**Standard Operating Procedure:**

**Guidance on Clinical management of a patient with suspected or confirmed COVID-19 on a psychiatric inpatient ward**

1. **Introduction**

Coronavirus disease 2019 (COVID-19) is a respiratory tract infection caused by a newly emergent coronavirus. While most people with COVID-19 develop only mild or uncomplicated illness, approximately 14% develop severe disease that requires hospitalisation and around 5% require admission to an intensive care unit.In severe cases, COVID-19 can be complicated by the acute respiratory distress syndrome (ARDS), sepsis and septic shock, multiorgan failure, including acute kidney injury and cardiac injury. Older age and co-morbid disease have been reported as risk factors for death.

The guidance in this document is taken from the: World Health Organisations clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected, Update 13/03/2020, and designed in collaboration with the Leeds Teaching Hospitals Trust.

1. **Purpose/Scope**

This document will inform staff of the clinical management of a patient with suspected or confirmed COVID-19 on a psychiatric inpatient ward.

On all wards within the Leeds and York Partnership NHS Trust we anticipate cases of COVID 19 and it is critical all staff are aware how to manage mild cases on the ward and when to refer patients on to care at local acute hospital trusts.

1. **Process and Management**

**Clinical syndromes associated with COVID-19:**

**Mild Illness**: Patients uncomplicated upper respiratory tract viral infection may have non-specific symptoms such as fever, fatigue, cough (with or without sputum production), anorexia, malaise, muscle pain, sore throat, dyspnea, nasal congestion, or headache. Rarely, patients may also present with diarrhoea, nausea, and vomiting.The elderly and immunosuppressed may present with atypical symptoms.

**Severe Pneumonia:** fever or suspected respiratory infection, plus one of the following: respiratory rate > 30 breaths/min; severe respiratory distress; or SpO2 ≤ 93% on room air.

**Acute respiratory distress syndrome:** Onsetwithin 1 week of a known clinical insult or new or worsening respiratory symptoms. Chest imaging(radiograph, CT scan, or lung ultrasound): bilateral opacities, not fully explained by volume overload, lobar or lung collapse, or nodules.

**Sepsis:** Life-threatening organ dysfunction caused by a dysregulated host response to suspected or proven infection. Signs of organ dysfunction include: altered mental status, difficult or fast breathing, low oxygen saturation, reduced urine output, fast heart rate, weak pulse, cold extremities or low blood pressure, skin mottling, or laboratory evidence of coagulopathy, thrombocytopenia, acidosis, high lactate, or hyperbilirubinemia.

**Septic shock:** Adults: persisting hypotension despite volume resuscitation, requiring vasopressors to maintain MAP MAP ≥ 65 mmHg and serum lactate level > 2 mmol/L.

**Clinical management of suspected COVID 19 on mental health inpatient units:**

When a person with suspect or confirmed COVID 19 is present on a mental health ward, they should be nursed in isolation or a specified COVID 19 clinical area, in line with trust standard operating procedures.

Leeds and York Partnership NHS Foundation Trust Guidance for isolation procedures and personal protective equipment (PPE) and swabbing should be adhered to and can be found in the following link:

 <http://staffnet2/clinicalstaff/infectioncontrol/Pages/Coronavirus-Update.aspx>

**Guiding principles of ward based management:**

* Clear lines of communication should be maintained and communications via SBAR format both when ward nurses escalate care to ward doctors, and when ward doctors escalate care to general hospital doctors –appendix 1.
* Seek help early.
* Discuss the situation and plans family members, ward managers and the patient’s responsible clinician at the earliest possible opportunity.
* Treat suspected cases as you would confirmed cases.
* If there is a high clinical suspicion of COVID-19, treat as such, evenwhen upper respiratory tract COVID-19 PCR testing is negative (currently swap sensitivity is reported at around 80%, repeat testing may be required to account for false negative tests).

**Management of mild COVID 19 – Symptomatic treatment and monitoring.**

* Patients with mild disease do not require hospital interventions, but isolation is necessary to contain virus transmission.
* Provide patients with mild symptomatic treatment such as paracetamol or opening windows for fever.
* Take baseline blood tests including FBC, U&E, LFTs, CRP.
* Where possible obtain a baseline ECG.

**Monitoring of mild COVID 19.**

* Monitor for signs of severe disease (see above).
* Monitor vital signs including pulse, blood pressure, oxygen saturations (SpO2) and respiratory rate four times daily, to be recorded on MEWS chart.
* Repeat blood investigations with any signs of deterioration, including reduced urine output. (It is unlikely in patients who are ambulatory and not catheterised that you will be able to get an objective measure of urine output. Use subjective measures where possible – e.g. reports of not passing urine, dark urine etc.)
* Give a clear plan of when nursing staff should escalate care to the ward doctor. Unless specifically stated a change in MEWS score of ≥ 2, respiratory rate of >30 or Sp02 of <96% should automatically trigger review by a doctor on the ward.

**Management of COVID 19 related pneumonia, ARDS, and sepsis**:

Unless specifically stated in an advanced care plan (see below) all require (at minimum) oxygen therapy, and potentially ventilatory support that cannot be managed in a psychiatric inpatient setting.

Patients who develop symptoms consistent with COVID 19 related pneumonia, ARDS or sepsis should be discussed with the on call medical team at Leeds Teaching Hospital Trust, available via switchboard on 0113 2060000. Unless specified in the advanced care plan, the following should trigger an automatic referral:

* Oxygen saturations ≤ 95% on room air.
* Respiratory rate >30 breaths per minute.
* Persistent hypotension, and tachycardia.
* Other signs of sepsis – Weak pulse, reduced urine output, cold extremities, skin mottling.

Information at hand over should be communicated in SBAR format as set out in appendix 1.

In such an instance, while assistance is being obtained, the following should be considered:

* Commence oxygen therapy via venturi or fixed performance mask then titrate to reach a target SpO2 >93%.\*
* If target SpO2 cannot be achieved with venturi / fixed performance mask then consider high flow 15L O2 via non-rebreathe mask.\*\*
* Where transfer is required this should be organised via emergency ambulance services, being sure to inform them that the patient is COVID 19 positive.
* Inform the responsible clinician (usually ward consultant or in their absence on call consultant) to arrange necessary mental health act arrangements.

In a peri-arrest situation or where sepsis is clinically suspected emergency transfer to the acute hospital trust should be organised without delay as a priority via ambulance while providing high flow 15l oxygen therapy via none rebreathe mask to the patient.

If managing a cardiac arrest for a person with COVID 19, please refer to the document: Standard Operating Procedure: Guidance on resuscitation of suspected and confirmed COVID-19 patients in hospital. March 2020. <http://staffnet2/clinicalstaff/infectioncontrol/Pages/Coronavirus-Update.aspx>

**Caring for older persons with COVID-19:**

Older age and comorbid diseases such as diabetes and hypertension have been reported as a risk factor for death in people with COVID-19*.* Therefore, older people are at highest risk for fatality and are one of the most vulnerable populations. It is important to recognise that older people have the same rights as others to receive high-quality health care, including intensive care.

In line with NICE guidance [NG159] (COVID-19 rapid guideline):

* Consider all patients comorbidities and underlying health conditions.
* Where possible use the clinical frailty score as part of holistic assessment on all admissions - [https://static1.squarespace.com/static/5b5f1d4e9d5abb9699cb8a75/t/5dadc90bb11ecf3bce47f27e/1571670285023/Rockwood+CFS.jpg](https://static1.squarespace.com/static/5b5f1d4e9d5abb9699cb8a75/t/5dadc90bb11ecf3bce47f27e/1571670285023/Rockwood%2BCFS.jpg)
* For older people with probable or suspected COVID-19, provide person-centred assessment, including not only conventional history taking, but a thorough understanding of the person’s life, values, priorities, and preferences for health management.
* Ensure multidisciplinary collaboration among physicians, nurses, pharmacists, and other health care professionals in the decision-making process to address multimorbidity and functional decline.
* Where possible, in all older people advance care planning should be undertaken at the earliest possible opportunity by their ward team.
* Where a decision is unclear or not made in advance as to whether a person should receive hospital based secondary care, they should be referred to the medical teams as above and discussed the on call psychiatry consultant urgently.
* A dedicated medical consultant (working hours) or on call medical consultant at Leeds teaching hospitals trust is available for case by case consultant to consultant discussions. Contact arrangements are documented in appendix 2.
* Where it is decided that a person with severe symptoms of COVID 19 is to receive ongoing or palliative care on a psychiatric inpatient unit. Please refer to separate guidance, these are currently under urgent development.

\*Due to a lack of piped oxygen long term oxygen therapy cannot be provided and this is an emergency measure only while assistance is sought.

\*\* Avoid oxygen delivery via nasal cannulae as this is an aerosol producing procedure require full FFP3 personal protective procedure. N.B. information on aerosol producing procedures is being updated regularly, so please refer to NHS England / local policy if in doubt.

**Appendix 1 - Referral to medical team for suspected COVID-19 Patient**

1. **Check it’s not an Emergency**

**Call 9-999 FIRST if patient has:**

* signs of a heart attack - pain like a very tight band, heavy weight or squeezing in the centre of their chest
* signs of a stroke - face drooping on one side, can’t hold both arms up, difficulty speaking
* severe difficulty breathing - gasping, not being able to get words out, choking or lips turning blue
* heavy bleeding - that won’t stop
* severe injuries - or deep cuts after a serious accident
* seizure (fit) - someone is shaking or jerking because of a fit, or is unconscious (can’t be woken up)
* sudden, rapid swelling - of the eyes, lips, mouth, throat or tongue
1. **Check MEWS score**
* Follow MEWS escalation procedure and
**Call 9-999 FIRST if indicated**
1. **Contact ward doctor or duty doctor OOH using SBAR
(even if 9-999 has been called)**

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| **Situation** | Who are you? (name, job and grade)Where are you calling from? (ward AND hospital)Who is the patient?State: “suspected COVID-19 (or Coronavirus)”State symptoms i.e. continuous cough and/or feverState severity: Emergency symptoms and NEWS score |
| **Background** | Patient DetailsAge, co morbidities, identifiersCurrent medication**Advanced care plan/ DNAR** |
| **Assessment**  | What has been done i.e. paracetamol given, oxygen started, physical observationsHas 999 been called, has isolation been started, have infection control been contacted. |
| **Response** | What would you like the doctor to do?Is this an emergency that needs medical assistance right away? (think 9-999)Do you need medical support whilst waiting for an ambulance?Is this non-urgent but you would like advice? |

**Appendix 2**

Within Leeds Teaching Hospitals Trust two medical consultants have been identified and agreed to be available for consultant to consultant discussions about escalation of medical care.

The named consultants are:

* Adam Burns - for patients age 18-65.
* Gurjit Chhokar – for patients aged 65 and over.

They can be contacted via LTHT switchboard and their direct contact details have been sent to all LYPFT consultants.

Out of hours, there will be an operational consultant who has oversight for admissions and staffing, they can be contacted via LTHT switchboard on 0113 2060000.

End 27.3.20