conversations (appendix 16 and appendix 17)

7.8 Waste disposal

Large volumes of waste may be generated by frequent use of PPE; advice from the local waste management team should be sought prospectively on how to manage this.

Dispose of all waste as clinical waste.

7.9 Linen

All linen should be placed in a red linen bag inside the isolation room and then placed in a white linen bag outside the isolation room.
No special procedures are required; linen is categorised as 'used' or 'infectious'.
All linen used in the direct care of patients with possible and confirmed COVID-19 should be managed as 'infectious' linen. Linen must be handled, transported and processed in a manner that prevents exposure to the skin and mucous membranes of staff, contamination of their clothing and the environment:

- disposable gloves and an apron should be worn when handling infectious linen
- all linen should be handled inside the patient room/cohort area. A laundry receptacle should be available as close as possible to the point of use for immediate linen deposit

7.10 Deep cleans

Within the cohort wards, deep cleaning between positive patients is not required unless additional isolation requirements are present i.e. MRSA, CDT, CPE, and VRE.

On non-cohort wards staff need to follow usual procedure in requesting a deep clean stating COVID19 positive. Domestic team should seek guidance from their team leaders if they raise any questions or concerns regarding the procedure they should be following.

7.11 Catering services

There is no need to use disposable plates or cutlery. Crockery and cutlery can be washed by hand or in a dishwasher using household detergent and hand-hot water after use.

On cohort wards, the catering service runs their usual service, ensuring that catering staff are made aware of the correct donning and doffing procedures. Advise catering staff to liaise with their catering supervisors with any questions they have based around catering services.

7.12 Communication

Record a list of all bedside Hospedia telephone numbers as communication, when applicable via telephone, will reduce staff exposure to COVID19 positive patients. Staff can also communicate with patients via their personal mobile number. Ensure all patients have access to ward buzzers, ward mobile or landline numbers. On admission staff to must ensure an accurate next of kin contact number is recorded.

Hospedia currently provides free services for inpatients, for both TV and google.

7.13 Visiting

No visiting is permitted for any patients except for compassionate reasons when a patient may be dying imminently. This is generally limited to one visitor only and must be discussed with nurse in charge prior to agreement.

7.14 Intranet

Please check emails daily and utilise Trust intranet, this has regular updates for staff, guidance for managers and frequently asked questions.

There is a staff Covid website to make it easier for staff to access covid related information. This is accessible 24/7 from any personal or Trust device including:

- Mobile phones
- iPads
- Laptops
- Desktop computers

Url: covid.sthk.nhs.uk
Password: STHKcovid19

There may be changes to policies including the use of PPE and it is each individual's responsibility to keep up to date with current Trust guidance.

7.15 Discharge from hospital

As with all admissions to hospital, we must continue to commence discharge planning from point of admission. Patients must be provided with the relevant government documents to support an effective discharge process (see appendix 19, appendix 20 appendix 21 and appendix 24). See appendix 25 and appendix 26 for discharge leaflets from AED and hospital stay.

7.16 Death

Follow normal last offices procedure. On advising families of the next stages following a death of a COVID 19 positive patient, offer the same information regarding collecting death certificate, as outlined in the Trust bereavement booklet. In relation to COVID 19 patients this information will be updated in the near future. The principles of SICPs and TBPs continue to apply whilst deceased individuals remain in the care environment. This is due to the ongoing risk of infectious transmission via contact although the risk is usually lower than for living patients. Where the deceased was known or possibly infected with COVID-19, there is no requirement for a body bag, and viewing, hygienic preparations, post-mortem and embalming are all permitted.

On advising families of the next stages following a death of a COVID 19 positive patient, offer the same information regarding collecting death certificate, as outlined in the Trust bereavement booklet. In relation to COVID 19 patients this information will be updated in the near future.

7.17 Staff Support

Staff need to remember that this is a very difficult time for all frontline staff; staff must remember to treat each other with respect and empathy and keep morale up. Staff

are encouraged to look out for one another and provide the support we all need. Staff need to be mindful what we are sharing on social media as this can add to others' anxiety; you are very much a role model for others now, please remember this.

Please utilise the support from your managers and be familiar with support networks such as insight. Employees can contact INSIGHT Confidential Helpline on 0300 131 2067.

Staff must remember that we need to continue providing the Trust five-star patient care and adhere to trust ACE behavioural standards. Staff need to remember we are here in a professional role to provide care.

7.18 Staff attendance management

Full guidance for managers is provided on the intranet, this is updated regularly, and managers should refer to this at all times.

It is each staff member's responsibility to keep their manager informed whilst they are off duty, either self-isolating or household isolating. Standard Trust documentation must be completed.

7.19 Grab and Go Guide

The Grab and Go guide has been designed in partnership with people with learning disabilities, families and nurses. The grab and go form is not a replacement for the everyday, detailed hospital passport. The hospital passport should be updated and taken to hospital along with the Grab and Go guide – see appendix 22 and appendix 23.

Appendix 1 – COVID-19 Care Plan

PATIENT CARE PLAN
Name ……Ward ……..
Hosp No/D.O.B……

Problem The patient is Covid 19 positive		Expected Outcome Treat and manage symptoms. Prevent the spread of infection	
Date/Time	Plan of care	Evaluation Date & Sign	Discontinued Date & Sign
	Introduce staff to patient each shift		
	Maintain dignity and respect at all times		
	Maintain a clean, safe environment at all times and ensure the nurse call bell is to hand		
	Ensure all patient contact numbers are up to date and patients are provided with the ward phone number to aid communication		
	Monitor observations as per News 2 (temperature, oxygen, oxygen saturations, blood pressure, pulse, pain) and liaise with medics re all concerns, escalating according to Trust policy		
	Liaise with medics to ensure escalation plan is clearly documented in patient's notes, including target oxygen saturation range.		
	Isolate as per infection prevention policies and guidelines		
	Follow correct Donning and Doffing posters when attending to patients		
	If removing any equipment from the isolation room, ensure that this is cleaned with chlor-clean 1000ppm before removing from the isolation room		
	Use apron, gloves, fluid resistant surgical mask and eye protection (goggles or visor) when caring for patients with non-aerosol generating procedures (AGP) and display white sign outside of room		
	When caring for patients who are receiving aerosol generating procedures, use full PPE (gloves, surgical gown, FFP 3 mask and visor) and display pink sign		
	Remove PPE except mask and eye protection before leaving the isolation room, wash hands with soap and water and leave the room		
	Remove mask in corridor when contaminated, used for AGPs or worn for more than 3 hours; ensuring it does not touch any skin or clothing and dispose in clinical waste bin. Decontaminate hands. If eye protection is reusable, make your way to the dirty utility, gel hands and remove eye protection and mask. Clean eye protection with chlor-clean 1000ppm using the appropriate PPE.		
	Reapply gel to hands		
	Ensure that all specimen pots are labelled prior to entering the isolation room and placed in a clear bag inside the room. Chlor-clean the outside of specimen if contaminated and ensure this is dry before placing in clear bag. Change gloves, place clear bag into a second clear bag outside of the isolation room, without leaving the room yourself, you will need a colleague to assist you with this.		
	Ensure all specimen samples are double bagged, placed in laboratory request bag and then placed inside a blue transport bag before sending to the lab.		
	Administer all prescribed medications and monitor for side effects		
	Complete all planned tests and investigations and monitor for side effects		
	Encourage oral diet and fluids and liaise with medics where intake is poor		
	Inform patients they are not allowed visitors as per executives		
	Advise patients not to use the hand wash basin in their rooms for personal hygiene as they are for hand washing only. Patients must use the basins in their en-suite for personal hygiene		
	Keep patient and family updated		

Appendix 2 - Donning and doffling PPE when undertaking non-aerosol generating procedure (NAGP's)

Donning and Doffing Personal Protective Equipment when undertaking Non - Aerosol Generating Procedure (NAGP's)

The Following are **NOT** Considered to be AGP's

- Administration of pressurised humidified oxygen
- Administration of medication via nebulization

The following are considered AGP's

- Intubation, extubation and related procedures
- Tracheotomy/tracheostomy procedures
- Manual ventilation
- Open suctioning
- Bronchoscopy
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure Ventilation Surgery and post-mortem procedures in which high-speed devices are used
- High-frequency oscillating ventilation (HFOV)
- High Flow Nasal Oxygen (HFNO)
- Induction of sputum
- Some dental procedure (e.g. high speed drilling)

Donning PPE in isolation room with lobby.

Don PPE In Lobby Room

- Apron
- Surgical Mask
- Goggles/face Visor (use in event of splashing)
- Gloves

Donning PPE in side room without lobby or for a cohort bay

- Apron
- Surgical Mask
- Goggles/face visor (use in the event of splashing)
- Gloves

Doffing PPE in isolation room with lobby

(Start in patient's room standing near sink and bin, well away from patient)

1. Remove gloves (roll off) and discard into foot operated bin
2. Wash hands with soap and water, dry hands
3. Remove gown, roll down and try not to touch the outside, discard into foot operated bin
4. Remove eye protection and discard into foot operated bin
5. Exit room into lobby
6. Gel hands
7. Remove surgical mask and discard to foot operated bin
8. Wash hands with soap and water, dry hands
9. Exit lobby and shut door
10. Gel Hands outside the lobby

Doffing PPE in side room without lobby or for a cohort bay

- Follow steps 1 to 4 above
- Wash hands with soap and water, dry hands
- Exit the side room or cohort bay
- Remove surgical mask and discard to designated foot operated bin
- Decontaminate hands with gel

Appendix 3 - Donning and doffing PEE when undertaking aerosol generating procedure (AGP's)

Donning and Doffing Personal Protective Equipment when undertaking Aerosol Generating Procedure (AGP's)

- Intubation, extubation and related procedures
- Tracheotomy/tracheostomy procedures
- Manual ventilation
- Open suctioning
- Bronchoscopy
- Non-invasive ventilation (NIV) e.g. Bi-level Positive Airway Pressure (BiPAP) and Continuous Positive Airway Pressure Ventilation Surgery and post-mortem procedures in which high-speed devices are used
- High-frequency oscillating ventilation (HFOV)
- High Flow Nasal Oxygen (HFNO)
- Induction of sputum
- Some dental procedure (e.g. high speed drilling)

The Following are **NOT** Considered to be AGP's

- Administration of pressurised humidified oxygen
- Administration of medication via nebulization

Donning PPE in isolation room with lobby.

Don PPE In Lobby Room

1. Gown (long sleeved fluid repellent, disposable)
2. FFP3 respirator, ensure good seal, perform personal fit check
3. Googles/face visor (prescription glasses alone are NOT sufficient
4. Gloves – pull on so they go over the cuffs of the gown

BUDDY MUST DOUBLE CHECK THAT ALL PPE IS CORRECT

Donning PPE in side room without lobby or for a cohort bay

- PPE must be put on outside the side room or bay
- Follow the above steps

Doffing PPE in isolation room with lobby

(Start in patient's room standing near sink and bin, well away from patient)

1. Remove gloves (roll off) and discard into foot operated bin
2. Wash hands with soap and water, dry hands
3. Remove gown, roll down and try not to touch the outside, discard into foot operated bin
4. Remove eye protection and discard into foot operated bin
5. Decontaminate hands
6. Exit room into lobby
7. Remove FFP3 by snapping the ties and discard into foot operated bin
8. Wash hands with soap and water, dry hands
9. Exit lobby and shut door
10. Gel Hands outside the lobby

Doffing PPE in side room without lobby or for a cohort bay

- Follow steps 1 to 4 above
- Wash hands with soap and water, dry hands
- Exit the side room or cohort bay
- Remove FFP3 mask and discard to designated foot operated bin
- Decontaminate hands with gel

Appendix 4 - Public Health England – Quick Guide to putting on PPE for aerosol generating procedures (AGO's)

Public Health England

COVID-19

Quick guide

Putting on (donning) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

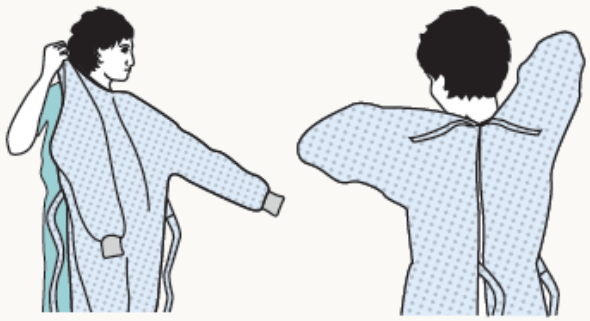
This is undertaken outside the patient's room.

Pre-donning instructions

- ensure healthcare worker hydrated
- tie hair back
- remove jewellery
- check PPE in the correct size is available

Perform hand hygiene before putting on PPE

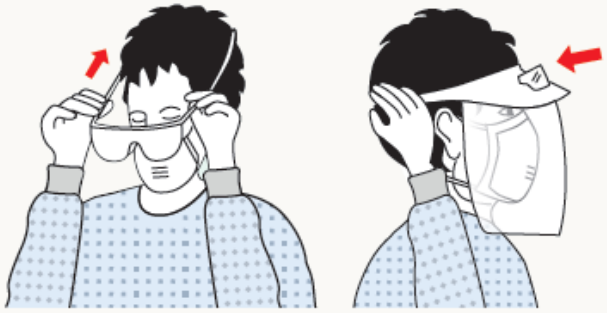
1 Put on the long-sleeved fluid repellent disposable gown



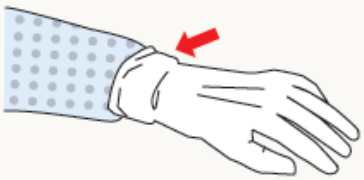
2 Respirator

Perform a fit check.

3 Eye protection



4 Gloves



Appendix 5 - Public Health England – Removal of PPE for aerosol generating procedures (AGP's)

COVID-19

Public Health England

Removal of (doffing) personal protective equipment (PPE) for aerosol generating procedures (AGPs)

PPE should be removed in an order that minimises the potential for cross contamination. Unless there is a dedicated isolation room with ante room, PPE is to be removed in as systematic way before leaving the patient's room i.e. gloves, then gown and then eye protection.

The FFP3 respirator must always be removed outside the patient's room.

Where possible (dedicated isolation room with ante room) the process should be supervised by a buddy at a distance of 2 metres to reduce the risk of the healthcare worker removing PPE and inadvertently contaminating themselves while doffing.

The FFP3 respirator should be removed in the anteroom/lobby. In the absence of an anteroom/lobby, remove FFP3 respirator in a safe area (e.g., outside the isolation room).

All PPE must be disposed of as healthcare (including clinical) waste.

The order of removal of PPE is as follows:

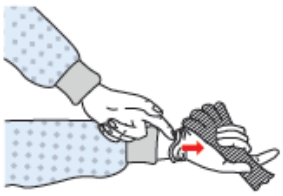
1 Gloves – the outsides of the gloves are contaminated

Firstly:

- grasp the outside of the glove with the opposite gloved hand; peel off
- hold the removed glove in gloved hand

Then:

- slide the fingers of the un-gloved hand under the remaining glove at the wrist
- peel the remaining glove off over the first glove and discard



Clean hands with alcohol gel

2 Gown – the front of the gown and sleeves will be contaminated

Unfasten neck then waist ties

Pull gown away from the neck and shoulders, touching the inside of the gown only using a peeling motion as the outside of the gown will be contaminated

Turn the gown inside out, fold or roll into a bundle and discard into a lined waste bin

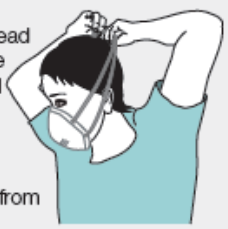
3 Eye protection (preferably a full-face visor) - the outside will be contaminated

To remove, use both hands to handle the retraining straps by pulling away from behind and discard.

4 Respirator – In the absence of an anteroom/lobby remove FFP3 respirators in a safe area (e.g., outside the isolation room). Clean hands with alcohol hand rub.

Do not touch the front of the respirator as it will be contaminated

- lean forward slightly
- reach to the back of the head with both hands to find the bottom retaining strap and bring it up to the top strap
- lift straps over the top of the head
- let the respirator fall away from your face and place in bin



5 Wash hands with soap and water

Appendix 6 - PPE Stock Check Form

NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

PPE Stock Check Form

All departments should have suitable PPE stock to ensure safe provision of care, in line with the national guidance. There is a central storage area where stock can be called upon in emergencies or due to unexpected peaks in demand. At all other times PPE should be ordered through your usual ordering methods.

To ensure the consistent supply and security of all our PPE equipment we ask that 3 times a week you complete a summary report from your department, to ensure that we have suitable PPE levels at all times.

Please complete the simple form below and send each Monday, Wednesday and Friday, no later than 2pm to purchasing@sthk.nhs.uk

Your name:

Department:

Date:

Product code if known (there are sometimes various codes for these products)	**Product description (ie goggles/FFP masks)**	**Quantity in your department (ie 1 box of 100)**
Any other PPE:		

Form to be emailed to purchasing@sthk.nhs.uk Monday, Wednesday and Friday by no later than 2pm.

Appendix 7 - Pandemic Store Stock Request Form

Pandemic Store Stock Request Form

Please complete this form to obtain access to PPE equipment.

All wards should have suitable PPE stock to ensure safe provision of care, in line with the national guidance. If there is a need to request stock from the onsite storage area please complete all of this form. Incomplete forms will not be accepted.

The stock is locked in the "White Space" (on the corridor between the Main Entrance and Pharmacy, at Whiston Hospital) and access is strictly controlled and monitored. Stock will not be released until this form is completed and signed by a Ward Manager.

PPE equipment **will only be issued between 10am and 11am and 2pm and 3pm Monday- Friday** at Whiston Hospital. To obtain PPE equipment this form must be fully completed and taken to the "White Space" store at these times. Whilst we will aim to fulfil all requests some requests may be reduced to assist with the controlled stock levels. If these items are on your regular ward provisions then please contact the Materials Management Team.

- **All other times (nights and weekends):** Security to be called and this form to be handed to them upon collection of the goods- please meet them at the "White Space" at an agreed time.

Your name:

Department:

Ward Manager's name:

Ward Manager's signature:

Date:

Time of collection:

Products required:

Security/Procurement person who allocated:

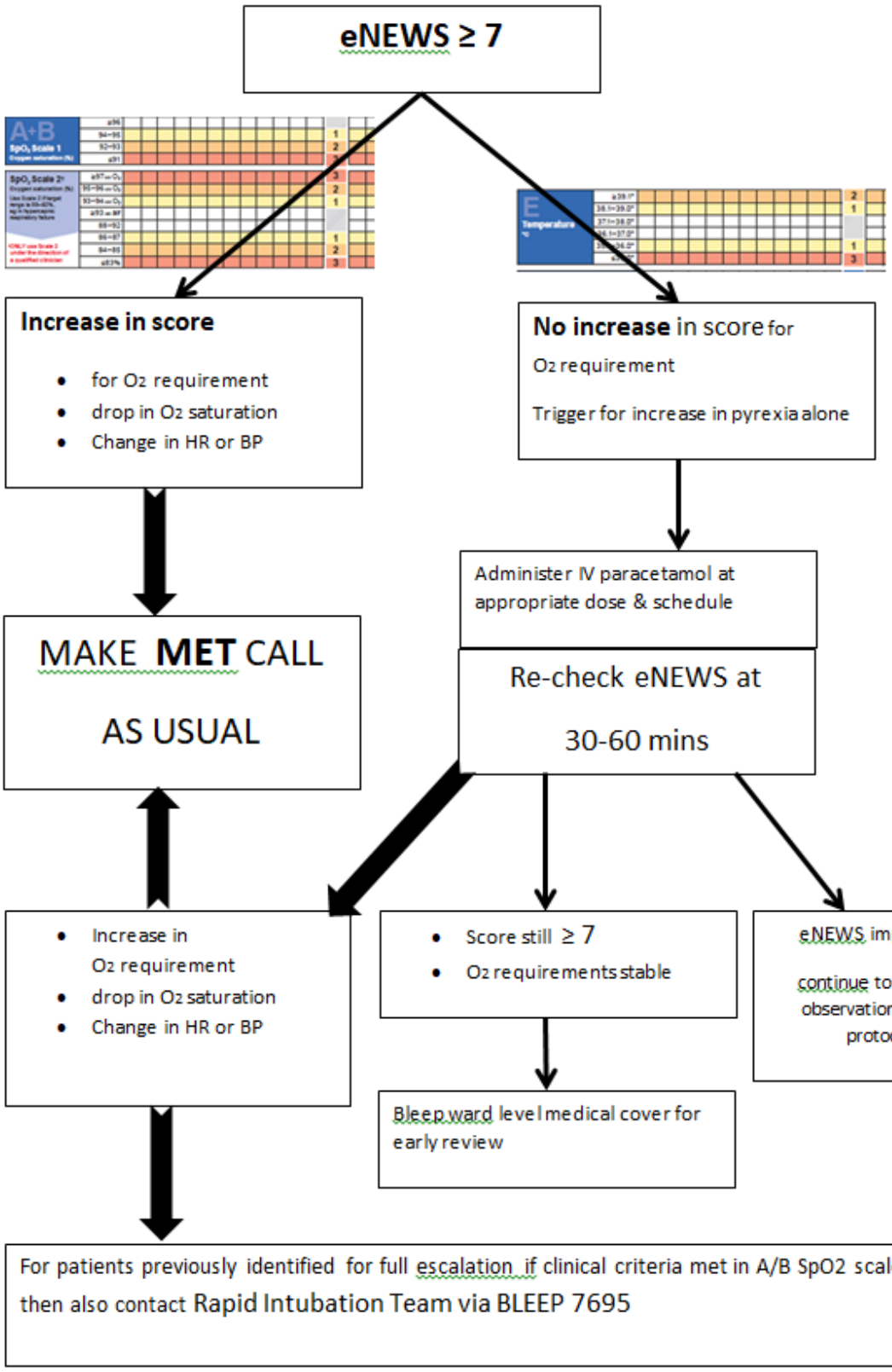
Product code if known	Product description (ie goggles/FFP masks)	Reason for request	Department items are for:	Cost Centre(Transfer point) if known	Quantity required (ie 1 box of 100)

List of the equipment held in the Pandemic Store:

Description	Box size
Nitrite glove small	box 200
Exam gloves-nitrile medium	box 200
Exam glove-nitrile large	box 200
Nitrile glove xl	box 200
Disposable gowns universal	box 50
Disposable aprons	roll200
Clinical waste bags	roll25
Surgical masks	box50
Face Visor	Box 24
FFP3 respirator masks (non valved)	box20
Fit test kits (bitter)	each
Fit test kits (sweet)	each
Bitter solution	box 6
Sweet Solution	box 6
Shrouds	pack10
Safety glasses	box 12
Extra long cuff gloves S	box 100
Extra long cuff gloves M	box 100
Extra long cuff gloves L	box 100
Extra long cuff gloves XL	box 100
P3 particulate filters	pack20
Reusable half masks	each
Reusable half masks	each
Reusable half masks	each
Yellow aprons	TBC
Tubs sani cloth wipes	each
Sani chlor tub	each
FFP mask (valved - from national pandemic stock)	Box 10 (8 boxes of 10 in big box

Form to be left in the White Space

Appendix 8 – MET Call Protocol



Appendix 9 – Pyrexia Management

MET calls

Patients with Covid 19 will frequently have episodes of pyrexia and often will trigger on eNEWS a score that would ordinarily mandate a MET call. In this situation, there is little alteration required in patient's management. This will lead to increasing numbers of MET calls. In order to reduce this:

If a patient who is confirmed Covid 19 positive has eNEWS ≥ 7 and this is associated with pyrexia but no increase in their oxygen requirement (i.e. fall in oxygen saturations requiring an increase in the oxygen delivered to the patient), this patient should be given paracetamol (ideally IV) and the eNEWS repeated in 30-60 minutes.

If at this stage the eNEWS remains but the oxygen requirement is stable the ward nurse should bleep the on call medical SHO for advice

If the oxygen requirement has increased then it is appropriate to place a MET call

If the eNEWS improves then nothing further is required except from continuing to monitor observations as per eNEWS protocol

If a patient with Covid 19 scores eNEWS ≥ 7 outside of pyrexia and remain for MET calls then this should be placed as per policy

Consider giving regular rather than as required paracetamol to patients
These patients should not be given NSAIDs for pyrexia outside of end of life care.

Appendix 10 – Oxygen Titration in Coronavirus

Target oxygen saturations (SaO2) is 92 – 96% for all patients (except for patients who meet the criteria for scale 2 on NEWS scoring i.e. patients with chronic hypercapnic respiratory failure most commonly seen in some patients with exacerbation of COPD).

Please ensure that all oxygen is prescribed on EPMA with this target specified.
When reviewing patients:

- **If Sa02 are 96% or more** **decrease oxygen** to the next step down Venturi mask (e.g. from 60% to 40%) until they are on 28%.
    - If they are on 28% Oxygen then change to nasal cannulae 3L oxygen and reduce as able until patient is on room air
- **If SaO2 are 91% or lower** then **increase oxygen** to the next step up Venturi mask (e.g. from 35% to 40%) until they are on 60% Oxygen
    - If they are already on 60% oxygen and SaO2 are 90% or less:
        - If patient is **for escalation** of treatment then refer to critical care and change to 15L oxygen via Non rebreather mask
        - If patient is **not for escalation** of treatment then change to 15L oxygen via non breather mask
- **If SaO2 within target range** for 24h **decrease oxygen** to the next step down Venturi mask (e.g. from 40% to 35%)
    - If they are on 28% O2 then change to nasal cannulae 3LO2

Check SaO2 in 15 minutes after you change the amount of oxygen to ensure that their SaO2 are at an acceptable level.

Appendix 11 – Conscious Proning Process

intensive care society 50 YEARS
proud to be the voice of critical care since 1970

Figure 1 – Flow diagram decision tool for Conscious Proning process

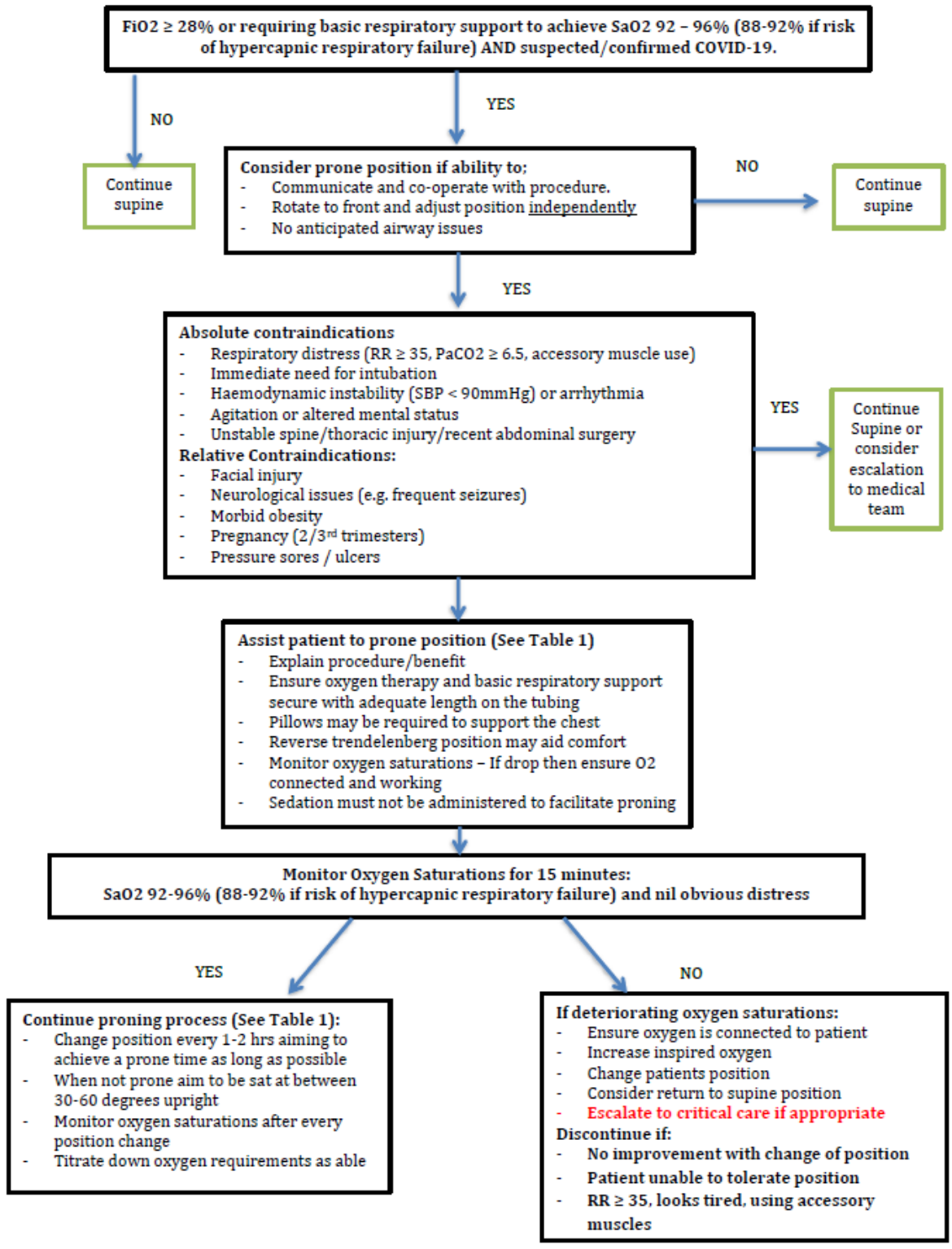


Table 1 – Timed position changes for patients undergoing conscious proning process

Timed Position Changes:

If patient fulfils criteria for proning ask the patient to switch positions as follows. Monitor oxygen saturations 15 minutes after each position change to ensure oxygen saturation has not decreased. Continue to monitor oxygen saturations as per the National Early Warning Score (NEWS)

- 30 minutes to 2 hours lying fully prone (bed flat)
- 30 minutes to 2 hours lying on right side (bed flat)
- 30 minutes to 2 hours sitting up (30-60 degrees) by adjusting head of the bed
- 30 minutes to 2 hours lying on left side (bed flat)
- 30 minutes to 2 hours lying prone again
- Continue to repeat the cycle.....

Patient information sheet For "Conscious Proning"

intensive care society 50 YEARS
proud to be the voice of critical care since 1970

These instructions are for patients who have been advised to undertake "Conscious Proning"

Please try to not spend a lot of time lying flat on your back. Lying on your stomach and in different positions will help your body to get air into all areas of your lungs.

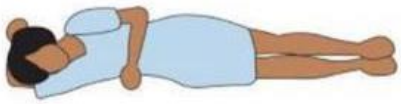
It is recommended to change your position every 30 minutes to 2 hours rotating as below. Please note sitting up is better than lying on your back:

1. 30 minutes – 2 hours: lying fully prone on your stomach (bed flat)
2. 30 minutes – 2 hours: lying on your right side (bed flat)
3. 30 minutes – 2 hours: sitting up (30-60 degrees) by adjusting head of the bed
4. 30 minutes – 2 hours: lying on your left side (bed flat)
5. Then back to position 1 and continue to repeat the cycle.

In pictures:

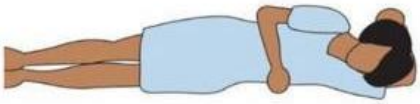
1. 30 minutes – 2 hours: lying fully prone (bed flat)

2. 30 minutes – 2 hours: lying on your right side (bed flat)

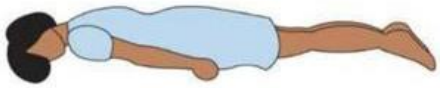


3. 30 minutes – 2 hours: sitting up (30-60 degrees) by adjusting head of the bed

4. 30 minutes – 2 hours: lying on your left side (bed flat)



5. Then back to Position 1. Lying fully prone (bed flat)



Adapted from Self Positioning Guide. Elmhurst Hospital. SB, https://www.embeds.co.uk/wp-content/uploads/2020/04/Self-Proning-Positioning-leaflet.pdf

Appendix 12 - Diarrhoea and COVID

1) Incidence of diarrhoea could around 20 – 25% even at presentation; not necessarily associated with other abdominal symptoms
2) Once in hospital, the reasons for diarrhoea could be multifactorial – including use of antibiotics
3) When infected patients with diarrhoea visit the gastroenterology department, it may increase the risk of infection of healthcare workers.

For patients with confirmed COVID and presenting with diarrhoea – symptomatic management with antidiarrhoeal agents only.

For patients with confirmed COVID and developing symptoms of diarrhoea during the course of the admission – send stool samples to exclude C Diff and if negative, for symptomatic treatment only.

Abnormal LFTs

4) 29.7% (44/148) had abnormal LFTs even on admission
5) 14.9% (22/148) of patients with normal tests on admission developed abnormal LFTs – is multifactorial including drug induced. The pattern of derangement reported in current studies show mainly a hepatic transaminitis; elevated serum alkaline phosphate and bilirubin are infrequent; liver failure is rare.

For these patients, monitor LFTs with repeat tests to be done in patients in six weeks on discharge. For USS if the derangement is cholestatic (disproportionate rise in ALP).

Other GI symptoms

- Effect on oesophagus, stomach, biliary tree and pancreas are unreported at present;
- if patients develop symptoms of gastritis – treat for symptoms (PPI and / or antiemetics)
- if patients develop symptoms of GI bleed – for low to moderate risk treat with supportive therapy and PPI; OGD reserved only if there is haemodynamic instability.

Appendix 13 - In-patient Echocardiography (British Society of Echocardiography)

British Society of Echocardiography

In-Patient Echocardiography

Appropriate triage categorization is dependent on accurate information being given in the request form. It is recognized that failure to provide adequate information may lead to delay. The triage categories are:

Category 1 (Emergency)

Echocardiography is to be done 'immediately' following discussion with on call Consultant Cardiologist.

1. Likely **acute pericardial tamponade** (following interventional procedure including intracardiac catheter or pacing manipulation)
2. Likely **acute (massive) pulmonary embolism** to inform a decision regarding thrombolysis when CTPA is not available or possible.

Category 2 (Urgent)

Result is likely to change immediate patient management and to be done <24 hours. Priority within that time should be discussed with on call Consultant Cardiologist

1. Detection of **high-risk complications of infective endocarditis** where patient is *haemodynamically unstable*.
2. Murmur following acute or recent myocardial infarction where **papillary muscle rupture** or **ventricular septal rupture** suspected.
3. **Persistent hypotension of unknown cause** where patient *haemodynamically unstable and not responding to intensive care*.
4. Suspected **pericardial tamponade**.
5. Suspected **pericardial effusion** or bleeding (including after serious chest trauma).
6. Suspected **aortic dissection** (including following possible deceleration injury)

Category 3 (Routine)

Echocardiography indicated but may not change immediate management. Echocardiography should be done as an in-patient if possible. If resources do not allow this, it may be performed as an outpatient but should be discussed with the referring clinicians.

This applies to all other indications for echocardiography

Special category :Confirmed or Suspected Covid- 19 where heart failure related myocarditis is suspected as a factor in respiratory failure:

These needs to be considered carefully in discussion with the on call cardiologist and /or the echocardiography lead. As a guide below factors may point to heart failure related myocarditis:

1- Clinical suspicion of heart failure where features of pulmonary oedema rather than pneumonia /pneumonitis dominates radiologically and clinically.

2- Significant rise in BNP.

3- Significant rise in TnI.

European experience suggests myocarditis is uncommon in older patients. aSmall TnI rise is very common in all acute illnesses, hence interpretation for a cardiac cause must be in light of other clinical and ECG features.

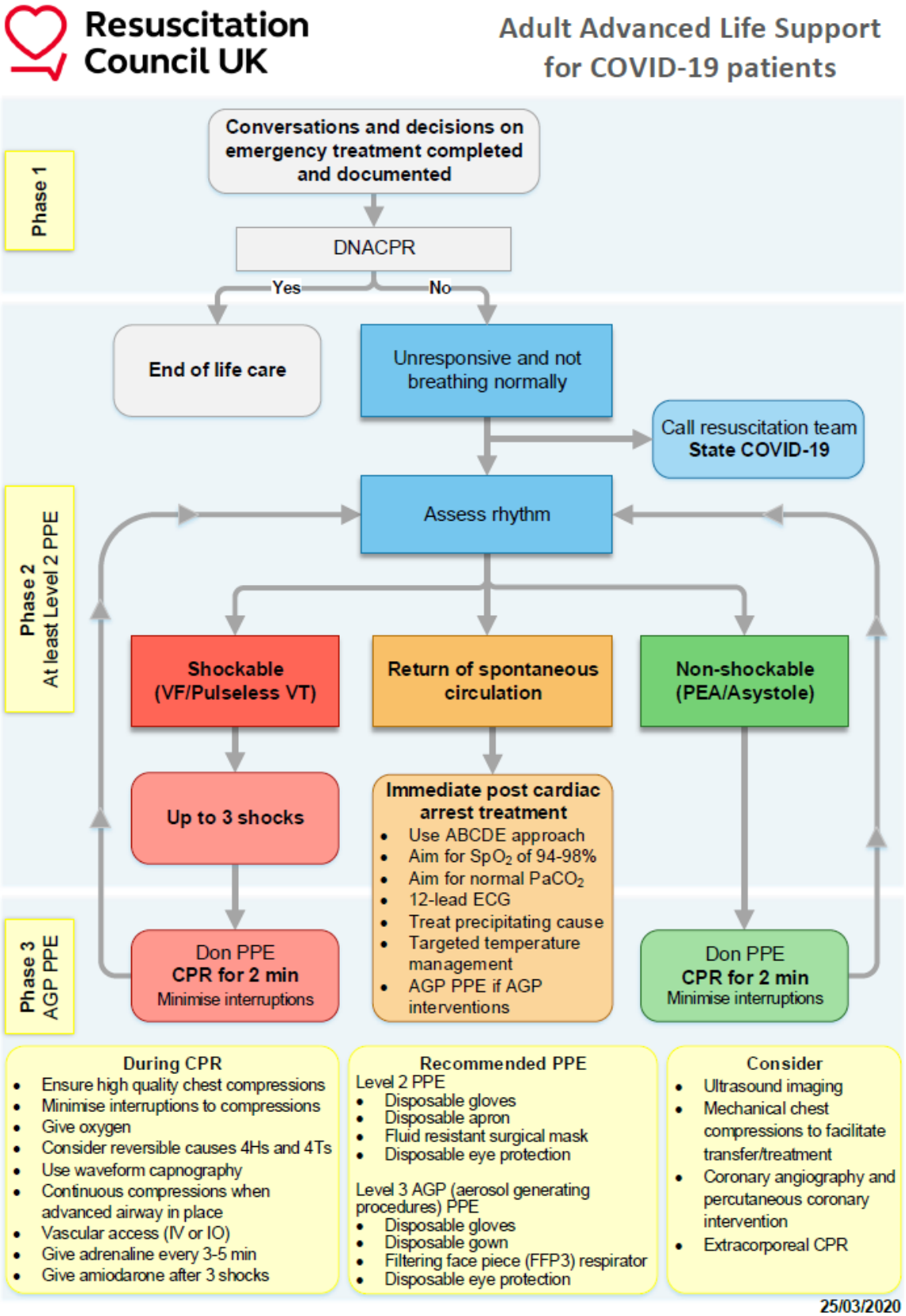
Please balance the benefit of echocardiography in changing patient management against the risk of infection to staff and other patients before requesting any close staff –patient contact tests such as echocardiography.

General Advice Regarding In-Patient Requests for Echocardiography

The following is a list of patients who **do not** require an in-patient echo unless agreed by the on call consultant cardiologist:

1. Previous echocardiogram demonstrating severely impaired LV function.
2. Previous echocardiogram demonstrating mild valve disease within the last 12 months.
3. PAF/SVT with previous normal echocardiogram within the last 12 months.
4. Previous echocardiogram demonstrating non-diagnostic echo windows.

Appendix 14 - Resuscitation Council UK – Adult Advanced Life Support for COVID-19 patients



Procedure for ALL patients in cases of actual or suspected cardiac arrest

- Cardiac Arrest Trolleys **MUST** stay outside the room/bay!!
- Defibrillator with connected pads is passed into room/bay first – those present should follow the new ALS algorithm
- One member of staff stays with the trolley outside the room
- This person must be wearing PPE (surgical mask, plastic apron, gloves & eye protection
- They are known as the “Gatekeeper” & must ensure no more than 5 team members enter the room/bay whilst the event is ongoing
- The Gatekeeper must ensure staff follow correct AGP PPE guidance (long sleeved disposable gown, gloves, FFP3 mask & goggle or visor) prior to entering the room/bay
- The Gatekeeper alone is responsible for passing items from the trolley into the room as required by the team
- This must be carried out in as contactless a manner as possible – finger-tip passing etc
- No disposable equipment is to leave the room/bay until bagged for disposal (excluding blood samples which are to be placed in a blue bag held by an external member of the team, they will complete a requisition form if required; The receiving/external person (someone who can do ABG testing) should take the ABG sample to the nearest ABG machine available to carry out the testing by wearing gloves and washing hands thereafter.)
- Non-disposable equipment – defibrillator, leads etc must be cleaned as per IPC instructions

Appendix 15 - End of Life – Symptom Control Guidelines

COVID-19: Symptom Control Guidelines and the Dying Patient

Patients may become rapidly symptomatic. Ensure these guidelines are initiated as soon as symptoms develop and please call Palliative Care if the patient does not respond to treatment described below

Indication	Medication	Dose	Guidance notes
PAIN **Not taking a regular opioid**	MORPHINE SULPHATE	2.5mg to 5mg **SC or IV** 1 to 4 hourly PRN **If the first dose is ineffective after 30 minutes:** 5mg to 10mg **SC or IV** 1 to 4 hourly PRN	**Contact Palliative Care for advice if:** ◦ the patient is taking a regular opioid and/or adjuvant analgesia ◦ has significant multi-morbidity e.g. renal or liver impairment ◦ symptoms not controlled after more than 2 doses ◦ the patient requires a syringe pump
	If morphine intolerance or allergy, or if eGFR is <30mL/min:		
	OXYCODONE	2.5mg to 5mg **SC** or **IV** from 1 to 4 hourly PRN **If the first dose is ineffective after 30 minutes** 5mg to 10mg **SC** or **IV** from 1 to 4 hourly PRN	
DELIRIUM	LEVOMEPROMAZINE	12.5mg to 25mg **SC** from 1 to 4 hourly PRN	**Consider Haloperidol if Levomepromazine not available** **Contact Palliative Care for advice if:** ◦ has significant multi-morbidity e.g. renal or liver impairment ◦ symptoms not controlled after more than 2 doses ◦ the patient requires a syringe pump
	If *not* effective:	25mg to 50mg **SC** (for severe delirium/agitation)	
AGITATION / RESTLESSNESS	MIDAZOLAM	5mg **SC** STAT	**Consider Lorazepm 1mg SL if midazolam not available** **Review reversible causes:** • For example: constipation, urinary retention, pain, withdrawal (medication, nicotine, alcohol), spiritual and psychological needs **Supportive measures:** • Assurance and explanation. Adequate positioning of the patient to aid breathing, oxygen if evidence of hypoxia **Contact Palliative Care for advice as for Delirium**
	If effective, continue with:	2.5mg to 5mg **SC** from 1 to 4 hourly PRN	
	If *not* effective: MIDAZOLAM	5mg to 10mg **SC** from 1 to 4 hourly PRN	
BREATHLESSNESS COUGH **Not taking a regular opioid**	**USE MORPHINE OR OXYCODONE AS FOR PAIN. *If not effective, add*:**		**Use of a FAN not recommended** **Supportive measures:** • Assurance and explanation. Adequate positioning of the patient to aid breathing, oxygen if evidence of hypoxia **Contact Palliative Care for advice if** ◦ the patient is taking a regular opioid ◦ symptoms not controlled after more than 2 doses
	MIDAZOLAM	2.5mg to 5mg **SC** from 1 to 4 hourly PRN **If the first dose is ineffective after 30 minutes:** 5mg to 10mg **SC** from 1 to 4 hourly PRN	

Discuss with the Specialist Palliative Care Team for St Helens, Knowsley via the Advice Line: 0844 225 0677

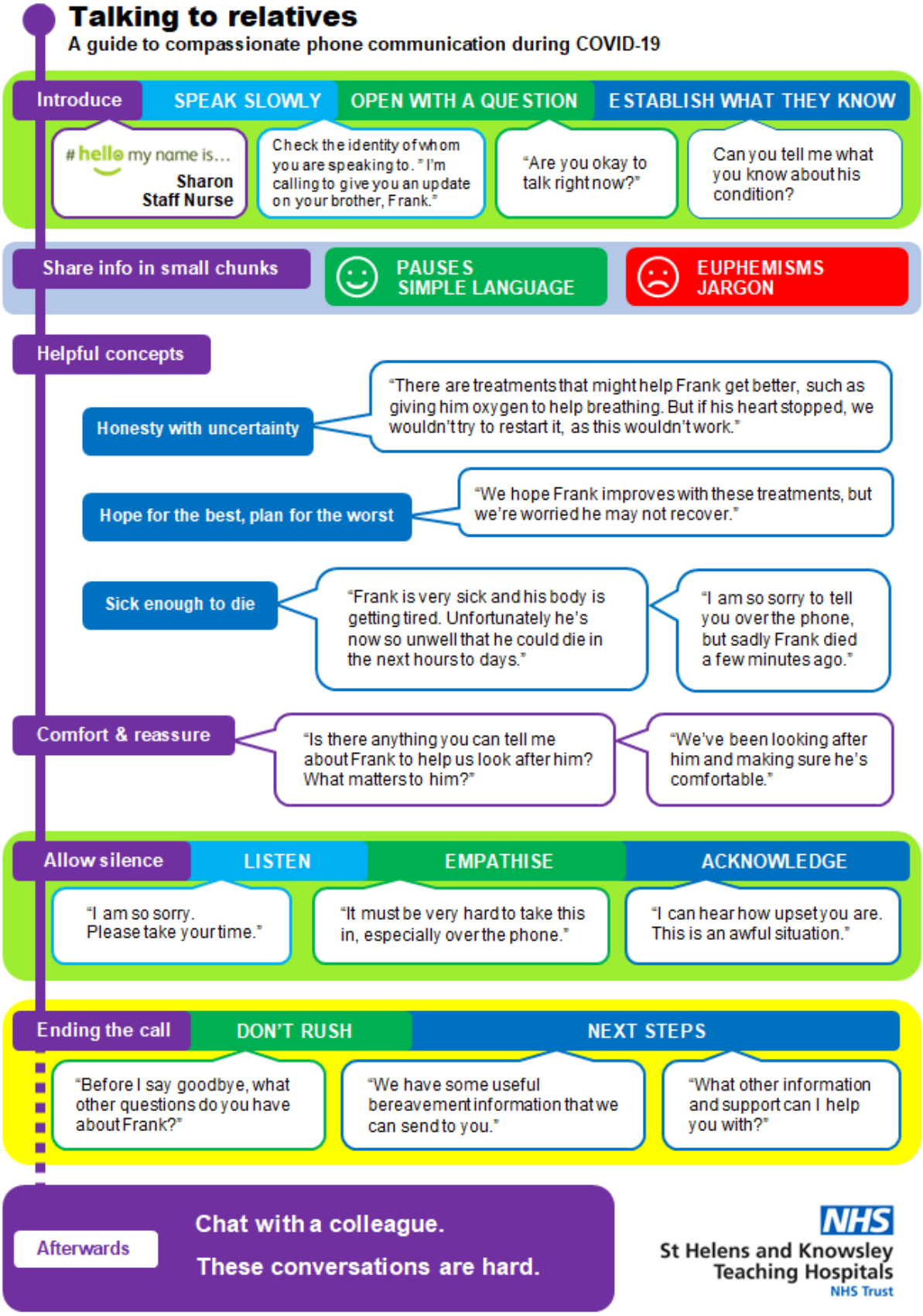
COVID-19: Symptom Control Guidelines and the Dying Patient

Patients may become rapidly symptomatic. Ensure these guidelines are initiated as soon as symptoms develop and please call Palliative Care if the patient does not respond to treatment described below

Indication	Medication	Dose	Guidance notes
PAIN **Not taking a regular opioid**	MORPHINE SULPHATE	2.5mg to 5mg **SC or IV** 1 to 4 hourly PRN **If the first dose is ineffective after 30 minutes:** 5mg to 10mg **SC or IV** 1 to 4 hourly PRN	**Contact Palliative Care for advice if:** ◦ the patient is taking a regular opioid and/or adjuvant analgesia ◦ has significant multi-morbidity e.g. renal or liver impairment ◦ symptoms not controlled after more than 2 doses ◦ the patient requires a syringe pump
	If morphine intolerance or allergy, or if eGFR is <30mL/min:		
	OXYCODONE	2.5mg to 5mg **SC** or **IV** from 1 to 4 hourly PRN **If the first dose is ineffective after 30 minutes** 5mg to 10mg **SC** or **IV** from 1 to 4 hourly PRN	
DELIRIUM	LEVOMEPROMAZINE	12.5mg to 25mg **SC** from 1 to 4 hourly PRN	**Consider Haloperidol if Levomepromazine not available** **Contact Palliative Care for advice if:** ◦ has significant multi-morbidity e.g. renal or liver impairment ◦ symptoms not controlled after more than 2 doses ◦ the patient requires a syringe pump
	If *not* effective:	25mg to 50mg **SC** (for severe delirium/agitation)	
AGITATION / RESTLESSNESS	MIDAZOLAM	5mg **SC** STAT	**Consider Lorazepm 1mg SL if midazolam not available** **Review reversible causes:** • For example: constipation, urinary retention, pain, withdrawal (medication, nicotine, alcohol), spiritual and psychological needs **Supportive measures:** • Assurance and explanation. Adequate positioning of the patient to aid breathing, oxygen if evidence of hypoxia **Contact Palliative Care for advice as for Delirium**
	If effective, continue with:	2.5mg to 5mg **SC** from 1 to 4 hourly PRN	
	If *not* effective: MIDAZOLAM	5mg to 10mg **SC** from 1 to 4 hourly PRN	
BREATHLESSNESS COUGH **Not taking a regular opioid**	**USE MORPHINE OR OXYCODONE AS FOR PAIN. *If not effective, add*:**		**Use of a FAN not recommended** **Supportive measures:** • Assurance and explanation. Adequate positioning of the patient to aid breathing, oxygen if evidence of hypoxia **Contact Palliative Care for advice if** ◦ the patient is taking a regular opioid ◦ symptoms not controlled after more than 2 doses
	MIDAZOLAM	2.5mg to 5mg **SC** from 1 to 4 hourly PRN **If the first dose is ineffective after 30 minutes:** 5mg to 10mg **SC** from 1 to 4 hourly PRN	

Discuss with the Specialist Palliative Care Team for St Helens, Knowsley via the Advice Line: 0844 225 0677

Appendix 16 – Talking to relatives



Appendix 17 – Difficult Conversations – Summary guidelines for staff dealing with COVID-19

These guidelines have been developed to help you have difficult conversations with patients and/or their families, carers or friends.

Conversations may involve issues such as "breaking bad news" or discussing the possibility of an uncertain recovery. EVERY consultation should be individualized and in the current climate should be under-pinned by a risk assessment.

You should ask yourself if a face to face conversation is essential, think creatively can you speak by phone or Skype

If a face to face is essential you should aim to time-limit the conversation to ensure your exposure is as short as possible

The flowchart below provides an "at a glance guide" to the steps you might be taking in preparing for and having these conversations.

1 - Setting the scene

- Arrange for adequate time keeping in mind a time limit for face to face conversations.
- Turn pager to silent mode or leave with colleagues.
- Choose the most private setting available.

2 – Preparation

- Review relevant clinical information.
- Take into account psychological /social issues.
- Mentally rehearse, identify words or phrases to avoid.
- Talk through your approach with a colleague.
- Try to pre-empt potential questions/ concerns and how you may answer.

3 - Communication: general principles

- Proceed at the patient's pace, share information in small chunks using pauses and simple language.
- Be frank but compassionate.
- Avoid euphemisms and medical jargon.
- Be aware of non-verbal communication and use of the space in the room.

4 - Starting the conversation

- Introduce yourself "Hello my name is……"

5 - Ask the patient and/or family member for their assessment of the situation and try to establish what they know

- "How are you finding the treatment?"

- "How do you feel your relative is responding to the treatment they are receiving?"

6 - Warn the patient or family that the patient's recovery is uncertain

- "I am very concerned about you Mr X. Even though we are doing (treatment /intervention) you are not picking up as quickly as we hoped."
- (To relatives/carers) "We are concerned with what is happening and are not sure which way things are going to go" "We hope X improves with these treatments but we're worried he/she may not recover."
- (To relatives /carers) "Our plan is to continue treatment X but as she/he is so ill we are concerned it may not work" "X is very sick and his/her body is getting tired. I am worried he/she is so unwell he/ she could die in the next hours or days.

7 - Outline the medical plan clearly and say when it will be reviewed

- Discuss current and on-going treatment plan.
- Explain what will be done should deterioration continue i.e. symptom relief, anything that the medical team would consider as beneficial at this time and focus on comfort for X.
- You may need to explain ceilings of treatment.
- Explain uDNACPR decisions e.g.:
  "Sometimes when people are as sick as you are things can happen quite suddenly, pause, your heart could stop beating, pause, if this was to happen we wouldn't try to restart it as this wouldn't work. I'm sure this is upsetting news so I will communicate this decision with my colleagues so that this conversation doesn't get repeated to you."

8 - Check the patient's understanding of news

- Repeat information if needed.
- Allow for silence and tears.
- Allow for denial.

9 - Plans for the future

- Be realistic about hope according to patient's goals.
- Acknowledge that you have divulged difficult information "I'm sure this has been very difficult for you to hear."
- Ascertain what is important to the patient "What is most important to you at the moment" "What is going round your head at the moment."

10 - Closing down, identifying support and preventing patients/carers being left vulnerable

- "Who do you have at home who you can talk to?"
- Summarise what has been discussed.
- "Shall we leave it there?"

- “If you have any questions we can always talk again.”

11 - Record in the patient’s healthcare record that the conversation has taken place

- Use the clinical case notes to record any important details which other members of the team need to know / ensure information is shared across the multi-disciplinary team.
- Please ensure that uDNACPR has been completed where appropriate.

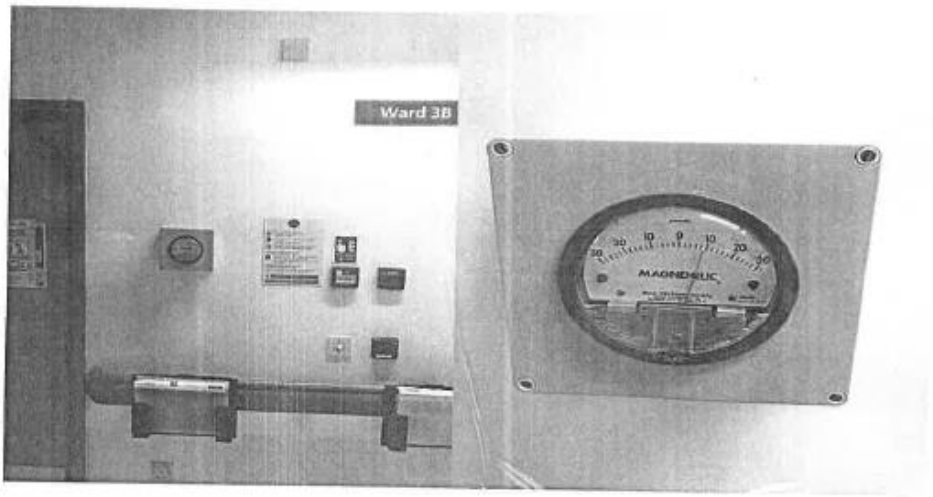
Appendix 18 – Isolation room daily check

VINCI FACILITIES

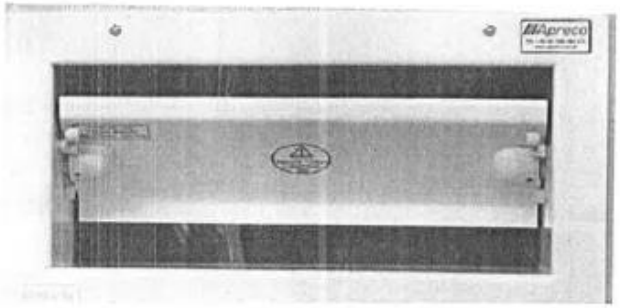
NHS
St Helens and Knowsley Teaching Hospitals
NHS Trust

Isolation Room Daily Check

- Daily checks of the magnehelic gauge are required to be undertaken by ward staff (one check per shift). Readings should then be recorded in the log book.
- The magnehelic gauge should read between 8-12 pascals. **Only if the gauge** is reading below 8 pascals, or above 20 pascals contact VINCI on extension 1188



- All doors should be closed, This will provide a safe ventilation criteria. It will also prevent an alarm sounding at the nurse station.
- Pressure stabilisers should also be in the open position when all doors are closed. (see image below) If they are not please contact VINCI on extension 1188



HM Government

NHS

Hospital discharge information

It is important that our hospitals are ready to look after people who contract coronavirus (COVID-19) and need hospital care. Due to these pressures, once you no longer need care in hospital, as decided by the health team looking after you, you will be discharged. You will not have a choice over your discharge, but it is always our priority to discharge people to a safe and appropriate place.

In most cases this will be to your home. You might need some extra support, for example with your care needs or shopping.

If you require more complex out of hospital care, this could be in another bed in the community, for example a residential nursing home.

Your needs and discharge arrangements will be discussed with you.

What is Coronavirus?

COVID-19 is a new illness that can affect the lungs and airways. It is caused by a virus called coronavirus.

There is currently no specific treatment and some people who contract the illness will need to be admitted to hospital.

You can find out more about coronavirus and the best ways to stop it spreading by visiting www.nhs.uk/coronavirus

Appendix 20 - HM Governance Your Hospital Discharge

HM Government

NHS

Your hospital discharge: going home

This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged from hospital as your health team have agreed that you are now able to return home.

Why can't I stay in hospital?

The health system is busy helping patients affected by coronavirus (COVID-19). This is a new illness that can affect the lungs and airways and some people who contract the illness will need to be admitted to hospital. It is important that our hospitals are ready to look after those people who need this hospital care.

Because of this, you will not have a choice over your discharge. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

What can I expect?

It is our priority to ensure that you are discharged safely from hospital and to the most appropriate available place.

Your health team will discuss discharge and transport arrangements with you (and a family member, friend or carer if you wish). If you require care and support when you get home, this will be arranged.

Any care provided will be free of charge for a period of time to support your recovery. After this time you may be required to contribute to the cost of your care.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can contact the ward that discharged you via main switch

To find out more about coronavirus (COVID-19) and find out how to avoid catching or spreading it, visit www.nhs.uk/coronavirus

HM Government

NHS

Your hospital discharge: another place of care

This leaflet explains why you are being discharged from hospital and what you might expect after your discharge.

Why am I being discharged from hospital?

You are being discharged as your health team have agreed that you are now able to continue your recovery in another care setting, outside of hospital.

Why can't I stay in hospital?

The health system is busy helping patients affected by coronavirus (COVID-19). This is a new illness that can affect the lungs and airways and some people who contract the illness will need to be admitted to hospital. It is important that our hospitals are ready to look after those people who need this hospital care. Because of this, you will not have a choice over your discharge. You will not be able to remain in hospital if you choose not to accept the care that is being offered to you.

It is our priority to ensure that you are discharged safely from hospital and to the most appropriate available place.

What can I expect?

Your discharge and transport arrangements will be discussed with you (and a family member or carer if you wish) and you will be discharged with the care and support you need to a bed in the community. The care provided will be free of charge for a period of time to support your recovery. After this time you may be required to contribute to the cost of your care.

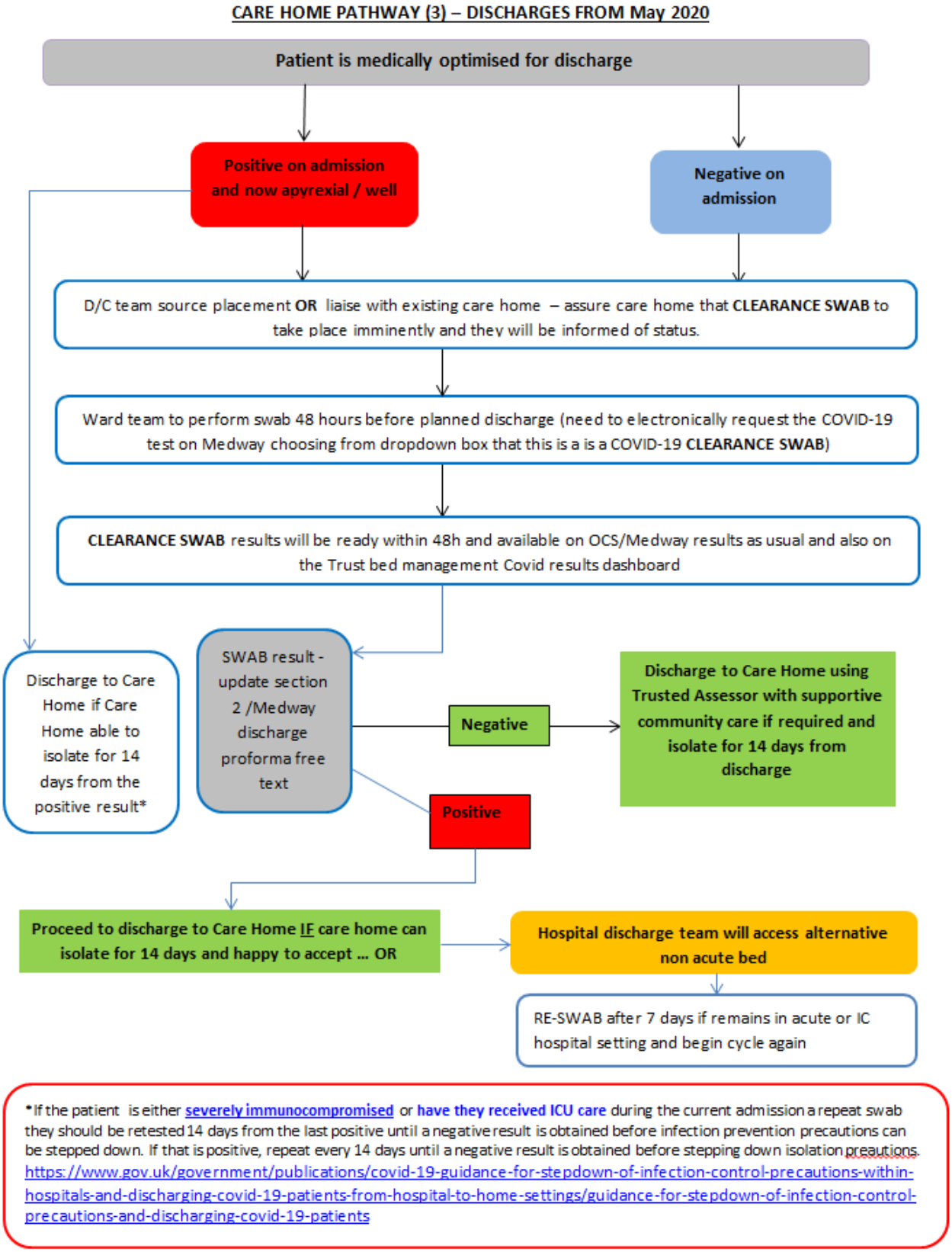
It is possible that you may be moved more than once after your discharge. This is because we will be trying to find the best place for your long term care. Your health team are here to answer any questions you might have.

Who can I contact?

After you have been discharged, if you have any concerns or need to speak to someone about your care, you can get in touch with the ward that discharged you via main switch

To find out more about coronavirus (COVID-19) and find out how to avoid catching or spreading it, visit www.nhs.uk/coronavirus

Appendix 21 – Discharge to Care Homes



Appendix 22 – Guidance note to complete a grab and go guide form

COVID-19 Grab and Go guide

Guidance notes

Use these guidance notes to help you complete the Grab and Go guide form

The Grab and Go guide has been designed in partnership with people with learning disabilities, families and nurses.

It gives the information that doctors and nurses will need if you go to hospital because of COVID-19 and, for example, are struggling to breathe.

It is not a replacement for the everyday, detailed hospital passport. You should update your hospital passport and take that to hospital along with the Grab and Go guide if you need to be admitted.

If you haven't got a hospital passport you can download your local passport by searching on the internet for (hospital name) hospital passport or choose one you like from here:

https://www.autism.org.uk/about/health/hospital-passport.aspx

https://www.mencap.org.uk/advice-and-support/health/health-guides

If you need help completing the form please ask:

- someone who knows you well like a family member or support worker
- a social worker
- a support group you are in touch with
- sign up for a webinar with Learning Disability England. You can sign up at https://www.learningdisabilityengland.org.uk/what-we-do/events/lde-webinars or email info@LDEngland.org.uk to suggest a webinar topic or get a recording of any previous ones.

How to complete the Grab and Go guide form

The information in the form must be short and clear. Everyone is different but we have given some examples to show what kind of information is useful in answer to each question in the form.

You must fill in the form to show the best way you can be supported (or the person you are supporting).

I am able to indicate YES and NO to your questions by: The doctors need to know if you can indicate yes and no without speaking. Nobody with serious breathing difficulties can speak easily. If you have a unique way of doing this you must write it clearly, for example: • *I sign yes by clenching my right hand.* • *I indicate no by sticking my tongue out.*
I have previously had the following breathing problems (asthma / history of infections etc): The doctors need to know your history so they can give you the right treatment. If you have had breathing problems in the past, list the issues you have had. For example: *asthma, lots of chest infections, pneumonia,* etc.
Any other things that may compromise my airway, for example past surgery: The doctor needs to know about any conditions or past surgery that might affect your airways to treat you safely. For example: *smaller airways because of a genetic condition like Down's syndrome, past surgery, tracheotomy, a stomach procedure like fundoplasty* (you or the people who support you will know if you have any problems with your airways).
What you need to know about my other past and current health, for example diabetes, epilepsy, etc: Your medical history is important. List any health conditions you have now or have had in the past. Include surgery you have had.

continues…

I usually take the following medication (include dose of tablets or liquid, or any other way I take medicine):

The doctors need to know this to make sure the medicine they give you works with the medicine you are already taking. Use the name and dose details that are on the packaging. If you can, take all your medication with you in a clear plastic bag.

If you need any support to take medication, describe that support clearly. For example:

- *I need my tablet to be crushed in a spoonful of jam.*
- *Tip my tablets into my mouth one at a time, hand me a glass of juice and stay with me until I have swallowed them. I might need a whole glass of juice.*

Swallowing and oral care, including how I drink (for example, small amounts or thickened or cooled or any other way I need to take it):

If you have difficulties drinking and swallowing, give clear support instructions to avoid choking and becoming dehydrated. For example:

- *I need 4 teaspoons of thickener in a cup and to be fed this one teaspoon at a time. It will take me 15 minutes to drink a cup of tea.*
- *I need my drink in a sippy cup. Please remind me to drink every five minutes to keep me hydrated.*

This is how people usually know I'm in pain:

If you are not able to say when you are in pain and where it hurts, it is important to be specific so that doctors and nurses know when something is wrong. For example:

- *If I say I've got a headache, ask me to point to where it is.*
- *I'm usually in pain when I fidget a lot.*
- *I might be in pain if I go quiet and avoid eye contact.*

If I'm worried or upset I may:

If you can't say what's wrong, how might you show you are worried or upset? How can someone help or reassure you?

Give clear descriptions of what might happen and what to do about it. For example:

- *If my eyes are darting around and teary, sit with me and let me know what is going on. Ask if I would like to listen to my playlist. Help me to phone or Facetime my mum.*
- *If I try to leave, I might be feeling overwhelmed. Stay with me and offer quiet reassurance. If possible, lower the lights and reduce distractions.*

continues…

I communicate by:

Good communication is very important. What do people need to know? For example:

- *It takes me a while to understand information and respond. Give me 30 seconds to reply (that feels like ages).*
- *Use easy words and short sentences. Give me information in small chunks.*
- *It's complicated – check my detailed hospital/communication passport.*

My hearing and my eyesight (for example, hearing aids, glasses or anything else you need to help you hear or see):

Is there anything people need to know that will help you understand each other? For example:

- *My hearing isn't brilliant especially when there is background noise. So get my attention before you start speaking to me.*
- *I need information in large font (say what size if you know).*
- *Please clean my glasses every morning and evening.*

Top tips for family and paid carers

- Laminate, double laminate or put the Grab and Go guide in a sealed plastic bag.
- Find out the name and contact details of the Learning Disability Liaison Nurse at your hospital, write it down somewhere safe in case you need it.
- Check your local hospital trust's policy about allowing carers to be present if a person with a learning disability or autism is admitted to hospital with coronavirus.
- Family carers – make plans for if you get unwell yourself. Make sure:
  - You have a list of phone numbers of people who can help out in an emergency.
  - You have enough supplies for two weeks.
- Put a hospital bag together now for the person with a learning disability or autism, you won't have time in an emergency. Include:
  - Laminated COVID-19 Grab and Go guide.
  - Ordinary hospital passport.

  - Phone and charger, headphones and a playlist of favourite music.
  - Toothbrush, soap and towel and change of clothes/pyjamas.
  - Prepare a similar bag for yourself, include money to buy food and drink for yourself (carers aren't fed).

- Look after your own health, do something, however little, for yourself every day.
- Stay in touch with friends and family by phone.
- Check https://www.learningdisabilityengland.org.uk/ for updates and easy information.

Appendix 23 – Grab and Go Guide Form

COVID-19 Grab and Go guide Form

I have a learning disability or I am autistic

- **This guide is really important during the COVID-19 pandemic**
- The Human Rights Act means that staff in the NHS must respect and protect my human rights when making decisions about my care even in the time of the COVID-19 pandemic.
- Decisions about treatment should be made on an individual basis and in consultation with families, taking into account my usual health. Decisions about my treatment and resuscitation should not be made based on my learning disability or autism or the Clinical Frailty Scale.
- All decisions must be made in accordance with the principles of the Mental Capacity Act.

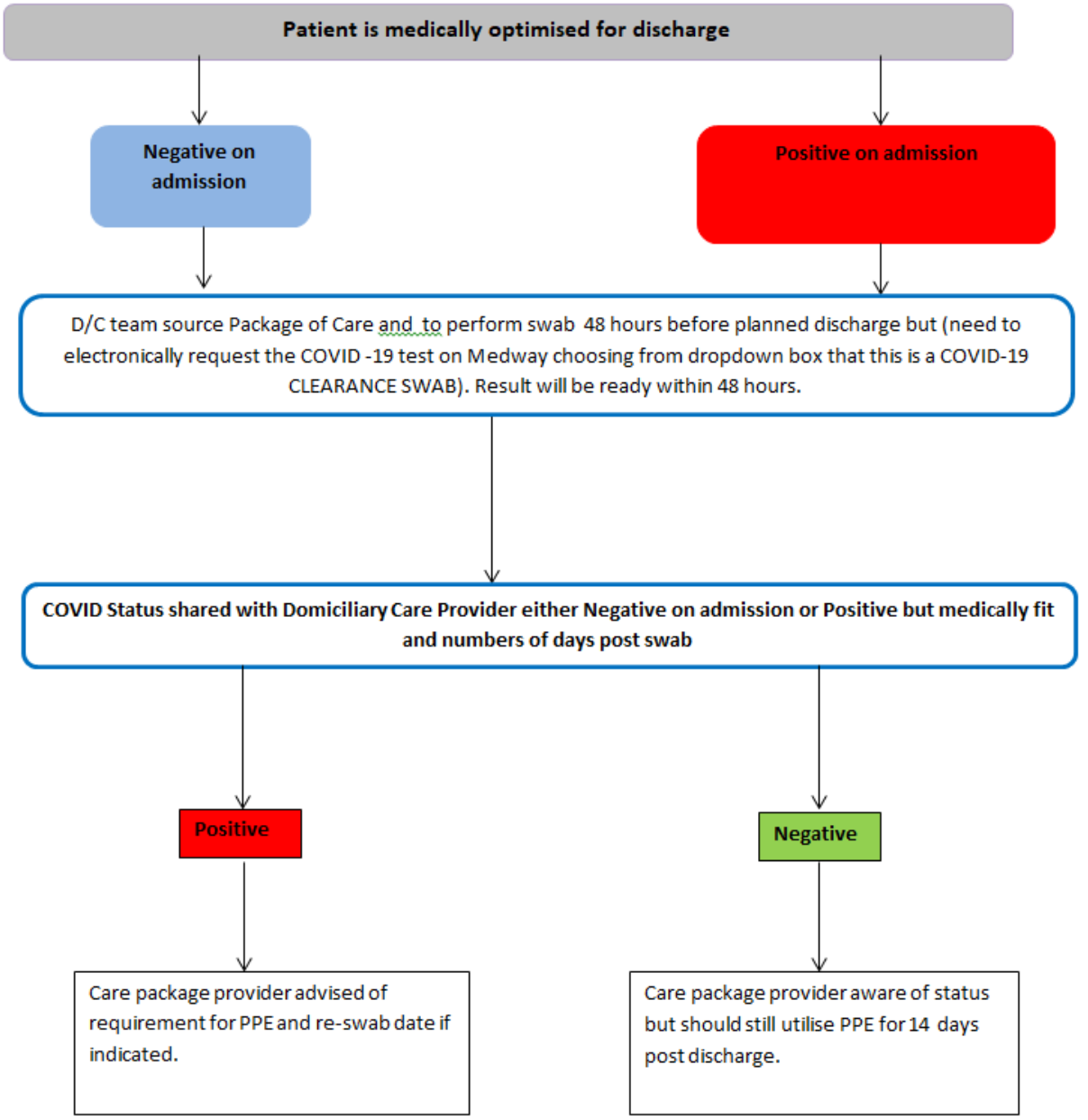
My name is:			
I like to be called:		**Date of birth:**	
My NHS Number is:			
My next of kin/ representative:			
Their phone number:			
I am able to indicate YES and NO to your questions by:			
I have previously had the following breathing problems (asthma/ history of infections, etc):			
Any other things that may comprise my airway, e.g. past surgery:			

What you need to know about my other past and current health (e.g. diabetes / epilepsy):	
I usually take the following medication (include dose of tablets or liquid or any other way I take medicine):	
This is the help I need to understand what is happening and the support I may need with any treatment:	
Swallowing and oral care, including how I drink (e.g. small amounts or thickened or cooled, or any other way I need to take it):	☐ **No issues** ☐ **Detail below**
This is how people usually know if I am in pain:	
If I'm worried or upset I may:	
I communicate by:	
My hearing and my eyesight (e.g. hearing aids, glasses or anything else I need to help me hear or see):	

This should be read in conjunction with my hospital passport

Appendix 24 - Domiciliary Care Pathway

Domiciliary Care PATHWAY – DISCHARGES FROM SHK APRIL 2020



If the patient is either **severely immunocompromised** or have they received ICU care during the current admission a repeat swab they should be retested 14 days from the last positive until a negative result is obtained before infection prevention precautions can be stepped down.

https://www.gov.uk/government/publications/covid-19-guidance-for-stepdown-of-infection-control-precautions-within-hospitals-and-discharging-covid-19-patients-from-hospital-to-home-settings/guidance-for-stepdown-of-infection-control-precautions-and-discharging-covid-19-patients#immsupp

Appendix 25 – Discharge from A&E or GP consultant Patient Advice Leaflet

COVID-19 Infection

Discharge from A&E or GP consultation Patient advice leaflet

NHS

Information on COVID-19

What is COVID-19?

COVID-19 is an infectious disease caused by a newly discovered coronavirus strain that first emerged in China in December 2019.

In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe disease.

The new coronavirus outbreak (COVID-19) was declared a pandemic by the World Health Organisation on 11 March 2020.

The most important symptoms of coronavirus (COVID-19) are recent onset of any of the following:

- a new continuous cough
- a high temperature
- loss or change to your sense of smell or taste

For most people COVID-19 will be a mild illness. However if you have any of the symptoms listed you should self isolate at home.

After your visit to A&E or GP

You have been identified as having symptoms of COVID-19 infection

You need to go home and self isolate for seven days from the onset of your symptoms. If you live with others they need to isolate for 14 days from the onset of your illness. If anyone else in the household starts displaying symptoms, they need to stay at home for 7 days from when the symptoms appeared, regardless of what day they are on in the original 14 day isolation period.

What happens after my visit to A&E or my GP?

At this point you are considered well enough to manage your symptoms at home. You will have been prescribed medication if required. If you did not require any prescribed medication then you should be able to manage your symptoms yourself. Ensure you stay hydrated and take paracetamol if you have a temperature. To aid recovery, try to avoid spending long periods of time lying flat in bed, trying sitting up or in a chair, or moving around at home.

You may have a cough or feel tired or breathless for several weeks despite the COVID-19 having cleared, however if the symptoms persist please call your GP for a review.

If you are still struggling to manage your symptoms at home, or your condition gets worse please contact:

_____

Your care team may wish to give you some specific guidance below:

_____

_____

_____

_____

For a medical emergency, dial 999 immediately

www.gov.uk/coronavirus

COVID-19 Infection

Discharge from A&E or GP consultation Patient advice leaflet

NHS

When you get home

Can I spread COVID-19 to friends and family?

There is a risk that other members of your household or others that you have been in close contact with over the previous 2 weeks have been exposed to the virus but it is possible that they have not. Therefore each of you should follow the government's isolation guidance:
https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

Please continue to monitor this guidance as it is updated regularly as more evidence becomes available. This will ensure you have the most up to date information on when it is safe to end your self-isolation (and household isolation if you live with others).

Please note that a persistent cough alone does not mean someone must continue to self-isolate beyond the duration advised by the government.

Can I get COVID-19 again?

If you have tested positive for COVID-19, you will probably have developed some short term immunity to coronavirus. However, if another person in your household develops symptoms and they have not previously tested positive, then they need to isolate along with all other members of the household except for you.

Do I need to wear a facemask?

You may be issued with a mask to wear as you travel home. Find the latest guidance regarding face masks here:
https://www.gov.uk/government/publications/staying-safe-outside-your-home

What if I feel unwell again?

Monitor your symptoms regularly and if you have any concerns go to:
https://www.nhs.uk/conditions/coronavirus-covid-19/check-if-you-have-coronavirus-symptoms/

Protecting yourself and others from coronavirus

Wash your hands frequently and thoroughly, for at least 20 seconds. Use alcohol-based hand sanitizer if soap and water aren't available.

Cover your mouth and nose with a tissue when you cough or sneeze and then throw the tissue in the bin and wash your hands. Alternatively, cough or sneeze into your elbow

Avoid touching your eyes, nose and mouth with unwashed hands

Avoid close contact with people who are sick, sneezing or coughing.

www.gov.uk/coronavirus

Appendix 26 – Discharge from Hospital Stay Patient Advice Leaflet

COVID-19 Infection

Discharge from hospital stay
Patient advice leaflet

NHS

Information on COVID-19

What is COVID-19?

COVID-19 is an infectious disease caused by a newly discovered coronavirus strain that first emerged in China in December 2019.
In humans, several coronaviruses are known to cause respiratory infections ranging from the common cold to more severe disease. The new coronavirus outbreak (COVID-19) was declared a pandemic by the World Health Organisation on 11 March 2020. The most important symptoms of coronavirus (COVID-19) are recent onset of any of the following:

- a new continuous cough
- a high temperature
- loss or change to your sense of smell or taste

For most people COVID-19 will be a mild illness. However if you have any of the symptoms listed you should self isolate at home.

If I have COVID-19 what does that mean?

The severity and duration of symptoms for people who have COVID-19 can also vary although symptoms are reported to reduce in most cases within 7 days of symptom onset.

Most people who have COVID-19 will not require admission to hospital and can be sent home to recover naturally. Others will require monitoring in hospital and a small proportion will require treatment in intensive care.

Leaving hospital after a COVID-19 infection

What happens once I leave hospital?

At this point you are considered well enough to leave hospital. You will have been prescribed medication if required. If you did not require any prescribed medication then you should be able to manage your symptoms yourself at home. Ensure you stay hydrated and take paracetamol if you have a temperature. To aid recovery, try to avoid spending long periods of time lying flat in bed, trying sitting up or in a chair, or moving around at home.

You may have a cough or feel tired or breathless for several weeks despite the COVID-19 having cleared, however if the symptoms persist please call your GP for a review.

If you are still struggling to manage your symptoms at home, or your condition gets worse please contact:

_____

Your care team may wish to give you some specific guidance below:

_____

_____

_____

_____

For a medical emergency, dial 999 immediately

www.gov.uk/coronavirus

COVID-19 Infection

Discharge from hospital stay
Patient advice leaflet

NHS

When you get home

Can I spread COVID-19 to friends and family?

There is a risk that other members of your household or others that you have been in close contact with over the previous 2 weeks have been exposed to the virus but it is possible that they have not. Therefore each of you should follow the government's isolation guidance:
https://www.gov.uk/government/publications/covid-19-stay-at-home-guidance/stay-at-home-guidance-for-households-with-possible-coronavirus-covid-19-infection

Please continue to monitor this guidance as it is updated regularly as more evidence becomes available. This will ensure you have the most up to date information on when it is safe to end your self-isolation (and household isolation if you live with others).

Please note that a persistent cough alone does not mean someone must continue to self-isolate beyond the duration advised by the government.

Can I get COVID-19 again?

If you have tested positive for COVID-19, you will probably have developed some short term immunity to coronavirus. However, if another person in your household develops symptoms and they have not previously tested positive, then they need to isolate along with all other members of the household except for you.

Do I need to wear a facemask?

You may be issued with a mask to wear as you travel home. Find the latest guidance regarding face masks here:
https://www.gov.uk/government/publications/staying-safe-outside-your-home

What if I feel unwell again?

Monitor your symptoms regularly and if you have any concerns go to:
https://www.nhs.uk/conditions/coronavirus-covid-19/check-if-you-have-coronavirus-symptoms/

Protecting yourself and others from coronavirus

Wash your hands frequently and thoroughly, for at least 20 seconds. Use alcohol-based hand sanitizer if soap and water aren't available.

Cover your mouth and nose with a tissue when you cough or sneeze and then throw the tissue in the bin and wash your hands. Alternatively, cough or sneeze into your elbow

Avoid touching your eyes, nose and mouth with unwashed hands

Avoid close contact with people who are sick, sneezing or coughing.

www.gov.uk/coronavirus