



British Geriatrics Society
Improving healthcare
for older people

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

GOOD PRACTICE GUIDE

VERSION 4

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The COVID-19 pandemic raises particular challenges for care home residents, their families and the staff that look after them. This guidance has been developed to help care home staff and NHS staff who work with them to support residents through the pandemic. **This is Version 4.**

This guidance is written as the United Kingdom moves into the second wave of the COVID-19 pandemic. It is designed to be applicable to care home residents across all four nations of the UK. Residents of care homes for older people have been particularly affected by COVID-19. Across the four nations 28-50% of all COVID-related deaths occurred in care home residents.^[1]

The majority of people living in care homes are over the age of 80. Most have multiple long-term health conditions, and the majority of residents are affected by physical disability and cognitive impairment. These factors explain, in part, the vulnerability of older people living in care homes to COVID-19. But there is much that can be done in care homes to improve outcomes for residents during the pandemic.

Since the BGS first produced guidance on COVID-19 in care homes in March 2020, health and social care teams have learned much about how to manage both the illness and spread of infection in care homes. In addition, there have been multiple versions of government guidance across the four UK nations during the intervening period.

We provide here an updated version of our previous guidance. We have taken account of suggestions from colleagues in the care home sector and have therefore designed this version to be brief, outlined as bullet-points, written in plain English, and compatible with all existing government guidance. This guidance covers the following issues that care home staff are likely to come across when managing COVID-19 in a care home environment:

1. Infection control
2. Staff and resident testing
3. Admissions to care homes
4. Family visiting
5. Diagnosing COVID-19 in care homes
6. Management and treatment of COVID-19 in care homes
7. Advance Care Planning
8. End of life care
9. Continuing routine healthcare

The intended audience includes, but is not limited to, care home staff, primary care teams including general practitioners (GPs), community teams providing care for older people including Hospital At Home teams, hospital discharge teams, and those providing advice on infection control to care homes.

1. Infection control

- Effective use of Personal Protective Equipment (PPE) is essential to effective infection control in care homes during COVID-19. Care homes must work with local health and social care professionals to ensure that any potential shortages of PPE are identified and addressed promptly and a continuous supply is maintained.
- Local health and social care providers must work with care homes to ensure they have access to training on the use of PPE.
- Staff must wear recommended PPE for contact with all care home residents. Staff who are unable to wear PPE should not be involved in direct care of residents. Careful consideration must be given as to whether a safe role can be found for them within the care home during the pandemic.
- Where care home staff are required to conduct aerosolising procedures, such as tracheostomy suctioning, they should work with local health and social care providers to ensure that they have FFP3-rated equipment and that staff are fit-tested and trained to use it.
- All visitors to the care home, including family members and visiting health professionals, must follow the same PPE guidance as care home staff. This is to protect both care home residents and those who are visiting. We recommend that all care homes have an allocated staff member available when visiting is open, to ensure that visitors don and doff PPE correctly.
- Care homes should review their care environment for infection control against national guidance where it is available. Where such guidance is not available for individual nations, the Bushproof guidance is a useful summary of current expert advice.^[1]
- Care homes should develop a strategy that enables safe quarantine of any residents who become COVID positive. They should explore whether the home can be zoned so that such residents can maintain some freedom of movement whilst under quarantine.

2. Staff and resident testing

- COVID-19 is often asymptomatic and, as such, regular testing of care home staff is essential.
- Staff who decline regular testing must not be involved in direct care of residents.
- National policies on regular testing of residents vary. Care homes should adhere to the current resident testing policy within their nation.
- Residents are entitled to decline COVID-19 testing. Care homes should develop a strategy for supporting residents who make an informed choice not to be tested.
- For residents who lack capacity to provide consent to COVID-19 testing, a best interests approach should be taken in line with relevant Mental Capacity legislation. This will involve discussions with their family, or other relevant consultees. An Independent Mental Capacity Advocate, or equivalent in other legislations, may be required to consult on behalf of residents without a consultee.
- While point-of-care tests COVID-19 have been developed, many available on the open market have not been validated for use in care homes. Point-of-care tests should not be used in place of formal laboratory tests unless this approach is specifically recommended either through government guidance or local Directors of Public Health and Health Protection Teams. At the time of publication, this was not the case.

3. Admissions to care homes

- Care homes should not, under normal circumstances, accept admissions from hospital or the community until they have been informed of a resident's COVID status. This will usually be based upon a swab taken in the 48 hours prior to admission into the care home. Under some circumstances, residents may have tested positive earlier in their hospital admission, and recommendation for quarantine duration can be based upon these swab results.
- Local authorities and/or public health teams must have pathways in place to test admissions to care homes from the community ahead of arrival at the care home. This must be communicated to all health and social care professionals – for example social workers, GPs, and community matrons – who may play a role in care home admission from the community.
- In England, but NOT other parts of the UK, care homes may be asked to accept COVID positive residents from hospital or the community. They should only accept COVID positive residents if:
 - Their home has been inspected by the CQC and approved as a 'designated setting' to accept COVID positive residents.^[iii]
 - They understand the resident's care needs and are confident that they have the skills, equipment and staff resource to be able to meet them whilst maintaining quarantine.
- Local health and social care teams should model how much COVID-designated capacity is likely be required over winter and work with the CQC and local providers to ensure this is in place.
- In all circumstances, moves between care venues are harmful to older people with frailty and cognitive impairment and should be minimised. It may be preferable for care home residents to remain in hospital a few days longer, rather than moving them to an interim placement ahead of returning to their own care home.
- All admissions to care homes, regardless of COVID status, should be quarantined for 14 days after admission.^{[iv],[v],[vi],[vii]}
- Care homes should not be persuaded or forced to admit residents who are COVID positive if they do not feel able to do so. Local authorities should consider providing contact details for a designated staff member who can support care homes around difficult admission discussions.
- CQC designation that a care home can accept COVID positive admissions should not be taken as meaning that a particular care home can accept ALL COVID-positive residents. Risk assessments will be highly context-specific and should be led by care home staff based on resident care needs and organisational capacity.

4. Family visiting

- Social isolation is harmful to care home residents and can result in low mood and cognitive or functional decline. Reopening care homes to visitors as the pandemic continues, with appropriate safeguards, should be regarded as a public health priority.
- Care homes must work with local authorities, health protection teams and families to establish visiting policies which take account of:
 - The benefits and risks to the individual resident
 - The potential risks to the wider care home population
 - The current prevalence of COVID in the surrounding community
- Approaches to visiting that rely upon physical barriers and social distancing may be confusing for older people with cognitive impairment and are not a satisfactory long-term solution. In addition, visiting policies that require visits to take place outdoors are not practical for the coming winter months and should not be encouraged. Care home residents require direct interaction and physical contact to establish meaningful communication and this must be prioritised.
- As testing capacity becomes available, visitors should be given priority for testing to support more open visiting policies. This may include point-of-care testing once this is validated in care homes.
- Many care home visitors may be at risk from COVID infection. Care home providers should develop materials that enable visitors to understand the risks and benefits of visiting.

- In England, the Department for Health and Social Care has issued guidelines outlining how visiting should be enabled during the period of the second lockdown.^[viii] These guidelines have been the subject of campaigning by organisations who believe that more open visiting could be enabled.

5. Diagnosing COVID-19 in care homes

- Care home residents do not always present with typical symptoms. Care home staff and clinical teams who support them must be on constant alert for both typical and atypical COVID symptoms in care home residents.
- During the pandemic, COVID-19 should be considered as the likely diagnosis in any residents who present with:
 - New continuous cough
 - Temperature of 37.8°C or above,
 - Loss of, or change in, normal sense of smell or taste
- In addition, COVID-19 should be considered as a possible diagnosis in residents who have:
 - New onset confusion and/or drowsiness
 - Decreased mobility
 - Loss of appetite and/or reduced oral intake
 - Diarrhoea or abdominal pain
- Residents who with suspected COVID-19 should be tested immediately, and isolated from other residents pending their test result. The resident's GP, or designated primary care team contact (care home nurse/advanced care practitioner), should be notified as soon as possible.
- Ruling out COVID-19 can be difficult and testing is not 100% accurate. Where care home staff have a high suspicion of COVID-19, but a test returns as negative, they should discuss the case with the resident's GP, or a member of the local Health Protection Team, before the resident moves out of isolation.

6. Management and treatment of COVID-19 in care homes

- Care home residents who walk with purpose (wander) may struggle to follow zoning or quarantine recommendations. Such residents may be distressed by the changes to their routine due to COVID-19. While care for these residents will vary according to the individual, the following points should serve as guidance:
 - They should not be sedated or restrained.
 - If necessary, one-to-one care should be provided. Care home managers may need to speak to local commissioners or health boards to access additional funding to support this.
 - Community Mental Health Teams may be able to provide useful advice about using meaningful activity to help support residents who walk with purpose within infection control zones.
- All care home staff should have access to medical grade thermometers to measure temperatures of both residents and staff and be trained to interpret the results.
- Care homes should ensure that staff have the skills and equipment to be able to conduct pulse oximetry on residents with suspected or confirmed COVID-19. In England, training and support for using pulse oximetry is available and the COVID Oximetry @home monitoring diary has been tailored for care home usage.^[ix]
- Care homes should consider developing the skills and obtaining equipment to measure other vital signs – blood pressure and heart rate. Again commissioners may consider supporting training to facilitate this.
- All care home staff should be trained in how to identify and respond to residents who deteriorate medically. The RESTORE-2 tool has been used successfully by many care home staff during the pandemic and is useful even when staff are not trained to measure or record vital signs.^[x]

Oxygen therapy

- Oxygen has been used successfully in a number of care homes during the COVID-19 pandemic.
- Knowing residents' usual oxygen levels is useful when prescribing oxygen and care homes should consider documenting this in care records.
- Oxygen should be considered where:
 - A resident with COVID-19 is hypoxic (has oxygen saturations which are significantly lower than usual. For most people this will be an oxygen saturation of <92%, but for those with Chronic Obstructive Pulmonary Disease who normally have low oxygen levels, a threshold of <88% may apply).
 - The resident, or a family member where the resident lacks capacity, has indicated that they would wish active therapy in the care home setting.
 - Care home staff are able to monitor saturations on a regular basis after commencement of oxygen therapy.
 - A local pathway is agreed with community oxygen teams to support oxygen delivery in care homes.
- Acute community-based clinical support can be provided (via Hospital At Home teams, GP or other services depending on local context) to monitor response to active treatment and adjust treatment as needed.
- Oxygen should not:
 - Be used in a care home as a holding measure for residents who want active treatment in hospital and where it would be of benefit. Such residents can deteriorate rapidly after becoming hypoxic and should be moved to hospital urgently.
 - Be used in an ad hoc way without support from local clinical teams.

Dexamethasone therapy

- Dexamethasone therapy is associated with improved survival and clinical outcomes in people with severe COVID. It should be considered for use in a care home, where oxygen therapy is being used to treat a care home resident with COVID-19.
- Where given, dexamethasone 6mg once daily should be administered orally for ten days in keeping with current guidance from the National Institute of Health and Care Excellence.^[xi]
- If dexamethasone is administered, residents with diabetes should have capillary blood glucose measurements conducted and recorded twice daily. One of these should be taken in the evening after dinner, when blood sugar measurements tend to be highest.
- If capillary blood glucose measurements rise above 15 mmol/L, the next dose of dexamethasone should be withheld and medical advice should be sought.
- For residents receiving dexamethasone, care home staff should watch for signs of agitated delirium. If these develop, the next dose of dexamethasone should be withheld and medical advice should be sought.

Thromboprophylaxis

COVID-19 is commonly associated with thromboembolic events. For residents being treated in a care home setting, consideration of thromboprophylaxis may be necessary and should be tailored to the potential risks and benefits for an individual patient.

Subcutaneous fluids

Some local healthcare teams have developed pathways for giving subcutaneous fluids to older people in care homes. These can be useful where a resident has become drowsy and is at risk of becoming dehydrated, where local supply chains and care pathways are in place, and where care home nurses have training in their administration. Hospital At Home teams may be able to support administration of

subcutaneous fluids in care homes. Leeds CCG has published an example of a pathway for administration of subcutaneous fluids in care homes.^[xiii]

7. Advance Care Planning

- Advance care planning is a way to understand a resident's preferred priorities of care and ensure these are respected in the event of deteriorating health.
- Advance care plans can also enable residents to state what they value and find important in life – including ideas about important activities and interests, and spiritual care needs.
- Where possible advance care planning discussions should involve:
 - The resident, if they have capacity to participate.
 - Any formal Power of Attorney with responsibility for health and wellbeing.
 - Family or friends of the resident, who can provide emotional support and also important information about the resident's priorities.
 - A healthcare professional, who can help with discussions about prognosis and what treatments can be offered in hospital or the care home.
 - A member of the care home staff, who can inform discussions about what non-medical care can be provided in the care home to meet the resident's needs.
- Videoconferencing enables these discussions to be held remotely, with all parties present, if necessary.
- Advance care plans must be individualised. They should never be approached in a blanket way across the care home population. They should, though, be considered for every care home resident to ensure that their choices about care are respected during the pandemic.
- Emergency medical services and out-of-hours GP services should not over-rule an advance care plan unless they have a very strong case for doing so. Residents, though, are allowed to change their minds about treatments they had previously declined or requested.

8. End of life care

- Care home residents who have opted for palliative care in the context of COVID-19 may deteriorate rapidly. Anticipatory palliative medications, to be administered as required, should be organised for such residents as soon as a diagnosis is made. Ordering such medicines should not be delayed overnight, or over the weekend.
- Arrangements for reuse of palliative care medications have been put in place for care home residents in both England and Scotland. Care home managers and staff should be familiar with these and know how to repurpose a medication if required to do so.
- Visiting should be given particular priority for the families of residents who may be dying.
- Care homes should speak with local faith leaders to ensure they have access to remote support for residents and families during end-of-life care.

9. Continuing routine healthcare

- Care home residents have complex healthcare needs which must be attended to during the COVID-19 pandemic.
- Clinical leads for care homes, working with the GPs responsible for individual residents, should ensure that arrangements are in place for assessing other acute non-COVID illnesses, including ensuring capacity to review face-to-face if required for clinical care.
- Clinical leads for care homes, working with the GPs responsible for individual residents, should ensure that arrangements are in place for monitoring and providing advice for long-term conditions in care home residents.

- Care home staff should be attentive to routine specialist appointments for long-term conditions that may have been cancelled during the COVID pandemic and inform GPs when this occurs, so that alternative arrangements can be put in place.
- Local healthcare teams should consider how to provide both remote and in-person allied health professional support (e.g. dietetics, Speech and Language Therapy, physiotherapy, occupational therapy, podiatry).

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