Webinar Two- Managing Covid-19 Outbreak – key essentials
Thursday 26th November 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 your 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 174 118 3291

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

Outbreak Control: Early steps you can take when first case of COVID-19 Identified

Sarah O'Donnell, Nurse- CHO7 Public Health COVID-19 Outbreak Team

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Outbreak Control: Early steps you can take when first case of COVID-19 Identified

Sarah O'Donnell Nurse- CHO7 Public Health COVID-19 Outbreak Control Team

Dr. Ruth Mc Dermott- Specialist in Public Health Medicine CHO7

26th November 2020

What is an Outbreak

X2 or more confirmed with a link = an outbreak

X1 single confirmed case = suspect outbreak

Full 'outbreak control measures' should be implemented for both scenarios

Steps

1. Implement full outbreak control measures
2. Contact trace each individual case
3. Infection prevention and control

Implement Outbreak Control Measures

Start

Isolate COVID Detected cases, suspect cases and ‘close contacts’

Designated staff & equipment

Monitor residents

Working in zones- minimise crossover of staff between zones

Staggered break-times

Twice daily cleaning & sanitizing- do cleaning staff know what that means

Communication

Stop

Admissions & visiting

Communal dining & activities

Identify ‘Close Contacts’

When was the case infectious?

- Symptomatic 48hrs prior to symptom onset
- Asymptomatic 24hrs prior to test

What is a ‘Close Contact’

- Someone who has had unprotected exposure
- Cumulative 15 minutes or more, face to face contact without PPE
- Eg. breach in PPE, those sharing rooms

Manage correctly!

- Exclude (staff)/ isolate with contact and droplet precautions (residents)
- Count 14 days beginning at date of exposure

Infection Prevention and Control

Basic standard precautions with all persons, in all locations, all of the time

Simple basic hand hygiene measures at the appropriate time, physical distancing and using PPE appropriate to the task at hand

Testing

Mass-testing is not the first public health action in response to a new case

Risk-assessment

Public Health Specialist will usually advise

Timing

Outbreak control team meeting

Three steps

1. Implement full outbreak control measures
2. Contact trace
3. Infection prevention & control practices

Know the contact details for your local Department of Public Health.

For notification of a new case in CHO6, CHO7 and CHO9 please email:

Idnotifications.east@hse.ie

Prepare and plan…

Thankyou

Medical management of outbreak- key messages

Dr Siobhán Kennelly, NCAGL,
Consultant Geriatrician

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Medical Management of Covid 19 in LTRC- update on learning since March 2020

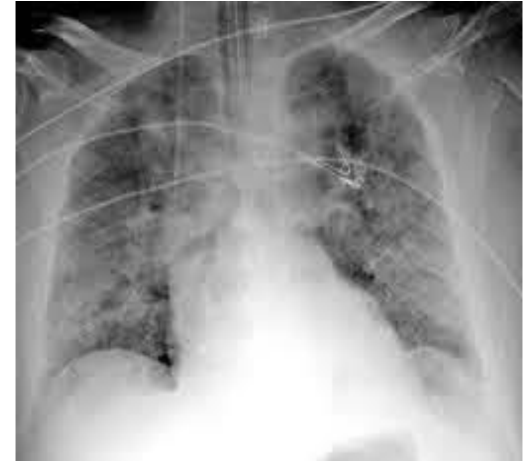
HSE Nursing Home Webinar Series - 26.11.2020

Dr Siobhán Kennelly

Case Presentation 1

- 86 year old man, in RCF x 2 years
- Background CCF, COPD, osteoarthritis with limited functional mobility
- No significant cognitive issues
- Sept 2019, RCF C 19 outbreak identified on staff testing
- Patient asymptomatic positive on PCR testing of residents
- D4 generally unwell, lack of appetite
- D9, fever, shortness of breath, cough
- D 11, transferred to acute hospital as per ACP and discussions with resident and family

- On arrival in acute hospital O2 sats 88% (4 L), RR 20, BP 170/ 90
- Bilateral chest crackles
- Mostly orientated and alert
- CRP 230, Creat 210, lymphopenia
- Oliguric
- CXR with significant b/l infiltrates



Care Plan

- High flow oxygen, fluids, supportive care
- Low molecular weight heparin, antibiotics
- Couldn’t tolerate proning, Non Invasive Ventilation
- Dexamethasone
- Oxygen requirements initially stabilised but from day 17 further deterioration
- Ward-based management as per discussion with patient and family
- Palliative supports and symptom management, passed away day 21

Case Presentation 2

- 78 year old woman
- Bkgrd Multiple myeloma, dementia, IHD, Type 2 Diabetes
- Ambulant, walking with purpose
- Off food, worsening confusion
- Diagnosed c 19 positive following testing
- Can’t tolerate face coverings, anxious, distressed with isolation protocol
- ‘Safe area’ identified where walking could be managed with staff and cleaning protocols
- LMWH, dietary supplements (little and often offered), fluids
- Full recovery after 10 days

Learning from LTC Outbreaks March-May 2020 Asymptomatic carriage rates and case-fatality of SARS-CoV-2 infection in residents and staff in Irish nursing homes

- Survey of 45 NHs across 3 CHOs with Covid 19 outbreaks
- High Incidence of C 19 in confirmed outbreaks (43%) with approx. 27% 'asymptomatic'
- Resident case – fatality 27% but later outbreaks seemed to fare better with lower mortality
- Significant correlation between high numbers of symptomatic staff and symptomatic residents (implications for safe staffing levels and care ratios)
- Previous 'compliance' under regs no guide to how

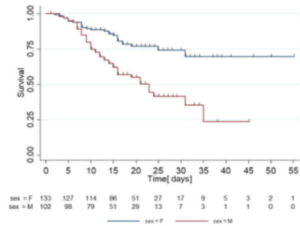
  LTC fared with COVID 19

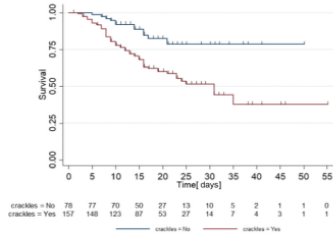
? What may be influencing mortality rates in LTRC outbreak

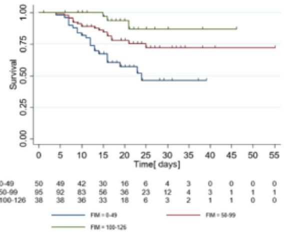
- Patient factors (individual and LTC population e.g. high numbers with high dependency, significant dementia care needs)
- Staff factors (Skillset, Training, Preparedness)
- Environment (facility size ? 60-80 more at risk, layout and overall ‘concentration’ of residents seems to influence)

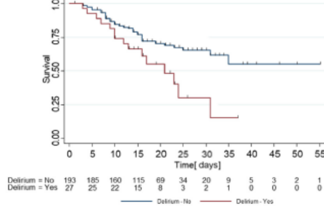
- Coronavirus (COVID-19): care home outbreaks - root cause analysis (Scotland)
- Long-term care staffing study (Ontario)
- COVID-19 Nursing Homes Expert Panel: Final Report – recommendation 9 – Staffing/workforce

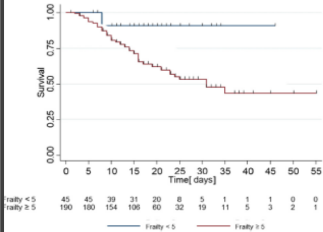
A Mendes et al. / JAMDA 21 (2020) 1546–1554











Patent factors- COVIDAge study (all older patients)

- Male Sex
- Crackles
- Delirium
- Frailty / Functional Impairment

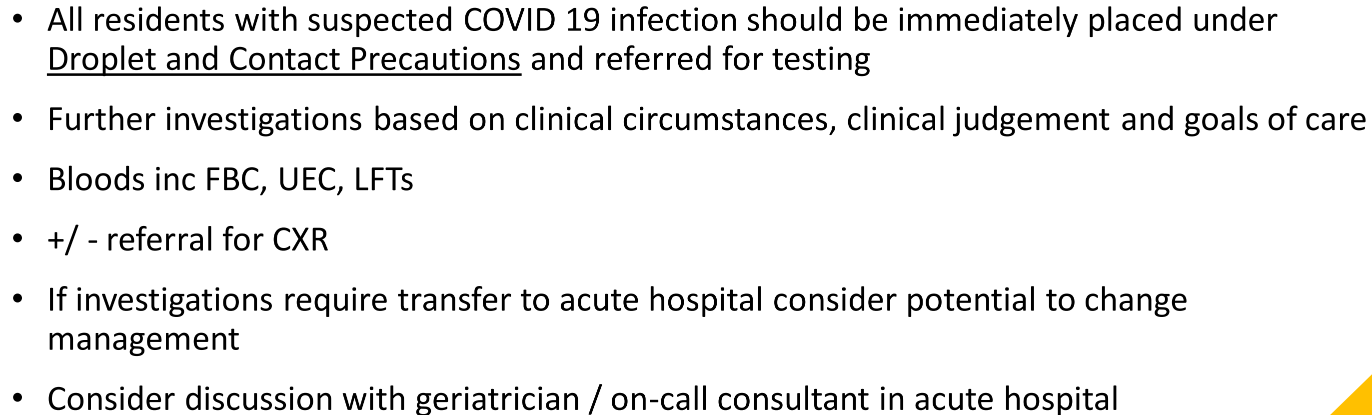
Active medical management

- Can often be provided in the NH
- Depends a lot on staffing skills, leadership
- Interventions must be consistent with resident goals of care, expressed wishes and documented advance care plans
- Can be challenged in an environment struggling with staff shortages and the capacity of the NH to meet the residents needs to be considered
- Ideal should be that for those who wish to remain in place with active medical management and are not responding to same / deteriorating, focus of care discussion on alleviating pain and symptoms / transition to PC approach should be discussed

? Appropriate monitoring

- In C 19 Temp, BP, Oxygen sats monitoring at least daily
- Focusing on the basics always worthwhile…fundamentals of oral intake and what may / may not get missed
- Note typically indolent clinical course week one followed by changes in week 2 and beyond
- Be aware of hypoxia picture…sometimes significant less respiratory distress at low oxygen levels; decline in oxygen saturations can be precipitous
- Update care plan to reflect evolving picture especially in recovery which can be prolonged

Investigations



- All residents with suspected COVID 19 infection should be immediately placed under Droplet and Contact Precautions and referred for testing
- Further investigations based on clinical circumstances, clinical judgement and goals of care
- Bloods inc FBC, UEC, LFTs
- +/ - referral for CXR
- If investigations require transfer to acute hospital consider potential to change management
- Consider discussion with geriatrician / on-call consultant in acute hospital

Severity assessment

Twice daily observations appropriate but use judgement

Resp rate…tachypnoea

O2 saturations

Signs of dehydration

Mental status; drowsy / delirium/ obtunded

Skin..peripheral cyanosis

Based on initial assessment, attempt to determine severity

Severity 'guide' in RCF

- Asymptomatic (e.g. diagnosed on contact tracing)
- Mild illness- residents with some signs or symptoms of COVID 19 but without shortness of breath / Dyspnoea / abnormal imaging
- Moderate illness- residents with evidence of lower respiratory tract disease by clinical assessment / imaging with $SpO_2 \geq 90\%$ on room air
- Severe illness – Residents with $SpO_2 < 90\%$ RA, RR >30/ min; lung infiltrates > 50% on imaging
- Residents who have resp failure, septic shock and / or multiple organ dysfunction (i.e. are sick enough to require ventilator and / or circulatory support for shock)

(Ref Interim Guidance; Canada, July 2020)

Caveats on ‘Severity assessment’ in LTC setting

- Non-respiratory symptoms can predominate in LTC population
- Importance of monitoring residents with asymptomatic / mild disease for change
- Can be helpful in discussions with staff / families / resident themselves
- Current guidance does not advise use of corticosteroids / Dexamethasone in LTC setting to manage C 19

Medical Management of C 19 in LTRC- essentials

- Good supportive care and monitoring
- Careful attention to diet and nutrition
- Hydration inc. supplementation with sc fluids
- Liaise with GP to look at what medications can be held..e.g. diuretics if poor fluid intake, antihypertensives if low BP etc, calcium supplements, laxatives etc
- Low Molecular weight Heparin..
- Nutritional Care for Patients with COVID-19 **(CD 19-036001/03.04.20)**

Oxygen

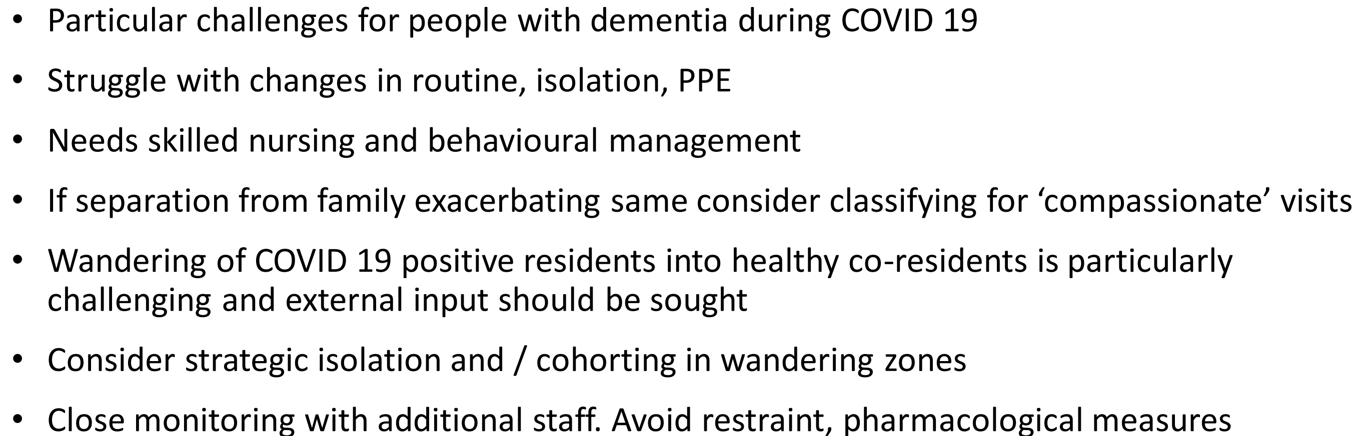
Interim Guidance on the use of oxygen in long term residential care settings for older people during the Covid-19 pandemic (CD19-076 /10.04.20)

- Possibly playing less of a role than might have been anticipated in the LTRC setting
- Oxygen is a treatment for hypoxia and should be prescribed in the medication kardex by the registered medical practitioner or nurse prescriber. All changes to prescription / flow rate must be discussed with the prescriber.
- Maximum titration flow in care settings outside hospital is 4 l/min. When supporting a patient with Covid-19 for recovery with oxygen, supplementary oxygen can be commenced when saturations are less than 94%.
- Avoid using as a 'holding measure' in residents who want active treatment and where hospitalisation may be of benefit

Potential co /super-infection & Thromboembolism

- True rate of bacterial co-infection in Covid-19 is unknown
- Typically rates of 8% quoted, ? Higher in older patients
- If prescribing antibiotics, consider illness severity, antibiotic risks, antibiotic associated diaorrhea, potential for C Diff infections
- Antibiotics should not be prescribed routinely in NH residents with suspected or confirmed COVID 19, particularly in cases of mild illness
- Empiric antibiotic treatment should be considered in NH residents with COVID 19 when there is a clinical suspicion for bacterial infection…tends to be clinically determined; imaging, bloods etc don't really help differentiate
- N.B. other potential sources of sepsis / non-Covid presentations
- Thromboembolism Interim guidance VTE prevention in people with COVID-19 in community or residential settings **(CD19-176 / 25.05.20)**
- If no contraindications and body weight 50kg, Enoxaparin 40mg sc for 14 days

Responsive behaviours during COVID 19



Key Clinical Guidance and Resources

- https://hse.drsteevenslibrary.ie/Covid19V2/olderpersons
- https://hse.drsteevenslibrary.ie/Covid19V2/residentialhomes
- https://hse.drsteevenslibrary.ie/Covid19V2/palliativecare
- https://hse.drsteevenslibrary.ie/Covid19V2/pharmacy/medicinesmanagement#s-lg-box-wrapper-17932682
- **HPSC Interim Public Health, Infection Prevention & Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities (V6.1 12/11/2020)** – Click here

‘Lived Experience’- Optimising Care of Residents during an outbreak

Fiona Dunne
Assistant Director of Nursing, Nurse Practice Development, St Marys Phoenix Park

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

Lived experience: optimising care of residents during an outbreak.

Fiona Dunne
Assistant Director of Nursing
Nurse Practice Development
St. Mary's Hospital & Phoenix Park Community Nursing Unit
26th November 2020

Background to St. Mary's Campus

- **St Mary's Hospital: 48 beds**
  - Stroke rehabilitation
  - General rehabilitation
  - Community response unit
- **Day Hospital**
- **Healthy Ageing Clinic**

Phoenix Park Community Nursing Unit

- 150 beds - 6 units with 25 residents
- Includes a dementia focused unit

COVID 19

Europe situation

- **27 January 2020:-** In the WHO European Region, COVID-19 surveillance was implemented
- **21 February**:- nine European countries reported **47 cases**

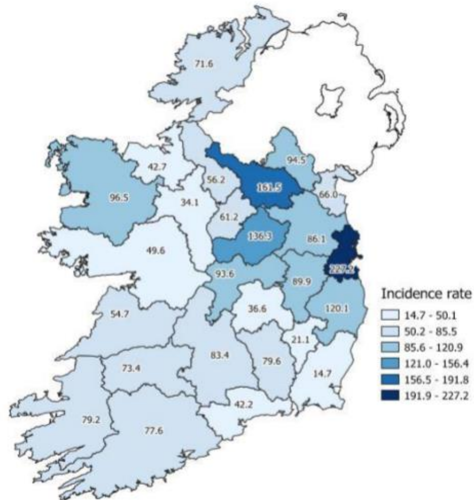


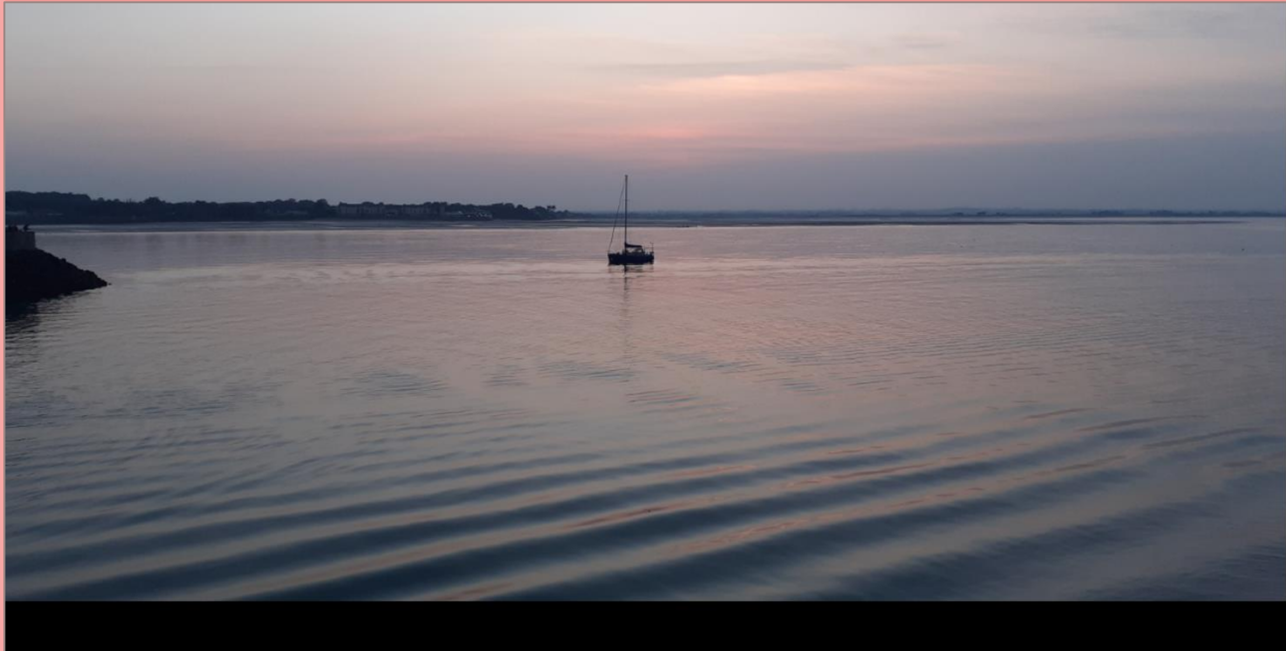
Figure 4: Cumulative incidence rates per 100,000 population of confirmed cases of COVID-19 notified to midnight April 5th 2020 by county, Ireland

Ireland – Timeline in early 2020

- **29th February:-** Ireland confirmed **1st case** of COVID 19
- **11th March:-** Ireland confirmed its **1st fatality** due to COVID 19
- **27th March:- 2121 cases** and **22 fatalities** in Ireland
- **5th April:- 5993 cases** and **204 fatalities**
- **5th April:- 86 clusters** in Irish Nursing Homes

Source:- *https://www.hpsc.ie*

Planning for a *storm* but a Tsunami was actually approaching.



COVID 19

St Mary's Campus

- **February** Commencement of COVID-19 Pandemic preparation meetings.

- **During March**
- Campus closes to visitors (Nursing Homes Ireland) followed by reopening with restricted visiting on advice from NPHET, followed by closure to all visitors except for compassionate reasons.
- Day Hospital closes, volunteers students & external staff activity restricted.
- Severe pressures nationally on new Covid-19 testing and tracing processes

- **30th March:-** Public Health confirm an outbreak on campus

Infection Prevention & Control

- ✓ Staff hand hygiene education
- ✓ Staff bare below the elbow
- ✓ Educating service users and families
- ✓ Supplying hand hygiene leaflets
- ✓ Posters & signage around campus
- ✓ Procurement of PPE and IPC help
- ✓ Access to & throughout campus
- ✓ Identifying isolation areas
- ✓ Protocol for dealing with a suspected case of COVID 19.

COVID-19……… Our Reality

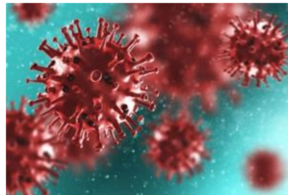
Reduced staffing due to sickness/isolating

PPE guidance in the acute settings

Crisis management – doing the best for the resident under very stressful circumstances

Bereaved staff

COVID 19



Information overload and continually changing sometimes on an hourly basis

Redeployment of staff to provide support

Increased anxiety among all staff due to fear of the unknown

Fear for self, colleagues and residents

Staff report the experience was very isolating, traumatic and sometimes relentless for the staff

Impact of COVID 19

Nursing/MDT team	Residents	Family & Friends
New ways of working	New ways of living	New ways of working & living
Increased workload	Decreased activity	Decreased visiting and interaction
Isolation	Isolation	Isolation
Wearing PPE 12 hour shifts	Lack of understanding and fear of PPE	Concerns about PPE (media)
Skill mix challenges	Unfamiliar carers led to disruption in familiar routine	Concerns regarding care
Fear and anxiety	Fear and anxiety	Fear and anxiety
Communication challenges	Communication challenges	Communication challenges
Physical impact Fatigue exhaustion burnout	Physical impact – reduced activity due to isolation	Witnessing physical impact on loved ones
Reduced/lack of meal breaks	Altered meal times and locations	Increased concern regarding altered mealtimes of loved one
Overwhelmed	Unsettled	Anxious and fearful
Fear for safety of own family and residents	Fear for personal safety and own family and friends	Fear for own safety and loved ones

Challenges To Optimising Care

Public health - frequent changes in guidance due to emerging evidence

Guidance on PPE- acute services versus residential

Asymptomatic – confirmed COVID -19 on routine testing – staff and residents

Atypical presentation – G.I. symptoms, loss of appetite, confusion, fatigue, often no fever or respiratory symptoms

Lack of understanding of the true reality of the situation

Their home – Cohorting challenges /respect for their rights

Communication with families – sub optimal due to reduced staffing levels, visitor restrictions, priority to patient care

Isolation challenges with residents due to lack of understanding

Daily media reporting - sometimes inaccurate causing hurt and distress to all

High level of sickness among staff – new staff requiring high level support

Optimising care to combat the impacts

- Need to support all emotional, social and spiritual needs
- Unprecedented challenges
- Frailty and pre-existing medical conditions
- Nursing home with benefits: Support of a multidisciplinary team of onsite professionals
- Doctors, nurses, therapists, social workers, activities staff, ancillary staff

Activities department response

- Adaptation to 1: 1 activities
- Social interaction, visiting, meaningful conversations,
- Psychological support, listening, reassuring
- Reminiscence, story-telling, gentle hand massages, board games, knitting, crosswords
- Gentle chair based exercises
- Outdoor walking to get fresh air
- Phone/video calls to family/friends.
- Longing for companionship associated with previously cherished group activities with peers

Revised activities assessment

One ought to each day hear a little song, read a good poem, see a fine picture and if it were possible to speak a few reasonable words.

Goethe

Addressograph or complete below

Name: ____________________

Date of birth: ________________

Medical Record No: ___________

Ward: ____________________

Phoenix Park Community Nursing Units,
St. Mary's Campus, Phoenix Park, Dublin 20

During Covid 19

Therapeutic Activities Assessment
Activities resident enjoys taking part in either independently or with assistance on 1:1 basis

ACTIVITY	Yes
Art/ Crafts	
Bingo 1:1	
Board Games	
Cards	
Crossword	
Gentle Exercise	
Knitting/ Crochet	
Listening to Music	
Manicure/Nail care	
Mass on TV	
News/Current affairs	
Phonecall to family/friend ☐ Videocall ☐	
Poetry	
Prayers	
Proverbs	
Quiz	
Radio	
Reading: Magazines ☐ Books ☐	
Reading Daily Newspaper	
Reminiscence	
Singing: Ballads ☐ Hymns ☐	
Snoezelen	
Social chat 1:1	
Sonas 1:1	
Spending meaningful time alone	
Sports on TV	
TV Programmes	
Walk: Indoors ☐ Outdoors ☐	
Wordgames	

gnature: ______________________________

Optimising Nutrition

- All those affected by COVID -19 were at high risk of malnutrition/unintentional weight loss
- Weight loss also seen in those *unaffected* by COVID-19.
- Apathy, depression & anxiety too

Optimising nutrition

- Individualised nutrition care plans devised.
- Every resident impacted was provided with optimal nutrition and opportunities to increase their daily energy and protein intakes.
- Evidence based pathway (rolled out nationally)
- Outcomes: reports of improved energy levels, reduced apathy and improved dietary intakes

Optimising spiritual care

"Health is not just the absence of disease, it is a state of physical psychological, social and spiritual well being
(WHO, Precis of Discussion, 1948)

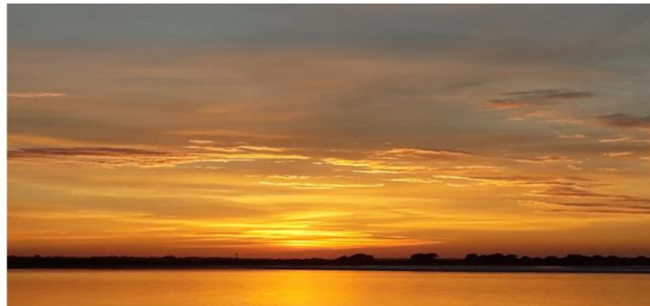
The need to give & receive love, to be understood, to be valued as a human being, the need for forgiveness, hope and trust, the need to explore beliefs & values and express feelings honestly, to express faith or belief, to find meaning & purpose in life"
Narayanasamy (1991)

End of life care

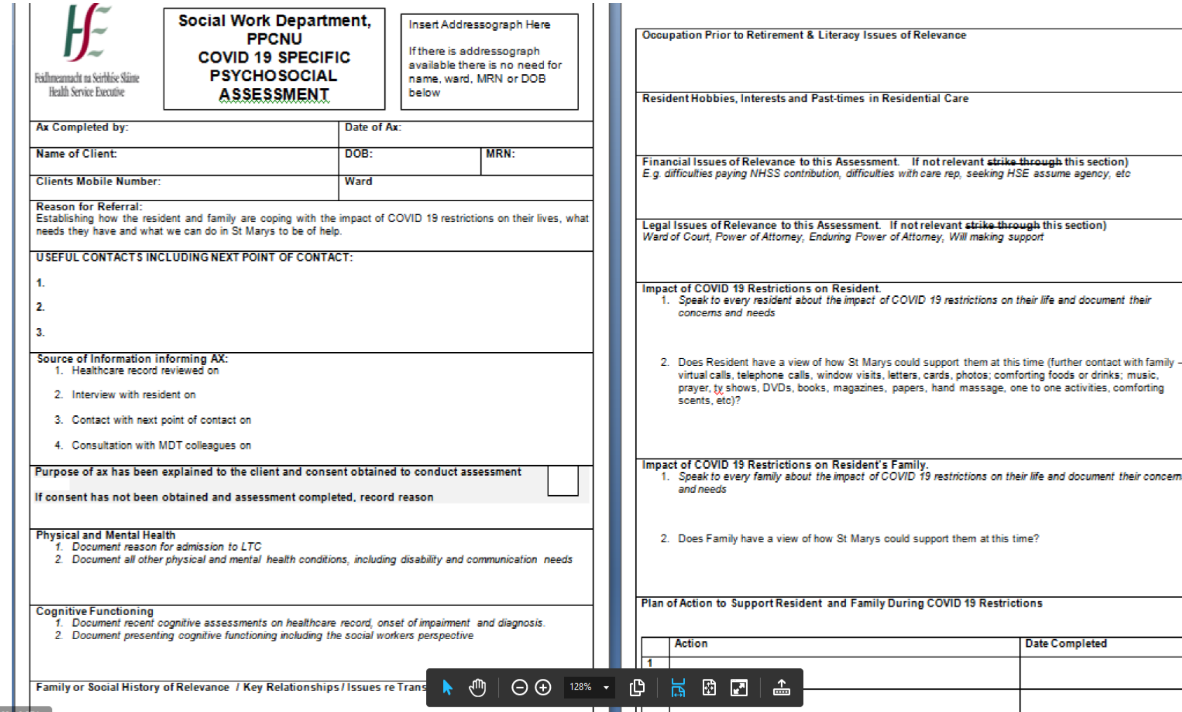
- Emotionally challenging
- Tragic loss of life
- Residents lost best friends
- Advanced care planning
- Anticipatory prescribing
- Companionship assured at end of life

Optimising Spiritual needs at end of life

- What the person wanted at this time
- What the person may have wanted
- Engagement in therapeutic, supportive work with residents/families.
- Template drafted by Social Workers: “Family view on residents end of life wishes”



Modified tool



Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Social Work Department, PPCNU COVID 19 SPECIFIC PSYCHOSOCIAL ASSESSMENT

Insert Addressograph Here

If there is addressograph available there is no need for name, ward, MRN or DOB below

Ax Completed by:	Date of Ax:	
Name of Client:	DOB:	MRN:
Clients Mobile Number:	Ward	

Reason for Referral:
Establishing how the resident and family are coping with the impact of COVID 19 restrictions on their lives, what needs they have and what we can do in St Marys to be of help.

USEFUL CONTACTS INCLUDING NEXT POINT OF CONTACT:

1.

2.

3.

Source of Information informing AX:
1. Healthcare record reviewed on
2. Interview with resident on
3. Contact with next point of contact on
4. Consultation with MDT colleagues on

Purpose of ax has been explained to the client and consent obtained to conduct assessment ☐

If consent has not been obtained and assessment completed, record reason

Physical and Mental Health
1. *Document reason for admission to LTC*
2. *Document all other physical and mental health conditions, including disability and communication needs*

Cognitive Functioning
1. *Document recent cognitive assessments on healthcare record, onset of impairment and diagnosis.*
2. *Document presenting cognitive functioning including the social workers perspective*

Family or Social History of Relevance / Key Relationships / Issues re Trans

Occupation Prior to Retirement & Literacy Issues of Relevance

Resident Hobbies, Interests and Past-times in Residential Care

Financial Issues of Relevance to this Assessment. If not relevant ~~strike through~~ this section)
E.g. difficulties paying NHSS contribution, difficulties with care rep, seeking HSE assume agency, etc

Legal Issues of Relevance to this Assessment. If not relevant ~~strike through~~ this section)
Ward of Court, Power of Attorney, Enduring Power of Attorney, Will making support

Impact of COVID 19 Restrictions on Resident.
1. *Speak to every resident about the impact of COVID 19 restrictions on their life and document their concerns and needs*
2. Does Resident have a view of how St Marys could support them at this time (further contact with family – virtual calls, telephone calls, window visits, letters, cards, photos; comforting foods or drinks; music, prayer, tv shows, DVDs, books, magazines, papers, hand massage, one to one activities, comforting scents, etc)?

Impact of COVID 19 Restrictions on Resident's Family.
1. *Speak to every family about the impact of COVID 19 restrictions on their life and document their concerns and needs*
2. Does Family have a view of how St Marys could support them at this time?

Plan of Action to Support Resident and Family During COVID 19 Restrictions

	Action	Date Completed
1		

New template

Family View on Resident's End of Life Wishes

Resident: **Ward:** **Date:**
Family Member (s) spoken to: **Phone No:**
Social Worker Speaking to Family: **Doctor who spoke with Family:**

Issue Discussed with Family	**Outcome**
Any **possessions of significance** that their relative would want with them at end of life, both before and after they pass, e.g. rosary beads, photographs, etc	
Any **words** that the family feel their relative would **find comforting** that our nursing and HCA colleagues can say to the resident	
Whether the relative wished to have prayers, music, pastoral support, etc at this time	
Any **jewellery** that the family wish to have **removed after death** and placed in safekeeping for collection at a later date	
Family wishes in relation to **in-room visiting**: Risk ax completed by Social Worker: Confirmed with family that: ✓ they have no symptoms of COVID 19 ✓ they are not a close contact of someone with suspect or confirmed COVID 19 ✓ there is a risk of them contracting COVID 19 by visiting the ward ✓ the is a risk to their household of transmitting the virus ✓ they will need to self monitor for 14 days • Visiting procedure explained: one relative, hand washing, PPE, short period in the room.	
If visit is not pursued, **other communication options** can be explored such as: (1) facilitating a telephone call (using residents own mobile or asking family to bring a mobile to the ward) (2) skype call (similarly asking family to set up the call and volunteer a phone) (3) viewing their loved one through a window on the ground floor or at balcony if possible on top floor (please ensure we are aware of residents location on ward) (4) letters or cards from family members including grandchildren that will be placed close to the residents heart (5) any other options put forth by family	
Other Requests	

Nursing response

- Recognition of potential for loneliness, isolation & exacerbation of existing problems
- Fundamentals of physical care, social, psychological and spiritual aspects of care.
- Redeployment /working in unfamiliar settings
- Invaluable in the provision of holistic care

Optimising communication

- Implementing solutions to enable face to face contact with loved ones , cognisant of IPC rules
- “Communication facilitators”
- Phone contact, virtual contact, window and balcony visits
- Computer tablets uploaded with apps to facilitate meaningful activities

Feedback from residents

- "Delightful to see my grandchildren in England"
- "Feels like they were right here with me in the room singing, its cheered me right up"

Feedback from families

- Ward clerks (redeployed staff)
- “Hugely beneficial, very reassuring to see Mum, gave great piece of mind, group calls are great for family”
- “Its brilliant that you can devote the time in these circumstances”

Preparing for optimising care and living with COVID 19

- Planning & recovery meetings
- Enhanced measures to support visiting & communication
- Psychological support for staff, residents, families & friends, debriefing and reflection.
- Developing new ways of working with technology – online meetings, communication, telehealth
- Reconfiguration and enhancement of existing facilities

All in this together

Staff camaraderie

Willingness

Pulling out all the stops

Staff flexibility

Unsung heroes

Redeployment – new roles

Support

Helpless at times

Over and above

Natural leadership evolved

Support from families and friends of residents and patients

Surprises from local businesses – lift spirits felt valued

Staff numbers down

Communication - staff commitment

New hope

After darkness comes light

Acknowledgements

- Daragh Rodger Advanced Nurse Practitioner
- Aisling Coffey Principal Social Worker
- Catherine Lawlor CNM11 Activities Department
- Teresa Stenson, Dietitian Manager
- Andreya Ellis Occupational Therapy manager
- Aideen Lawlor Speech & Language Therapy Manager

Staff, residents, families and friends for sharing your journey through COVID 19

Email:- fionam.dunne@hse.ie

Managing resident care needs at end of life in LTC

Dr Paul Gregan, GP & Palliative Care Physician, Blackrock Hospice

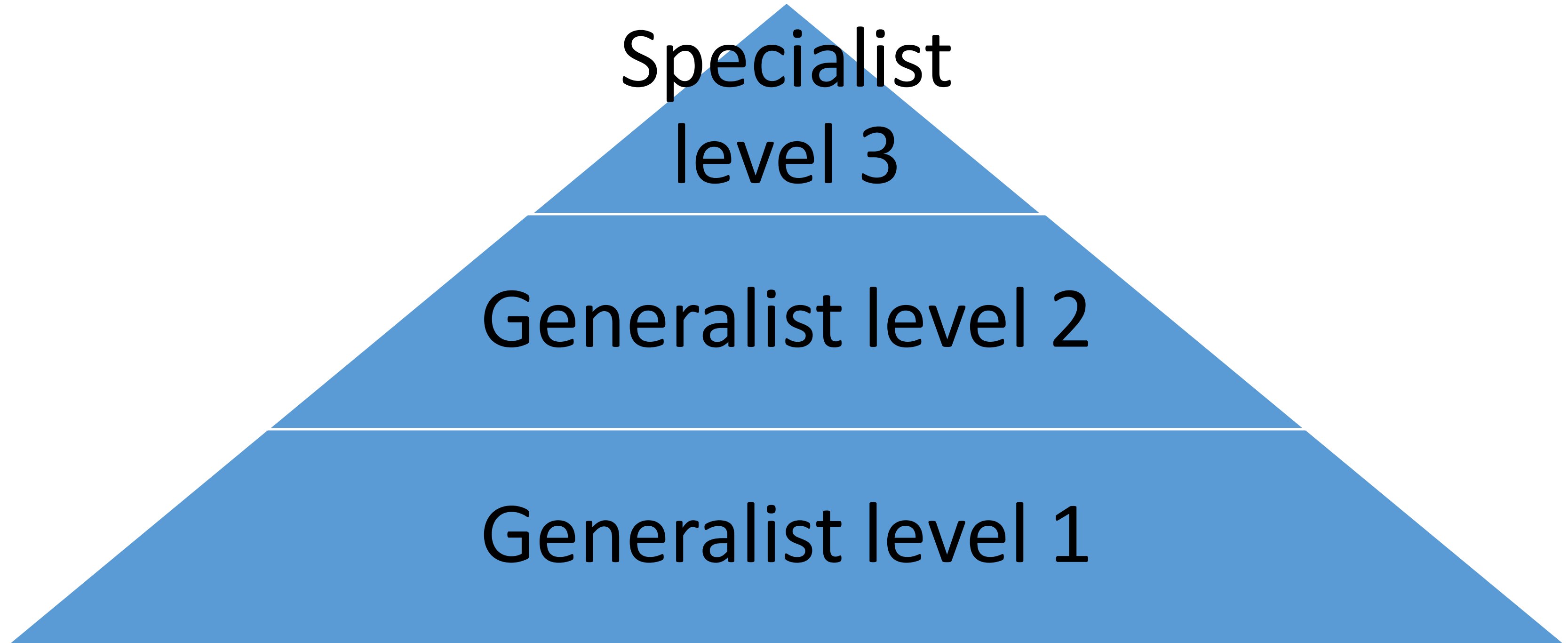
Online webinar series hosted jointly by ONMSD and the National Integrated Care Programme Older Persons.
As part of COVID 19 Pandemic Response.

Covid 19 pandemic 2020

Dr Paul Gregan

- Lessons learned in nursing home palliative care delivery

Palliative care in community



SYMPTOM management of 101 COVID hospital based patients (UK) Lovell JPSM April 2020

- Dyspnoea 66%
- Agitation/restlessness 43%
- Drowsiness 36%
- Delirium 24%
- Pain 23%
- Respiratory tract secretions 11%
- Fatigue 9%
- Fever 9%
- Cough 4%

Palliative care clinical program

Coronavirus
For COVID-19 information, updates & support, visit our Clinical Hub »

Irish College of General Practitioners
Coláiste Dhochtúirí Teaghlaigh Éireann

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Palliative Care and COVID-19

This guidance is aimed at all health care professionals supporting patients with COVID-19 who are in the last hours or days of life.

These guidance documents were developed by the National Palliative Care Consultant Advisory Group, National Palliative Care Nursing Lead and relevant stakeholders and authorised by the National Clinical Lead. This pertains to the duration of the COVID-19 pandemic and may be subject to updates.

Anticipatory Prescribing – Anticipatory prescribing in the last hours or days of life >> read more

Syringe Pump Prescribing – Syringe pump prescribing in the last hours or days of life >> read more

Non-Pharmacological Care – Non-pharmacological care in the last hours or days of life >> read more

Severe Breathlessness – Management of severe breathlessness in the last hours or days of life » read more

Subcutaneous Medications – Prescribing regular subcutaneous medications in last hours or days of life » read more

Opioid Conversion Chart – Opioid conversion chart for palliative care » read more

Podcasts and Webinars – Dr Paul Gregan's podcast on palliation in end of life care for COVID-19 positive patients » read more

Palliative Care Out of Hours – A list of Specialist Palliative Care (SPC) OOH contacts. » read more

Oxygen Use in Long Term Residential Care – Interim Guidance Use of Oxygen in Long Term Residential Care Settings for Older People. » read more

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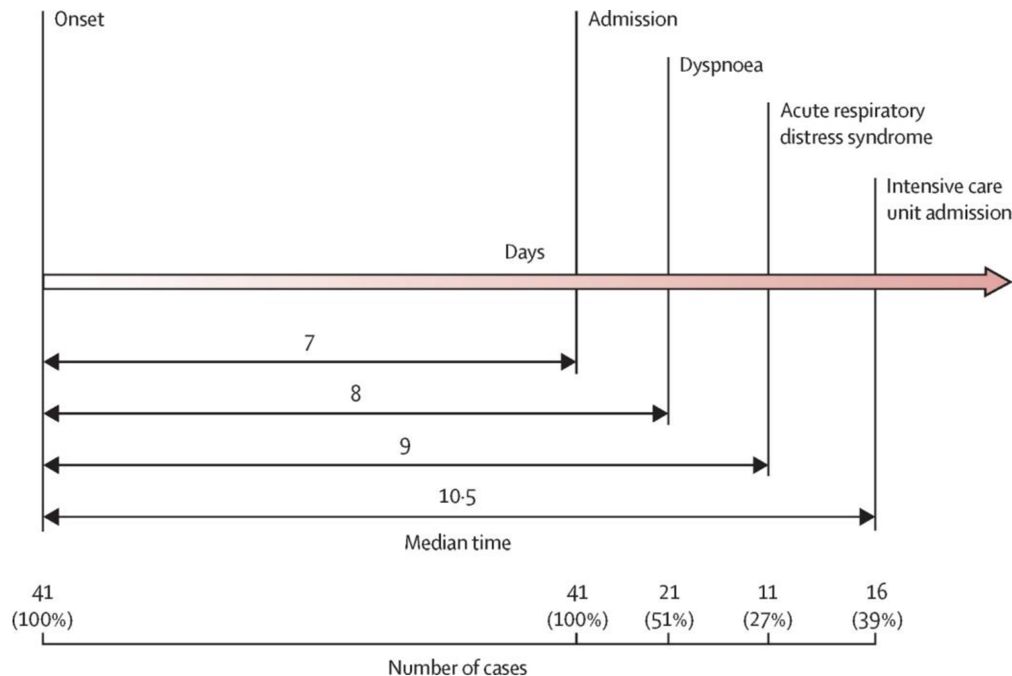
Last hours/days 'one-pagers'

AIIHPC, ICGP

- Anticipatory prescribing guidelines
- Management of severe breathlessness in last hours/days
- Syringe driver prescribing
- Subcutaneous administration of medication in last hours/days
- Opioid conversion chart
- Non pharmacological care in last days of life
- Specialist palliative care contacts OOH
- Podcast

DISEASE PROGRESSION

The Lancet 2020 395, 497-506DOI: (10.1016/S0140-6736(20)30183-5 Copyright © 2020 Elsevier Ltd



The typical timeline of the disease is of a few days of malaise followed by dry cough, fever and dyspnea. The average time from hospital admission to requirement for critical care is 24-48 hours.

Adherence to guideline recommendations will not ensure a successful outcome in every case. It is the responsibility of all professionals to exercise clinical judgement in the management of individual patients. Palliative care specialists occasionally prescribe or recommend other drugs, doses or drug combinations.

For which patients?
If a patient is in the last hours or days of life it is helpful if 'anticipatory medication' is prescribed for symptom control at the end of life (EOL).

What medications?
Commonly required medications for symptom relief at the EOL are:

1. Opioid for pain and/ or breathlessness / and/ or severe cough (for opioid naïve patient)

Morphine sulphate injection (10mg/ml ampoules)

- Dose: 2.5mg SC repeated at hourly intervals as needed for pain, breathlessness or severe cough
- If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review
- If more than 6 doses are required in 24 hours seek advice or review

Note: Patients who are severely distressed may require rapid dose titration and urgent palliative care advice should be sought to guide management in these cases.

Opioid for pain and/or breathlessness (for patient already on regular opioids)

If the patient is on a regular opioid, the prn dose is 1/6th of the 24-hour dose of the regular opioid and converted to SC dose, which is half

2. Anxiolytic sedative for anxiety or agitation or breathlessness

Midazolam injection (10mg in 2ml ampoules)

- Dose: 2.5mg SC, repeated at hourly intervals as needed for anxiety/distress
- If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review
- If more than 6 doses are required in 24 hours seek advice or review
- Note: if on large background doses of BZDs, a larger dose may be needed (if they are frail, a smaller dose may be enough)

Levomepromazine or **haloperidol** can be used in agitated delirium.

- Levomepromazine 3.125 to 6.25mg SC, hourly as needed **OR** haloperidol 0.5 to 1mg hourly as needed if levomepromazine not available
- If 3 or more doses have been given within 4 hours with little or no benefit seek urgent advice or review
- If more than 6 doses are required in 24 hours seek urgent advice or review

3. Anti-secretory for respiratory secretions

Hyoscine butylbromide injection (Buscopan®) (20mg/ml ampoules)

- Dose: 20mg SC, hourly as needed. (Maximum dose 120mg in 24 hours)

4. Anti-emetic for nausea or vomiting

Levomepromazine injection (25mg/ml ampoules)

- Dose: 3.125 to 6.25mg SC, 12 hourly as needed.

Or: Haloperidol 0.5 to 1mg SC, 12 hourly as needed if levomepromazine not available.

Always review the effect of any PRN medicine within one hour of administration to see whether it has relieved the symptom(s) or not.

- If symptoms persist or three or more PRN doses are needed, regular medications for symptom control should be started or, if in place already need to be increased.
- If a syringe pump needs to be started please see the HSE Syringe pump one-pager guidance

Always review the treatment plan within 24 hours

- Does the treatment plan ensure comfort?
- Review the doses of regular medications given by all routes, including oral, transdermal and subcutaneously via a syringe pump. If there are signs of opioid toxicity, a dose reduction, or drug switch, may be required.

If needed, please seek advice from your local specialist palliative care service

Version 4. 24.03.20 For more detailed information

Non-Pharmacological Care of Imminently Dying One-pager

This guidance aims to promote improved outcomes for the patient and their family. However, it is the responsibility of all professionals to exercise clinical judgement in the management of individual patients. In the event of a patient unexpectedly stabilising / improving, reconsider the diagnosis of 'dying'. Continually individualise the care plan. This document relates to care during an irreversible and inevitable process of dying as diagnosed by the treating senior clinician.

SHIFT TO FOCUS ON COMFORT CARE:

General Considerations

Discontinue unnecessary prescriptions, monitoring activities, and procedures. Anything that doesn't focus on comfort and alleviating symptoms and distress should stop unless there is a particular reason to continue. Common areas that require review include:

- ✓ I/V fluids, antibiotics, s/c heparin, insulin, enteral nutrition & TPN.
- ✓ O_2 masks and nasal prongs unless clear symptom benefit.
- ✓ Stop blood and radiological tests.
- ✓ Stop monitoring vital signs including oxygen saturation, fluid balance etc.
- ✓ Deactivate ICDs and remove cardiac monitors.
- ✓ Ensure DNAR order signed / EWS stopped.

ENVIRONMENT:

General Physical environment:

- Where possible a quiet, peaceful environment is preferable.
- Minimise loud noises and bright lights (delirium is not uncommon in last days / hours of life).

Bedside environment:

- Calm, reassuring bedside presence .
- Orient patient (even if unresponsive) as to who you are and what you are doing or about to do.

PSYCHOLOGICAL / SPIRITUAL CARE:

Insight:

- ✓ Where appropriate, patient insight should be assessed and fears / wishes explored.
- ✓ Consider if formal pastoral care support needed / rituals which are important to patient & family..

PHYSICAL CARE:

Secretions / Death rattle:

- ✓ Explain to family & reassure that it does not always represent discomfort.
- ✓ Re-positioning patient on side may help.
- ✓ Assess need for pharmacological intervention.
- ✓ Some patients who have secretions with drooling may benefit from gentle suctioning if medications insufficient.
- ✓ Deep suctioning is not recommended.

Bowel care:

- ✓ Invasive procedures for bowel care rarely needed when imminently dying.

Urinary care:

- ✓ Catheterize if in urinary retention or incontinence likely to cause loss of skin integrity or aids the general comfort level of patient.

Mouth care:

- ✓ Ensure mouth and lips are clean and moist.
- ✓ Regularly moisten oral cavity with sips of water /water-based gel when able to swallow or with moist mouth sponge when unable.

Food and fluid:

- ✓ Continue to offer variety of soft foods / sips of water through teaspoon / straw while conscious , able to sit up, and is appropriate.
- ✓ Accept when patient unable / refuses as this is natural part of dying. Never force.

General comfort:

- ✓ Repositioning, regular turning 2 – 4 hourly to prevent pressure sores.
- ✓ Regular skin and eye care.

SOCIAL / FAMILY CARE * Physical presence will depend on infection control protocols

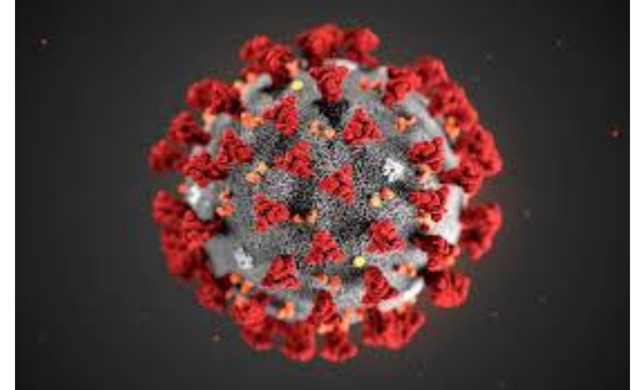
- ✓ Explain to family that death is approaching in sensitive yet unambiguous way.
- ✓ Explain management focus is on comfort and dignity.
- ✓ Explain the expected changes in physical and cognitive function as this will relieve distress for family.
- ✓ Check previous experiences and understanding of dying as it may allow you to correct misunderstandings.

QUESTIONS FAMILY MEMBERS OFTEN ASK

- How long has (s)he got?
  "We can't be certain, but it's likely to be within a few hours or days at most. What would you like for her?"
- Can (s)he still hear?
  "We don't know for sure but if you would like to say something, now is the time "
- How will you know if (s)he has pain?
  "We will watch carefully for signs of distress; we can always see it in the person's face. We will give whatever medication is needed to keep him/her pain free and comfortable"
- Is (s)he dying of dehydration or starvation?
  "At this time, all of the vital organs including his heart and kidneys are shutting down. His/her body cannot cope with food or fluid right now."

Why was SPC resource not tapped as expected??

- Poor understanding of role of specialist palliative care?
- mostly generalist palliative care requirements and others were providing generalist palliative care advice e.g. GP/ Med El
- Lack of recognition of dying?
- Acute dying.
- Poor local contact with SPC teams in general?
- Avoiding extra personnel coming into NH as innocent vectors of Covid 19.
- Avoiding stigma? Secretive
- Assumption that SPC would not visit in a pandemic?



SPC in care of Nursing home patients with Covid 19

- Early referral after first confirmed case in nursing home?

- Advance care planning
- Anticipatory prescribing
- Symptom control
- End of life care-phone referral if rapidly dying
- Connection for family into bereavement

Report of the Nursing homes expert panel

August 2020

- Every nursing home linked with community (specialist) palliative care team.
- Visitor guidelines to developed and to include compassionate visiting arrangements for EOLC.
- Initiate a joint collaborative HSE-IHF programme for palliative care, EOLC and bereavement care in the nursing home sector.
- GP lead.

Grief/Bereavement

- HSE –Irish Hospice Foundation collaborative project on end of life care and bereavement care
- “It is well acknowledged that one’s experience of the death of a loved one will affect how one deals with one’s own impending death”.
- Guilt

The Irish Hospice Foundation Care & Inform Series

APRIL 2020 - VER 2

Planning a funeral during the COVID-19 pandemic

Irish Hospice Foundation
Care & Inform

Planning a funeral when your relative has died from COVID-19

April 2020

www.hospicefoundation.ie

Irish Hospice Foundation
Care & Inform

Acknowledging and coping with grief from a COVID-19 death

pril 2020

www.hospicefoundation.ie

The Irish Hospice Foundation Care and Inform Series

MARCH. 2020

Helping children grieve during COVID-19 restrictions

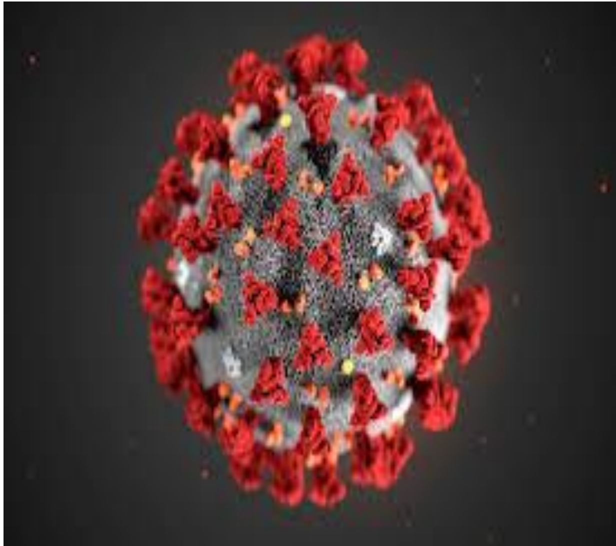
Proudly developed with The Irish Childhood Bereavement Network

Irish Hospice Foundation Care & Inform Information hub: https://hospicefoundation.ie/covid19careandinform/

Non-Covid Care

- Delayed referrals/Requests for rapid triage 3 engagement (under 48hrs)
- Virtual assessments
- Reduced visiting- see HSE advice in general/local policies

Palliative care lessons April 2020!



- NURSING HOMES
- GET OUT OF THE BLOCKS EARLY -PRODUCE GUIDANCE RAPIDLY AND EVOLVE
- NOVEL VIRUS, DYNAMIC SITUATION
- GOOD INTERDISCIPLINARY WORKING
- RESPECT
- KEEP PATIENT CONTACT OPEN
- TELEMEDICINE
- MAINTAINING EXISTING PRACTICES
- DIGNITY
- BREAKING DOWN BARRIERS e.g. digital prescribing
- BALANCE NEED FOR PATIENT TO BE VISITED V NEED NOT TO BE VISITED
- PLAN NEXT PANDEMIC NOW!