# WAHT Guidance on Escalation of Respiratory Support in Patients with COVID-19

- This guidance should be read alongside the WAHT COVID CPAP Guideline and WAHT Policy: Ethical decision making in the COVID-19 Pandemic (http://www.treatmentpathways.worcsacute.nhs.uk/EasysiteWeb/getresource.axd?AssetID=207581&servicetype=Attachment
- CPAP use in patients with COVID-19 must be restricted to those most likely to benefit
- ALL patients must have a ceiling of care (including what level of respiratory support is appropriate) documented and a RESPECT form completed
- Patients will fall outside of this guidance and on call/ward teams are encouraged to contact the respiratory/ITU teams when there is uncertainty
- This guidance may change with further experience/evidence
- Referral for CPAP may start to be considered when a patient requires ≥ 40% fi02 to maintain 02 sats ≥ 94%

## Age < 65 years

Assess co-morbidities

**Discuss with Respiratory or Intensive Care Team** unless clear indication against CPAP

## Age > 65 years

**Assess co-morbidities and Clinical Frailty Score** 

The CFS should be based on the patients usual level of function in the last month. It is not valid in patients with longstanding disability

### CFS 1-4

Discuss with Respiratory or Intensive Care

Team unless clear indication against CPAP

**ALL patients considered for CPAP** (including those not appropriate for intubation) MUST be reviewed by/ discussed with a respiratory physician or ITU prior to transfer to ARU/Ward 1. Out of hours, the ITU registrar or consultant is required to phone the ARU/Ward 1 nurse in charge to arrange the admission - referrals cannot be taken from other sources.

## Contact Details WRH

RESP (9-5 Mon to Fri/Sat am)

Nurse Prac - Bleep 189 SpR (Mon to Fri) - Bleeps 179, 134, 129 Consultant available on ARU ITU - Bleep 702

# Contact Details Alex

RESP(9-5 Mon to Fri/Sat am) Consultant on Ward 1 ext 43855 ITU - bleep 0933

#### CFS 5 or significant co-morbidities

CPAP may be considered however if any of the following are present, the patient is unlikely to tolerate or benefit from CPAP and therefore oxygen therapy should be the ceiling of care.

- Delerium
- Confusion or dementia with loss of mental capacity to understand CPAP treatment and decisions
- Unable to sit up on the edge of bed unaided
- Unable to lie on side and change sides independently in bed
- GCS < 15
- Systolic BP < 90
- >2 acute organ failures
- Significant comorbidities making CPAP

Please note - If the patient has had major surgery during the current admission please contact the ITU team rather than respiratory for discussions related to escalation of respiratory support.

#### CFS 6 - 9

Ward based oxygen therapy is usually the ceiling of care

# **Prognosis and Patient Expectations when CPAP** is the ceiling of respiratory support

Patients must be involved in the decision making process however realistic expectations must be carefully explained.

Patients with respiratory failure secondary to COVID-19 requiring CPAP respiratory support have a poor prognosis.

Patients and their families must be counselled that after commencing CPAP, if there is deterioration eg increasing FiO2/work of breathing within 24 hours OR lack of improvement within 3 days, withdrawal of CPAP and palliation of symptoms is likely.

# Clinical Frailty Scale\*



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



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



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



 $\label{prop:continuous} \textbf{Vulnerable} - \textbf{While} \ \textbf{not} \ \textbf{dependent} \ \textbf{on} \ \textbf{others} \ \textbf{for}$ daily help, often symptoms limit activities. A common complaint is being "slowed up", and/or being tired during the day.



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



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



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

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



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

# Scoring frailty in people with dementia

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

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

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

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

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