ICGP Nursing and Care Home Special Interest Group

General Practice and Residential Care Facilities during the COVID-19 Pandemic

27 April 2020

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Supporting Best Practice

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The World Health Organisation declared the **Coronavirus Disease 2019 (COVID-19)** pandemic on 11 March 2020. Older people and those with co-morbidities have proven to be particularly vulnerable to the severe acute respiratory tract infection[1].

The mortality rate increases with age and emerging European data indicates an average 50% of deaths are occurring in the care home setting[2] . Irish data shows that 57% of our **clusters** are in Residential Care Facilities (RCFs) [3].

General Practice is an important provider of medical care to this sector and therefore is the cornerstone of the response to COVID-19 in residential care facilities. As doctors, we need to balance our duty of care to maintain medical services with the risk of harm to ourselves and the risk of transmitting infection to residents. Therefore, when assessing or treating patients, some tasks may be done remotely in keeping with social distancing while the care of a deteriorating or palliative patient will often involve on site clinical review with appropriate PPE.

Heightened observation for the **presenting symptoms** of COVID-19 with a view to early isolation is essential and an awareness that presentations are often atypical in this cohort which may include lethargy, confusion or change in baseline condition[4 5].

Current HSPC guidelines advise that all residents and staff in residential facilities are monitored for symptoms of COVID-19 with temperature checks advised twice daily for residents and for staff when coming on shift.

Testing of a symptomatic resident is by National Ambulance Service priority testing requested through Healthlink. In the circumstance of an outbreak, all residents and staff in the facility may be tested.

An outbreak is defined by public health as a single suspected case or one confirmed case of COVID-19 in a resident or staff member acquired in the residential care facility.

Under the Infectious Diseases Regulations 1981, any medical practitioner who is aware of a case of COVID-19 or an outbreak, is obliged to **notify** the Medical Officer of Health (MOH) at the regional Department of Public Health. Contact details are on the HSPC site here.

An outbreak will be managed by the outbreak control team which will include but not be limited to a Specialist in Public Health, GP or Medical Officer, Residential Care Facility manager or CEO and Director of Nursing.

Additional resources required to manage an outbreak may include

PPE: Send Form here to covid19.procurement@hse.ie
Staff
Occupational Health Advise: HSE Helpline 1850 420 420
Infection Prevention Control
Specialist Advice: Local hospice Palliative Care Consultant and or Medicine for the Elderly, make early contact as part of preparation phase.

Isolate/cohort residents: in so far as possible:

- Single room placement with ensuite bathroom.
- Group residents with confirmed/suspected COVID-19 in adjacent rooms to define a contaminated zone.
- Allocate separate staff groups to care for those with confirmed/suspected COVID-19 and those without.
- Staff should don PPE before entering contaminated zone and remain in PPE until leaving the zone.

Contact and droplet precautions will include hand hygiene, surgical mask (FFP2 for aerosol generating procedures), gloves, long sleeve gown (high contact)/apron (low contact) and eye protection (face shield or googles).

Advance care planning, it is good practice to establish the ceiling of care for individual residents who are deemed at risk of deterioration. This may already be in place but if not then it is indicated in the context of a symptomatic patient during the COVID-19 pandemic. Do Not Attempt Resuscitation (DNAR) status should be based on individual assessment and never assigned to groups of people.

Case management will generally be supportive with antipyretics, oxygen if hypoxic and regular observations (the National Early Warning Score used alongside clinical judgement may be a useful tool here but it's use is not validated in primary care[6]) for deterioration. The majority of residents cared for in RCF's will survive COVID-19 infection, this information may provide comfort to patients and families [7].

Predictors of poor survival from COVID-19 that account for the higher mortality rate in residential care facilities which include: older age >70 years and co-morbidities: (hypertension, cardiovascular disease, diabetes, chronic lung disease and immunosuppression) [1].

Decisions to transfer a patient from the familiar surroundings and familiar staff of their nursing home should only be made if there is likely to be clinical benefit for the patient. Survival data for the elderly in relation to ventilation and COVID-19 will form part of the discussion [8].

Chest compressions and air way management are aerosol generating procedures and should only be undertaken in full aerosol PPE where the benefit is deemed to outweigh the risk.

A compassionate, pragmatic and proportionate approach is required in the care of those who are dying. **Anticipatory prescribing** is recommended for good symptom control for residents approaching end of life. Vigilance by both the Nursing Team and the GP is important in avoiding sudden unexpected deteriorations. When an individual is diagnosed as COVID-19 Positive or Presumed COVID-19, anticipatory (prn) prescribing may be charted, to avoid delays in administration. Link to summary documents here. Oxygen is not helpful in end of life breathlessness symptom management.

VITAL talk has developed a communication tool box here for discussing COVID-19 related issues with patients and their families which can aid with difficult conversations.

GPs have shown remarkable resilience and flexibility in adapting to the rapid changes of this pandemic. There are very good self-care supports available and the easiest way to access them is through the ICGP website link here.

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