British Geriatrics Society
Improving healthcare for older people

Managing the COVID-19 pandemic in care homes

GOOD PRACTICE GUIDE

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The COVID-19 pandemic raises particular challenges for care home residents, their families and the staff that look after them. This guidance has been developed to help care home staff and NHS staff who work with them to support residents through the pandemic. *This is Version 3 of this document.*

Key recommendations

1. Care homes should have in place standard operating procedures for individual residents with suspected and confirmed COVID-19 infection, including appropriate infection control precautions to protect staff and residents.

2. Care home staff should be trained to check the temperature of residents displaying possible signs of COVID-19 infection.

3. Where possible, care home staff should be trained to measure other vital signs including blood pressure, heart rate, level of consciousness, new confusion, pulse oximetry and respiratory rate. This will enable external healthcare practitioners to triage and prioritise support of residents according to need.

4. All staff working with care home residents should recognise that COVID-19 often presents atypically in this group. An isolate and test approach, erring on the side of caution, is advised.

5. If taking vital signs, care homes should use the RESTORE2 tool, or other equivalent tools supported by local healthcare providers, to recognise deterioration in residents, measure vital signs and communicate concerns to healthcare professionals.

6. For most residents, the risks of exposure to COVID-19 from visitors outweigh the benefits. Exceptions may include residents nearing the end of life and some residents with a mental health disorder such as dementia, autism or learning disability where absence of visiting from an immediate family member or carer would cause distress. Visiting policies should be based upon individualised risk-assessments and shared decision making with residents, their families and care home staff.

7. Where face to face visits with with carers or family members aren't possible, these should be facilitated using other means such as telephone and/or technology such as tablet with video.

8. Care homes that allow visitors should have an infection control and PPE policy that applies to visitors.

9. Care homes should have standard operating procedures for managing COVID positive residents who 'walk with purpose' (often referred to as 'wandering') as a consequence of cognitive impairment. Physical restraint should not be used. Community health services should provide clinical advice and support for managing these situations. Having areas for residents to explore safely should be considered as part of zoning and cohorting policies.

10. Care homes should review available guidance on zoning and cohorting and consider whether this could work in their home. Zoning and cohorting plans should be written in advance of any outbreak and should be subject to review as situations change. Such approaches may involve temporarily moving residents away from their usual room during an outbreak.

11. During an outbreak, care homes should consider cohorting staff teams into those who work with COVID positive and negative patients to minimise cross-infection.

12. Care homes staff, General Practitioners, community healthcare staff and community geriatricians should work to review Advance Care Plans with care home residents. This should include discussions about how COVID-19 may cause residents to become critically unwell and what they and their families would wish if their health deteriorates.

13. There are some situations in which supportive treatments such as care home-based oxygen therapy, antibiotics and subcutaneous fluids should be supported as part of the local response to COVID-19. The harms and benefits of such treatments must be considered carefully.

14. Advance Care Plans must be recorded in a way that is useful for healthcare professionals called in an emergency situation. A paper copy should be filed in the care home records and, where the facility already exists, an electronic version used which can be shared with relevant services.

15. In accepting new admissions which are, or could be, COVID-19 positive from hospital or the community, care homes must establish that they have sufficient resource to safely isolate them. They must obtain written confirmation of when the diagnosis was made and when isolation is anticipated to end. In Scotland, residents must be confirmed COVID negative prior to admission.

16. New admissions who do not have suspected or confirmed COVID-19 should be undergo swab testing to confirm status. They should be isolated for 14 days regardless of the result.

17. New or returning residents should not be accepted by a care home if there is insufficient resource to manage them in isolation.

18. Care homes should work with GPs and local pharmacists to ensure that they anticipate palliative care requirements and order anticipatory medications early in the illness trajectory.

19. Care homes should work with community pharmacists and GPs to ensure that they have a Standard Operating Procedure in place to reuse anticipatory medications in line with government legislation.

20. Care homes should work with residents and families to ensure residents' emotional needs are being met.

21. Multiprofessional local or regional peer-support groups should be established to provide support to care home staff who may feel isolated and worried by the pandemic.

22. Effort should be made to provide appropriate urgent medical care within a care home to prevent urgent admissions to hospital, thereby risking infection with COVID-19 to the resident and others in the home. This could take the form of urgent senior medical advice for care home and ambulance staff or making appropriate use of hospital at home services if available.

Introduction

Approximately 400,000 older people in the UK live in care homes[1] and a significant proportion of these will be living with frailty. This is a bed base three times that of the acute hospital sector.[2] Most care home residents have cognitive impairment, multiple health conditions and physical dependency[3] and many are in their last year of life.[4]

Care home residents are particularly vulnerable to COVID-19 as a consequence of their complex medical problems and advanced frailty. In some situations, outbreaks in care homes have proven to be devastating and it is clear that care home residents have a particularly guarded prognosis if they become hypoxic secondary to COVID-19.

Whilst many care home staff are trained in recognising and managing acutely unwell residents, this is not universally the case, particularly in care homes without nursing. They

are, though, expert in supporting people with cognitive impairment and behavioural symptoms. They are often very experienced and skilled in providing end-of-life care.

This document is written with two main audiences in mind: firstly, care home staff, many of whom feel isolated and exposed as a result of the COVID-19 pandemic; secondly, NHS and social services staff who plan for, work with and support care home staff, many of whom are trying to develop standardised approaches to care home residents in light of the pandemic. The document is not aimed at, but may be useful for, residents and relatives who want to understand what to expect from their care home and healthcare providers.

This document focusses on care homes for older people. It is not written with care homes for those with learning disabilities in mind.

Identifying residents who may have COVID-19 and how to respond

Public Health England have suggested that COVID-19 should be suspected in any resident with a persistent cough (with or without sputum), nasal discharge or congestion, hoarseness, sore throat, wheezing, sneezing, loss of sense of smell or taste, or high temperature (at least 37.8°C).[5] However, COVID-19 in care home residents will present with non-respiratory symptoms in up to 31% of cases.[6] These include loss of appetite and reduced oral intake, new onset/worsening confusion, or diarrhoea. Care home staff, with detailed knowledge of residents, are well-placed to intuitively recognise these subtle signs ('soft signs') of deterioration.

Care home staff – particularly in care homes without nursing – have not, to date, been routinely required to take observations for their residents. It is important that, in the context of this outbreak, all care homes have the capability to take a temperature using a medical grade thermometer and have staff trained to be able to do this. This is necessary to diagnose the illness and is an absolute requirement. The skills and equipment to measure heart rate, blood pressure, new confusion and pulse oximetry are a useful adjunct and care homes should, where possible, ensure that equipment to do so is available and that staff have the relevant competencies. Online training is available at: https://www.youtube.com/user/HealthEducationEng/videos

Once care home staff have a suspected case, they should isolate that resident to their room. During the pandemic, PPE should be worn at all times when caring for care home residents, even those without COVID-19, but staff should note the changes to PPE requirements when a resident is suspected to be positive. Care homes should ensure that all staff are kept up to date on the guidance issued by Public Health England, or relevant national bodies for other jurisdictions such as Health Protection Scotland, and that they know where to access the guidance.[7]

Once a resident is isolated, swab tests for the SARS-CoV-2 virus should be taken and sent as soon as possible. Arrangements for swab testing have changed multiple times during the pandemic. Local NHS care home teams should ensure that this information is circulated whenever arrangements change and care home managers should work to stay abreast of changes to how they access swab tests. Swab tests can be particularly distressing for residents with a mental health disorder such as dementia, autism or learning disability. Staff should anticipate possible distress, and allow extra time to provide the necessary emotional support to such residents.

False negative tests for COVID can occur, particularly when staff are new to taking the swabs. Healthcare teams should work with care home staff to establish how likely COVID-19 is in each resident. For those residents where there is a strong suspicion of COVID-19 based on clinical findings, residents should stay in isolation for the full period of 14 days, even if they have a negative swab. For those residents where the diagnosis is less likely, step-down from isolation should be considered on a case-by-case basis. Given the devastating rapidity with which infections can spread through care homes, erring on the side of caution is advisable.

Care homes who do not yet have the capability to measure heart rate, blood pressure, respiratory rate and pulse oximetry should be provided with, or consider buying, equipment (approximate cost £75-100). A number of soft signs, observation and reporting tools have been supported by NHS providers. The most widely used is the RESTORE2[1] system, which has been supported by the Patient Safety Collaborative, and employs 'soft signs' to identify deterioration, vital sign measurement and the National Early Warning Score (NEWS) to guide response, and the SBAR tool (situation, background, action, recommendation) tool to communicate concerns with external healthcare professionals. Care home staff are encouraged to consider how to operationalise RESTORE-2 in their unique context and to use online training materials to facilitate this.[8] There are some areas where RESTORE-2 is not supported and here care homes should liaise with their local NHS providers to consider alternative approaches.

Isolating residents

It is now recognised that preventing carriage of SARS-CoV-2 into the care home setting is particularly important in preventing outbreaks. Current government guidance suggests that family members and friends should be advised not to visit care homes. There are, though, some residents, particularly those with mental health disorders such as dementia, learning disability or autism, or those approaching the end of life, where there may be a strong welfare case for allowing families to visit in order to reduce distress for the resident and/or family. We recommend working with residents, and their relatives, to establish, on a case-by-case basis, the risk-benefit ratio of visiting. For most residents, it is likely to be beneficial for families to stay away but, for some, visits may be required. This should be a shared individualised decision between the resident, care home staff and family. When visiting the home, family members should be encouraged to wear PPE, to wash their hands on entry and exit of the home, and when moving between areas of the home. Care homes should work to identify visiting locations which pose least risk and facilitate social distancing and/or plan access routes to individual residents to visit. Gardens and outdoor spaces are an important extension of care homes during the summer months and using these as visiting areas should be considered. It must be recognised that dementia is common in care homes and excessively permissive visiting policies could introduce infection.

To mitigate against the fact that widespread visiting will not be possible, care homes should take advantage of videoconferencing software on smartphones, tablets and portable computers as much as possible to maintain human contact for residents. Consideration must be given to how sensory impairment impacts upon the use of such devices and apps and adaptations used to take account of these. Care home staff, and healthcare professionals supporting them, must recognise and respond to the strain that social isolation puts on residents and their families.

Isolation will pose particular challenges for residents who 'walk with purpose' (often called 'wandering'). Care homes should consider what Standard Operating Procedures could enable such residents to be supported if they develop COVID. Physical restraint should not be used. An antecedent, behaviours, consequences approach[9] should be used to understand the behaviour and try to modify it where possible. Care homes should be prepared to work

with residents' families, and community mental health and dementia teams. Such teams should be prepared to prioritise support to care homes who need to isolate a resident 'walking with purpose'. Delirium may contribute to walking behaviour and the BGS guidance on managing delirium in COVID-19 positive patients may prove useful in this regard.[10] Please note, that at the time of writing, there is no relaxation of Deprivation of Liberty Safeguards (DoLS) associated with the pandemic and care homes should ensure that they adhere to DoLS guidelines. Useful guidance for supporting those with dementia, or who walk with purpose, during COVID can be found at: www.northerntrust.hscni.net/CLEAR and http://www.yhscn.nhs.uk/mental-health-clinic/Dementia.php.

There are emerging recommendations from a number of overseas countries and some authorities within the UK, about asking care home residents to stay in their rooms during the COVID-19 pandemic. There is no doubt that residents will be less likely to develop COVID-19 if they do not mingle together. There are, though, challenges to safe staffing when care homes support people away from shared areas of the home. These issues have to be explored in full before a decision is made about whether such an approach is safe. One approach is to ask residents to stay in their rooms during a COVID outbreak, but to relax restrictions 14 days after isolation of the last identified case in the home.

Several care homes around the country have reported successfully implementing Zoning approaches. These enable residents with suspected or confirmed COVID-19, to be managed in separate parts of the home from those without COVID-19. In addition, careful attention to the route by which staff and visitors enter and exit the home, and where they don, doff and dispose of PPE, reduces the risk of COVID-19 being brought into the home, or being transferred between areas. Zoning plans should be developed in advance of any outbreak and should be reviewed at regular intervals to consider whether they meet the current requirements of residents and staff. It is important to recognise that, to be effective, zoning and cohorting approaches must be embedded in a broader approach incorporating hand hygiene, structured approaches to staff health and wellbeing, considering how staff are rotated and allocated to different parts of the home, and policies for waste, laundry, PPE reuse and shared. An example of comprehensive guidance that has been implemented successfully by a number of homes can be found at: https://www.bushproof.com/wp-content/uploads/2020/06/Care-home-strategy-for-IPC-of-Covid-19.docx

As part of cohorting and zoning considerations, care homes should look at how they use staff teams during an outbreak. It may be possible to cohort staff so that they exclusively look after those who are COVID positive and negative respectively. This is an important measure to avoid cross-infection, if possible.

Receiving residents from hospital or the community into a care home

Receiving new, or returning, residents into a care home, from either hospital or community, is an important event which could inadvertently introduce COVID-19 into the care home. In Scotland, it is now necessary to have a negative swab for SARS-CoV-2 prior to entering a care home. In England, however, government guidance continues to allow COVID-19 positive residents to be admitted.[11] Before accepting a COVID-19 positive resident care home managers and staff must:

- Consider whether they have the PPE, space, and staff resource to be able to safely isolate the resident. This must take into account the resident's own care needs, including walking with purpose and any aerosolising procedures, but also those of other residents within the home. It may be possible to manage one COVID-19 positive resident who walks with purpose, but not two, for example. Care homes should err on the side of caution and should not accept new residents if they are not confident in their ability to safely isolate them.
- Obtain written confirmation from the NHS professionals who made the diagnosis of COVID-19 about when symptoms started, when the swab was taken, and their recommendation about how long isolation should continue.
- Be aware that isolation periods may extend, should the resident remain symptomatic for longer than expected.

For new residents who do not have suspected or confirmed COVID-19, the most sensible approach is to take swab tests from the new resident on the day of admission and to isolate them from the rest of the care home for fourteen days, regardless of swab results.

Where care homes do not have the staff or space resource to safely isolate returning or new admissions, then these residents should be cared for elsewhere until their isolation period is completed.

Advance care planning and escalation

Many care home residents are in the last year of their life. The perils of hospitalisation for care home residents, such as delirium, are well-documented and many residents admitted to hospital would prefer to be treated at home. The COVID-19 pandemic has received much coverage in the news and residents and their families will almost certainly have considered what this means for them. This represents an important opportunity for care home staff to revisit, or visit for the first time, advance care planning, including plans about escalation to hospital, for all their residents. This should include discussions with residents and their families about how the COVID-19 pandemic may affect residents with multiple comorbidities. It should also consider whether people want to be admitted for other long-term conditions, such as COPD, heart failure, or dementia.

Where care home staff feel unable to explore such issues, they should be supported by GPs and primary care teams, with appropriate support from specialists in geriatric medicine, mental health and/or palliative care, to do this with residents and their families. This could include redeploying relevant staff from other tasks specifically to do so. These discussions may need to be held by telephone, or using videoconferencing software on tablets or phones. This is not ideal and will require conversations to be planned in advance to avoid confusion or distress as much as possible. A series of resources to support such conversations is available through the Royal College of General Practitioners' Palliative Care Toolkit.[12]

Advance care plans should include decisions about whether hospital transfer would be considered (for oxygen therapy, intravenous fluid and antibiotics) for COVID-19-related illness. Advance care plans should be shared with the primary care out-of-hours service.

Decisions about escalation of care to hospital

Because most care home residents live with frailty and multiple medical conditions, there may be occasions where paramedics, general practitioners, or other healthcare

professionals make decisions not to escalate their care to hospital. These decisions will not be taken lightly and care home staff must be prepared to work with healthcare providers to support families and residents if such difficult decisions have to be taken.

Healthcare professionals may find the Clinical Frailty Scale (CFS) to be a useful resource to inform shared decision-making with patients and families.[13] At the time of writing, the NICE guidance on escalation of COVID-19 positive patients to critical care suggests that the severity of frailty diagnosis plays an important part in this process.[14] It has been suggested that those with a CFS of 5 or more are less likely to benefit from critical care. Primary care providers may wish to consider this as part of their discussions with residents and relatives, and decisions about escalation to acute care. Some information on the CFS can be found here. Escalation to ICU is only one reason for admission to hospital and it is important that these discussions do not conflate admission to hospital with admission to ICU.

Recognising that hospital transfer carries increased risks and burdens for care home residents during COVID-19, we would highlight longstanding recommendations of the British Geriatrics Society about offering supportive treatments such as oxygen, subcutaneous fluids and antibiotics in care home settings. We would encourage commissioners to enable such treatments, which may be appropriate both for suspected COVID-19 and other non-COVID related presentations. All treatments can have harms as well as benefits. These need to be carefully weighed within the context of an agreed care plans about ceilings of treatment and review. When a resident is nearing the end of life, oxygen and subcutaneous fluids are often inappropriate and treatments and focussing on symptom control may be better.

At the time of writing, it is not possible for care homes to hold a stock of anticipatory medications for use when residents are approaching the end of life. Working collaboratively, care homes, GPs, and local pharmacists can recognise and anticipate residents who are approaching the end of life and ensure that anticipatory medications are prescribed in a timely fashion.Recent changes to government legislation mean that care homes can reallocate unused palliative medications, after a resident has died, to another resident who might need them. In practice, the steps required to do this are complex and require input from a pharmacist and a prescriber, usually a GP. Care homes should develop Standard Operating Procedures, working with their local pharmacists and their clinical lead, to support this.

Supporting care home residents and staff

Physical deconditioning due to isolation during the COVID-19 pandemic is a real risk in care home residents. Signs of deconditioning include reduced mobility, falls, increased confusion, loss of appetite, new swallowing problems, weight loss, constipation, worsening incontinence, drowsiness and becoming more withdrawn. These could all be presenting features of COVID-19, or other underlying illness and these must be excluded before attributing deterioration to deconditioning associated with isolation. Deconditioning can be prevented by maintaining activity and interaction as much as possible. Care homes should consider how to support residents to exercise and to interact with others, whilst maintaining social distancing.

Care home staff are encouraged to work with residents to address their fears and vulnerability about COVID-19, especially while they are unable to have visitors. Residents' individual emotional needs should be monitored and any signs of deterioration recorded. Remedial strategies, which take account of the limitations of the COVID-19 pandemic

should be discussed with families and friends, and visiting healthcare professionals, noted in care plan and implemented.

The COVID-19 pandemic is also expected to add to the strain on care home staff who were already working under challenging circumstances. Advice on the pandemic shifts on a daily basis and care home managers may struggle to support staff who feel isolated from the rest of the health and social care system and hence vulnerable.

Multi-professional support networks can help to support care home staff through this. A national COVID-19 online care home community or practice, led by Anita Astle, has been established, and care home staff, NHS and social care professionals are encouraged to join by emailing Anita at: anita@wrenhall.com. The Queens Nursing Institute has set up a Facebook support page for Care Home Registered Nurses. Other local health and social care systems may consider setting up similar, or complementary, networks to support care home providers and staff.

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Resources

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- John's Campaign: Blog

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