General Observation Chart for Track & Trigger System Visual Prompts

Modified Early Warning Scores				0	1	2	3	Resident Name:										
Date:																		
Time:																		
Resp Rate: < 5 or > 36	≥ 38																	
	31-35																	
	21-30																	
	9-20																	
	≤ 8																	
Resp Rate Score:																		
Oxygen Delivery (L/min)																		
SpO2	≥ 93																	
	90-92																	
	85-90																	
	≤ 84																	
SpO2 Score:																		
Temp (°C)	≥ 39.6																	
	38.6 - 39.5																	
	38 - 38.5																	
	37 - 37.9																	
	36.1 - 36.9																	
	35.1 - 36																	
	34.1 - 35																	
	≤ 34																	
Temperature Score:																		
↑ Blood ↓ Pressure <u>Scoring:</u> Systolic BP Falls < 90 = 3 90 – 99 =2 100-110 = 1 Or rises by 20-29 = 1 30 – 40 = 2 > 40 = 3 • Heart Rate **Heart Rate <40 or >140	Residents Usual Systolic BP: 200																	
	190																	
	180																	
	170																	
	160																	
	150																	
	140																	
	130																	
	120																	
	110																	
	100																	
	90																	
	80																	
	70																	
	60																	
	50																	
	40																	
Heart Rate Score:																		
BP Score:																		
Sedation Scoring 0 = Alert / conscious 1 = to voice 2 = to pain 3 = unresponsive	0																	
	1																	
	2																	
	3																	
Sedation Score:																		
Urine output over 4 hours	> 800mls																	
	120 - 800mls																	
	80 – 119mls																	
	< 80mls																	
Urine Score:																		
Total Early Warning Score:																		
Pain (√ if present)																		
New onset confusion (√)																		
Nurses Initials:																		

Name:	Room No:	DOB:	Unique Id:	GP:

General Observation Chart for Track & Trigger System Visual Prompts

Interpreting Scores

This chart is not a validated early warning system - it is simply to provide nurses with visual prompts.

It is the responsibility of the registered nurse to exercise clinical judgement in the care and management of individual residents.

Long-term conditions or illnesses / co-morbidities e.g., COPD, CCF may trigger a higher score.

0 – 1: This is a low score; but it suggests the need for a new control for the following 12 to 24 hours. This may include but not limited to:

- **Discuss with the clinical nurse manager / assistant director of nursing.**
- **Increase the frequency of vital signs monitoring**
- **May need Oxygen delivered at 2 – 3 L / min based on O_2 Saturations**
- **If blood pressure is low, may need subcutaneous fluids as per GP instructions**
- **If pyrexia present, consider paracetamol as prescribed.**

2– 4: This is a medium score; it suggests that the following needs to take place: The resident should be reviewed by / discussed with the general practitioner:

- **Possible need for transfer to hospital where appropriate and in accordance with residents wishes and preferences.**
  Or
- **A clear decision to incorporate a palliative care approach**

5 and above: This is a high score; it suggests that the resident needs the following interventions:

- **Immediate transfer to Hospital where appropriate and in accordance with residents wishes and preferences in order to benefit from specialized care according to the medical needs.**
  Or
- **A clear decision to incorporate a palliative care approach, if not already implemented.**

Covid-19 may result in a resident experiencing severe, uncontrolled breathlessness that requires rapid dose titration and urgent palliative care advice.

Name:	Room No:	DOB:	Unique Id:	GP:

Name:

Room No:

DOB:

Unique Id:

GP:

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Initial Management of Severe Breathlessness in Dying Patients with Covid-19 (in the Last Hours or Days of Life) one-pager.
For more detailed guidance, see https://www.palliativecareguidelines.scot.nhs.uk AND/OR contact Specialist Palliative Care team for advice.

Adherence to guideline recommendations will not ensure a successful outcome in every case. It is the responsibility of all professionals to exercise clinical judgement in the management of individual patients. Palliative care specialists occasionally prescribe or recommend other drugs, doses or drug combinations.

Who is this guide for?

The anticipatory prescribing and syringe pump one-pagers will provide symptom control for most patients, however some patients with Covid-19 may experience **severe, uncontrolled breathlessness** that requires rapid dose titration and urgent palliative care advice.

This is a guide to assist in the **first 90 minutes** of management of severe breathless **only.**

Principles of management:

- A clear decision to incorporate a palliative care approach has been made by senior decision-maker
- Start with lowest effective dose and titrate to effect.
- Reassess frequently.
- Use in combination with other one pagers.
- Seek specialist palliative care advice early
- Start a regular infusion to maintain symptom control once acute distress is relieved (specialist palliative care can advise as needed).

1. Supplemental Oxygen for patients at end of life

- Patients who are hypoxic may benefit from supplemental oxygen for comfort, if available.
- However, patients who are agitated/distressed by oxygen masks or tubing can have oxygen discontinued and breathlessness managed with an opioid/anxiolytic combination instead.
- Monitoring oxygen saturations is not required at end of life.
- High flow oxygen systems, NIV (BiPAP and CPAP) are not appropriate for patients at end of life.

2. Medication titration in the first 90 minutes

Initial Medication:

- **Opioid naive**: Give Morphine Sulphate 2.5mg SC
- **If already on opioids:** Give the appropriate PRN dose of the patient's regular opioid. The appropriate PRN dose is calculated as follows:
  - Divide the total 24-hour oral dose of opioid by 6 to get the oral PRN dose
  - Divide that number by 2 to obtain the SC PRN dose
  - E.g. The SC PRN dose for a patient taking MST 30mg PO BD is Morphine Sulphate 5mg SC hourly prn.

Reassessment at 30 minutes:

➢ If **effective** and patient is now comfortable PRNs may be repeat at hourly intervals as needed.

OR

➢ If **ineffective** repeat previous PRN opioid dose SC in combination with midazolam 2.5mg SC.

Reassessment at 60 minutes:

➢ If **effective** and the patient is now comfortable PRNs may be repeated at hourly intervals as needed

OR

➢ If **ineffective** increase the Morphine Sulphate PRN dose to 5mg SC (or in non-opioid naive increase dose by 50%) and give in combination with midazolam 5mg SC.

Reassessment at 90 minutes:

➢ If **ineffective**, repeat the last dose of the PRN opioid and midazolam **AND** seek **IMMEDIATE** palliative care advice which is available 24/7.

3. Diuretics if evidence that fluid overload is contributing to breathlessness

- Patients who have a history of congestive cardiac failure or who have received large volume fluid resuscitation may benefit from Furosemide 20-40mg SC PRN.

4. Non-Pharmacological

- Reassurance
- Well ventilated room/open window if possible
- Partial upright supported positioning in the bed as tolerated (see images below)

5. Further management

- Patients will require commencement of a syringe pump to maintain comfort following initial period of dose titration. Specialist palliative care will advise on appropriate doses.

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