

Managing the COVID-19 pandemic in care homes for older people

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 consider whether it is feasible to manage residents entirely within their rooms during the COVID pandemic. This will have implications for safe staffing, which should be considered before adopting such a policy.
9. 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.
10. 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 responses to COVID-19. The harms and benefits of such treatments must be considered carefully and they should not be used in place of good palliative care.
11. 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.
12. 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.
13. 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-19 positive and to isolate them on return, as part of efforts to ensure capacity for new COVID-19 cases in acute hospitals. They should follow the advice from Public Health England when accepting residents without COVID-19 back when there are confirmed COVID-19 cases within a home.

14. 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. Legislators should work to make it possible for care homes to hold stocks of regularly used anticipatory medicines so that they can be prescribed and dispensed at short notice during the pandemic.
15. 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 homes¹ 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 England². Most care home residents have cognitive impairment, multiple health conditions and physical dependency³ 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. 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.

COVID-19 can rapidly overwhelm health care systems, 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. 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 a result 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 any resident with a new continuous cough and/or high temperature (at least 37.8°C).⁵ 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 that, in the context of this outbreak, 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. The skills and equipment to measure heart rate, blood pressure 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.

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.

When a suspected case develops, the local Public Health England contact should be notified. If care home staff are unable to contact this person, they can speak to their allocated GP, or delegated primary care health professional. 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 [RESTORE2](#)¹ 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 to 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.

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. It may be possible, in some homes, to ask residents to restrict their movements to only part of a home, thus reducing the risk of an outbreak whilst also allowing some freedom of movement.

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 approach² 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-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.

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-19 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 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 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 with residents and their families. This could include redeploying relevant staff from other tasks specifically to do so. 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 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.

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.

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.

:This guidance has been written for care homes in England; but its recommendations may be applied to the other three countries of the UK.

References and resources

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