Webinar Managing C 19 outbreak- supporting residents and families (1)
Thursday 3rd December 2020
7pm – 8.30pm

Thank you for joining, the webinar starts at 7pm, all attendees videos and audios are muted, sit back and relax and we will be with you shortly.

If you experience any audio issues, check your volume is turned on via your IT device or please dial-in via phone using the following number
Phone number: 01 5339982
Access code 174 079 9325

Online webinar series hosted jointly by ONMSD and the National Integrated Care Programme Older Persons. As part of COVID 19 Pandemic Response.

Enabling visiting in LTRC guidance update

Prof Martin Cormican
HSE Lead, Health Care Associated Infection
and Antimicrobial Resistance

Online webinar series hosted jointly by ONMSD and the National Integrated Care Programme Older Persons.
As part of COVID 19 Pandemic Response.

Coronavirus
COVID-19
Public Health
Advice

Enabling visiting in LTRC during COVID-19 pandemic
Guidance update 03 December 2020

Martin Cormican HSE Clinical Lead for Antimicrobial Resistance and Infection Control

hpsc

HSE

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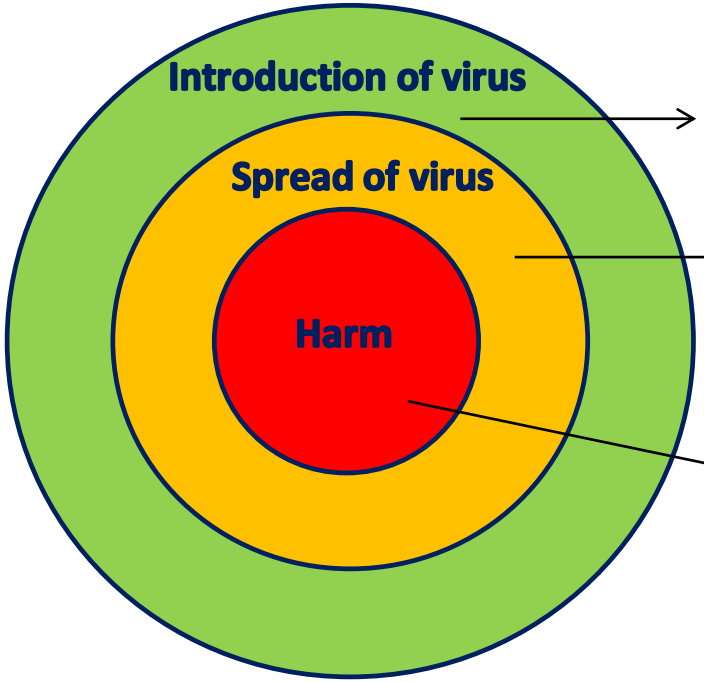
Government of Ireland

How do we prevent infection in any building

Coronavirus COVID-19 Public Health Advice



Making sure as much as practical that anyone entering the building does not have COVID-19 and is not a COVID-19 contacts

Making sure the virus does not spread if it gets in.
Infection prevention and control

How well do we care for people who get COVID and how quickly do we detect and react to outbreaks

Introductions do not need to lead to outbreaks

Is there a risk that a visitor will introduce the virus?

- Yes
- So why do we do it ?
- Because there is also major risk of harm if people don’t have visitors

Hospitals managing outbreaks have identified a number of themes

Coronavirus COVID-19 Public Health Advice

Virus often spreads rapidly once introduced

Involves patients and staff

Introduction usually staff or by patients (usually people with un-recognsied COVID-19)

Similar experience to WHO July 9th (Scientific brief) found hospital transmission when contact and droplet precautions were appropriately used is very uncommon

The parameters we work within

Coronavirus COVID-19 Public Health Advice

Five Level Framework of Public Health Restrictive Measures

Framework Level	Visiting Policy*
Level 1	Open with protective measures
Level 2	Open with enhanced protective measures
Levels 3,4 and 5	Suspended other than in critical and compassionate circumstances*

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Key Points From The Guidance

Coronavirus
COVID-19
Public Health
Advice

- **The challenge for service providers**
- **Communication**
- **Definitions – who is a visitor and who is not?**
- **(**essential service provider/important service provider/accompanying person)
- **What is critical and compassionate?**
- (it's a lot more than end of life)

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Framework Level 1 – protective measures

Coronavirus COVID-19 Public Health Advice

- 2 visits with up to 2 people each visit (subject to capacity)

- Check for symptoms
- Check if they are a contact
- Check if they are currently required to restrict movement (travel related)
- Hand hygiene
- Distance
- Mask

Framework Level 2 – enhanced protective measures

Coronavirus COVID-19 Public Health Advice

- 2 visits with 1 person (subject to capacity)

- Check for symptoms
- Check if they are a contact
- Check if they are currently required to restrict movement (travel related)
- Hand hygiene
- Distance
- Mask

Framework Level 3,4 and 5 Suspended

Coronavirus COVID-19 Public Health Advice

- Suspended but
- Critical and compassionate grounds includes up to 1 visit by one person per week at levels 3 and 4 and up to 1 visit by one person every two weeks at level 5
- And other reasons not just end of life

Home for Christmas (or other religious or cultural celebration)

Coronavirus COVID-19 Public Health Advice

- Guideline promotes facilitation at levels 1 and 2
- It does not look likely that level 1 or 2 will be in place for Christmas
- Level 3 and above does not recommend visits to private home
- Constraint - consistency with the Five Level Framework)
- 1 person for 1 hour once per week under very controlled conditions week ending 18 December is not consistent with extended visit with multiple people in completely uncontrolled conditions week ending December 25th
- **I am not the Grinch but the virus will not take a break for Christmas**
- But a guideline is a guideline – facilitation of a planned visit to a private house at levels 3 or above may be appropriate if it is what the residents wants and the person in charge is satisfied that the risk to other residents is manageable

Thank you and closing point

- **All guidelines must be applied with professional judgment, kindness and compassion**

Key Points From What We Have Seen

Coronavirus COVID-19 Public Health Advice

- **Preventing it Get Started - Staff**
- Do not come to work if you have symptoms of viral resp tract infection
- Do not come to work even if you are told you don't need a test (until 48hrs after symptoms resolve)
- Do not come to work even if you have a not-detected test (until 48hrs after symptoms resolve)
- **Declaration of fitness for work possible?** (protecting patients and colleagues)

- **Go home if you become symptomatic**
- Remind colleagues to go home if they are symptomatic
- **The role and methods for staff testing**
- Method of sample collection (nasopharyngeal swab or deep nasal swab)
- Method of laboratory testing (PCR or antigen)

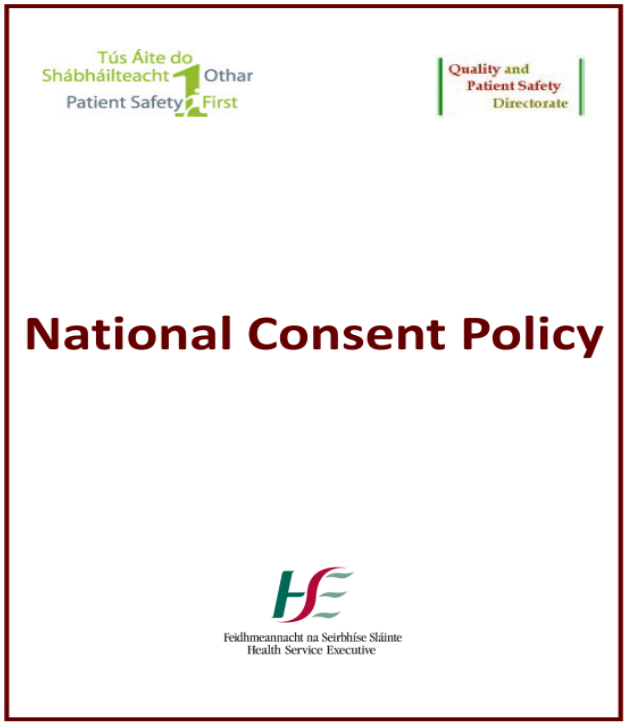
HSE Guidance update regarding CPR

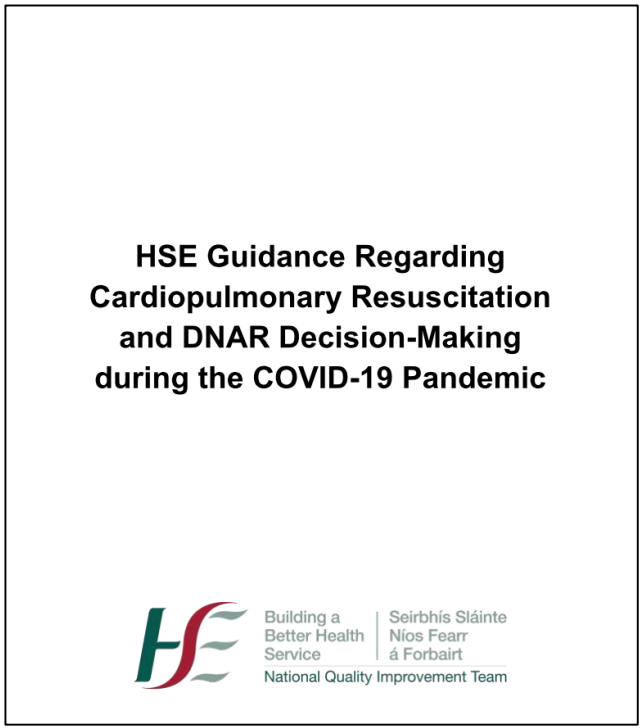
Prof Shaun O Keefe
UHG & co-chair HSE National Consent Policy group

Online webinar series hosted jointly by ONMSD and the National Integrated Care Programme Older Persons.
As part of COVID 19 Pandemic Response.

Guidance regarding Cardiopulmonary Resuscitation and DNAR Decision-Making during the COVID-19 Pandemic

Shaun O'Keeffe
Galway University Hospital





Part 4: Do Not Attempt Resuscitation decisions

N.B. Word ‘consent’ appears nowhere in DNAR policy

What’s Changed? Nothing (Almost!)

Non-COVID Developments

- HSE DNAR policy due to be revised this year
- Implications of “Tracey case” - Not to discuss a decision about CPR a breach of Art 8 European Convention on Human Rights.
- Assisted Decision-Making (Capacity) Act 2015 includes advance healthcare directives - not in force yet

COVID 19 & DNAR

Fundamental principles of good clinical practice in DNAR decision-making and advance care planning remain the same.

- Having timely discussions
- Eliciting preferences, educating
- Balancing benefit and harm
- Non- discrimination

So, what's different then?

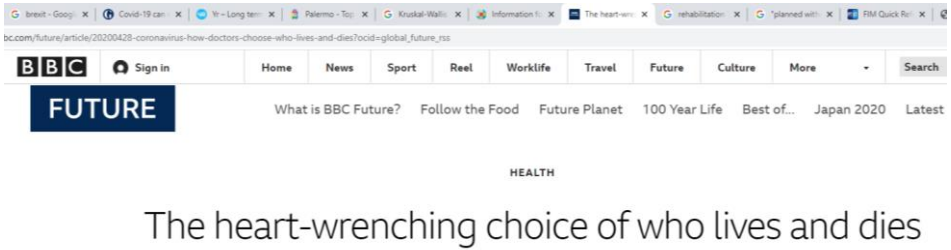
- New challenges - More difficult to get it right
- New pitfalls - New ways to get it wrong

New challenges

- Nature of severe COVID 19 alters benefit/harm of CPR and added urgency to need for advance planning
- Communication in an age of PPE, masks, restricted visiting and face to face consultations
- Risk to staff during CPR/ PPE issues - risk of aerosol exposure and infection from some procedures.
- Planning in case of shortage of resources: if too few beds for those with severe COVID needing and wanting ICU

ITV REPORT 2 April 2020 at 12:10am

Coronavirus patients could have treatment withdrawn to save others if hospitals become overwhelmed



Ventilators 'are being rationed for those most likely to survive coronavirus'

FINANCIAL TIMES

"NHS 'score' tool to decide which patients receive critical care"

New pitfalls

‘Pandemicization’ of decision-making

- Allowing surge precautions to influence other care
- Conflating not for ICU with not for hospital admission/ CPR
- Discriminatory group decision-making – especially abuse of scoring systems, frailty scores, older people, people with disabilities, residential care

Coronavirus: GP surgery apology over 'do not resuscitate' form

1 April 2020

Coronavirus pandemic

Purpose new guidance

- Restate existing policy to deal with challenges and avoid pitfalls
- Incorporate relevant new guidance from Department of Health
  - *Ethical Framework for Decision-Making in a Pandemic,*
  - *Ethical Considerations Relating to Critical Care in the context of COVID-19*
  - *Ethical Considerations for Personal Protective Equipment (PPE) Use by Health Care Workers in a Pandemic .*
- Stronger emphasis on advance care planning: In specified circumstances *"it is the responsibility of the senior clinical decision maker to ensure that advance care discussions occur in a timely manner*".
- Clearer guidance on reviewing and disseminating decisions

General Principles

- A decision not to attempt CPR applies only to CPR.
- DNAR decisions should be made in the context of the person's overall goals and preferences as well as the likelihood of success and the potential risks and harms.
- If a person with decision-making capacity refuses CPR, this should be respected
- General presumption in favour of CPR…**but**

- Non Discrimination:
  - *An individual should not be obliged to put a DNAR order or advance healthcare directive in place to gain admission to a long-stay care setting...*
  - There should be no discrimination for or against persons who have or are suspected to have COVID-19 in relation to DNAR decisions.
  - The pandemic does not justify deviating from that approach by making DNAR decisions on a group basis.

- Role of family or friends
  - *If the person is unable to participate in discussions after being given appropriate supports… those close to them may have knowledge of their previously expressed goals and preferences. However, [their role] is not to make the final decision regarding CPR or to 'consent' to a DNAR decision as this authority does not exist under current Irish law. The purpose of these discussions is to help the senior clinical decision maker make the most appropriate decision having regard to the goal and preference of the person.*

Emergency Radiology | Published: 09 November 2017

Use of whole body CT to detect patterns of CPR-related injuries after sudden cardiac arrest

- 85% rib fractures
- 31% sternal fractures
- 13% mediastinal haematoma
- 10% pneumothorax
- 8% pneumomediastinum
- 3% haemothorax
- 8% abdominal injuries

'If the expected outcome is death, a procedure less dignified and peaceful could hardly be devised'.

(Saunders 1992)

Miscommunication

- CPR is not a cure for ordinary dying
- “Would you like CPR?” – an invitation to sign your own death warrant?
- Need for education, direction from healthcare professionals

A physician who merely spreads an array of vendibles in front of his patient and then says "Go ahead, choose, it's your life" is guilty of shirking his duty...

Inglefinger, NEJM 1980

Experience of families at end of life, findings from Kelleher report

Brigid Doherty
Service Users and families voice

Online webinar series hosted jointly by ONMSD and the National Integrated Care Programme Older Persons.
As part of COVID 19 Pandemic Response.

Managing C 19 outbreak- supporting residents and families

Expert Panel Report- Examination of Measures to 2021

Brigid Doherty – Panel member

3rd December 2020

COVID-19 Nursing Homes Expert Panel

Examination of Measures to 2021

Report to Minister for Health

- Panel appointed by MOH on 20 May 2020 to examine the complex issues in this particularly vulnerable group of Nursing Home residents:
- Prof C Kelleher (Chair)
- Prof Cillian Twomey
- Ms Petrina Donnelly
- Ms Brigid Doherty

Report published August 2020
https://www.gov.ie/en/publication/3af5a-covid-19-nursing-homes-expert-panel-final-report/

Approach & Methodology

- An evidenced-based and consultative approach
- Analysis of available epidemiological data
- Rapid systemic review of literature on older people living in long stay centres
- Three part stakeholder engagement
- Three Nursing Home site visits
- Engagement with several residents and relatives

It was clear from a range of stakeholders that staff worked tirelessly for the residents and all now require ongoing support. Working with frail and older vulnerable people, end of life care and care of the dying are aspects of care that staff are experienced in and do well. However, as in some nursing homes, the experience of many deaths so close to each other was new. This experience was both shattering and frightening. - *the ongoing supports are reflected in the recommendations*

The panel acknowledges:

To their eternal credit, many nursing homes managed to cope with COVID-19 outbreaks/clusters when they arose. Others were more seriously challenged especially those with bigger case numbers; indeed, the consequences were overwhelming and devastating for their residents, their families and the staff themselves.

Carefully planned post pandemic support will be required

Impact of the Pandemic

- Staff view: visiting restrictions – rationale understood
- was thought to have been cruel, especially for those close to death
- residents with dementia – diminished insight compounded by not seeing relatives
- Reduced regular staffing numbers as a result of illness/isolating requirements added to the challenges
- Staff felt guilty if needed to be off due to COVID+ or self isolation/close contact

Resident and relatives views

- Sudden change of visiting policies
- Frustration bordering on anger with ‘no visiting’ policy
- Frustration not allowed ‘home’ visits
- Window/phone face time, while appreciated – also emotionally traumatic
- Lack of information regarding relatives condition
- Difficulty with speaking to staff/unanswered phone lines

End of Life

- End of life: No family member allowed ‘to say goodbye’
- Particular issue for larger families where one member only policy
- Guilt of not being present at end of life –significant impact
- Gap in information – not knowing how loved one was during last days/hours of life - May result in request for resident care files
- How end of life care is managed, our experience of it, will effect how we deal with our own impending death
- *Recommendation 11.1 Every NH should be linked with a palliative Care Team in their area*

Bereavement Support

- Bereavement support for individual residents
- Facilitation of informal bereavement gatherings for residents
- Bereavement support for relatives

Communication challenges

- It was difficult to communicate with family members due to logistical challenges, less frequency of visits, or multiple family members requesting information
- Staff can have challenges with communication due to limited experience, skills or confidence
- Agency staff may not be familiar with residents/families as regular staff would be

Communication – some suggestions

- Ask how the resident and family prefer to receive information
- Agree with family a designated member for updates to share with rest of family (be conscious of family dynamics)
- Use face-to-face communication to promote visual contact as far as possible
- Use written materials to provide to residents
- Plan for repetition of the information in multiple interactions and formats

Change to visiting and other activities due to restrictions - explain

- Why are changes being introduced?
- How will the changes impact the entire facility?
- How will the changes impact the resident
- How will the changes impact on the family member?
- When will the change be implemented?

- *Recommendation 13.1:* Communication
  Meaningful communication with residents and family, should take place regularly in relation to visiting protocols, changes in processes and explanations in relation to same

Recommendations 11.2, 12.3, 15.2

- VISITING:
- *Recommendation 11.2:* Individual assessments undertaken and documented and compassionate visiting should be followed as recommended by HSE /HSPC visiting guidance
- *Recommendation 12.3* End of life visiting must be arranged on compassionate grounds based on clinical judgement and take account of public health measures
- *Recommendation 15.2:*

  HPSC should proactively/regularly review visiting guidelines in order to achieve a balance between individual freedoms and protective public health measures, in line with DOH ethical guidelines

Advocacy

- Independent advocates were identified as being very supportive for families helping to address and negotiate meaningful engagement in difficult situations
- Helped to navigate the system, facilitated communication between providers/relatives
- Some resistance by some NH's to welcome advocacy intervention

- *<u>Recommendation 15.2:</u> The DOH and HIQA should explore the requirement that all Nursing Home providers, promote, facilitate and engage meaningfully with independent advocacy services*

Share the Load

- Family/relatives :– see relative as ‘extra eyes and ears’ of residents deteriorating condition

  Support role – relatives may be in unique position to better understand, articulate & support the emotional, social and health preference s of the resident
- Build relationships with the community support teams
- Local palliative care team
- Irish Hospice Foundation – Bereavement support
- The advocacy organisation for your area i.e. SAGE Advocacy

Extract from Report conclusion:

"A major part of modern public health is the improved life expectancy. Older people have contributed as citizens and taxpayers and the benefits of cross generation interactions and engagement are many. Young adults today know their grandparents in a way not seen in the past and benefit from the experience. Many have acted as carers for their children's children

People over 65 include the baby boomer generation (1946-1955) and the older old, born around the War of Independence and the establishment of the Republic of Ireland(1920-1945)

These are the people who survived into old age but were inordinately the victims of the pandemic."

"While often overlooked by the health system and the communities they serve, nursing homes are essential to the continuum of care across the life cycle, particularly in times of crisis.

As we mourn the profound loss of life of nursing home residents, in the wake of COVID-19, may we forever honour these lives by learning from this tragedy and creating a better system"

Supporting People with Cognitive Impairment/Dementia during COVID-19

Norma Sheehan
Saint Josephs Shankill

Online webinar series hosted jointly by ONMSD and the National Integrated Care Programme Older Persons.
As part of COVID 19 Pandemic Response.

Supporting People with Cognitive Impairment/Dementia during COVID – 19

Saint Joseph's Shankill is a residential home for 62 people living with varying types of dementia and at various stages. We are the only dementia specific home in Ireland of this size.

In 2017 we completed a project with Dementia Care Matters in implementing the 'Butterfly Household Model of Care'.

The essence of the Butterfly Household Model of Care is based on 4 key beliefs:

- ***The coming alive of PEOPLE – everyone wants to feel needed and they*** **have a purpose in life**
- **STAFF development of emotional intelligence**
- **Belief from the LEADERSHIP in the change and culture**
- **Creating real homes**

This approach involved a major culture change and an environmental change and both of these changes have really helped us in this last year since the arrival of COVID- 19.

Saint Joseph's Shankill
Dedicated to Dementia Care

The Culture – this is the hardest part to change – we all think we are very person centred and deliver ‘person centred care’ but Person Centred Care has become a much overused term and often people just ‘talk the talk’. The culture has to change from a task orientated clinical approach to one that reflects everyday normal life and focusses on the individual and how they are feeling, their personality and perspective on life and their need for social interaction.

We removed all the clinical / institutional things from our home, nobody wears uniforms or name badges, there are no drug trolleys or nurses’ stations.

We created 6 lodges at different stages of dementia and between 8 -13 people live in each lodge. Every house has its own front door and is different from the next and care is geared to the people who live there. People are profiled to determine what stage of dementia they’re at and then matched to a house so that people more or less at the same stage live together. We use a tool from Meaningful Care Matters to profile people, that gives an idea of what stage a person is at in their dementia and Meaningful Care Matters describes four stages: (adapted from Naomi Feil’s Model)

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- **Early Experience** – 1st stage - is for people who are still functioning well, they may be aware that they have dementia and try to hide/deny it.
- **Different Reality** – 2nd stage - At this stage people have moved on and often are living in a different reality to our own – For example they may say they have to go to work or collect the children from school.
- **Repetitive Emotion** - 3rd stage – At this stage people often express feelings through repetitive sounds, words or actions to communicate their feelings or to try and tell you what they want. These are often described as responsive behaviours – we would say that every behaviour is an expression of need - The emotion is in the motion.
- **Late experience** – 4th stage – people who have intense **later 'stage'** dementia care needs. At this stage they may have very little communication and may appear to have shut out the world.

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Lately I've heard reports NH transformed overnight from a social model to a clinical model because of COVID -19 and infection prevention and control measures.

This was not the case for us. The majority of residents are not aware of any difference to their lives since the onset of the pandemic.

Why is this? The model itself promotes small households living together so cocooning and staying at home with our own family was already in place.

Staff work in the same house and are part of that family. The small houses/lodges made it easy to keep staff in their own individual homes with no crossover except at night time. This would also aids contact tracing if needed.

Initially we tried social distancing within each house but people with dementia don't understand this and don't remember so after positively risk assessing it we treat each house as I already said as a family/pod.

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Residents see and feel that staff are part of their family. Staff very early on in the pandemic realised that they would need to compensate for the lack of people's loved ones visiting. Extra hugs and touch show comfort and love. Touch is really important it is a way of connecting with someone especially at later stages of dementia.

People with dementia are very much feeling beings - so with recognition and security, the love they are given from staff (in absence of family) makes them contented and their needs are met.

Meals are always taken within each lodge, they all have their own kitchens cum dining rooms so there is no large movement of people to the dining room. Most of the time they are already in the kitchen/dining room and don't have to move very far to the table.

Meals are real social occasions and staff make a point of sitting down with people, normally they would share the meal together but with covid they just share the experience and not the food!

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People's Quality of Life remains a priority and this has been maintained throughout Covid, People still have a purpose to their day, they know they are needed and that they still matter. Everyone does activities not just the activities co-ordinator.

Everyday life continues as it always did except (like at home) baking increased, I think the smell of home cooking was very comforting for everyone.

We do not use the term 'COVID- 19 as the people living here would have no understanding of it, instead we talk about a bad flu.

If people are doing something that goes against Infection, Prevention and Control or something you don't want them to do we don't say 'you can't do that / you can't go in there, we use distraction techniques, talk to them about something from their past that they might respond to.

If you are negative to them, they may respond negatively because they don't understand. It is really important to always use positive language and make connections with people.

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Staff say that residents haven't been bothered by them wearing masks and they feel it is because they often dress up to create 'occasions' so the wearing of masks doesn't seem as threatening and has become part of the creativity.

'eye contact' is also really important so that you can really connect with a person. The person then doesn't really see the mask.

Staff are matched to particular houses as well as residents and they develop different skills depending on the stage. Early and Different Reality stage people are very active and need lots of stimulation, whereas at repetitive and later stages they need a much more calm environment and focus on the senses. Staff working in an individual house develop a real bond with people and often describe them as like their own family.

This knowledge of knowing someone so well helps staff to recognise when someone is 'not themselves' and know e.g. when someone displays a certain behaviour like walking leaning to the left that they probably have a UTI – it is not something new for them that could possibly be COVID – 19.

Communication

They also know people's families and friends really well which has aided virtual communication, staff know who needs daily communication and what is really important to them. They know the little treats/favourite foods that families often brought in for them e.g. a can of Guinness or bar of chocolate. It's the little things that make all the difference. When restrictions were lifted in the summer we opened up to visiting which was facilitated by our wonderful volunteers.

We developed our open area where we held social occasions and had 4 pods where people could visit.

All visitors were screened and adhered to IPC precautions and were escorted to and from the visiting area. We allowed hugs and hand holding because this is so important for people with dementia.

Each visitor was allocated a ½ hour, while this in some instances very short in others ½ hour can be very long and people can run out of conversation very quickly. So we geared the visit to the person e.g. Music they like, a laminated card with talking points from their life or nice smells – flowers, incense.

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When visiting was restricted again we didn't allow window visiting as we found that this only benefited the visitor. The person with dementia couldn't understand what the person was doing on the other side of the window and why they couldn't talk properly to them or touch them and this was very distressing for some.

Like everywhere else we encouraged families to send in postcards and letters this can promote reminiscence. We also use what's app and ZOOM, and send pictures and videos to families capturing the 'good moments' their loved ones have every day.

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Isolation

We know that the recommendations from HSE/PH are that when people return from / admitted from hospital / home they must isolate for 14 days. This can be very difficult and at times impossible!!

First of all we addressed this by filling up the person's room with things to distract / occupy etc bring the world to them, but for people at repetitive stage whose attention span might be for 1- 2 minutes this doesn't work for very long. While we encourage people to stay in their room as much as possible, and in keeping with our positive risk taking ethos we also decided that we weren't going to lock someone in or sedate them in order to comply. We treat the person as part of the pod and social distance where we can, they have been tested prior to admission, however if they were to develop symptoms then they would isolated in a different area if unable to remain in their own room.

We have been very fortunate (so far) in our experience of this pandemic, yes we have adopted all the IPC measures and increased cleaning regimes and developed many contingency plans, but we are proud that the people in our care still enjoy a quality of life that enables and supports them all to be themselves and be happy.