Supporting Information

Supplementary material

This appendix was part of the submitted manuscript and has been peer reviewed.
It is posted as supplied by the authors.

Appendix to: Cheyne S, Lindley RI, Smallwood N, et al. Care of older people and people requiring palliative care with COVID-19: guidance from the Australian National COVID-19 Clinical Evidence Taskforce. *Med J Aust* 2021; doi: 10.5694/mja2.51353.

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MANAGEMENT OF PEOPLE WITH COVID-19 WHO ARE OLDER AND LIVING WITH FRAILTY AND/OR COGNITIVE IMPAIRMENT

NATIONAL COVID-19 CLINICAL EVIDENCE TASKFORCE

LEGEND

EBR: Evidence-Based Recommendation
CBR: Consensus-Based Recommendation
PP: Practice Point

Living guidance

Not prioritised for review

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Older people (> 65 years) living with frailty and/or cognitive impairment

This population includes older people (usually > 65 years) with impairments of physical, cognitive and/or physiological function, or who have frailty. Frailty is a multifaceted syndrome that includes physical impairments and higher susceptibility to disease. Comorbidities are often present, such as cerebrovascular disease, dementia, heart failure and chronic lung disease [Hilmer 2017].

Overarching principles of care

GOALS OF CARE

Identify if the patient has an advance care directive or plan. If yes, reaffirm prior decision. **PP** [Taskforce]

Ensure early discussion with the patient around goals of care, which may include active disease-directed care. If the patient has a legal guardian for medical decision-making, they should be contacted. **PP** [Taskforce]

Respect priorities and preferences and take these into account where possible when deciding on and communicating the care plan. **PP** [Taskforce]

Undertake a clinical assessment to determine expected prognosis, taking into account COVID-19 illness and underlying conditions. **PP** [Taskforce]

COMMUNICATION

Establish a timely and ongoing regular line of communication, with a nominated family/caregiver. **PP** [Taskforce]

Visiting restrictions should be included in care planning discussions to enable patients and families to make informed decisions. **PP** [Taskforce/ANZSPM]

Minimise sensory impairment (e.g. hearing aids available and working, glasses available, and utilise other augmentative and alternative communication devices such as communication boards, electronic communication devices). **PP** [Taskforce]

Ensure effective communication, including the use of interpreters or cultural care workers where appropriate. Remember that those with sensory impairments may not be able to hear or use lip reading to assist in understanding if clinicians have masks on. Consider written communication via room boards or paper on clipboards. **PP** [Taskforce/ANZSPM]

Respiratory distress and a diagnosis of COVID-19 will likely cause high levels of anxiety and distress. There may be worsening of pre-existing mental health conditions. **PP** [SA Health]

Communicate with patients and support their mental wellbeing to help alleviate any anxiety and fear they may have about COVID-19. **PP** [NICE]

Ensure that regular conversations and communication continue and are supported digitally. For example, by use of two-way radios (such as baby monitors) or video tablets to communicate at length without masks and other PPE from outside the patient's room. **PP** [Taskforce/ANZSPM]

GENERAL PRINCIPLES

Ensure multidisciplinary collaboration amongst the health and social/community care teams within the decision-making process when managing people with multimorbidity, cognitive impairment and functional decline. **PP** [Taskforce/WHO]

Early specialist advice should be considered in older people living with frailty and/or with cognitive impairment. **PP** [Taskforce]

Provide opportunities for people to maintain activity, such as placing a chair beside the bed and delivery of rehabilitation interventions via virtual means where possible. **PP** [Taskforce]

POLYPHARMACY

Consider reducing polypharmacy or reaffirming clear indications for each medication. Polypharmacy is common and often harmful. In patients with COVID-19 and many medications can be omitted, stopped or converted to a once daily formulation limiting contact with patients, such as providing medications, is important during COVID-19 illness. **PP** [Taskforce]

Managing breathlessness or cough

COVID-19 SPECIFIC

Avoid fans and nebulised medications due to potential for aerosol generation. **PP** [Taskforce/ANZSPM]

GENERAL TREATMENT

Non-pharmacological measures to manage breathlessness should be considered; these include positioning, relaxation techniques, wiping the face with cool wipes, reducing room temperature. **PP** [Scottish Palliative Care Guidelines/NHS UK]

For further advice go to The Australian & New Zealand Society of Palliative Medicine.

For management of the symptoms of breathlessness or cough, use opioids as per usual care. Consider the addition of a benzodiazepine (for example midazolam) if breathlessness persists. **PP** [Taskforce]

For further advice go to The Australian & New Zealand Society of Palliative Medicine.

Active disease-directed care

If goals of care include active disease management, please see recommendations for the treatment of COVID-19 in our living guidelines. Of particular note are recommendations for respiratory support and disease modifying treatments.
EBR [Taskforce]

Treat potentially reversible causes of symptoms (e.g. delirium), such as urinary retention, pain or constipation and prevent and/or treat these causes. **PP** [ANZSPM]

Recognise that treatment may be required for other illnesses, not only for COVID-19. **PP** [Taskforce]

Escalation of care

When considering treatment options, take into account individual decision-making around goals of care. This includes decisions around proceeding to more invasive forms of ventilation, transfer to ICU and cardiopulmonary resuscitation.
PP [Taskforce/ANZSPM]

The net clinical benefit for each patient should be considered on a case-by-case basis, as older people with frailty and/or cognitive impairment may have reduced benefit and increase potential harms when escalating treatment. **PP** [Taskforce]

Decisions around proceeding to more invasive forms of ventilation should be discussed with the patient or their substitute/medical treatment decision-maker. **PP** [Taskforce]

If a person has symptoms such as breathlessness or delirium which are difficult to manage, and/or is imminently dying, specialist palliative care support and advice should be sought.
PP [Taskforce/SIGN]

Managing delirium, anxiety and agitation

COVID-19 SPECIFIC

Delirium may be the sole presenting symptom in some patients.
PP [Taskforce/ANZSPM]

Prevention of delirium, as per usual practice, is critical. In people with COVID-19, delirium can increase risk to other patients and staff as it may impact on the person's capacity to understand and follow infection control measures and maintain isolation.
PP [Taskforce]

Early detection of delirium to allow timely treatment requires regular screening. Delirium usually has multiple causes or contributing factors, and other aetiologies other than COVID-19 should be also considered. **PP** [Taskforce]

There are other additional factors which can promote anxiety, distress and agitation of patients, including clinicians wearing PPE, isolation and limitation of visitors. **PP** [ANZSPM]

If possible, optimise environment (within infection control restrictions):

- manage in a low-stimulus environment
- provide support with sleep hygiene
- use reorientation strategies (e.g. clock, calendar, radio, room board etc)
- avoid unnecessary patient movement between wards/rooms.

PP [ANZSPM]

GENERAL TREATMENT

For non-pharmacological prevention and management of delirium and agitation, follow guidance as per usual care. **PP** [Taskforce]
For further advice go to SIGN delirium guidelines and ACSQHC delirium clinical standard.

For pharmacological prevention and management of delirium and agitation, follow guidance as per usual care. **PP** [Taskforce]
For further advice go to SIGN delirium guidelines and ACSQHC delirium clinical standard.

Ongoing care

Recognise that ongoing care may be required for some patients who present with post-acute COVID-19 signs and symptoms.

For assessment of symptoms and signs that are described by people with post-acute COVID-19 refer to our flowchart for care of people with post-acute COVID-19. **PP** [Taskforce]

Sources

ANZSPM - The Australian & New Zealand Society of Palliative Medicine Inc. (ANZSPM) Guidance - palliative care in the COVID-19 context. April 2020.

ACSQHC - Australian Commission on Safety and Quality in Health Care (ACSQHC). Delirium Clinical Care Standard. 2016.

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NHS Scotland - Scottish Palliative Care Guidelines. Supportive and Palliative Care Temporary Guideline. End of Life Care Guidance when a Person is Imminently Dying from COVID-19 Lung Disease. 29 April 2020.

SIGN - Scottish Intercollegiate Guidelines Network (SIGN). COVID-19 position statement: Presentations and management of COVID-19 in older people in acute care. 29 May 2020.

National COVID-19 Clinical Evidence Taskforce – Australian guidelines for the clinical care of people with COVID-19. https://app.magicapp.org/#/guideline/L4Q5An.

WHO - World Health Organisation (WHO). Clinical management of COVID-19: interim guidance. 27 May 2020.

MANAGEMENT OF PEOPLE WITH COVID-19 WHO ARE RECEIVING PALLIATIVE CARE

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Overarching principles of care

GOALS OF CARE

Identify if the patient has an advance care directive or plan. If yes, reaffirm prior decision. **PP** [Taskforce]

Ensure early discussion with the patient around goals of care, which may include active disease-directed care. If the patient has a legal guardian for medical decision-making, they should be contacted. **PP** [Taskforce]

Respect priorities and preferences and take these into account where possible when deciding on and communicating the care plan. **PP** [Taskforce]

Undertake a clinical assessment to determine expected prognosis, taking into account COVID-19 illness and underlying conditions. **PP** [Taskforce]

COMMUNICATION

Establish a timely and ongoing regular line of communication, with a nominated family/caregiver. **PP** [Taskforce]

Visiting restrictions should be included in care planning discussions to enable patients and families to make informed decisions. **PP** [Taskforce/ANZSPM]

Minimise sensory impairment (e.g. hearing aids available and working, glasses available, and utilise other augmentative and alternative communication devices such as communication boards, electronic communication devices). **PP** [Taskforce]

Ensure effective communication, including the use of interpreters or cultural care workers where appropriate. Remember that those with sensory impairments may not be able to hear or use lip reading to assist in understanding if clinicians have masks on. Consider written communication via room boards or paper on clipboards. **PP** [Taskforce/ANZSPM]

Respiratory distress and a diagnosis of COVID-19 will likely cause high levels of anxiety and distress. There may be worsening of pre-existing mental health conditions. **PP** [SA Health]

Communicate with patients and support their mental wellbeing to help alleviate any anxiety and fear they may have about COVID-19. **PP** [NICE]

COVID-19 limits face-to-face contact, which is an important part of palliative care. Ensure that regular conversations and communication continue and are supported digitally, particularly if the patient is deteriorating or imminently dying. For example, by use of two-way radios (such as baby monitors) or video tablets to communicate at length without masks and other PPE from outside the patient's room. **PP** [Taskforce/ANZSPM]

People requiring palliative care and COVID-19
This population includes people with COVID-19 whose prognosis due to co-existing advanced progressive disease is limited or uncertain, or people with critical COVID-19 illness where recovery is not expected.

GENERAL PRINCIPLES

Ensure multidisciplinary collaboration amongst the health and social/community teams including pastoral care, within the decision-making process and care delivery. **PP** [Taskforce/WHO]

Early specialist advice should be considered for people requiring palliative care. **PP** [Taskforce]

Provide opportunities for people to maintain activity, such as placing a chair beside the bed and delivery of rehabilitation interventions via virtual means where possible. **PP** [Taskforce]

Risks of more complex grief and bereavement may be increased due to restrictions on patient contacts during the dying process, social distancing and community isolation, and increased financial and relationships stressors. **PP** [NSW Health]

MEDICATION MANAGEMENT

Consider immediate release medications or whether slow release medications or an alternative route of delivery may reduce staff interaction and support infection control. **PP** [Taskforce]

For further advice go to The Australian & New Zealand Society of Palliative Medicine.

Consider reducing polypharmacy or reaffirming clear indications for each medication. Polypharmacy is common and often harmful. In patients with COVID-19 and many medications can be omitted, stopped or converted to a once daily formulation limiting contact with patients, such as providing medications, is important during COVID-19 illness. **PP** [Taskforce]

Ensure cultural and spiritual/religious practices that are part of the person's wishes are identified, prioritised and observed/facilitated, where possible. Where not possible, due to infection control considerations, communication with the patient and family/carers is essential. **PP** [Taskforce/NSW Health]

Active disease-directed care

If goals of care include active disease management, please see recommendations for the treatment of COVID-19 in our living guidelines. Of particular note are recommendations for respiratory support and disease modifying treatments .
EBR [Taskforce]

Treat potentially reversible causes of symptoms (e.g. delirium), such as urinary retention, pain or constipation and prevent and/or treat these causes. **PP** [ANZSPM]

Recognise that treatment may be required for other illnesses, not only for COVID-19. **PP** [Taskforce]

Managing delirium, anxiety and agitation

COVID-19 SPECIFIC

Delirium may be the sole presenting symptom in some patients. **PP** [Taskforce/ANZSPM]

Prevention of delirium, as per usual practice, is critical. In people with COVID-19, delirium can increase risk to other patients and staff as it may impact on the person's capacity to understand and follow infection control measures and maintain isolation. **PP** [Taskforce]

Early detection of delirium to allow timely treatment requires regular screening. Delirium usually has multiple causes or contributing factors, and other aetiologies other than COVID-19 should be also considered. **PP** [Taskforce]

There are other additional factors which can promote anxiety, distress and agitation of patients, including clinicians wearing PPE, isolation and limitation of visitors. **PP** [ANZSPM]

If possible, optimise environment (within infection control restrictions):

- manage in a low-stimulus environment
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- use reorientation strategies (e.g. clock, calendar, radio, room board etc)
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PP [ANZSPM]

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NHS Scotland - Scottish Palliative Care Guidelines. Supportive and Palliative Care Temporary Guideline. End of Life Care Guidance when a Person is Imminently Dying from COVID-19 Lung Disease. 29 April 2020.

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