ReSPECT conversations in COVID:
A guide on how to approach conversations to guide patients/families through decision making around treatment options for COVID 19.

It may be that these plans are never required but will help people & their families feel reassured if prepared, & can lessen the burden of future difficult decision making out of hours.

Mortality from COVID 19 is much higher in the older age group (70-79 years 8%; over 80 yrs. mortality >15%), & with comorbidities (particularly chest, heart disease, cancer & immunosuppression).

30% of all deaths in Bradford have occurred in Care Homes so a significant of number of people who test positive & are asymptomatic will later develop symptoms & become unwell & this is commonly happening after day 9 post positive swab

Acute infection can precipitate an acute decompensation in frailty – the patient's 'house of cards' quickly tumbles & they are unlikely to recover to baseline.

Mortality rates for patients requiring ITU/ventilation are 50%. This excludes older co-morbid patients who were not offered ventilation.

Outcomes for frail older patients in ICU & ventilation are already very poor. There is potential for organ damage, cognitive impairment, loss of independence post ICU and a huge deconditioning needing a long time to recover, if the person survives the acute illness.

Non- invasive ventilation is of benefit in the acute phase, and can also be used for stepping down from intensive care or in COPD exacerbation.

Intravenous fluids appear in COVID19 to precipitate heart failure / ARDS so it is recommended to keep patients slightly hypovolemic, or euvolaemic.

There are now treatments which have been developed during the Pandemic (Steroids and anticoagulants) which can be used in a hospital setting, which have improved outcomes

Resuscitation is very unlikely to be successful, in frailty especially in the circumstances of sepsis (if successful would still be septic, have underlying

comorbidities, & now would likely have hypoxic multi-organ failure, so cardiac arrest is likely to happen again).

Ensure the patient/family know if palliated that their symptoms will be managed, by just in case meds as mainstay.

This is the presentation that we see at the beginning of COVID in older

Older patients, especially those with lots of other illnesses & long term conditions, may present with mild symptoms but have a high risk of deterioration

In addition to the common symptoms

- fever
- cough
- shortness of breath
- tiredness/fatigue)
- loss of sense of smell/anosmia

consider other less common symptoms

- sore throat
- conjunctivitis
- anorexia/not eating
- increased sputum
- dizziness
- headache
- runny nose
- chest pain;
- diarrhoea
- sickness/ nausea/vomiting

COVID should considered in older person presenting with delirium (Confused, more agitated or sleepy) or reduced mobility (falling, and 'off legs')

Later course of COVID in care homes: Anorexia, reduced drinking, delirium (sleepy or agitated) and reduced mobility which leads to Acute Kidney Injury and deterioration. This is a slow then sudden dramatic deterioration requiring either admission or palliation

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How do you have the conversation?

NHS
Yorkshire and the Humber Strategic Clinical Networks

Box 2 Communication tips

Initiating the conversation

Start with general open questions, then be guided by the patient's cues and responses to know whether to explore further

Examples:

- How have you been coping with your illness recently?
- Do you like to think about or plan for the future?
- When you think of the future, what do you hope for?[46]
- When you think about the future, what worries you the most?[46]
- Have you given any thought to what kinds of treatment you would want (and not want) if you became unable to speak for yourself?[47]
- What do you consider your quality of life to be like now?[47]

During the conversation

Use language that patients can understand and any other communication aids you might need

Give patients enough information to make informed choices without overloading them

Clarify any ambiguous statements that patients make—for example:

- Patient: "I don't want heroics"
- Professional: "What do you mean by heroics?"

Ending the conversation

Summarise what has been discussed to check mutual understanding, or ask the patient to do so

Screen for any other problems—for example: "Is there anything else you would like to discuss?"

Arrange another time to continue, complete, or review the discussion if necessary—for example, if the patient would like help completing an advance decision to refuse treatment

Document the contents of the discussion in the patient record

Share the contents (with the patient's permission) with anyone else who needs to know, such as family, carers, the community team, and the general practitioner or specialists

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