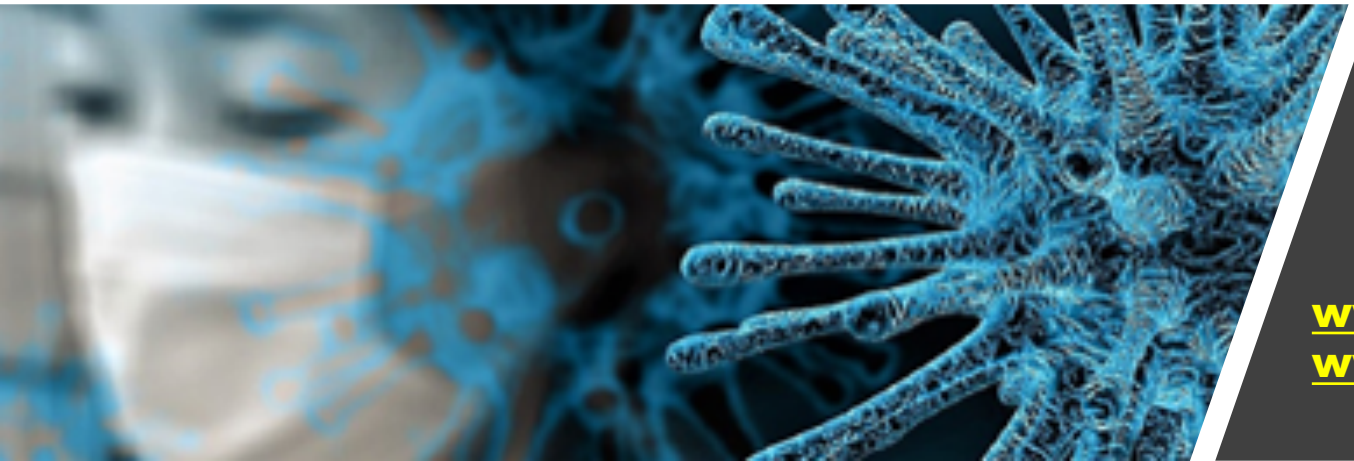
Coronavirus
COVID-19

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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- Click on the links as you go through the presentation to bring you to supporting documents and sites.
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- To play the presentation go to the 4th icon on the bottom right of your screen

Residential Services for Older People

Purpose:

Provide practical guidance to healthcare staff providing continuing care

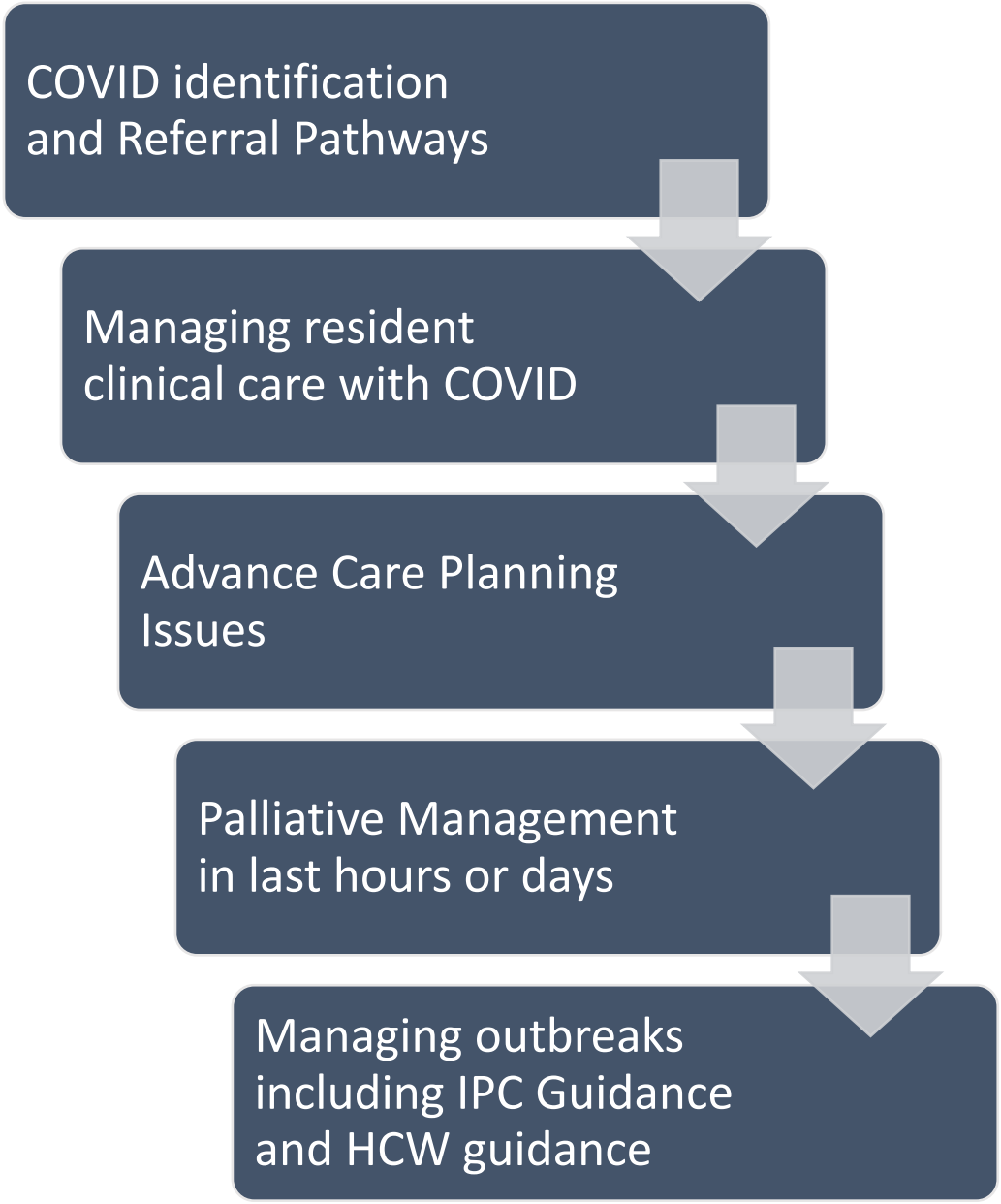
Re: the management of COVID-19

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



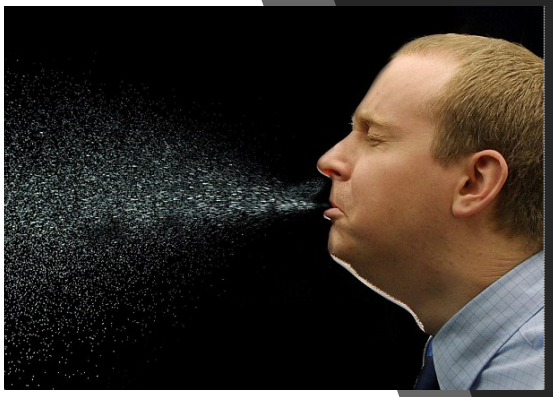
COVID Identification and Referral for Testing

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)



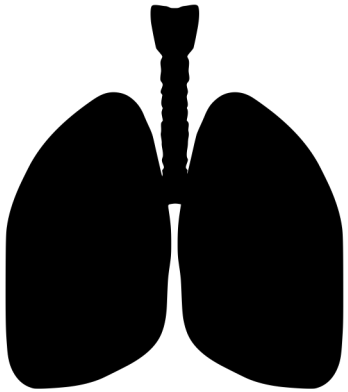
- **Transmission:**

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

(BMJ Best Practice)

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

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).

Click here for video

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 <u>isolate patient</u>**

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

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.

Meets criteria

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

No other 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, isolate the resident, **pending results**:

- **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.

Yes other suspected 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

Version 1.0 Publication date: 27/03/2020
Reviewed and approved by COVID-19 Expert Advisory Group: 27/03/2020

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

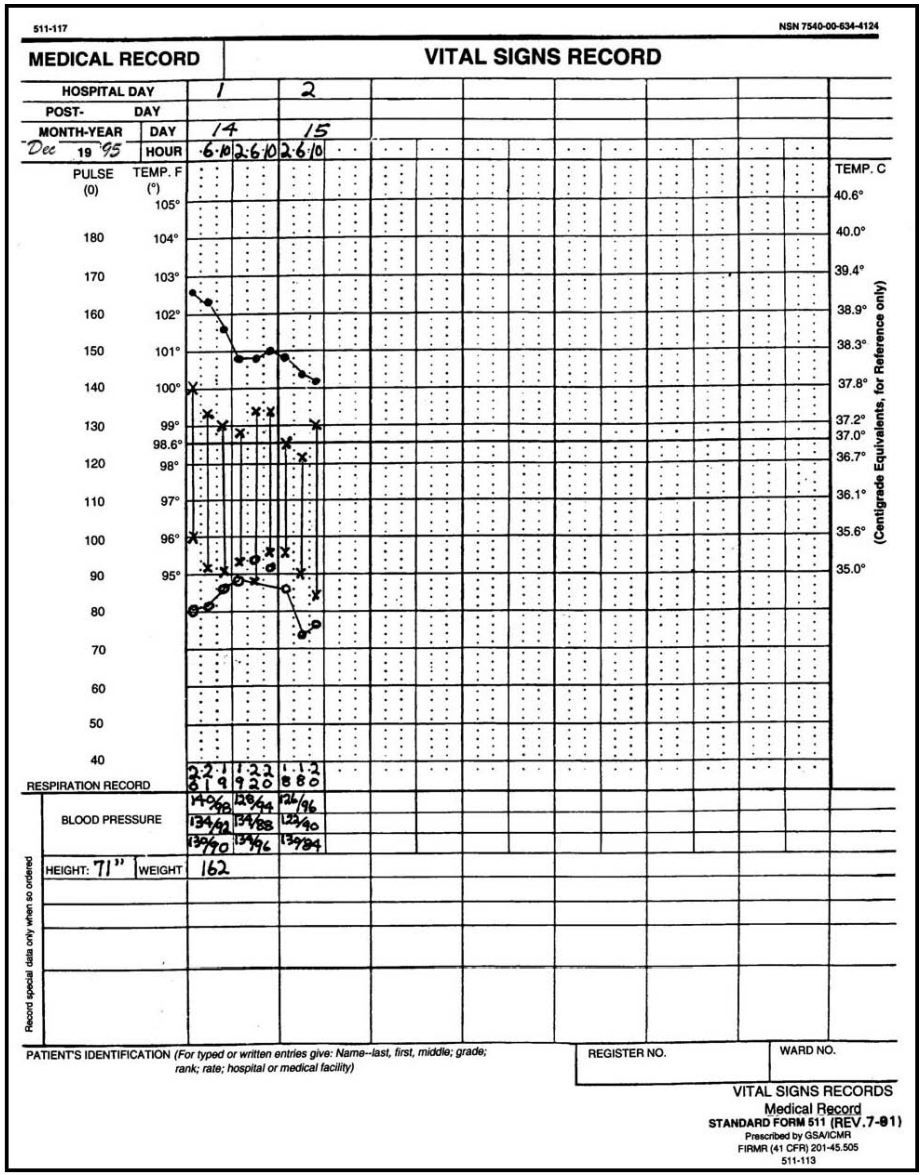
→ **Manage in Residential Care Facility**
- Monitor vital signs
- Use escalation protocol AND clinical judgement
- Monitor Intake & Output as appropriate/per local policy
- Review medication
- Consider antibiotic therapy
- Evaluate Vital Signs and interventions as appropriate
- Evaluate signs and symptoms 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



511-117

NSN 7540-00-634-4124

MEDICAL RECORD — **VITAL SIGNS RECORD**

HOSPITAL DAY	1	2
POST- DAY		
MONTH-YEAR DAY	14	15
Dec 19 95 HOUR	6 10 2 6 10	2 6 10

PULSE (0) | TEMP. F (°)

105° 104° 103° 102° 101° 100° 99° 98.6° 98° 97° 96° 95°

180 170 160 150 140 130 120 110 100 90 80 70 60 50 40

TEMP. C: 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD: 22 18 | 12 19 | 12 20 | 11 18

BLOOD PRESSURE: 140/98 | 134/92 | 130/70 | 128/94 | 134/88 | 134/96 | 126/96 | 122/90 | 130/84

HEIGHT: 71" | WEIGHT: 162

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; rank; rate; hospital or medical facility)*

REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS
Medical Record
STANDARD FORM 511 (REV.7-91)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
511-113

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

Communication using ISBAR

ISBAR For Clear Communication	
I	**IDENTIFY**: Yourself (name, position, location) & patient
S	**SITUATION**: Why you are calling (if urgent-say so)
B	**BACKGROUND:** Tell the story
A	**ASSESSMENT:** What you think is going on
R	**REQUEST:** What you want from them

Click on link below to bring you to further information on using ISBAR

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

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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.

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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 al 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

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

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

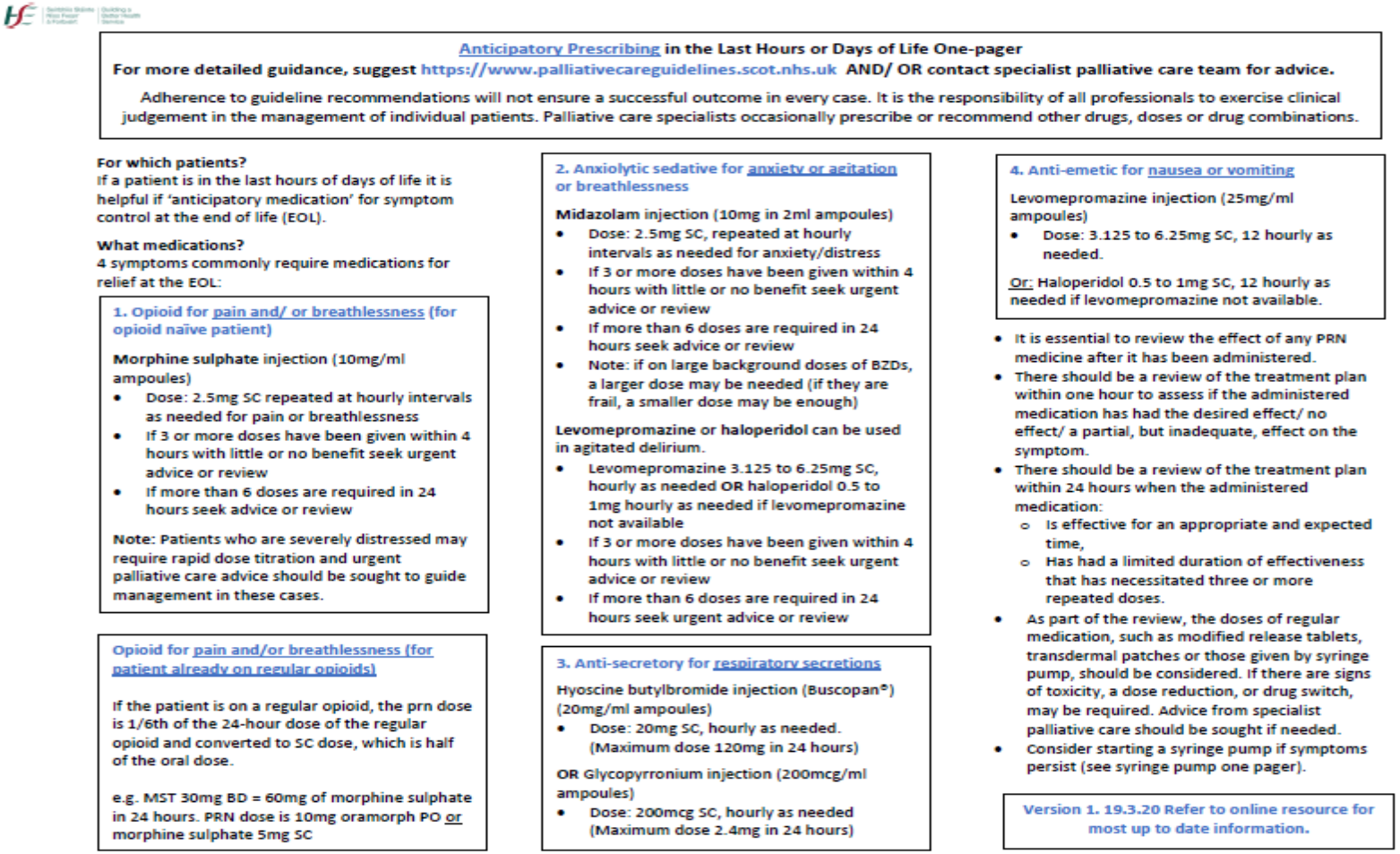
- Clinical decision making is an essential component to end of life care
- Nurses at the frontline of care can influence the experience of care
- Using their skills of assessment, being with the patient and relatives
- Effective communication

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

https://www.palliativecareguidelines.scot.nhs.uk/



Anticipatory Prescribing in the Last Hours or Days of Life One-pager

For more detailed guidance, suggest 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.

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: 2.5mg 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.

Opioid for pain and/or breathlessness (for patient already on regular opioids)

If the patient is on a regular opioid, the prn dose is 1/6th of the 24-hour dose of the regular opioid and converted to SC dose, which is half of the oral dose.

e.g. MST 30mg BD = 60mg of morphine sulphate in 24 hours. PRN dose is 10mg oramorph PO or morphine sulphate 5mg SC

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 BZDs, 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 (Buscopan®) (20mg/ml ampoules)

- Dose: 20mg SC, hourly as needed. (Maximum dose 120mg in 24 hours)

OR Glycopyrronium injection (200mcg/ml ampoules)

- Dose: 200mcg 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 pager).

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

http://nhi.ie/wp-content/uploads/2020/03/Anticipatory-prescribing-v1-20-3-20.pdf

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.
- ✓ O_2 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.

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.

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.
- ✓ For AGP and PPE guidance refer to https://www.hpsc.ie/az/respiratory/coronavirus/novelcoronavirus/guidance/infectionpreventionandcontrolguidance/Interim%20Guidance%20for%20use%20of%20PPE%20%20COVID%2019%20v1.0%2017_03_20.pdf

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.

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.

Summary

- Patient care is straight forward
- 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