**This document was developed for Kent and Medway Home Treatment Service (HTS). It was written and shared with BGS by Dr Shelagh O’Riordan.**

**Practical tips for the active treatment in care home project**

We have now agreed a pathway and SOP for active management of covid in care homes. The bundle is “activated” when a patient becomes hypoxic. The bundle consists of:

Oxygen 1-4L/min

Dexamethasone 6mg orally for 7-10 days

Anticoagulation

SC or IV fluids if appropriate

I have tried to answer some of the questions as we have learnt in the pilot.

1. **Who is referred for the Active Covid Bundle?**

All care homes with covid outbreaks should have pulse oximeters. They are asked to monitor the resident’s oxygen saturations twice a day and some are also doing daily temperatures and pulse rates.

The primary care team or the covid virtual ward (CVW) are responsible for discussing the results of these readings on a daily basis. The primary care team are also asked to jointly agree a Treatment Escalation Plan (TEP) with the patient and their NOK if this hasn’t already been done.

If a resident deteriorates and is for active treatment in hospital then an ambulance should be called. If however they are for active treatment in the home then consideration should be made regarding starting the active treatment bundle (see below)

1. **Things to consider when deciding if the bundle is appropriate**

Could the resident tolerate oxygen via nasal specs or a mask?

Is the resident able to swallow medication?

Is the patient actively dying? If yes then consider palliative management as a matter of priority.

1. **How to refer for the active covid bundle**

This differs in different areas for Kent – we could put all referrals routes in or write a separate one for each area**?**

1. **Accepting referrals for the active covid bundle**

Patient s who might be appropriate for the active bundle should be discussed with the team responsible for providing it. A joint decision between the primary care team, the care home and the team actually providing the service about whether the resident should be started on the bundle. This should take into account the resident and the capacity of the teams including the care home.

1. **Who is responsible for actually initiating the active covid bundle?**

The responsibility for this lies with the urgent team but collaboration between them and primary care has been shown to be very useful. Oxygen is ordered via the HOOF form system and delivered to the home. They teach the staff how to use it and how to adjust the flow. Care homes so far have found this to be relatively easy.

IV or SC fluid will remain the responsibility of the urgent team and negotiated with the care home.

**Please note: The urgent team will, in most cases undertake the assessments virtually.** This is to limit the number of people actually entering the care home. A visit may be required if the diagnosis is uncertain other reasons.

1. **Who is responsible for monitoring the patients on the active treatment bundle?**

This remains the responsibility of the urgent team. However, as the primary care team will be still monitoring the patients who are positive and not on the bundle, it makes sense to pair up, learn form each other and reduce the administrative burden to the care home. We have been using a daily quick teams meeting to discuss all positive patients and this works well.

The care home staff need to prepare by documenting for each resident:

**Temperature**

**Pulse**

**Oxygen saturations**

**Oxygen flow rate if on oxygen.**

**BM’s (if diabetic on dexamethasone). In residential homes this may need to be done by the community nursing team.**

**Presence absence of anticipatory medication (JIC) and a CMR form.**

1. **How does a resident come off the active covid bundle?**

As the resident is monitored daily, the flow of oxygen will be increased or decreased. As a person improves the flow rates reduced and eventually oxygen removed. They continue and complete the full 7-10 days of dexamethasone.

If a patient deteriorates and moves to a palliative pathway then again oxygen is removed and oral medication discontinued.

The oxygen concentrators can be sent back to Dolby by phoning them on the number on the machine.

**Process for Monitoring Covid 19 +ve patients in Care homes for Frailty HTS Team**

**When to commence oxygen:**

Non COPD patients if hypoxic <93% oxygen sats (ie 92% or less)

Aim for >93% oxygen saturations.

COPD patients if hypoxic <88%

Aim for 88-92% oxygen saturations

Daily monitoring:

Ring Care homes daily for update on patients that were commenced on the Covid #Active Treatment Bundle (CATB) by HTS

Obtain the following observations from Care home staff

Temp

Oxygen saturations and oxygen flow rate

Pulse

Blood sugar if diabetic

Date of commencing Covid treatment Bundle

How many days on Covid bundle

If a patient has been off oxygen for over 24 hours doing well and still on the other medication, discharge from Home treatment service (HTS) caseload

If patient is still on oxygen advise staff to titrate and try to wean off if reaching target saturations.

If over 12 days and still on oxygen, a clinical assessment to be carried out by General Practitioner (Gp) to rule out other respiratory problems.

Gp to take full responsibility of patient after 12 days.

**Admitting patients onto HTS caseload:**

HTS will only accept patients that have been referred by the GP during the working week.

HTS does not have full patient clinical details and it is not safe practice

If it is a weekend or bank holiday Care homes can refer directly to HTS

**Guide to oxygen adjustments of patients at home and in a care home on active covid bundle.**

**Patients without COPD**

**Aim for sats range 93-98% if not COPD**

If sats in normal range (93-98%) and on following flow rate

1L- advise to stop oxygen for 1 hour and repeat oxygen sats monitoring. If still in required range, keep off oxygen. If less than 93%, restart at 1L

2-4L- advise to reduce flow rate by 1L and repeat oxygen sats monitoring. If in required range, continue at that dose. If less than 93% then increase to previous level.

If sats below normal range (less than 93%) and on following flow rate

1-3L- increase flow rate by 1L and repeat oxygen monitoring after 1hour. If oxygen sats in required range keep on that flow rate, if not increase by 1L again.

4L- if patient still has low oxygen levels despite 4L of oxygen, consider if need to move to a more palliative approach or whether to continue on active pathway. This decision will be made by the clinician in collaboration with care home staff, patient and family.

**Patients with COPD**

**Aim for sats range 88-92% if COPD**

If sats more than 92% and on following flow rate:

1L- advise to stop oxygen for 1 hour and repeat oxygen sats monitoring. If back in required range, keep off oxygen. If less than 88%, restart at 1L

2-4L- advise to reduce flow rate by 1L and repeat oxygen sats monitoring. If in required range, continue at that dose. If still more than 92% then decrease again until in the required range.

**If sats below normal range (less than 88%) and on following flow rate**

1-3L- increase flow rate by 1L and repeat oxygen monitoring after 1hour. If the oxygen sats are back in the required range then keep on that flow rate, if not then increase by 1L again until a maximum of 4L

4L- if patient still has low oxygen levels despite 4L of oxygen, consider if need to move to a more palliative approach or whether to continue on active pathway. This decision will be made by the clinician in collaboration with care home staff, patient and family