Physical health management for psychiatric inpatients with COVID-19; a small project aimed at assimilating new evidence, devising appropriate pathways and adopting suitable prescribing guidelines.

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Background

In the face of the COVID-19 pandemic, trainees in their psychiatric rotations formed a new team to provide medical cover to general psychiatric wards on which patients with either suspected or confirmed COVID-19 were cohorted. The team's priority was to focus on physical health safety and infection control for patients whose mental health needs could not be met in less restrictive settings out of hospital[1].
This shift in focus meant integrating existing guidelines for aspects of physical health care and assimilating ever evolving evidence and information regarding the novel virus to ensure optimal patient care.

Aims

To outline pathways which were important in the management of psychiatric inpatients' physical health care during the COVID-19 pandemic.

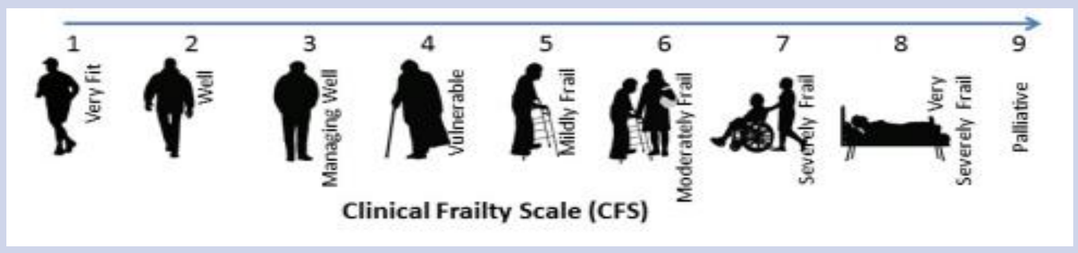
Specific new pathways

Advance Care Decisions

Factors to consider on admission:
-Discussion and documentation of escalation decisions
-Recognition of a patient that is likely to have a poor outcome
-Establish escalation for COVID-19 illness and other relevant conditions[2]

•ALL - COVID escalation based on general overview of health + CFS (if >65yrs)
•GREEN - Consider in depth discussions around Advanced Care Plans (ACPs)
•YELLOW - Should at this stage have documentation around ACPs. Consider pre-emptive medications in case of deterioration
•RED - End of Life pre-emptive medications to be prescribed and utilised

CFS was used to guide these discussions and decisions[3]:



VTE prophylaxis

What we knew:

Patients with COVID-19 infection appear to be at increased risk of thrombosis, particularly in severe disease[4].

All inpatients should be assessed on admission for the risk of VTE[5].

Patients who have reduced mobility plus another risk factor should receive anticoagulation.
Risk factors include antipsychotics.

What we did:

-Unless contraindicated we started prophylaxis in all patients with COVID-19 when in isolation and mobility was decreased

-When patients refused VTE prophylaxis we assessed capacity and where relevant made a best interests decision.

-We did not feel it was proportional to restrain patients to administer VTE prophylaxis under normal circumstances.

Vitamin D

Psychiatric patients, especially those who are institutionalised, are likely to be subject to many of the main causes of vitamin D deficiency.
There is evidence that vitamin D reduces risk of developing respiratory infection and also the severity of infection.

South London and Maudsley guidelines recommend[6]:
'All adult psychiatric in-patients are prescribed Vitamin D3 4000 IU per day for 4 weeks.
Vitamin D levels should be checked if possible during routine bloods but it has been recognised that it is not feasible to check everybody during a pandemic.'

Therefore patients should receive vitamin D supplementation regardless of the absence of a level. We prescribed it for all suspected and confirmed cases.

N.B the recommended dose is safe regardless of vitamin D level but specialist advice should be sought in the presence of:
Hypercalcaemia or a history of hypercalcaemia, Renal stones, Sarcoidosis, eGFR <60mls/min

Antibiotics

Most COVID-19 illnesses are uncomplicated and do not have a superimposed bacterial infection.
A minority will however require antibiotics and maybe hospital admission.
Local 'COVID-19 Antibiotics Guidance' was used to guide prescribing which divided patients based on severity:

Group 1	Group 2	Group 3
Asymptomatic or mild symptoms without dyspnoea Age <70, no changes on CXR	Mild/Moderate symptoms including dyspnoea CXR with Pneumonia	Severe Pneumonia with respiratory failure, ARDS or haemodynamic instability
Can continue treatment in 'community' setting No antibiotics indicated	Antibiotics likely indicated but can usually still be managed in the community setting	Antibiotics and admission to acute hospital

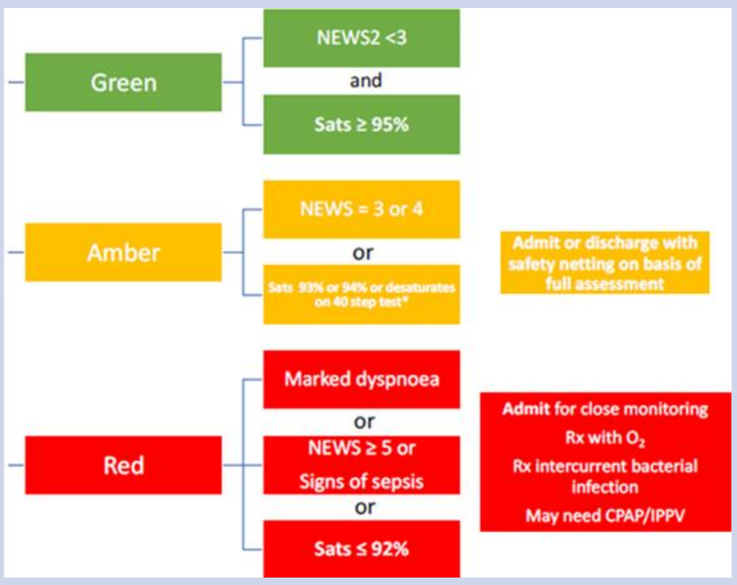
N.B where Azithromycin is recommended beware of QTc prolongation

Escalation

The vast majority of our patients were managed on the psychiatric wards however there were some who required transfer to the local acute facility.

Patients had plans around how often their NEWS should be monitored and this was reviewed a minimum of once a day during MDT.

The flow chart represents a guide to admission criteria for the local acute facility.



End of Life

Palliative care
•In general, principles of good palliative care remained the same. Visiting restrictions can make this a very difficult time and good communication with families is therefore vital.
•Fans are usually helpful for breathlessness however were not permitted during the pandemic.
•For uncontrolled symptoms, a syringe driver may be considered and continuing the patient's regular medical treatment at the end of life is made on a case-by-case basis.

Considerations for Confirming Death
•Standard PPE is considered sufficient (plastic apron, surgical mask and gloves).
•Confirm patient identification, resuscitation status and complete the examination as usual.

Considerations for After Death
•Death certificate and cremation form to be filled out.
•COVID-19 is an acceptable 1A.
•COVID-19 is not a reason on its own to notify the coroner.

Conclusion

As outlined in RCPsych guidance[1] 'if a patient displays COVID-19 symptoms, their physical healthcare takes priority'.

This led to changes in the organization and structure of daily clinical work on the wards.
As well as the necessary infection control measures we adopted care pathways and prescribing protocols to optimize the physical healthcare provided to our psychiatric inpatients with suspected or confirmed COVID-19.

References

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