Clinical Guidance for Nursing Home and Residential Care Residents and COVID-19

Version History

Version	Date	Summary of changes
1.1	13/03/20	First version of document
1.2	16/03/20	Updated to include: HPS advice on care home admissions, shielding advice, visiting

1. Introduction

This guidance provides targeted clinical advice about COVID-19 to support those working with adults in long term care such as residents of nursing home and residential care settings (care homes). It should be read in conjunction with infection control guidance developed by Health Protection Scotland (HPS) for Social or Community Care & Residential Settings.

It is recognised that those who are in care are often frail with complex needs and varying levels of dependence. Current estimates are that there are over 40,000 residents in care homes across Scotland. The average age of residents is estimated to be 84 years. 50% of residents have a formal diagnosis of dementia, although the real numbers may be far higher. Ordinarily mortality rates for these residents is between 13 and 17% illustrating the vulnerability of the group.

Most of those in care homes will be at greater risk if they were to contract COVID-19 due to conditions such as frailty, cognitive impairment including dementia, physical disability, neurological and other conditions, and learning difficulties or multiple comorbidities. For many, hospital admission may be inappropriate – this means additional support within the care home setting may be necessary for the acutely unwell.

The long term care/residential care sector is vital to the wider health and care system and it is essential that it continues to function in a safe and effective way as it provides an appropriate alternative in some cases to more acute settings such as hospital care. It is therefore imperative that care homes continue to take admissions if it is clinically safe to do so. This guidance will support you in doing this.

2. Measures to prevent and prepare for infection in residents

2.1 Presentation

COVID-19 should be suspected in residents with influenza-like illness such 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.

To support diagnosis in residents, it is important that care home staff take residents temperature and where necessary are supported to take other vital signs including blood pressure, heart rate, pulse oximetry and respiratory rate. This will enable external healthcare staff to triage and prioritise support of residents according to need.

While such monitoring will be helpful for diagnosis, it is important to note that for many older people living with frailty, their presentation when unwell may be very different to younger people. They may not have a cough and a temperature but may have a decline in function, falls or increased confusion as a symptom that they are unwell. Staff and family members will often be able to provide information on changes of health, behaviour or mood. The most important thing is simply to be vigilant that someone who is frail may experience health challenges in a different way and being aware of that may provide an opportunity to flag up when someone needs medical or nursing assessment.

2.2. Social distancing and shielding

Long term care facilities be subject to **'social distancing'** and **'shielding'** to reduce the risk of infecting residents and their carers.

Social Distancing: This measure reduces social interaction between people in order to reduce the transmission of the virus. It is intended for those situations where people are living in their own homes with or without additional support from friends, family or carers.

Shielding: This is for people (inc. children) who are at very high risk of severe illness from COVID-1 when an extremely vulnerable person is living in their own home, with or without additional support and those in long term care settings. The aim of shielding is to minimise interaction between individuals and others to protect them from coming into contact with the virus, thereby aiming to reduce mortality in this group. Information on which people are in this category and what to do are on the NHS Inform website

Within a long term care setting, this needs to operate at two levels:

- **Routing visiting should be suspended** – Only **essential visitors** permitted in line with HPS guidance. Local risk assessment and practical management should be considered, ensuring a pragmatic and proportionate response. Visits from appropriate health and care staff would be classed as essential. For family and friends, **visits should be restricted to end of life care situations or people with dementia who are distressed.** In such instances there should be a named contact for visiting, and ideally visits should involve one person at a time; no children should be permitted. These visitors must not visit any other care areas or facilities. Where a resident has COVID-19, it will be appropriate for visitors to wear PPE in order to be able to spend time with them. Visitors should also be asked about symptoms on arrival; symptomatic people should stay away. A log of all visitors should be kept**.** Consideration should be given to alternative measures of communication including phoning or face-time. Visiting may be suspended if considered appropriate.

- **Residents to remain in rooms as far as possible** - There is a high risk within a long term care facility that infections are spread between residents through communal areas such as lounges and dining areas. Residents should stay within their rooms as far as possible. Meals should be served in residents rooms where possible and communal sitting areas avoided. It may be practical to stagger meal times to allow staff to manage this and to allow adequate time for cleaning. If a communal area

does have to be used on occasions, then it is advised that the distance between residents should be approximately two metres where possible. Where a home has people with infections, communal activities should be avoided.

2.3 Handwashing between contacts should be maximised and the regular use of liquid soap and paper towels (see hand washing advice in appendix 2 of HPS guidance).

2.4 Appropriate Personal protective equipment (PPE) should be used for positive cases and long term facilities should ensure that they have access to adequate stock and that they know where to access additional supplies if needed. Advice on what to wear and how to don the PPE is available in Appendix 3 of the HPS guidance and all staff must be made aware of it. This includes the disposal of the equipment. All staff (of any grade) must be made aware of the guidance.

2.5 Anticipatory Care Plans (ACP) should be in place for as many residents as possible (and ideally all residents) in these settings. Clear documentation of 'What matters to me' is helpful in the event of changing circumstances. In many cases the staff in the care home settings are able to start these conversations with involvement of families. Healthcare Improvement Scotland are adapting ACP documentation to a 1-2 page summary tailored to dealing with the current situation. Do Not Resuscitate paperwork should be in place where appropriate and discussed appropriately with residents or carers. It may be judicious to ensure that just-in-case medication is prescribed for high risk residents. Similarly verification of death paperwork for appropriate ill residents may help staff to anticipate and manage death and minimise clinician contacts.

2.6. NHS Near Me video consulting (powered by Attend Anywhere) can be used to reduce exposure to coronavirus. It provides care homes with access to GPs, community teams and clinicians to help to reduce the number of visits whilst providing access to support and occasional clinical opinions. Scenarios where video consulting may be beneficial in homes include:

- To protect residents from potential exposure to coronavirus from visiting clinicians in situations where non hands-on care can be given.
- To avoid transporting residents to hospital for outpatient type clinic appointments.
- To maximise clinician capacity by avoiding travel time.

2.7 Cleaning of communal areas - there should be vigilance around cleaning in communal areas, particularly of frequently touched areas such as door handles, light switches and chairs arms where the virus can persist for up to 72 hours.

2.8 Staffing levels need to be considered in relation to higher dependency of residents and care provision in the isolation of their own room coupled with higher staff sickness levels. This will need to be considered in the context of business continuity planning of NHS Board's and Health and Social Care Partnerships where staff may need to be deployed to support care homes.

3. Mitigating factors to consider while caring for residents in long term care.

Implementing these measures including social distancing may have adverse effects that need to be considered. These could include:

- Increased immobility and higher falls risk for particular residents.
- Low mood from social isolation

- Boredom
- Loss of contact with families.

These factors may be more marked for residents with dementia who may be at increased risk of becoming anxious, frustrated and distressed by social distancing measures. Therefore the use of appropriate language will need to be carefully considered.

The use of personal protective equipment may also increase anxiety and distress in someone who is confused or evoke an unexpected reaction. Staff should be aware of this, where possible explain their appearance in ways that the person understands, be thoughtful and try to minimise any negative reaction.

Family members and friends who may not be permitted to visit will also need reassurance and understanding. Many will be anxious about the wellbeing of the person they care about and worry about the impact on their relative or friend of measures to reduce contact with others. Utilising and proactively facilitating alternative ways that they can continue to stay in contact using phone or digital technology will be essential for both the resident, their family and friends. Access to spiritual care through this means may be also be helpful.

4. Admissions, discharges and transfers involving social or community care and residential settings

As stated above the care home sector is a vital part of the health and social care system. It is imperative that the care homes continue to take admissions if it is clinically safe to do so in order to prevent flows out from acute hospital being hindered and where appropriate expedited.

The HPS guidance on social care settings includes updated advice on measures to be put in place prior to an admission to a care home from the community or hospital setting to ensure that individuals across the entire facility are managed appropriately and safely. This advice summarised below.

4.1 Admissions from the community to care home facilities

HPS guidance states, prior to admissions the care home facility should:

- source information on NHS Inform for current symptom and isolation advice, using the symptom and isolation checker
- discuss with local senior facility healthcare staff and or a designated senior decision maker in the community prior to planned admission, including consideration of current isolation advice for that individual or the household from which they are being admitted.

HPS guidance also states that people being admitted from home / the community do not need to be tested for COVID-19 and should be managed based on symptoms.

4.2 Admissions/transfer from hospital to care home facilities

HPS updated guidance states that if the individual is deemed clinically well and suitable for discharge from hospital, they can be admitted to the facility after:

- appropriate clinical plan.
- risk assessment of their facility environment and provision of advice about self-isolation as appropriate (See NHS Inform for details).

- there are arrangements in place to get return them to the facility

Decisions about any follow-up will be on a case by case basis.

If a patient being discharged from hospital is known to have had contact with other COVID-19 cases and is not displaying symptoms, secondary care staff must inform the receiving facility of the exposure and the receiving facility should ensure the exposed individual is isolated for 14 days following exposure to minimise the risk of a subsequent outbreak within the receiving facility.

Individuals being discharged from hospital do not routinely need confirmation of a negative COVID test. Facilities will be advised of recommended infection prevention and control measures on discharge. It is recommended that this includes a documented clinical risk assessment for COVID-19. Annex A contains a new admissions/ transfer form to provide a means for safely admitting a new resident and identifying that where possible they have been deemed clinically safe for transfer.

4.3 Advice on care home admissions where there are COVID-19 cases in homes

The updated advice from HPS states that social or community care and residential settings may remain open to admissions in the following situations:

- Where a single case of laboratory confirmed COVD-19 has been identified and all appropriate infection prevention and control procedures are in place.
- Where more than 1 laboratory confirmed case has been identified and following risk assessment and discussion with the local Health Protection Team (HPT), it is possible to manage cases and ensure all appropriate infection prevention and control measures are in place.

Where there is evidence of a cluster or outbreak of COVID-19, senior facility staff should discuss this with the local HPT. An outbreak is defined as two or more clinical or laboratory confirmed cases of COVID-19 in a 24 hr period which have occurred as a result of cross transmission. In this situation the facility should close to admissions day care facilities and visitors. Any derivation from this should be done following a risk assessment with HPT as there may be exceptional circumstance where for example the schematic layout of the facility may allow for partial closure.

4.4 Transfer from social or community care and residential settings to hospital

If a transfer from a Social or Community Care and Residential Settings to hospital is required, the ambulance service should be informed if the individual is a suspected or confirmed COVID-19. Staff in the receiving ward/department should be notified of this in advance of any transfer.

5. Managing COVID-19 cases in long term care settings.

Residents suspected of having symptoms of COVID-19 should be managed in line with other HPS guidance and specifically should be isolated in their own room. PPE equipment should be used as in line with other guidance for droplet spread precautions. Handwashing should continue rigorously in line with guidance elsewhere.

It is not advised that residents in long term care are admitted to hospital for ongoing management but are managed within their current setting.

Where a long term care facility is affected it may be necessary to deploy in-reach healthcare support for residents. That may mean community staff such as district nursing, Allied Health Professionals, GPs or where appropriate hospital at home services. This will be considered in the context of business continuity planning of NHS Board's and Health and Social Care Partnerships where staff may be deployed to support care homes.

In relation to dealing with a death, it is crucial to abide by guidance on the preparation of the body and transportation in line with existing guidelines.

6. Access to supplies

Social care providers who are registered with the Care Inspectorate, who are dealing with confirmed or suspected cases of COVID-19, and have urgent issues with obtaining PPE (disposable gloves, disposable aprons, fluid repellent surgical face masks) should contact the NHS National Services for Scotland (NHS NSS) triage centre for social care supplies for COVID-19.

Please note that in the first instance, the triage centre is to be used only in cases where there is an urgent supply shortage after business as usual routes have been exhausted and a suspected or confirmed case of COVID-19 has been identified.

The following contact details will direct registered providers to the triage centre:

Phone: 0300 303 3020

When contacting the helpline, providers will be required to:

a. Answer a series of short screening questions.
b. Confirm they have fully explored business as usual procurement routes
c. Confirm they have a suspected or confirmed case of COVID-19 and therefore have a need for Personal Protective Equipment (PPE)
d. Provide their Care Inspectorate registration number

The helpline will be open (8am - 8pm) 7 days

This helpline is for all social care providers registered with the Care Inspectorate.

This helpline is not for NHS staff or for NHS providers who have an NHS business as usual supply route.

Where providers report issues with supplies of products other than PPE, this information will be recorded and fed into wider work on supplies.

Professor Graham Ellis, Senior Medical Adviser to the Chief Medical Officer
Scottish Government
26 March 2020

Annex 1

New admission/transfer form.

(must be completed within 24 hours or admission or transfer)

Name:
Date of Birth/CHI:
Date of form completion:

The purpose of this document is to provide a means for safely handing over a resident and identifying that where possible they have been deemed clinically safe for transfer.
Swab testing for coronavirus is not recommended for patients who do not have symptoms or are not unwell and so a clinical judgement on an individual's safety to be admitted into a nursing or residential home environment is key.

NEWS Score: ☐

Does the patient have symptoms of:
New and enduring cough?
Y / N
(Chronic cough does not count)
Fever?
Y / N
In the clinical judgement of the most senior medical decision maker this person does not have new medical or infective problems. **Y / N**

Residents on admission should be isolated for 7 days to ensure that they do not develop new symptoms. This isolation period can include days in hospital spent in isolation. If they have already been in protective isolation, number of days:___________