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.

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, using a tympanic thermometer (inserted into the ear).

3. Where possible, care home staff should be trained to measure other vital signs including blood pressure, heart rate, 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 may present atypically in this group. It may be necessary to use barrier precautions for residents with atypical symptoms following discussion with General Practitioners or other primary healthcare professionals.

5. Where possible, primary care clinicians should share information on the level of frailty of residents (mild, moderate, severe frailty) with care homes, and use the Clinical Frailty Scale to help inform urgent

triage decisions.

6. If taking vital signs, care homes should use the RESTORE2 tool to recognise deterioration in residents, measure vital signs and communicate concerns to healthcare professionals.

7. Care homes should have standard operating procedures for isolating residents who 'walk with purpose' (often referred to as 'wandering') as a consequence of cognitive impairment. Behavioural interventions may be employed but physical restraint should not be used.

8. Care homes should work with General Practitioners, community healthcare staff and community geriatricians to review Advance Care Plans as a matter of urgency with care home residents. This should include discussions about how COVID-19 may cause residents to become critically unwell, and a clear decision about whether hospital admission would be considered in this circumstance.

9. Care homes should be aware that escalation decisions to hospital will be taken in discussion with paramedics, general practitioners and other healthcare support staff. They should be aware that transfer to hospital may not be offered if it is not likely to benefit the resident and if palliative or conservative care within the home is deemed more appropriate. Care Homes should work with healthcare providers to support families and residents through this.

10. 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.

11. Care homes should remain open to new admissions as much as possible throughout the pandemic. They should be prepared to receive back care home residents who are COVID positive and to isolate them on return, as part of efforts to ensure capacity for new COVID cases in acute hospitals. They should follow the advice from Public Health England when accepting residents without COVID back when there are confirmed COVID cases within a home.

12. Care homes should work with GPs and local pharmacists to ensure that they have a stock of anticipatory medications and the community prescription chart, to enable, at short notice, palliative care for residents.

13. All professionals should consider setting up multiprofessional local or regional WhatsApp groups, or other similar fora, to provide support to care home staff who may feel isolated and worried by the pandemic.

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 in England[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]

The emerging evidence from countries ahead of the UK in the COVID-19 pandemic suggests that care home residents are particularly vulnerable to the infection as a consequence of their complex medical problems and advanced frailty. 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.

Countries with more experience of COVID-19 than the UK also found that health care systems, in particular acute hospitals and intensive care units, can rapidly become overwhelmed by COVID-19 infections, impairing their ability to deliver even the most basic of care.

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. Care home staff are usually not trained in managing outbreaks of infectious diseases and most are not trained nurses. 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 audiences in mind. Firstly, care home staff, many of whom feel isolated and exposed as part of the COVID-19 pandemic. Secondly, NHS 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.

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

Public Health England have suggested that COVID-19 should be suspected in residents with influenza-like illness.[5] They define this as a fever of at least 37.8°C and at least one of: new persistent cough, hoarseness, nasal discharge or congestion, shortness of breath, sore throat, wheezing or sneezing. However, COVID-19 in care home residents may commonly present with non-respiratory tract symptoms, such as 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 on their residents. It is important, in the context of this outbreak, that all care homes have the capability to take a temperature using a tympanic thermometer (inserted into the ear) and have staff

trained to be able to do this. This is necessary to diagnose the illness and is an absolute requirement.

Once care home staff have a suspected case they should isolate that resident to their room and commence use of the personal protective equipment (PPE) provided by NHS England. This comprises gloves, aprons and face masks and its use has been described elsewhere by Public Health England. [6] It is important to note that the PPE requirements for care home staff are the same as those for hospital staff on general wards.

The resident's General Practitioner, or alternative primary care support team where available, should be notified. They will advise on the medical treatment plan and isolation requirements, to prevent transmission of COVID-19 to other residents. These requirements will change over time and we have not specified them here.[7]

GPs and primary care teams should recognise care homes are community-based health and social care facilities and help them to access the advice they need as quickly as possible.

As the pandemic progresses, GP and ambulance services may aim to triage residents remotely, based upon the level of carer concern and their vital signs. Primary care providers are encouraged to work with care home staff to enable video consultations, in order to inform triage and medical decisions. 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 £50). The RESTORE-21 system 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 this in their unique context and use online training materials to facilitate this.[8]

Isolating residents

In light of the latest government advice about staying at home, and the need to shield care home populations, it is recommended that care homes do not allow visiting. This will pose particular challenges at the end of life, and for residents who 'walk with purpose' (often called 'wandering') but require isolation (where families might previously have been asked to support). Care homes should take advantage of videoconferencing software on smartphones, tablets and portable computers as much as possible to maintain human contact for residents. They, and healthcare professionals supporting them, must recognise and respond to the strain that social isolation puts on residents and their families.
In the event of large numbers of residents with suspected or confirmed COVID-19, care homes are advised to work with local infection teams to separate symptomatic and non-symptomatic residents within the care home, if possible.

Residents who 'walk with purpose' require specific consideration. 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 community mental health and dementia teams and 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 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.

Public Health England will be updating its advice on whether and when care homes should remain open on a regular basis. Care homes should be prepared for the possibility that this could at times during the pandemic involve receiving residents back from hospital who are COVID positive in order to isolate them in the care home. They should do what they can to support this, in order to ensure that the whole health and social care system has capacity to care for the sickest people, following official guidance.[11]

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 have almost certainly 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 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 or heart failure. Where care home staff feel unable to explore such issues, they should be supported by GPs and primary care teams, with or without support from specialists in geriatric medicine or palliative care, to do this. This could include redeploying relevant staff from other tasks specifically to do this. The recent advice to stay at home, and to shield care home residents, means that 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 advanced to avoid confusion or distress as much as possible. A series of resources to support such conversations are available through the Royal College of General Practitioners' Palliative Care Toolkit.[12]

Advance care plans should should include decisions about whether hospital transfer would be considered (for oxygen therapy, intravenous fluid and antibiotics) for COVID-related illness. Advance care plans should be shared with the primary care out-of-hours service. Primary care providers should consider how to respond in a timely fashion.

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 in making and discussing escalation decisions. [13] At the time of writing, the NICE guidance on escalation of COVID positive patients to critical care suggests frailty will play an important part in decision-making.[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 in their discussions with residents and relatives, and decisions about escalation to acute care. Some information on the CFS can be found at: https://em3.org.uk/foamed/24/4/2017/lightning-learning-clinical-frailty-scale

Care home staff and external healthcare professionals are encouraged to ensure that care homes carry a stock of anticipatory medications, to enable symptom control for residents receiving community-based end-of-life care.

Supporting care home residents and staff

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. 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.

Multiprofessional support networks can help to support care home staff through this. A national Whatsapp group, led by Anita Astle, is emerging, 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.

References and resources

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