



Scottish Government
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COVID-19

Clinical Advice

Supporting people with COVID-19 related illness
in the community setting: Clinical management of
those with moderate to severe illness

Version 2.1

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1 | Purpose of this guidance

This guidance has been developed to support the GP-led clinical management, (including appropriate use of oxygen), of people with COVID-19 related symptoms in the community setting during usual practice hours and out of hours.

2 | Who is covered by this guidance?

This guidance relates to people with moderate to severe COVID-19 related symptoms who, after a person-centred care planning conversation and careful weighing up of harms and benefits, are assessed as being more likely to benefit from being cared for in a community setting rather than in a hospital setting.










This may include people who:

- do not wish to be admitted to hospital
- are unlikely to respond to medical procedures such as non-invasive positive pressure ventilation or mechanical ventilation.

Such care planning conversations should take account of:

- the person's current wishes, if known
- previous care planning multidisciplinary team (MDT) discussions or advance directives
- family and carer/s' views and knowledge of the individual's previously expressed wishes
- the person's clinical condition (consider clinical frailty scale score – see Figure 1) and likely benefit of specific hospital interventions (note - the frailty score should not be used in those under age 65).

Figure 1: Clinical Frailty Scale

CLINICAL FRAILTY SCALE		
	1	VERY FIT People who are robust, active, energetic and motivated. They tend to exercise regularly and are among the fittest for their age.
	2	FIT People who have no active disease symptoms but are less fit than category 1. Often, they exercise or are very active occasionally , e.g., seasonally.
	3	MANAGING WELL People whose medical problems are well controlled , even if occasionally symptomatic, but often are not regularly active beyond routine walking.
	4	LIVING WITH VERY MILD FRAILITY Previously "vulnerable," this category marks early transition from complete independence. While not dependent on others for daily help, often symptoms limit activities . A common complaint is being "slowed up" and/or being tired during the day.
	5	LIVING WITH MILD FRAILITY People who often have more evident slowing , and need help with high order instrumental activities of daily living (finances, transportation, heavy housework). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation, medications and begins to restrict light housework.
	6	LIVING WITH MODERATE FRAILITY People who 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.
	7	LIVING WITH SEVERE FRAILITY Completely dependent for personal care , from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~6 months).
	8	LIVING WITH VERY SEVERE FRAILITY Completely dependent for personal care and approaching end of life. Typically, they could not recover even from a minor illness.
	9	TERMINALLY ILL Approaching the end of life. This category applies to people with a life expectancy <6 months , who are not otherwise living with severe frailty . (Many terminally ill people can still exercise until very close to death.)

SCORING FRAILITY IN PEOPLE WITH DEMENTIA

The degree of frailty generally 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. In **very severe dementia** they are often bedfast. Many are virtually mute.



Clinical Frailty Scale ©2005–2020 Rockwood, Version 2.0 (EN). All rights reserved. For permission: www.geriatricmedicine.ca
Rockwood K et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489–495.

3 | Who is not covered by this guidance?

This guidance does not relate to any person who is unwell, and who, in your clinical opinion would be likely to gain additional benefit from more intensive hospital based care which cannot be provided in the community. People in this group should be admitted in accordance with their care plan and wishes, following the [national clinical guidance](#).

Shared decision making, taking the person’s own wishes and concerns into account, alongside the availability of local resource and support are key factors in agreeing person-centred management plans.

4 | Context

Our current understanding (from learned experience and emerging international evidence) is that 80% of people who are affected by COVID-19 will have mild symptoms. However a small number (estimated at around 5%) will become seriously ill and require intensive care management. Increased risks are associated with age, ethnicity and obesity alongside underlying long-term conditions.

COVID-19 can more severely affect people with frailty, in particular our care home population.

Research from the European Respiratory Journal suggests that approximately 15-22% of people with COVID-19 symptoms with frailty and/ or other comorbidities who are managed in the community will die. This means most will recover. It is important to ensure that those people who remain in the community have access to life-sustaining care, including oxygen where this is appropriate, as well as good palliative care where that is needed. As with any potentially life-limiting illness these are not mutually exclusive, and should be considered as part of the anticipatory care planning process.

Support from frailty in-reach, respiratory and palliative care teams should all be available to primary care community teams, with clear plans in place for managing a person in the community 24 hours per day.

Wherever possible, direct professional to professional communication lines and use of videoconsulting should support all staff working in settings such as care homes, and out-of-hours, to provide holistic care whilst minimising risk of infection.

All staff providing care to people with COVID-19 symptoms, being managed in the community, should follow [HPS infection and control guidance](#) at all times.

It is essential to note that community pathways are not mutually exclusive from acute hospital care and the clinical situation may change very rapidly. Clinical decision making and care plan review should reflect this.

There will be times when some treatments will cease to provide benefit, and palliative care should become the primary approach. It will be important to prepare families and care givers about that possibility and keep them informed and consulted.

5 | Supportive treatments with hope of recovery

The most common symptoms of acute COVID-19 illness are cough, fever and loss of taste/smell. Patients at any age can present with varying degrees of symptoms, from mild flu-like symptoms, to becoming rapidly unwell in a matter of hours. More information can be found in the [national guidance on community assessment of acute COVID-19 & referral to secondary care](#).

As we learn more about the progress of this disease, it is recognised that:

- people with milder symptoms may begin to deteriorate after the first week
- older people may present with less typical symptoms, including confusion, bladder and bowel problems.

Treatment options include:

- good hydration
- medication review if appropriate
- breathing techniques
- proning (see Figure 2)
(It has been found that some patients in hospital may benefit from changing positions. This may be considered in the community setting, but only where it is felt clinically appropriate to do so, recognising evidence to support this approach in the community has yet to be established).
- cooling using wet wipes (discarded in clinical waste after single use) - **DO NOT USE FANS**
- psychological support
 - importance of an explanation regarding personal protective equipment (PPE)
 - connections with the family and carers through information sharing and technology.
- consideration of:
 - delirium
 - bladder and bowel function
 - anxiety
- treatment of fever with paracetamol
- pain/breathlessness, consider oral dose morphine, or benzodiazepines if tolerated.

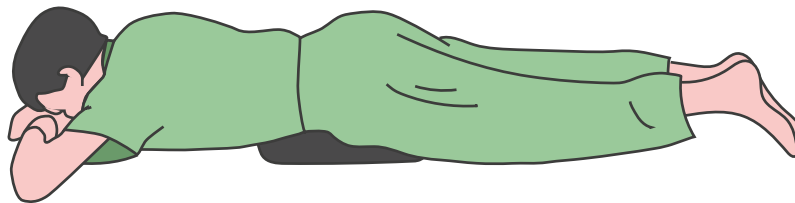
- where there are clinical symptoms suggestive of COVID-19, and where there is a new oxygen requirement consider starting Dexamethasone 6 mg once daily for 10 days (see section 7).

Thromboprophylaxis is used to support care in the acute hospital setting. There is currently no evidence to support this approach in the community, and advice should be sought from specialist teams before prescribing.

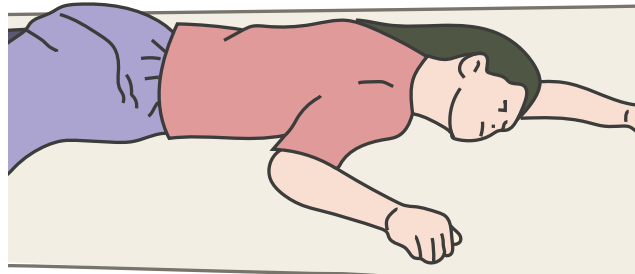
Figure 2: Proning

Lying 'Prone' on the ward

What is lying 'Prone'? This is when the clinical team judge that lying on your front for a period of time will help your breathing and your oxygen levels.



Try adding pillows under your pelvis and upper chest to make this position more comfortable



Why do we ask patients to lie in the prone position?

- Some patients who have pneumonia or similar problems have areas at the bottom of the lungs which are partly deflated. This means that air and oxygen isn't getting into them very well.
- Lying a patient prone on their front can improve 'ventilation' and opens up these partially deflated areas.
- Lying prone can improve breathlessness and help get some more oxygen into the body.
- Lying prone can also help cough be more effective. This helps with clearing out any secretions that are in your chest.

Available evidence suggests that lying prone must be considered early in acute lung conditions for best outcomes. This is why it might be suggested as part of your treatment on the ward, even if you're feeling better.

6 | Use of oxygen

See [Appendix A](#) for flow chart

Key points to consider

The primary role of oxygen in the management of COVID-19 is to correct hypoxaemia in order to try to improve outcome for the person.

- Is this clinically appropriate? Is the patient acutely breathless? ($\text{SpO}_2 < 94\%$ and $\text{RR} > 20$). Patients with suspected COVID-19 related breathlessness, and $\text{SpO}_2 > 94\%$ in room air do not require oxygen.
 - oxygen may be used on a “trial for benefit” basis - does the person’s breathlessness improve, do oxygen saturation levels improve?
- This must be a shared decision
- Does the clinical situation merit reconsideration of hospital admission?
- Is it safe to administer? (e.g. smoker in household, other risks)
- Is an oxygen supply easily available?
 - follow national guidance and contact local Health Board lead for supply (see [Appendix B](#) for information and [Appendix C](#) for list of local contacts)
- How will this be monitored and how will you know if the person is getting benefit, e.g. reduction in breathlessness symptoms, oxygen saturations are improved?
- SpO_2 levels should be checked at least four times daily - are staff available and clinically competent? Is there a supply of pulse oximeters?
- Monitoring will support clinical decision making, which may include:
 - reconsideration for admission
 - titration of oxygen levels
 - consider withdrawal if not helping.
- Are there non-COVID-19 related issues, e.g. COPD or other risks for hypercapnoeic respiratory failure? This will need to be taken into account when assessing for target SpO_2
- How long will it take to source sufficient supply?

Anecdotal evidence from Scottish clinicians suggests that the majority of people with COVID-19 related breathlessness, if they are going to respond to oxygen therapy, are likely to do so within approximately 30 minutes of starting oxygen. This might be helpful to consider when using emergency bag or other locally available supplies.

Administration of Oxygen

Start oxygen, via nasal cannula, (simple masks should not be used for flow rates below 5 L/min) starting at 2 L/min, titrating up to a maximum of 4 L/min, aiming for the following:

in patients who are NOT at risk of hypercapnoeic respiratory failure

- aim for target SpO₂ 94–96%

in patients who are at risk of hypercapnoeic respiratory failure (e.g. existing COPD, severe frailty)

- aim for target SpO₂ 88–92%

Sources of support

- local oxygen lead (see [Appendix B](#) for list of contacts)
- respiratory liaison team
- COVID-19 lead consultant

ASK FOR HELP IF UNSURE ABOUT USING OXYGEN – SUPPORT IS ALWAYS AVAILABLE

7 | Use of steroids

As the pandemic has progressed, new learning is emerging around treatment options.

A [randomised controlled trial](#) into use of dexamethasone in hospitalised patients with COVID-19, and subsequent [meta-analysis](#), suggest that 6 mg dexamethasone daily for up to 10 days reduces mortality in patients who are hospitalised with proven SARS-CoV-2 infection and who require respiratory support, either through mechanical ventilation or oxygen support.

There was evidence of harm for patients with no oxygen requirement, e.g. oxygen saturation >92% on room air.

A large proportion of the population recruited into the trial were in the same age category as nursing home residents and more than half of the patients in the trial had significant morbidity.

Care home residents with SARS-CoV-2 infection and increasing oxygen requirements may therefore benefit from dexamethasone prescription.

It is important that potential risks and benefits associated with the decision to use dexamethasone and oxygen is discussed early with patients and their families, including limitations of oxygen delivery in care homes (maximum delivery of 5 L/min) and possible adverse effects of steroids (including the potential need for blood glucose monitoring).

Care home residents with confirmed or suspected SARS-CoV-2 infection who are felt to be suitable for hospital admission should continue to be admitted to allow optimisation of oxygenation, potential for continuous positive airway pressure (CPAP) therapy and consideration of dexamethasone and other potential therapies in that setting.

Those patients, with suspected SARS-CoV-2 infection, who are felt not likely to gain benefit from hospital admission or do not wish hospital admission, could be considered for treatment with oxygen and dexamethasone in their care home. The target oxygen saturation would be >94% with oxygen concentrators able to deliver a maximum of 4 or 5 L/min via nasal cannula.

Oral dexamethasone at 6 mg daily for a maximum of 10 days can be prescribed with consideration of proton pump inhibitor (PPI) cover and blood glucose monitoring where appropriate. (Subcutaneous administration could be considered if oral route compromised).

Common adverse effects could include: worsening of delirium, fluid retention/pulmonary oedema/exacerbation of heart failure, worsening glycaemic control, increased bleeding risk, insomnia, and, in this age group in particular, myopathy.

Patients who are not for escalation to secondary care and who have increasing oxygen requirements despite these treatments may require a more palliative approach.

8 | Acutely ill and palliative care required

A key part of the decision to manage a person in the community is to ensure that through person-centred care planning, the person and their family are aware of the possibility that treatment intended to prolong life and aid recovery may not work, and a clinical decision may be discussed and agreed to focus goals of care on comfort and symptom management

Where a person is deteriorating rapidly, and is felt clinically to be towards the end of life, it is important to ensure they are kept comfortable, that family and next of kin are informed, and [where possible allowed to visit](#) (with all risks explained, wearing appropriate PPE and in strictly limited numbers).

Electronic means of communication such as a tablet or mobile phone can provide immense comfort for people and their loved ones, and should be considered.

Contact details of next of kin, including email addresses, should be confirmed.

Guidance to support communication can be found [here](#).

a) Points to note

- Decline may be rapid
- Wear appropriate PPE; treat reversible causes and confirm rapid irreversible decline
- High breathlessness/distress/delirium/agitation/fever/risk of death within hours - consider clinically appropriate prescribing (in line with the individual's anticipatory care plan) at higher / more frequent effective doses from the outset
- Syringe driver is the best option, but takes 4 hours to achieve full effect. **REMEMBER TO PRESCRIBE**
- If oxygen is no longer helping, titrate down with view to stopping
- Use subcutaneous butterfly if syringe driver equipment/expertise unavailable, use alternatives if needed - patients can be managed effectively with four- hourly subcutaneous injections to get medication levels to a steady state
- Patient positioning, excess bedding, cool wipes to face, cool room - **DO NOT USE FANS**
- Ensure DNA-CPR/nurse verification form/prescription chart completed as appropriate.

b) Sources of support

- palliative care team (See [Appendix B](#))
- community pharmacist
- Safer Prescription of Opioids Tool (SPOT) app (where available)

ASK FOR HELP IF UNSURE ABOUT PRESCRIBING OR DOSES NOT SUFFICIENT

- SUPPORT IS ALWAYS AVAILABLE

c) Prescribing if family/carer attending to patient (subcutaneous route **NOT** available):

- For pain, breathlessness, cough and fever:
 - Oral morphine sulphate (10 mg/ 5 ml bottle); 5 mg hourly oral prn AND Paracetamol 500 mg-1000 mg four times daily
- For secretions:
 - Hyoscine hydrobromide 1.5 mg patches; 1-4 patches every 72 hours transdermally OR
 - Hyoscine hydrobromide 300 microgram tabs; one tab every 6 hours orally
- For distress:
 - Midazolam buccal (Epistatus® 10 mg/ml or Buccolam® 5 mg/ml); 2.5 mg hourly buccal prn OR
 - Lorazepam 1 mg scored tabs; 500 microgram every 4 hours sublingual prn (the dispenser may be able to split the tablets if required).

d) links to further information

<https://www.palliativecareguidelines.scot.nhs.uk/>

<https://www.palliativecareguidelines.scot.nhs.uk/covid-19-guidance.aspx>

[Scottish Government pharmacy palliative care toolkit](#)

[Scottish rapid review breathlessness and end of life care](#)

[Community Palliative, End of Life and Bereavement Care in the COVID-19 pandemic](#)

9 | Authors

Dr Michelle Watts Associate Medical Director NHS Tayside & Medical Adviser, Scottish Government

Dr Sian Tucker Clinical Director, Lothian Urgent Care Services & Medical Adviser, Scottish Government

10 | Acknowledgements

National Primary Care Clinical leads

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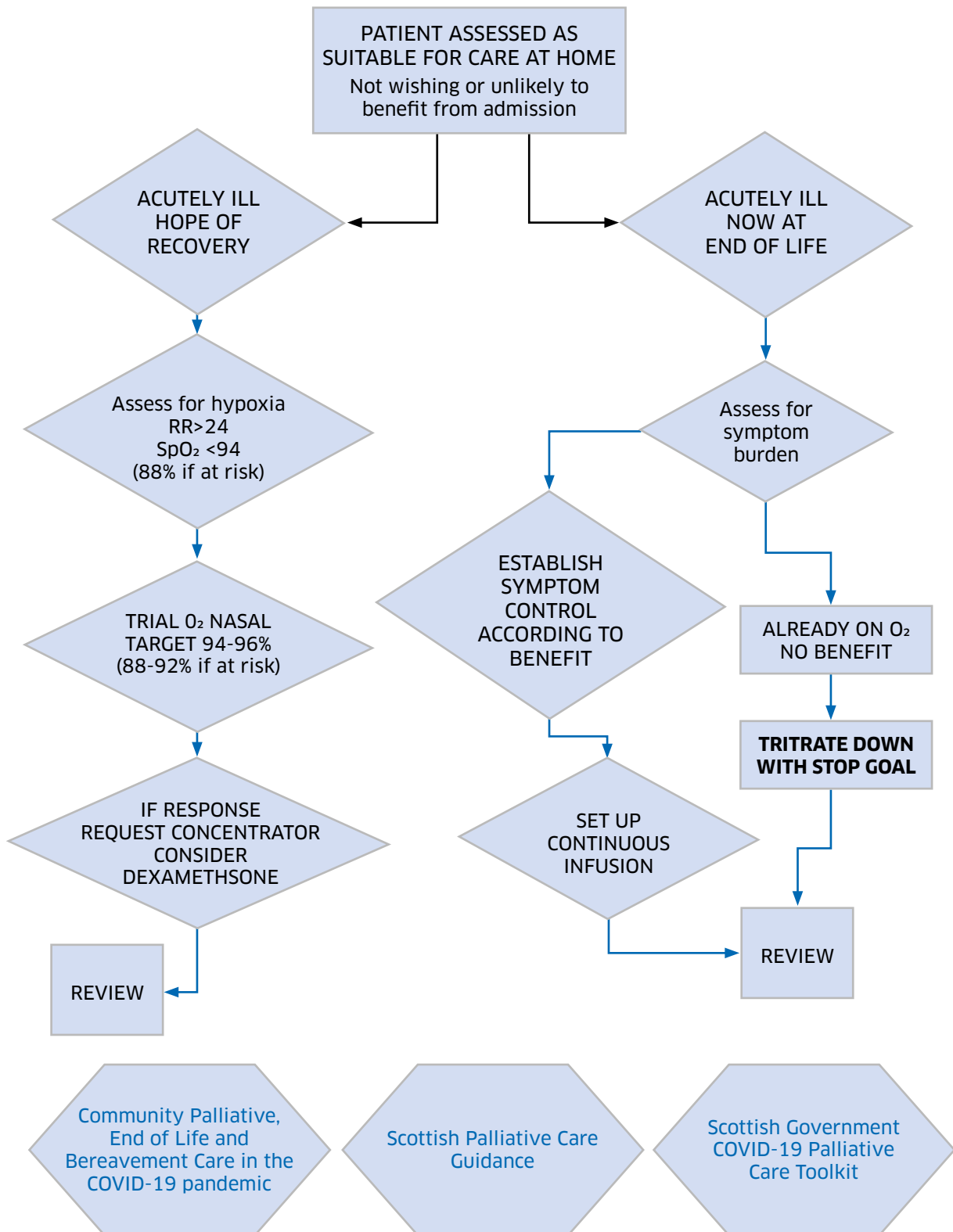
Scottish Government Professional Advisory Group

Scottish Palliative Care leads

SGPC and RCGP leads

Representatives from the care home sector

Appendix A



APPENDIX B

Home Oxygen Ordering

The Home oxygen service is provided by Dolby Vivisol, who are based in Stirling and have a network of field based engineers and depots across the country.

If an oxygen concentrator is required, this should be requested through nominated individuals in secondary care who have access to a Part A Scottish Home Oxygen Order Form (SHOOF). A note of the respiratory and palliative care contact for each Board has been provided in the table below. A target SpO₂ should be stated in section 11 on the part A SHOOF to assist the attending health care professional.

Dolby Vivisol will be able to provide an oxygen concentrator that will provide up to 5 litres per minute. A recognised industry standard risk assessment will be carried out during installation, taking into account COVID-19 related infection control procedures.

Dolby Vivisol can provide a next - day and a same - day service. For same day service a concentrator will be provided within 8 hours of receipt. Their normal working hours are Monday to Friday 9 am – 5 pm. During the current COVID-19 pandemic, hours may be extended dependent on demand, and they may also be able to receive requests for concentrators and install them on a Saturday and Sunday if required. Requests should state that the service is required for a COVID-19 patient.

Where oxygen is required out of hours then please refer to the local oxygen contact who may be able to refer to a local interim arrangement using locally held Transportable Concentrators, providing a maximum of either 2 or 3 litres per minute depending on the device held. Local teams are typically within out-of-hours, Hospital at Home, REACT or other local arrangements with hospices.

Local teams would typically issue a device in the out of hours period and then make a request through Trakcare or SCI store requesting a standard concentrator from Dolby Vivisol which will be delivered in the specified time frame, using the standard 4 day service, next-day service or same-day service. When installed, local teams will retrieve the Transportable Concentrators and take them back to their base for decontamination and reissue.

As part of the routine follow up and review, a judgement should be made as to whether the concentrator is still required. Where it is no longer required Dolby Vivisol should be contacted to arrange uplift. **Please note that you must advise them that the concentrator is to be uplifted from a COVID-19 positive patient.**

Appendix C

Health Board	Contact	Designation (if known)	Contact E-Mail address	Telephone Number
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NHS Ayrshire and Arran

Respiratory Contact	Philip Hodkinson	Respiratory Physician - Crosshouse Hospital	Philip.Hodkinson@aapct.scot.nhs.uk	01563 825 134
	Lorna McKay	Respiratory Nurse Specialist Ailsa - Ayr/South Ayrshire	lorna.mckay@aaaht.scot.nhs.uk	01292 513 161
Palliative Contact	Catriona Killin	Consultant in Palliative Medicine	Catriona.killin@aapct.scot.nhs.uk	01292 269 200 or 07870554784

NHS Borders

Respiratory Contact	Emma Dodd	Respiratory Nurse Specialist	emma.dodd@borders.scot.nhs.uk	01896 826635
	Debbie Cairns	Respiratory Nurse Specialist	debra.cairns@borders.scot.nhs.uk	01896 826635
Palliative Contact	Emma Dodd	Respiratory Nurse Specialist	emma.dodd@borders.scot.nhs.uk	01896 826635
	Michelle Scott	Palliative Care Nurse Consultant	michelle.scott@borders.scot.nhs.uk	01896 826829 or 01896 826000 ask for bleep 6828

NHS Dumfries and Galloway - Switchboard (01387 246246)

Respiratory Contact	Stuart Little	Respiratory Consultant	stuart.little@nhs.scot	01387 246246 ext 33757
	Yvonne Scott	Respiratory Nurse Specialist	Yvonne.scott2@dg.nhs.scot	01387 241007
Palliative Contact	Nigel Wilson	Specialist or McMillan nurses	nigelwilson@nhs.net	01387 241347
	Kirsty Gaffney	Specialist or McMillan nurses	Kirsty.gaffney@dg.nhs.scot	01556 612360

Health Board	Contact	Designation (if known)	Contact E-Mail address	Telephone Number
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NHS Dumfries and Galloway - Switchboard (01387 246246)

	Barbara Maxwell	Specialist or McMillan nurses	B.Maxwell@nhs.scot	01671 402587
	Katherine McMillan.	Specialist or McMillan nurses		01387244896
	Kirsty Morris	McMillan Nurse Specialist	kirsty.morris9@dg.nhs.scot	01387 246 246

NHS Fife

Respiratory Contact	Margaret Stevenson	Respiratory Nurse Consultant	margaret.stevenson@nhs.net	01592 643355
Palliative Contact	Margaret Vass	Pharmacy Technician Team Leader	Margaret.vass@nhs.scot	01383 565345 /07932676485

NHS Forth Valley

Respiratory Contact	Donna Read	Lead Respiratory Specialist Nurse	Donna.read@nhs.scot	01324 566 618
Palliative Contact	Sarah Miler	Palliative Care Consultant in the Community	sarah.miller25@nhs.net	01324 567 314

NHS Greater Glasgow and Clyde

Respiratory Contact	Kirsty Murray	Lead Respiratory Clinical Nurse Specialist	Kirsty.Murray4@ggc.scot.nhs.uk	0141 211 6763
Palliative Contact	Jane Edgecombe	Consultant Palliative Medicine	Jane.Edgecombe@ggc.scot.nhs.uk	0141 301 7042

Supporting people with COVID-19 related illness in the community setting:
Clinical management of those with moderate to severe illness

Health Board	Contact	Designation (if known)	Contact E-Mail address	Telephone Number
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NHS Grampian

Respiratory and Palliative Contact	Margaret MacLeod	Senior Respiratory Physiotherapist	margaret.macleod3@nhs.scot	01224 555796
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Golden Jubilee

Respiratory Contact	Karon Carson	SPVU Clinical Nurse Specialist	Karon.Carson@gjh.scot.nhs.uk	0141 951 5771
	Rachel Thomson	Nurse Specialist	Rachel.Thomson@gjh.scot.nhs.uk	
Palliative Contact	Sharon Robinson	Nurse Specialist	sharon.robinson@gjh.scot.nhs.uk	0141 951 5000 ext 5350
	Karon Carson	SPVU Clinical Nurse Specialist	Karon.Carson@gjh.scot.nhs.uk	0141 951 5771
	Rachel Thomson	Nurse Specialist	Rachel.Thomson@gjh.scot.nhs.uk	

NHS Highland

Respiratory and Palliative Contact	Lorna Murray	Consultant Respiratory Physician	lorna.murray@nhs.scot	Switchboard 01463 704000 / 01463 706294
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NHS Lanarkshire

Respiratory Contact	Tan, Dr Soong	Consultant Physician Respiratory Medicine	Soong.Tan@lanarkshire.scot.nhs.uk	01698 366074
Respiratory Contact	Tracey Miller	Lead Respiratory Nurse Specialist	Tracey.Miller@lanarkshire.scot.nhs.uk	01698 366508
Palliative Contact	Susan Jackson	Consultant in Palliative Medicine	Susan.Jackson@lanarkshire.scot.nhs.uk	01236 766951

Health Board	Contact	Designation (if known)	Contact E-Mail address	Telephone Number
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NHS Lothian

Respiratory Contact	Elspeth Christie	Advanced Respiratory Nurse Specialist	Elspeth.Christie@nhslothian.scot.nhs.uk	0131 536 1000
Palliative Contact	Gourab Choudhury	Respiratory Consultant	Gourab.Choudhury@nhslothian.scot.nhs.uk	0131 536 1000

NHS Orkney

Respiratory and Palliative Contact	Wendy Lycett	Clinical Pharmacist	wendylycett@nhs.net	01856 888015
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NHS Tayside

Respiratory Contact	Sandy Rolfe	Respiratory Nurse Specialist	sandy.rolfe@nhs.scot	01382 496564
Palliative Contact	Deans Buchanan	Consultant in Palliative Medicine/ Lead Clinician	deansbuchanan@nhs.net	01382 623055 ext 32055

NHS Shetland

Respiratory Contact	Pauline Wilson		paulinewilson@nhs.net	01595 743326
	Mary McFarlane	Pharmacist	mary.mcfarlane@nhs.net	01595 743 000
Palliative Contact	David Fryer		davidfryer1@nhs.net	01595 743000

NHS Western Isles

Respiratory Contact	Pauline Morrison	Respiratory Liaison Nurse NHS Western Isles	pmorrison@nhs.net	01851 708252
Respiratory Contact	Liam Callaghan	Lead Pharmacist	Liam.Callaghan@nhs.net	01851 708140
Palliative Contact	Gail Allan	Macmillan Lead Nurse Cancer, Palliative Care	gail.allan1@nhs.net	01851 763308

For out-of-hours supply, please follow local guidance.