**Conversations about COVID-19 to our patients in vulnerable groups**

We are working in extraordinary times.

GPs are being required to have conversations with our ‘extremely vulnerable’ population[[1]](#endnote-1) about what would happen if they contract COVID and become unwell with it.

This is part of advance care planning and constitutes and an ‘anticipatory clinical plan’.

There should be no clinical blanket ‘cut off criteria’ for those eligible for admission or for ventilation. However, it is clear to us, in primary care, that some of our deteriorating patients would not gain any clinical benefit from these interventions.

For these patients it is useful to take the opportunity to ask …

“*Whilst you are doing everything in your power to self-isolate so as not to catch COVID-19, have you considered what might happen if you do develop symptoms and become very poorly from it?*”

We can help them understand the possible options of what might happen in that scenario

1. Admission to hospital but
* that if they are –ve they have a greater chance of picking COVID up in hospital
* it is possible that they will not be offered ventilatory support or ICU admission at it is unlikely they will benefit from this intervention
1. Staying at home and being looked after at home with their symptoms controlled as much as we are able, with medication and non-pharmacological interventions.
2. The possibility that they may die in both scenarios needs to be discussed.

It is helpful to other health care professionals for these conversations to be documented in EMIS under the problem heading, “**Advance Care Planning**”. Out of Hours providers are looking for consultations under this heading when they consult EMIS.

The consultation should include

* Evidence of what the patient said and their thoughts
* If the patient does not have capacity, the evidence for your best interest decision.
* It could also be used to inform patients of any decisions you have made with regard to DNAPCR in the event of a cardiopulmonary arrest.

**Additional codes that might be helpful**

* *“Preferred place of death”*
* *“Not for attempted cardiopulmonary resuscitation”*
* *“Has appointed person with personal welfare lasting power of attorney (Mental Capacity Act 2005)”*
* *“NOK”* (whilst this has no legal standing in decision-making, it can be useful to ask the patient who they would like to speak for them, if they could not speak for themselves.)

**Other questions that might help in further discussion**

“*What is most important to you now?*”

“*Who would you like to speak on your behalf if you were unable to speak for yourself*?”

“*What can I do to make you feel better now?”*

**PLEASE NOTE**

There should NOT be a blanket policy (*eg* in your care home) for DNACPR decisions. The legal framework is clear that each of these decisions should be made on an individual basis. The risks and benefits of this clinical intervention should be weighed up for each person.

We are encouraging our secondary care colleagues to have similar discussions to the patients they see (or talk to) in clinic or who they discharge from hospital. This should NOT be purely a primary care responsibility.

1. <https://www.gov.uk/government/publications/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19/guidance-on-shielding-and-protecting-extremely-vulnerable-persons-from-covid-19>. Last accessed 23/3/2020 [↑](#endnote-ref-1)