Waitematā
District Health Board
Best Care for Everyone

Hospital Services
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22 October 2021

[redacted]

Dear [redacted]

Re: OIA request – COVID-19 treatment protocols

Thank you for your Official Information Act request received 28 September seeking information from Waitematā District Health Board (DHB) about COVID-19 treatment protocols.

Before responding to your specific questions, it may be useful to provide some context about our services.

Waitematā is the largest and one of the most rapidly growing DHBs in the country, serving a population of around 650,000 across the North Shore, Waitakere and Rodney areas. We are the largest employer in the district, employing around 8,600 people across more than 80 locations.

In addition to providing care to our own resident population, we are the Northern Region provider of forensic mental health services and child rehabilitation services, plus the metro Auckland provider of child community dental services and community alcohol and drug services.

In response to your request, we are able to provide the following information:

1. What is the Covid-19 treatment protocol for hospitalised cases?

Our COVID-19 Clinical Guide is attached – **Attachment 1**.

2. Are some DHBs following different treatment protocols from others?

Yes, some protocols differ from DHB-to-DHB.

3. Are DHBs free to make decisions about treatments for individuals with COVID-19?

While DHB protocols are based on the individual needs of each DHB, we are subject to Ministry of Health overview. In addition, the metro Auckland DHBs (Auckland, Counties Manukau and Waitematā) have a Clinical Technical Advisory Group (CTAG) to guide the treatment of COVID-19-positive patients.

4. To what extent are patients able to participate in decision-making about their treatment programmes?

Treatment cannot be provided unless patients give informed consent, except in certain limited circumstances, such as emergencies. Patients are able to fully participate in decision-making about

their treatment programmes. We comply with the Health and Disability Commission (HDC) Code of Health and Disability Services Consumers' Rights, including:

Right 6 - Right to be fully informed

(1) Every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, would expect to receive, including—

(a) an explanation of his or her condition; and
(b) an explanation of the options available, including an assessment of the expected risks, side effects, benefits, and costs of each option; and
(c) advice of the estimated time within which the services will be provided; and
(d) notification of any proposed participation in teaching or research, including whether the research requires and has received ethical approval; and
(e) any other information required by legal, professional, ethical, and other relevant standards; and
(f) the results of tests; and
(g) the results of procedures.

(2) Before making a choice or giving consent, every consumer has the right to the information that a reasonable consumer, in that consumer's circumstances, needs to make an informed choice or give informed consent.

(3) Every consumer has the right to honest and accurate answers to questions relating to services, including questions about—

(a) the identity and qualifications of the provider; and
(b) the recommendation of the provider; and
(c) how to obtain an opinion from another provider; and
(d) the results of research.

(4) Every consumer has the right to receive, on request, a written summary of information provided.

5. If a patient requests a blood test for Vitamin D and/or the administration of high-dosage Vitamin C, are hospital staff able to provide these?

Clinicians are only able to provide treatment as clinically indicated. If their clinical view is that Vitamin D and/or the administration of high-dosage Vitamin C will not benefit the patient and, therefore, is not clinically required, they are not required to provide it.

Patients have a right to care of an appropriate standard, taking into account their clinical circumstances.

6. Do hospital staff have the right to refuse a patient's request and, if so, is there a process for a patient to appeal the decision?

Hospital staff have the right to refuse a patient's request if their clinical view is that the treatment requested is not indicated for the patient's condition or there is insufficient scientific evidence supporting its use for the patient's condition.

Where a patient requests a second opinion, this is facilitated where possible.

Clinical staff discuss treatment options and pathways with each patient, providing the information necessary for the patient to provide informed consent. If the patient does not agree with the proposed treatment(s), they have the right to refuse treatment.

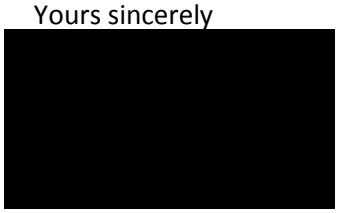
They also have the right to obtain honest and accurate answers to their questions and to seek a second opinion from another provider.

I trust that this information is helpful.

Waitematā DHB supports the open disclosure of information to assist community understanding of how we are delivering publicly funded healthcare. This includes the proactive publication of anonymised Official Information Act responses on our website from 10 working days after they have been released.

If you consider there are good reasons why this response should not be made publicly available, we will be happy to consider your views.

Yours sincerely



Executive Director Hospital Services
Waitematā District Health Board

Waitematā District Health Board
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COVID-19

Attachment 1

(PLACE PATIENT LABEL HERE)

SURNAME: _____ NHI: _____

FIRST NAMES: _____

Date of Birth: _____/_____/_____ SEX: _____

COVID-19 CLINICAL GUIDE

Date:	Time:	Clinician:	Sign:

SCOPE

At Waitematā District Health Board, patients are screened via the COVID Screening and Clinical Assessment tool to determine an appropriate management stream based on clinical criteria and epidemiological risk (higher index of suspicion).

This clinical guide is recommended for use in **probable** or **confirmed COVID-19 cases**. This includes patients who have had a confirmed COVID diagnosis in the community and are presenting for acute assessment in ED or ADU. It has been adapted from the Australian National COVID-19 Clinical Evidence Taskforce and the National Institute of Health COVID-19 Treatment Guidelines, and aligns with clinical guidance across the Auckland region.

The COVID/ID physician on call would expect to be involved at an early stage in the management of these patients.

START OF CLINICAL GUIDE - PPE AND ISOLATION

Ensure appropriate PPE and isolation measures are in place at the time of assessment
The guidelines on recommended PPE for different clinical settings is located on the intranet here.

RELEVANT HISTORY TO BE DOCUMENTED AT TIME OF ASSESSMENT AT WDHB

CLINICAL CRITERIA - (***RECENT ONSET INFECTIVE SYMPTOMS***[1])	EPIDEMIOLOGICAL LINKS
☐ Fever ☐ Sore throat ☐ Anosmia or dysgeusia ☐ New or worsening cough ☐ Shortness of breath	**Ensure a full interrogation of current locations of interest** Until the extent of community transmission is identified, all adults with respiratory symptoms with onset after 12 August will be initially managed as Blue stream Note that patients with clinical criteria who have exited a MIF within 2 weeks will be Blue stream

☐ Relevant comorbidities known to confer high risk of severe disease - *Chronic respiratory disease, cardiovascular disease, obesity, age >65, diabetes, active malignancy or chronic organ failure*

1. Patients meeting the clinical criteria for COVID-19 should be tested. Some people may present with less common symptoms such including diarrhoea, headache, myalgia, nausea, vomiting, or confusion/irritability. **If there is not another more likely diagnosis, perform SARS-CoV2 testing**

COVID-19 CLINICAL GUIDE

LABORATORY INVESTIGATIONS	TIPS FOR RE-STREAMING TO LILAC
☐ Nasopharyngeal swab - *contact Laboratory 42326 if result required urgently* - *add extended viral PCR panel if compatible illness* ☐ Lower respiratory sample (sputum) - *Consider testing if >1-2 weeks into illness Test for SARS-CoV-2, M/C/S, viral respiratory panel and atypical respiratory panel* ☐ Full blood count ☐ Serum chemistry - *Electrolytes, Renal function, Liver Function, Ferritin, CRP* ☐ Coagulation studies and D-dimer ☐ Consider ABG *if hypoxia or concern re: hypercapnoea* ☐ Screen for alternative infective aetiology as indicated -*consider blood cultures, urinary legionella and pneumococcal antigens*	• *Consider vaccination, community prevalence, exposure history (Locations of interest, family primary contacts), alternative cause for symptoms* • *PCR sensitivity highest (90-94%) first 1-2 weeks of illness* • *CXR reduced specificity in low prevalence setting* • *Repeat NP swabs are not routinely required but may be requested by ID*

IDENTIFY PATIENTS ABLE TO BE STREAMED FROM BLUE TO LILAC

If no exposure or incompatible timing of symptom onset, negative PCR (conducted ≥1d but <7-14d of symptoms) or alternative source found - can change stream from blue to lilac

If you are not confident to exclude COVID-19 based on negative SARS-CoV2 PCR result for the above or other reasons please contact COVID ID SMO. **The patient will remain Blue Stream 'under investigation'**

ID will advise on streaming and additional investigations. Possible work up may include repeat NP PCR, sputum (prolonged illness or specific CXR changes), additional imaging including CT chest, serology (if >14d of symptoms). ID will review and advise on change of stream in these cases.

COVID CONFIRMED: ASSESS CURRENT SEVERITY OF COVID DISEASE

Consider the current stage of the disease and the potential trajectory.
Note - patients have the potential to deteriorate in the second week of illness.

SEVERITY	SIGNS AND SYMPTOMS
Mild illness	Symptoms and signs consistent with COVID-19 but no symptoms or signs of pneumonia and normal (or unchanged) oxygen saturation
Moderate illness	COVID-19 disease with pneumonia or dyspnoea but not meeting criteria for severe illness (SpO2 ≥ 92% on room air at rest)
Severe illness	COVID-19 pneumonia with one of the following: RR ≥30/min, oxygen saturation <92% on room air at rest, or PaO2/FiO2 ≤ 300.
Critical illness	Respiratory failure, shock, impairment of consciousness, or multiple organ dysfunction/failure

MANAGEMENT RECOMMENDATIONS FOR CONFIRMED COVID CASES	
☐ **Consider need for admission**	Discuss whether this patient should be admitted with the ID/COVID physician. Patients with severe or critical COVID-19 should be admitted to hospital as should some patients with mild or moderate COVID-19 but who are vulnerable or need admission for other reasons (e.g. infection prevention and control if from an Aged Residential Care facility).
☐ **Goals of Care**	Establish ceiling of care and resuscitation decisions. Discuss with patient and whānau, documenting the outcome. Check whether the patient has an advanced care plan or EPOA.
☐ **Oxygen**	Give supplemental oxygen if hypoxic. This should be prescribed on MedChart. • Target saturations of 92-96% or 88-92% if Type 2 Respiratory Failure Oxygen via High-Flow Nasal Prongs can be considered in a negative pressure room with appropriate PPE if required to maintain SaO2 ≥ 92%. Link here [Paul's doc]
☐ **Anticoagulation**	Discuss enrolment in the ASCOT trial (liaise with Dr Bhally). Use treatment dose enoxaparin (1 mg/kg bd) for patients with moderate / severe COVID-19 disease who are not admitted to ICU/HDU with normal renal function and no risk for major bleeding. Consider therapeutic anticoagulation 1 mg/kg once daily in renal impairment with a CrCl <30 ml/min. Discuss with haematology if platelets <50 or fibrinogen <1. Discuss dosing and duration of enoxaparin in pregnancy with obstetric medicine.
☐ **Antivirals**	Consider giving five days of remdesivir (protocol here) to patients who meet the following Pharmac inclusion criteria: Oxygen saturations ≤92% on air and requiring supplemental oxygen ALT <5x the upper limit of normal Do not give remdesivir to patients who meet any of the exclusion criteria (e.g. multiorgan failure, renal impairment with an eGRF <30 ml/min or requiring dialysis, requiring mechanical ventilation for > 48 hours, receiving ECMO) Give 200 mg IV on day one and then 100 mg IV daily for four more days.
☐ **Immune modulation**	Give dexamethasone 6 mg IV/PO daily for up to 10 days in patients requiring oxygen and/or ventilatory support to maintain oxygen saturation ≥92%. Steroids can be given for another evidence-based indication (e.g. asthma/COPD exacerbations) as per usual practice. Give tocilizumab (protocol here) 8 mg/kg (up to 800 mg) as a single dose to patients receiving dexamethasone (or where dexamethasone is contraindicated) with a persistent oxygen requirement, evidence of systemic inflammation (e.g. CRP ≥75mg/L), and no evidence of an active and severe secondary infection.
☐ **Nutrition**	Low threshold for regular supplementation – liaise with dietitian if required
☐ **Fluid Balance**	Take a conservative approach to fluid if there are no signs of shock, aiming for SBP >100mmHg. • Use crystalloid solutions for fluid replacement *e.g normal saline or plasmalyte* • If the patient is able to drink, encourage oral fluids If not, maintenance fluids are 30mls/kg/day + 500-1000mls
☐ **Antimicrobials**	Antimicrobials are not routinely recommended • Give empiric antibiotics if clear signs of pneumonia on chest x-ray (refer to WDHB Antibiotic guidelines). *Note - bacterial co-infection with COVID is relatively uncommon compared to other viral respiratory illnesses*
☐ **Regular medications**	Regular medications should be continued as appropriate for the clinical setting • Patients who are already taking ACEi / ARB medications should continue on these unless there are other contraindications *e.g. hypotension, AKI etc* • Regular paracetamol should be used for all patients as the anti-pyretic of choice but NSAIDs are not contraindicated in COVID patients.

PALLIATIVE CARE RECOMMENDATIONS

The Palliative Care Service have developed COVID-19 Palliative Care pages on the WDHB intranet for guidance around symptom management, shared goals of care, communication, compassion, and care of the dying patient.

☐ **Symptom management**	Symptoms should be assessed and managed for all patients regardless of prognosis, alongside active and supportive therapies for COVID infection. • There is a stepwise protocol for symptom management available on the intranet
☐ **Shared Goals of Care**	Conversations about goals of care and treatment escalation should be initiated early, involving patient, family and whānau when possible.
☐ **Care of the dying patient**	Information about care of the dying patient is outlined in detail on the intranet • Inform family and whānau of what to expect when their loved one is dying • Ask what practices are important for them. • Ask if they would like additional support *e.g. chaplain or social worker* • Be aware of particular changes in care around death *e.g. family unable to remain with the body or changes to funeral arrangements*

DISPOSITION

☐ **Any patient discharge must be discussed with both the COVID/ID physician and ARPHS**
Please refer to the latest guidance from the Ministry of Health - advice for health professionals

☐ **Admit all COVID patients with severe or critical illness**

☐ **Consider admission of vulnerable adults regardless of their current severity of illness**
Vulnerable adults are patients at risk of rapid deterioration. They are defined as:
- *Older adults (aged 65 years or older)*
- *Patients who live in residential care facilities*
- *Patients with underlying medical conditions: Chronic respiratory disease, Cardiovascular disease, Diabetes, Cancer, Chronic organ failure(s)*

Note - Repeating nasopharyngeal swabs to document 'clearance' for confirmed cases is not generally recommended and should be discussed with the ID SMO on a case-by-case basis.

Useful additional clinical resources include:
The World Health Organisation case management guide
Australian National Covid-19 Clinical Evidence Taskforce living guidelines (endorsed by the Australasian Society for Infectious Diseases)