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For Action
Chief Executives NHS Boards

For information
NHS Board Medical Directors
Directors of Public Health

20th May 2020

Dear Colleagues,

Specialist support to older people in care homes

You will be aware that a significant focus in the COVID-19 pandemic has shifted. We are currently seeing a major impact of the infection in the care home sector and the consequences of the infection in this vulnerable population are significant.

Furthermore, just as care for non-COVID disease in the general population has been impacted by the need to focus on the effects of the virus, so too has care for care home residents with intercurrent illness of many different forms.

Scotland has 1083 adult care homes. The great majority provide care and support for older people, who often have high levels of physical dependence and dementia, and many of whom are in the last years or months of life.

Outbreaks are difficult to prevent in this setting for several reasons. Firstly, the care required to support personal activities of daily living, such as dressing, washing and toileting, cannot be provided without close, frequent and often prolonged personal contact with caregivers. Second, atypical presentations of infection are common. This makes it much harder to recognise the infection in some residents. Many residents are physically frail, with multiple comorbidities, which in themselves increase susceptibility. In addition, the high infectivity of the virus means it spreads faster than many other infections.

Geriatricians, as specialists in the management and care of older people with frailty and dementia, have much to offer in this setting. Their expertise can support differential diagnosis, tailored management of comorbidities and complex polypharmacy, and personalised care planning that ensures care in accord with an individual's preferences and their capacity to benefit. For many, simple measures delivered in the care home can make a big difference. For some, hospitalisation may be both desirable and potentially beneficial, particularly for non-COVID disease.

We encourage the involvement of geriatricians in supporting older people in care homes. Their input should be planned and delivered in collaboration with existing community services such as primary care as well as palliative care where available.

All care home residents are registered with their local GP practice which is usually the first port of call for all scheduled and unscheduled medical care. There are also many good examples of models which provide additional support to care homes across Scotland such as:

- *Hospital at Home teams*: Specialist led multidisciplinary teams providing hospital level care in place as an alternative to hospital admission have been shown to be effective.
- *Advanced nurse practitioners supporting care homes*: These are roles created to support older people with frailty in nursing home settings that link with specialist and community services where necessary.
- *Care home GP teams responding to acute crises.* Multidisciplinary teams led by GPs responding to acute problems across several care homes in a sector and linked where necessary to specialist advice.
- *Named geriatricians associated with particular care homes*: Providing rapid access to specialist support for GPs providing the usual care by way of advice or NearMe consultations to specific care homes as part of a longer-term relationship with community teams and care homes.

We are attaching guidance for managing older people in the care home sector that has been created to provide advice and support and we hope will be useful for the medical management of COVID-19. (**Appendix A**)

In addition, we have published guidance for the care home sector to help them prevent, prepare and support those at risk. [LINK]

We would like to encourage you to consider ways to provide support to the care home sector from secondary care and consider developing services such as the examples listed above which would utilise the expertise of the geriatricians as part of a multidisciplinary team approach. Implementation will depend on local contexts and resources at your disposal in terms of what is feasible or practical.

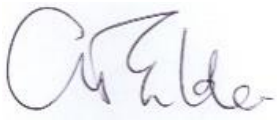
This letter has the support of Gabe Docherty as the Chair of the Scottish Directors of Public Health who are currently playing a key role in this outbreak. We recommend strong links with the local Director of Public Health and local clinical response teams.

Appendix A: Older People in Long Term Care

Yours sincerely,

Dr Gregor Smith
Interim Chief Medical Officer

Dr Miles Mack
Chair, Scottish Academy



Prof Andrew Elder
President Royal College Of Physicians of Edinburgh

Prof Jackie Taylor
Royal College of Physician and Surgeons of Glasgow

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Dr Alan McKenzie
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Appendix A: Older People in Long Term Care

COVID19 - Presentations and Management in Older People in Care Homes.

Older people are worst affected by the COVID-19 pandemic with 75% of deaths occurring in the over 75s. Many in this age group, may still have a mild illness and recover, however in this age group the presentation and management of illness may be different. It is important then that each resident is assessed and treated on an individualised basis. As with the situation prior to COVID, the priority is the appropriate level of care for an individual's needs and that may depend on what services are available in the community. If care appropriate to an individual's needs or expressed wishes cannot be delivered in the home, hospital may be the most appropriate setting for treatment. Many of the principles about the systematic assessment of a care home resident illustrated here may be useful for non-COVID related illness and it is important that usual best care is still followed for these conditions.

Presentations

Older people are less likely to present with cough, fever, or flu like illness. Instead, other symptoms or clinical presentations may include:

- Delirium [use 4AT]
- Loss of smell or taste and anorexia
- Vomiting or diarrhoea and sometimes abdominal pain
- Low grade fever or absence of fever
- Fatigue may be profound and confused with hypoactive delirium
- Falls
- AKI
- Functional decline
- General malaise
- Hypoxia without marked breathlessness

6Ms Approach

A systematic approach using the **6Ms** along several domains simultaneously can be beneficial:
Medical: Older people may have more than one diagnosis as a cause for their acute illness. It remains important to continue to look for other non – COVID causes of illness, as these may be treatable. See below.
Medication: Review the resident's medication. Could any contribute to illness? Do they still need the same medication? Do they need anticipatory prescribing or 'Just in Case' medications?
Mental health: Are there significant issues needing addressed in relation to mood or cognition? Use the 4AT to assess.
Mobility: Has there been a change in function or mobility? In residents > 65 years old a frailty assessment using the CFS or other frailty tool may be useful to determine the level of functional change and to tailor appropriate care. (The CFS must not be used in children, those under 65, those with autism or those with lifelong physical or learning disability.) [**CFS]**
Matters to Me: Does the resident have an anticipatory care plan? Have they made their wishes clear in relation to their changing health needs?
Me and Mine: Are family and NOK aware of the situation? Have any welfare attorneys been consulted?

Management

Residents may present earlier in the disease trajectory (within a few days of symptom onset), day to day variability may be marked and deterioration can be late and sudden.
Testing is available for any symptomatic resident however testing can be uncomfortable and distressing in very confused or frail patients and a person-centred approach needs to be taken over whether it is in the patient's best interests.
Occasionally, a repeat swab may be indicated if the initial test result is negative despite the clinical index of suspicion of COVID-19 being high (e.g. if there is a suspicion the initial swab was poorly taken).
Face masks can impair communication especially for deaf residents. Be aware when communicating that your facial expressions and voice tone may be harder to interpret.

Most residents with COVID-19 will not need additional ventilatory or critical care support, however, other symptoms and clinical conditions will arise and should be managed in a thorough and systematic fashion. These may include:

- Acute deconditioning and immobility.
- Attention to nutrition, hydration, pressure ulcer management and mouth care.
- Delirium: The strategy for residents who wander may need to take into account the risk to other residents. Appropriate risk assessment to ensure the safety of residents is maintained - or 1:1 care may be required in some cases. This may mean difficult decisions may need to be made in the use of pharmacological agents to manage Behavioural and Psychological Symptoms of Dementia (BPSD) or symptoms of stress/ distress associated with delirium. The BGS has a resource to help support this [LINK].
- Superimposed bacterial infection – prescribing antibiotics may depend on your clinical certainty around the diagnosis and suspicion of superimposed infection.
- GI symptoms such as nausea, anorexia, and diarrhoea – use of antiemetics may be beneficial.
- AKI – consider the use of S/C fluids where oral intake may be poor.
- DVT/PE [LINK] – the use of thromboprophylaxis may need to be individualised taking into account risks.
- Recovery may be prolonged and need to take account of latent fatigue.
- O_2 is seldom required but may be useful in supporting residents through acute illness and palliation.

Carers and visiting

Visiting for residents with dementia who are distressed or residents who are approaching the end of life should be considered as early as possible and PPE made available for visitors as per HPS guidance. All patients thought to be at the end of their life have the right to be visited by close family.
Communication with family and loved ones should be promoted through electronic means where possible such as with smart phones or tablets. Regular telephone updates from staff can be helpful.
Families may find a diagnosis of COVID-19 infection in their loved one traumatic and may need reassurance and advice.

Hospital transitions

Admission to hospital should be considered where there is clear benefit to the individual and needs forward communication about any COVID-19 diagnosis for admission pathways.
For patients admitted to hospital who are found to have COVID-19, urgent communication with the care home of any results is important.
Discharge planning should take account of the possibility for further unexpected deterioration in illness and advice given to residents and carers should the resident's condition deteriorate. This should include ensuring robust plans are in place and communicated such as TELPs and ACPs and any COVID swab results. It is crucial to let GPs know about any such conversations for the eKIS.
For more advice see [LINK],[LINK].

Planning ahead

An anticipatory care plan or treatment escalation plan is suitable for all residents to capture their wishes in the face of a changing clinical scenario. Ideally this should be captured at the earliest practical time point, with a focus on realistic and available options for treatment and symptom management. It should take into context the current illness, previous health status, and 'what matters' to the patient and family. It is important to be clear and honest in describing treatments that will not work and may be harmful.
Support for clinicians in having these conversations is available using for example, the 'REDMAP framework' available at [LINK].
Cardiopulmonary resuscitation (CPR) is not a treatment suitable for all residents. When it is clear that CPR attempts would not be successful or be harmful, it is important to discuss this in a sensitive way with the patient and/or their relative/ next of kin or power of attorney. Appropriately conducted this discussion can help relatives be better prepared in the event of death.

Palliation

Palliative care guidance is available here [LINK].

Deterioration in the context of COVID-19 can be very rapid and it is crucial to ensure that carers and families are aware at all times. Preparations for visiting can be put in place with key NOK and they should have PPE and support to understand the changing situation.

It is important to note that older people may require lower doses of relevant medication and treatment plans should be individualised. Reversible causes of agitation should always be considered such as urinary retention, pain or constipation.

Just in Case prescribing is worth putting in place in patients who have significant symptoms.