

## Inpatient wards (guidance for clinicians) – End of life care during the COVID-19 pandemic.

*Please note that this advice is for clinicians. It describes situations and procedures which may be distressing for the general reader. All questions within each section are linked to each other and should be read in conjunction. Below each question are the weblinks to the sources of evidence to support the guidance recommendation.*

Clinical question	Guidance
<p><b>How do we best manage end of life care in suspected/confirmed COVID-19 positive patients on the ward?</b></p> <p><a href="#">[link1]</a>  <a href="#">[link2]</a>  <a href="#">[link3]</a>  <a href="#">[link4]</a>  <a href="#">[link5]</a></p>	<p>In general, the treatment of physical symptoms in patients suffering from COVID-19 may be orientated towards:</p> <ul style="list-style-type: none"> <li>• Supportive measures – for example, provision of fluids and/or oxygen.</li> <li>• Targeted treatment – for example, provision of antibiotics to treat pneumonia.</li> <li>• Organ support – for example, ventilator support, renal replacement therapy, etc.</li> </ul> <p>These are aimed at preserving and prolonging life. It is important to remember that most people with COVID-19 will survive and recover.</p> <p>Patients also have the option to complete a ‘<a href="#">COVID-19 Advance Care Plan</a>’ – a summary of preferences for a patient’s care if they develop severe COVID-19 symptoms. (Note that this does not replace an advance care plan, advance decision to refuse treatment (ADRT) or a ‘living will’. Any decision to refuse advance treatment would need to be made separately. Further details on ADRT or DNACPR can be found <a href="#">here</a>).</p> <p>However, <b>if there is a risk of acute deterioration or cardiac arrest, this should be identified early</b>. Appropriate steps to prevent cardiac arrest and avoid unprotected CPR should be taken. Use of physiological track-and-trigger systems (e.g. NEWS2) will enable early detection of acutely ill patients.</p> <p><b>Patients for whom a ‘do not attempt cardiopulmonary resuscitation’ (DNACPR) and/or other similar decision is appropriate should also be identified early.</b></p> <p>Where CPR is appropriate and required, follow <a href="#">specific guidance for resuscitation procedures in the context of COVID-19</a>.</p> <p>For those who are dying as a consequence of COVID-19 and/or who do not wish to have active or invasive treatments, <b>the switch in focus to high quality, compassionate, palliative care at the end of their life is equally important.</b></p> <p>In this case, consider whether <b>referral to specialist palliative care is appropriate if:</b></p> <ul style="list-style-type: none"> <li>• The patient is <b>already known to specialist palliative care</b>.</li> <li>• <b>Symptoms are not responding to clinical guidelines</b>, including when a patient is imminently dying.</li> <li>• <b>Complex symptoms</b> require specialist advice.</li> <li>• <b>There is a decision not to escalate treatment</b> in the face of deterioration or uncertain prognosis.</li> </ul>

- **There are other complexities**, for example, young children or other dependents who rely on the patient.

Consider management of the most common symptoms of COVID-19:

- breathlessness
- cough
- fever
- delirium

according to PHE guidance

Management of other symptoms, including pain, should be treated in accordance with local guidelines and policies.

Some medication strategies for symptom management may not be possible or may be difficult to manage on mental health wards (for example subcutaneous infusions via a syringe driver). Consider **alternative routes of administration or medication regimes** (see [an example of guidance in Oxford University Hospitals Health NHS Foundation Trust](#)).

The summary below is derived from the Association for Palliative Medicine of Great Britain and Ireland (22/03/20). Information from WHO guidance (24/03/20) is contained in footnote 1.

**In summary:**

**General points**

- The utmost **consideration and care must be given to the safety of other patients, visitors and staff** by maintaining infection control procedures at all times.
- **Bereavement Offices, mortuary teams and Coroners Offices** can be contacted for additional support and guidance.
- **Clear and complete documentation** should be completed.
- **Open, honest and clear communication** with colleagues and the deceased's family/significant others.
- **Consider the emotional/spiritual/religious needs** of the deceased & their family/significant others.
- Consider using the [SWAN model of care](#).

**Before death**

- **Decisions regarding escalation of treatment** should be made on a case by case basis.
- **Take into account relevant ethical considerations** as well as **patient and family preferences and wishes**.
- **Consider appropriate symptom control and medication** (see the [RGCP website](#) for resources).
- If death is imminent and the family wish to stay with their loved one **staff must advise them that they should wear full PPE**.

**At the time of death**

- **Inform and support the family and/or next of kin**.
- **Appropriately trained professional should complete the Verification of Death** process wearing PPE and maintaining infection control measures.
- **Appropriate doctor completes MCCD** (Medical Certificate of Cause of Death) as soon as possible.
  - COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the MCCD.
  - COVID-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009.

- that COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status.
- If the deceased is to be cremated, **doctors will not be able to physically see the deceased due to the risk of COVID-19 infection.**
- Where next of kin or a possible informant are following self-isolation procedures, **arrangements should be made for an alternative informant who has not been in contact with the patient to collect the MCCD** and attend to give the information for the registration.
- If referral to HM Coroner is required for another reason, **a telephone conversation should take place as soon as possible with HM Coroner's Office** and guidelines within Care after Death policy should be followed alongside this guidance.
- **Mementoes/keepsakes (e.g., locks of hair, handprints, etc) should be offered and taken at the time of care after death.** These cannot be offered or undertaken at a later date. Mementoes in care after death can be provided, on the ward. **These should be placed in a sealed bag and the relatives must not open these before 7 days.**
- **Full PPE should be worn for performing physical care after death.**
- Moving a recently deceased patient onto a hospital trolley for transportation to the mortuary might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk – **a body bag should be used for transferring the body and those handling the body at this point should use full PPE.**
- **The outer surface of the body bag should be decontaminated immediately** before the body bag leaves the anteroom area. This may require at least two individuals wearing PPE.
- **Registered nurses on the ward should complete Notification of Death forms fully** including details of COVID-19 status and place in pocket on the body bag along with the body bag form, ID band with patient demographics placed through loops in body bag zip, body bag wiped over with, for example, Chlor-Clean and porters contacted to transfer to mortuary.
- **The deceased's property should be handled with care as per policy by staff using PPE** and items that can be safely wiped down such as jewellery should be cleaned with, for example, Chlor-Clean.
- **Clothing, blankets, etc., should ideally be disposed of.** If they must be returned to families they should be double bagged and securely tied and families informed of the risks.
- **Hospital linen should be treated as Category B laundry.**
- **Property bags** should still be used for property that has been properly cleaned / bagged.
- **Organ/tissue donation is highly unlikely** to be an option as per any other active systemic viral infection.

**Footnote 1:** General considerations after death from the [WHO](#) (24/03/20).

- To date there is **no evidence of persons having become infected from exposure to the bodies of persons who died from COVID-19.**
- **Hasty disposal** of a dead from COVID-19 **should be avoided.**
- **Authorities should manage each situation on a case-by-case basis**, balancing the rights of the family, the need to investigate the cause of death, and the risks of exposure to infection.
- Ensure that personnel who interact with the body (health care or mortuary staff, or the burial team) **apply standard precautions, including hand hygiene** before and after interaction with the body, and the environment; **and use appropriate PPE according to the level of interaction with the body.**
- If there is a risk of splashes from the body fluids or secretions, personnel should use **facial protection, including the use of face shield or goggles and medical mask.**
- **Ensure that any body fluids leaking from orifices are contained.**
- **Keep both the movement and handling of the body to a minimum.**
- Wrap the body in cloth and transfer it as soon as possible to the mortuary area.
- There is no need to disinfect the body before transfer to the mortuary area.

- Body bags are not necessary, although they may be used for other reasons (e.g. excessive body fluid leakage).
- No special transport equipment or vehicle is required.