Proposed structure for Care Homes MDT during Covid-19 outbreak

Members to include:

1) Care home manager/staff
2) Infection Prevention Nurse
3) GP
4) Neighbourhood Team Coordinator (NTC)
5) CCG support
6) Palliative Care (as needed/available)
7) Community Geriatrician (as needed/available)
8) Pharmacist

*… **other clinical specialists may helpfully contribute but the core group needs to be relatively small to be effective***

Frequency:

Weekly check in; more frequently if cases are increasing rapidly and/or if clinical needs are escalating.
This will require a careful balance between the benefit of meeting vs time away from delivering clinical care for attendees.

Clinical care protocol for incidents of Covid outbreak in a care home

The aim of this protocol is to ensure swift and pro-active clinical support to care homes experiencing an outbreak of Covid 19 amongst its residents. An outbreak is defined as two or more people testing positive that may or may not also have symptoms.

The protocol has three simple steps:

Step 1: IPC team screen daily infection reports and identify those homes who have 2+ residents with Covid 19

Step 2: IPC team member notifies the Neighbourhood Team Coordinator (NTC) for that care home the same day

Step 3: The Neighbourhood Team Coordinator (NTC) will convene an MDT meeting at the earliest opportunity with a representative from the home to identify what additional clinical support is needed

First MDT to cover:

Introductions

- Background of type of home – layout, number of residents, residential or nursing. (with enhanced care/ clinical lead almost certainly known by many but not necessarily all in the meeting)

Infections

- Infections in residents- no's, symptomatic or not
- Infections in staff
- IPC and PPE issues – Equipment and education
- Zoning- is it feasible to have separate "hot" and "cold" areas?
- Are residents isolated in rooms? Residents with dementia who "walk with purpose" v difficult to manage in an outbreak. LYPFT document helpful.

Staffing

- Staffing issues – morale, contingency plans for shortages

Dementia and Delirium

- Issues related to delirium/dementia/walking with purpose

Advance Care Plans

Categorise each resident (after appropriate MDT discussion and d/w resident or their families) as either;

- Hospital admission
- Supportive active care within the care home, including oxygen and subcutaneous fluids if appropriate
- Palliation

[NB: It may be helpful to use a colour coded system on a shared spreadsheet so everyone is aware of the plans]

Resident/family preferences for or against hospital admission, likelihood of being able to comply with care in hospital (i.e. keep in a drip or keep oxygen on etc.), susceptibility to adverse effects of hospitalisation (higher risk of falls, delirium, poorer nutrition, etc.) and proximity to the end of their life are all factors which can help in deciding how to advise families on what we feel to be the most appropriate pathway.

Note the following;

- Do all symptomatic residents have anticipatory meds in place? If it's Friday, have we ensured that anyone who may need them over the weekend has at least 2 or 3 vials of anticipatory meds in place.
- Are **relatives** up to date?

Symptoms and assessment

- (Twice) daily screening for fever/cough/SOB/malaise/fatigue/new confusion/GI symptoms, and (Twice) daily observations for unwell residents. (ideally using the RESTORE-2* tool)
- If outbreak, proactively ask staff daily if symptoms

Any issues that need escalating (test results, PPE, IP&C?– **how will the team be made aware?)**

- **Follow up**

First meeting should include all the members above. Make up of further weekly or more frequent check-ins depends on outcome of the first and how much support is needed. **And s**hould take the opportunity to do some meaningful advance care planning and address any issues around falls /delirium/ dementia and polypharmacy etc.

Also routes for escalating issues and sharing learning across MDTs need to be established

*Restore 2 is a tool using a composite of observations (e.g. BP, P, RR etc.) and "soft signs" eg more confused, not eating etc. Link below for more detail.

https://wessexahsn.org.uk/projects/329/restore2#:~:text=RESTORE2%20-%20a%20physical%20deterioration%20and%20escalation%20tool,2019%20and%20most%20recently%20the%20Deteriorating%20Patients%20