Practical Advice for Healthcare Professionals Working in Residential Care Settings for Older People

Webinar - 26th March 2020

www.hse.ie/coronavirus
www.hpsc.ie
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Residential Services for Older People

Purpose:
Provide practical guidance to healthcare staff providing continuing care
Re: the management of COVID-19

In general, residents in residential care who are COVID-19 Positive should be managed in their facilities.

Please refer to www.hse.ie/coronavirus
www.hpsc.ie regularly for updates
COVID 19 in LTCFs

- COVID identification and Referral Pathways
- Managing resident clinical care with COVID
- Advance Care Planning Issues
- Palliative Management in last hours or days
- Managing outbreaks including IPC Guidance and HCW guidance
COVID Identification and Referral for Testing
Novel Coronavirus (COVID-19, SARS-CoV2)

- Incubation period:
  - Current information suggests that it may range from 2-11 days. Can be up to 14 days
  - Clinical information about the disease is evolving.

Dr Toney Thomas, Beaumont Hospital and RCSI, Dublin, Ireland
Novel Coronavirus (COVID-19, SARS-CoV-2)

• **Transmission:**
The virus can spread from person to person, usually after close contact with a person infected with the virus.
  • directly, through contact with an infected person’s body fluids (e.g. droplets from coughing or sneezing)
  • indirectly, through contact with surfaces that an infected person has coughed or sneezed on
• **Similar to how Flu is spread**
• **How to prevent spread?**
  • One of the best ways to prevent person to person spread of respiratory viruses, including COVID-19, is to use proper hand hygiene and respiratory etiquette.
Co-morbidities associated with increased risk

• Age > 60 years, highest in >75
• Cardiovascular disease
• Hypertension
• Diabetes
• Chronic respiratory disease
• Cancer
• Immunocompromised
Suspect COVID-19

- Fever/Chills
- Cough
- Respiratory tract infection
CLINICAL PRESENTATION - note possible atypical presentations in older people

Based on an early analysis of case series, the most common symptoms are:

**MOST COMMON SYMPTOMS ARE:**
- Cough
- Dyspnoea
- Myalgia
- Fatigue
- Fever

**LESS COMMON SYMPTOMS INCLUDE:**
- Anorexia
- Sputum production
- Sore throat
- Confusion
- Dizziness
- Headache
- Rhinorrhoea
- Chest pain
- Haemoptysis
- Diarrhoea
- Nausea/vomiting
- Abdominal pain
- Conjunctival congestion.

(BMJ Best Practice)
Acute confusion/delirium

Atypical presentations may include acute onset confusion/delirium suspect COVID-19. However in the case of delirium other possible causes must also be out ruled (see video for more information on delirium).
PROTOCOL for suspected COVID-19

• Criteria:
  • Patient meets clinical criteria
  • Assess deviation from baseline condition
  • Clinical Judgement

• Consider Senior Clinician (GP/MO/DON/PIC) re ? Need for testing

• While awaiting review isolate patient
COVID-19 Assessment and testing pathway for symptomatic resident in Residential facilities (RF) and Long Term Care Facilities (LTCF)

Isolate the resident in his/her room. Resident’s GP or Medical Director to perform risk assessment

A patient with acute respiratory illness (fever and at least one sign/symptom of respiratory disease, e.g., cough, shortness of breath);

OR

A patient with any acute respiratory illness AND having been in contact with a confirmed or probable COVID-19 case in the last 14 days prior to symptom onset;

Clinical judgement should be employed when assessing these criteria. Clinicians should be alert to the possibility of atypical presentations in older patients and those who are immunocompromised, for example low temperature rather than fever. A higher index of suspicion is needed if there is a COVID-19 positive case or contact in the RCF/LTCF.

Criteria not met: Resident has some symptoms of respiratory tract infection but doesn’t meet the above criteria

Meets criteria

Check if there are any other residents with COVID-19 symptoms (i.e. outbreak) in the RF/LTCF

No other cases

Testing should be managed through NAS according to the NAS document on COVID-19 Testing in Residential Settings.

- If multiple residents / potential cluster are identified within a unit, this should be identified within the referring email to NAS
- Notify Public Health of outbreaks within unit as per Preliminary COVID-19 IPC Guidance including Outbreak Control in Residential Care Facilities and Similar Units
- Following confirmation of a COVID-19 positive diagnosis within the unit, it is assumed that all residents presenting with symptoms are COVID-19 positive. Multiple re-referrals to NAS for potential COVID cases should be avoided

Yes other suspected cases

Arrange COVID-19 testing:
A. If resident can attend a community testing site, they should be referred by a GP via Healthlink, as per Telephone assessment and testing pathway for patients who phone GP and healthcare settings other than receiving hospitals
B. If resident is unable to attend a community testing site, testing should be managed according to National Ambulance Service document on: COVID-19 Testing in Residential Settings

Unless assessment at hospital is indicated, the resident should remain isolated from other residents within the facility for a minimum of 14 days from symptom onset, the last 5 of which they should be without fever.

Please refer to information leaflets on patient self-isolation.

If positive, advise resident to self-isolate for a minimum of 14 days from the onset of symptoms, the last 5 days of which should be without fever.
If not detected: Advise resident to self-isolate until 48 hours after resolution of symptoms.

Adopt Infection Prevention and Control precautions as per Preliminary COVID-19 IPC Guidance including Outbreak Control in Residential Care Facilities and Similar Units.
COVID 19 in RCF

Clinical Management
Key Message

Residents with suspected or confirmed COVID 19 should be managed in the Long Term Care Facility in all but very exceptional circumstances.

Plan of care for most will be supportive treatment. Transfer to acute hospital will confer little if any additional benefit and may increase risk.

All staff need to understand this and early engagement with residents and families to make them aware of this needs to be happening around all discussions pertaining to COVID 19.
Initial Management - ? COVID

**Altered respiratory status**
- New or worsened cough
- New or worsening shortness of breath
- New or increased sputum

**Altered Mental Status**
- New signs or symptoms of increased confusion/delirium
- Decreased level of consciousness
- Inability to perform usual activities (due to mental status change)
- New or worsening agitation
- New or worsening delusions or hallucinations

**Altered body temperature**

**Manage in Residential Care Facility**
- Monitor vital signs
- Use escalation protocol AND clinical judgement
- Monitor Intake & Output as appropriate/per local policy
- Review medication
- Consider antibiotic therapy
- Evaluate Vital Signs and interventions as appropriate
- Evaluate signs and symptoms as appropriate for improvement/deterioration
- Check Advance Care Plan
- Communicate using ISBAR

**RECORD VITAL SIGNS**
- Escalation Protocol Flow chart see next slides

**Click on links below**
- Review COVID [guidelines](#)
- PPE as per current HPSC [recommendations](#)

**CONSIDER POSSIBILITY OF NON-COVID RELATED DETERIORATION !**
Vital signs should be recorded on a graph to ensure early alert to deteriorating resident.
Recognising deterioration

**Key early signs** of deterioration in all residents are:

- A change in respiratory rate; RR should be counted for a full 60 seconds
- A new requirement for supplemental oxygen or an increasing requirement to sustain SpO2 levels
- New confusion/ altered mental status
In Deteriorating Patient with suspect / COVID 19 consider following parameters of response

1. Be aware that deterioration can occur quite rapidly
2. Set an observation protocol in place that can be managed relative to your available staff and skillset and needs of the deteriorating resident
3. Be prepared!
4. Ensure first principles supportive Care for Hypoxia, Pain, Fever and / or other symptoms
5. Refer to Advance Care Plan and anticipatory guidance
6. Consider need for additional senior nursing and / or medical review especially if considering transfer out of unit
7. Stay in regular contact with the resident’s family
Investigations to be considered - use clinical discretion

- Monitor and record Vital signs
- Pulse oximetry
- If indicated by GP/MO/OOH/Senior Clinician:
  - Throat/ Nasal Swab
  - FBC
  - U&E, LFT
  - CXR
  - Investigations to out rule underlying non COVID-19 related conditions may be appropriate

PLEASE NOTE
Clinical discretion and judgement should be used regarding further investigation and risks posed by transfer to and from hospital facilities
Supportive therapies

• Monitoring of vital signs by pulse oximetry, BP, RR, Temp on minimum twice daily basis / as determined in conjunction with GP/ MO or other medical advice

• Monitor for common symptoms identified above and treat accordingly with supportive measures including paracetamol and oxygen

• Optimise and encourage good oral fluid and nutritional intake

• Use clinical judgement regarding appropriateness of monitoring where there is an expected change in the patient’s clinical condition

• Oxygen: supplemental oxygen maybe appropriate in certain situations to alleviate symptoms and distress
Use of Oxygen in LTCFs during COVID

- Patients who are hypoxic may benefit from oxygen
- Absence of oxygen in care facility should not determine decision to transfer a resident...this should be determined by the agreed ceiling of care
- Has a limited role in supportive care in this setting
- May help with symptom of breathlessness
- Where primary objective of care is supportive then titrate oxygen levels to provide comfort
- Generally appropriate O2 flow levels of 2 /3 L /min or to keep saturations at ≥ 90%
- If oxygen not adding to comfort then prioritise other palliative measures over oxygenation
Oxygen at End of Life

- Patients who are hypoxic at EOL may benefit from supplemental O2 for comfort, if available.
- However, patients who are agitated/distressed by oxygen masks or tubing can have O2 discontinued and have pharmacological management of breathlessness instead.
- Monitoring of oxygen saturations is not required in the EOL period.
Advance Care Planning
Advance Care Planning

- Should be part of normal good practice in this setting
- Reflect on current ACPs and residents baseline status
- Be aware that survival and outcomes with COVID 19 are poor in this patient group.
- For very frail (e.g. CFS 7,8,9) intubation / ventilation with COVID 19 won’t work for them. If the resident survives ICU they are likely to have significant functional decline.
- Most of the supportive care they need in LTC can be provided for them there
- Be aware that CPR in residents with COVID 19 poses significant risk of infection transmission to healthcare workers
Advance Care Planning—particularly important if:

- A resident has a life-limiting advanced progressive illness including dementia
- A resident is very frail
- When the answer is ‘No’ to the following question - “Would you be at all surprised if this resident were to die in the next year?”
- If there has been a recent significant deterioration in the resident’s condition
- If referral to specialist palliative care services is planned

The outcomes of advance healthcare planning, including any decisions about ceilings of care, should be carefully documented and communicated to all staff.
Summary response

- Management of all known or suspect COVID 19 residents will take place in the LTCF itself
- Need to ensure that the facility is prepared for same
- Ensure anticipatory care plan is available
- Avoid offering treatment that will not confer benefit in this setting
- If non-COVID related follow usual pathways of management and referral
Managing Care in Last Hours or Days of Life; COVID 19 Specific Issues
Nursing Considerations at end of life during Covid 19

Frances Neville
Nurse Lead Clinical Programme Palliative Care
March 26th 2020
Covid-19

- The COVID-19 outbreak currently being experienced around the world is unprecedented.
- We all need to work together to ensure our residents receive the care that they require.
- Important that the resident is supported at the end of their life or those who are very unwell as the result of both Covid-19 or other life-limiting illnesses.
Diagnosing dying

- Not easy to do, reassess, involve the team
- Clinicians must accurately diagnose dying in order to ensure that a high standard of end of life care is provided to all who need it
- Some physical signs: profound weakness, withdrawal from the world, reduced cognition, reduced levels of consciousness, reduced intake, difficulty with swallowing medications, bronchial secretions, reduced urinary output.
Nursing considerations

- Nurses and midwives have a vital role to play in treating patients and containing the virus, whilst also maintaining ongoing healthcare services. (NMBI, 2020)

- Dyspnoea or breathlessness is a distressing symptom which frightens both patients and caregivers

- Breathlessness common in the advanced stages of many chronic diseases and for Covid-19 positive patients
Nursing management of breathlessness

- In the last hours of life, breathlessness can be a distressing symptom, but nurses can reduce suffering and distress for the patient and the family.

- Have a comprehensive plan of care which focuses on the patient and symptom control considering psychological, social and spiritual issues.
- Aim to diminish the sensation of breathlessness
- Pharmacological management is key but overarching nursing care is important
- Reassure, comfort and reduce anxiety which will reduce suffering
Refer to Anticipatory Prescribing in the Last Hours or days of life

- Opioid (Morphine sulphate) combined with an anxiolytic (Midazolam) are very effective for breathlessness

- Very distressed patients will require subcutaneous injections PRN, hourly administration and dose titration may be necessary
Clinical decision making is an essential component to end of life care

Nurses at the frontline of care can influence the experience of care

Using their skills of assessment, being with the patient and relatives

Effective communication
Non-pharmacological management

- Positioning: forward lean, adapt with pillows/bed table
- Felling of ‘fresh air’, open window
- Use of hand held fan, assisted by family/carer
- Mouth care: ensure mucous membranes and lips are kept moist
- Acknowledge the feeling and fear, reassure them that the unpleasant feeling will pass
Palliative Care - Anticipatory Prescribing

For which patients?
If a patient is in the last hours of days of life it is helpful if ‘anticipatory medication’ for symptom control at the end of life (EOL)

What medications?
4 symptoms commonly require medications for relief at the EOL.

1. Opioid for pain and/or breathlessness (for opioid naïve patient)
   Morphine sulphate injection (10mg/ml ampoules)
   - Dose: 3.5mg SC repeated at hourly intervals as needed for pain or breathlessness
   - If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review
   - If more than 6 doses are required in 24 hours seek advice or review
   Note: Patients who are severely distressed may require rapid dose titration and urgent palliative care advice should be sought to guide management in these cases.

2. Anxiolytic sedative for anxiety or agitation or breathlessness
   Midazolam injection (10mg in 2ml ampoules)
   - Dose: 2.5mg SC, repeated at hourly intervals as needed for anxiety/distress
   - If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review
   - If more than 6 doses are required in 24 hours seek advice or review
   Note: If on large background doses of O2Ds, a larger dose may be needed (if they are frail, a smaller dose may be enough)
   Levomepromazine or haloperidol can be used in agitated delirium.
   - Levomepromazine 3.125 to 6.25mg SC, hourly as needed or haloperidol 0.5 to 1mg hourly as needed if levomepromazine not available.
   - If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review
   - If more than 6 doses are required in 24 hours seek urgent advice or review

3. Anti-secretory for respiratory secretions
   Hyoscine butylbromide injection (Buscapan®) (20mg/ml ampoules)
   - Dose: 20mg SC, hourly as needed.
   (Maximum dose 120mg in 24 hours)
   OR: Glycopyrronium injection (200mcg/ml ampoules)
   - Dose: 700mcg SC, hourly as needed.
   (Maximum dose 2.4mg in 24 hours)

4. Anti-emetic for nausea or vomiting
   Levomepromazine injection (25mg/ml ampoules)
   - Dose: 3.125 to 6.25mg SC, 12 hourly as needed.
   OR: Haloperidol 0.5 to 1mg SC, 12 hourly as needed if levomepromazine not available.

   - It is essential to review the effect of any PRN medicine after it has been administered.
   - There should be a review of the treatment plan within one hour to assess if the administered medication has had the desired effect/ no effect/ a partial, but inadequate, effect on the symptom.
   - There should be a review of the treatment plan within 24 hours when the administered medication:
     - is effective for an appropriate and expected time,
     - has had a limited duration of effectiveness that has necessitated three or more repeated doses.
   - As part of the review, the doses of regular medication, such as modified release tablets, transdermal patches or those given by syringe pump, should be considered. If there are signs of toxicity, a dose reduction, or drug switch, may be required. Advice from specialist palliative care should be sought if needed.
   - Consider starting a syringe pump if symptoms persist (see syringe pump one page).

Version 1. 19.3.20 Refer to online resource for most up to date information.

Non-Pharmacological Care in the Last Hours or Days of Life One-pager (Version 5. 25.3.20)

Adherence to guideline recommendations will not ensure a successful outcome in every case. For more detailed guidance, suggest https://www.palliativecareguidelines.scot.nhs.uk AND/OR contact specialist palliative care team for advice. It is the responsibility of all professionals to exercise clinical judgement in the management of individual patients. In the event of a patient unexpectedly stabilising / improving, reconsider the diagnosis of ‘dying’.

SHIFT TO FOCUS ON COMFORT CARE:

General considerations
Discontinue unnecessary prescriptions, monitoring activities, and procedures. Consider stopping anything that doesn’t focus on comfort and alleviating symptoms/distress unless there is a good reason to continue it. Common areas that require review include:
- I/V fluids, antibiotics, s/c heparin, insulin, enteral nutrition & TPN.
- O₂ masks and nasal prongs unless clear symptom benefit.
- Stop blood and radiological tests.
- Stop monitoring vital signs including oxygen saturation, fluid balance etc.
- Deactivate ICDs and remove cardiac monitors.
- Ensure DNACPR order signed / EWS stopped.

PHYSICAL CARE:

Respiratory Secretions:
- Explain to family & reassure that it may not represent discomfort.
- Re-positioning patient on side may help.
- Assess need for pharmacological intervention.
- Suctioning is rarely useful or indicated in last hours/days of life and has all the associated infection risks of an aerosol-generating procedure (AGP). It should be avoided where possible.

Bowel care:
- Invasive procedures for bowel care rarely needed when imminently dying.

Urinary care:
- Catheterise if in urinary retention or incontinence likely to cause loss of skin integrity or aids the general comfort level of patient.

Mouth care:
- Ensure mouth and lips are clean and moist.
- Regularly moisten oral cavity with sips of water /water-based gel when able to swallow or with moist mouth sponge when unable.

Food and fluid:
- Continue to offer variety of soft foods / sips of water through teaspoon / straw while conscious, able to sit up, and as appropriate.
- Accept when patient unable/declines to take as this is natural part of dying. Never force.

General comfort:
- Repositioning, regular turning 2 – 4 hourly to prevent pressure sores.
- Regular skin and eye care.

SOCIAL / FAMILY CARE * Physical presence will depend on infection control protocols
- Explain to family that death is approaching in sensitive yet clear way.
- Explain focus of care is on comfort and dignity.
- Explain the expected changes in physical and cognitive function as this will relieve distress for family.
- Check previous experiences and understanding of dying as it may allow you to correct misunderstandings.

ENVIRONMENT:

General Physical environment:
- Where possible a quiet, peaceful environment is preferable.
- Minimise loud noises and bright lights (delirium is not uncommon in last days/hours of life).

Bedside environment:
- Calm, reassuring bedside presence.
- Inform patient (even if unresponsive) who you are and what you are doing or about to do.

PSYCHOLOGICAL / SPIRITUAL CARE:

Insight:
- Where appropriate, patient insight should be assessed and fears / wishes explored.
- Consider if formal pastoral care support needed / rituals which are important to patient & family.

QUESTIONS FAMILY MEMBERS OFTEN ASK
- How long has (s) he got?
- “We can’t be certain, but it’s likely to be within a few hours or days at most. What would you like for her?”
- Can (s)he still hear?
- “We don’t know for sure but if you would like to say something, now is the time”
- How will you know if (s)he has pain?
- “We will watch carefully for signs of distress. We will give whatever medication is needed to keep him/her pain free and comfortable”
- Is (s)he dying of dehydration or starvation?
- “At this time, all of the vital organs including his heart and kidneys are shutting down. His/her body cannot cope with food or fluid right now.”

Version 5. 25.3.20 Refer to https://www.palliativecareguidelines.scot.nhs.uk/ for most up to date information.
Managing COVID 19 Outbreaks in RCFs - IPC and HCW Guidance
Key guidance information from the several infection prevention and control issues discussed on the webinar may have been hampered by sound difficulties.

HPSC Guidance for should be accessed and are available for all staff in the community residential facilities www.hpsc.ie

The National Infection Control Team in the HPSC are providing a 1 hour webinar on Friday 3rd April at 10am for all community residential facilities.

If you have a query you want raised or clarified that is not answered in the current guidance email to mary.mckenna@hse.ie and these will be included in the forthcoming webinar on Friday.
Please note: Invitation to COVID-19 IPC live webinar (dedicated to infection control management of Residents in Community Residential Facilities and in-Patient Facilities Outside of Acute Hospitals)

Presented by HPSC AMRIC Team: Prof. Martin Cormican, National HCAI Clinical Lead and Mary McKenna, IPC Asst. Director of Nursing,

Date and time: Friday, April 3, 2020 from 10-11am

Pre-register for the event at this address and follow the instructions: https://hse-webinar.webex.com/hse-webinar/onstage/g.php?MTID=e1acc1122f7a6b330b8b10409d2db78f

When you join the webinar you can listen to the presenters live over the computer but sound quality is better over the phone. Your phone line will be muted but you can log queries and comments to the speakers in the chat box on the screen when the webinar commences.

Irish dial in number: 015260058 Access code: 141 972 966
Important COVID-19 Guidance for RCFs

Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance include Outbreak Control in Residential Care Facilities (RCF) and Similar Units available at the following HPSC link

Guidance on the transfer of hospitalised patients from an acute hospital to a residential care facility in the context of the global COVID-19 epidemic

Current recommendations for the use of Personal Protective Equipment (PPE) in the management of suspected or confirmed COVID-19.

( Copy and past the attached link into your web browser)

Safe and appropriate use of PPE is essential for all healthcare workers
You are encouraged to complete the HSE-land module on Putting on and Taking Off PPE in the Community Healthcare Setting by logging onto HSE land on the following link

https://www.hseland.ie/dash/Account/Login

It only takes about 10 minutes to complete and there is certification following self assessment
Looking forward to having you at the IPC webinar on Friday 3rd April at 10am

Take home messages
• Hand Hygiene
• PPE worn and removed properly
• Social Distancing
• Keep everyone safe
Summary

• Patient care is straightforward
• IPC & PPE is hard to do right, every time
  • But it is your safe-guard
• Monitor for deterioration
• Timely anticipatory care planning will ensure optimal outcomes for patients/residents