

Preliminary Clinical and Infection Control Guidance for COVID-19 in nurse- led Residential Care Facilities (RCF)

1. Introduction

Data from international Covid outbreaks has identified significant levels of mortality and morbidity in high-risk groups. Therefore, particular attention is required in RCFs where significant numbers of vulnerable people are managed to support prevention, identification and clinical management scenarios arising within them. Structured approaches to supportive care, anticipatory planning and palliative care may also affect the course and disease outcomes although evidence at this stage of the outbreak is limited in this regards. Be aware that within the changing nature of the epidemic clinical guidance regarding management may change quite quickly and keep updated with relevant sites at www.hse.ie and www.hpsc.ie.

Who is this guidance intended for?

Clinicians (nursing and medical) and managers delivering care in residential care facilities where the main model of care delivery is nurse-led. This includes

- Residential care facilities for older persons (Public, Private & voluntary)
- Disability-care settings (including congregated settings) primarily nurse-led
- Long-term mental health settings e.g. Specialist Older persons Mental Health care services, approved centres

2. General Measures to reduce the risk of accidental introduction of COVID-19 into a Residential Care Facility

1. Close attention to national guidance set out on preventative measures for COVID-19 by all staff, residents and visitors on www.hsc.ie including
 - Careful attention to hand hygiene with provision of hand sanitiser and or hand washing facilities at all entrances (where practical to provide sinks)
 - Coughing / Sneezing into tissue / elbow crook
 - Visitor notices advising of hand hygiene measures before, during and after visiting
 - Visitor notices advising against visitors attending if they have been in contact with COVID-19 cases and if they have fever or symptoms of respiratory tract infection and until at least 48 hours after symptoms have resolved
 - Appropriate visitor restrictions in event of COVID- 19 outbreak
 - Appropriate Social Distancing measures being observed by staff and as appropriate for residents within facilities where clinically appropriate
2. Regular infection prevention and control training for staff with emphasis on Standard Precautions (including hand hygiene) and including the appropriate use of personal protective equipment. Training should include donning (putting on) and doffing (taking off) of PPE when required.
3. Prepare a facility preparedness plan that reflects staff training in IPC measures, contingency planning for outbreak management including isolation measures and cleaning procedures.
4. Outward transfer of residents for attendance or care off site should be minimised.

General advice regarding care of residents infected during COVID-19 epidemic

1. In general, residents in residential care who are COVID-19 Positive should be managed in their facilities.
2. Transfer to hospital is only appropriate where this will confer additional benefit. Decisions to transfer should be discussed in advance with senior clinician (DON / ADON /PIC) in conjunction with GP/MO/OOH and should be made in conjunction with the person, their families and their advanced care plans.
3. Ensure as far as possible that discussions with residents and families reflecting care preferences including at end of life have been identified, documented and updated. Be aware that significant and rapid clinical change can be a feature of COVID-19 disease in some older adults and encourage timely discussions in line with same.
4. Decisions regarding care should be individualised to the resident.
5. Seek advice from relevant acute hospital clinicians, older persons' specialist services and palliative care services when appropriate. This may assist with ongoing clinical management and inform decisions re clinical appropriateness of potential decisions regarding transfer
6. Close the RCF to all new admissions during time of outbreak
7. Proactively manage communications with residents, staff, families and others. Refer all for guidance from www.hse.ie and www.hscp.ie

Where resident presents as clinically suspect for COVID-19 status procedures to be applied:

1. As per current HPSC guidance suspected cases of COVID-19 based on clinical criteria of respiratory illness and / or fever and / or influenza like illness should be advised to the facility's GP / MO in the first instance.
2. Following risk assessment the GP/ MO /OOH can contact the National Ambulance Service to request COVID-19 home assessment and testing on electronic health referral.
3. Senior clinicians (such as Directors of Nursing / assistant Directors of Nursing/ Person In Charge) within RCFs should be involved in all discussions with GPs regarding referral of potential cases and appropriate discretion used in the application of clinical criteria to residents being referred for testing.

<https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/algorithms/COVID-19%20Risk%20Assessment%20and%20Management%20of%20patients%20who%20phone%20v3.0.pdf>.

4. All RCF are advised to isolate possible COVID-19 cases while awaiting results with precautions as advised in current HPSC guidance using Contact and Droplet Precautions in addition to Standard Precautions
5. Any resident requiring hospitalisation who they believe may have COVID-19 should be flagged with the receiving hospital beforehand.

Common Symptoms and Signs indicative of possible COVID-19 illness:

Most common:

Cough	Shortness of breath	Myalgia (Aches & Pains)
Fatigue	Fever $\geq 38^{\circ}$	

Less common:

Anorexia	Sputum production	Sore throat
Dizziness	Headache	Rhinorrhea
Conjunctival congestion	Chest pain	Haemoptysis
Diarrhea	Nausea/ vomiting	Abdominal pain

Risk factors for severe disease:

Ischaemic heart disease	Chronic heart failure	Hypertension
Diabetes	Chronic lung disease	1 ^o or 2 ^o immunosuppression
Cancer	Age > 75	Frailty

Red flags: Urgent Medical/Senior Clinician Review required

RR > 30 breathes/min	Severe respiratory distress	New onset SpO ₂ < 90% on room air
New onset confusion	Hypotension	Oliguria > 12 hours

Clinical Investigations supporting diagnosis of COVID-19

Throat and nose swab for laboratory detection of virus RNA is the method used to confirm the diagnosis. Although the test is considered generally reliable when taken in symptomatic people the test is not perfect and reliability depends on sample quality (a properly taken swab). Where there is a high clinical index of suspicion for COVID-19 (e.g. during facility outbreak), failure to detect the virus in a nose / throat swab does not entirely exclude the possibility of COVID-19.

Note also that if a resident has a clinical picture of viral respiratory tract infection, even if they do not have COVID-19 they are likely to be infected with another virus that can spread to other residents therefore additional infection prevention and control precautions remain appropriate until the resident has recovered.

On confirmation of a diagnosis of COVID-19 further investigations may be considered appropriate to assist with management. e.g. FBC, UEC, LFTs, CXR

Investigations to out-rule underlying non-COVID-19 related conditions may be appropriate

Clinical discretion and judgement should be used regarding further investigation and in particular in identifying whether same will alter overall patient management and risks posed by transfer to and from acute hospital facilities for same

Clinical Monitoring and management of patients with suspected or confirmed COVID-19 status in RCF

Monitoring of vital signs by pulse oximetry, BP, RR, Temp on twice daily basis / as determined in conjunction with GP/ MO or other medical advice

Monitor for common symptoms identified above and treat accordingly with supportive measures including paracetamol and oxygen, nasal prongs where appropriate

Optimise and encourage good oral fluid and nutritional intake

Use clinical judgement regarding appropriateness of monitoring where there is an expected change in the patient's clinical condition

Rapid and unexpected change in clinical status may occur (typically days 7-9). Ensure insofar as possible that appropriate measures to ensure comfort are made available and that staff are aware and trained in meeting resident's needs to cater for this situation.

Develop an anticipatory care plan with resident and / or family member using national palliative guidance and ethical framework

Put a supportive palliative management plan in place (with anticipatory prescribing measures) for care towards end of life in nursing home where this has been agreed as the preferred option for individual residents within an agreed management plan. (Separate guidance to be issued supporting EOL symptom management)

Decision algorithm in regards to escalation reflecting anticipatory guidance

The following anticipatory decision log below is to offer guidance to doctors and nurses who may not be familiar with the resident as to what approach to take in the event of their acute deterioration. This document cannot cover all clinical eventualities but it may act as a guide in deciding the appropriateness of certain interventions. It is not prescriptive. The treating clinician should use their discretion to provide whatever treatment they see fit, depending on the clinical scenario. All residents, at all times, are entitled to access immediate medical care to alleviate distress.

Intervention	Date	Date	Date	Date	Date	Date
Attempt CPR	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
IV/SC Fluids	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Antibiotics	Yes/only if aids symptoms					
Transfer to Acute Hospital	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No	Yes/No
Other						

3. Infection Prevention and Control Measures

Management of staff contacts in Residential Care Facilities

Where available contact local occupational health department

Contact local public health team

Follow guidance on www.hpsc.ie

<https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/occupationalhealthguidance/Healthcare%20Worker%20Risk%20Assessment%20Algorithm%20V4.pdf>

Infection Prevention and Control Management for following scenarios:

Note. Implementing infection prevention and control practice is extraordinarily difficult with residents who are unable to comply with requests from staff. In that setting the only practical approach is to apply the key principles of infection control as much as possible. These are to limit contact with others as much as possible, particularly in confined space, maintain a distance of at least 1 m (2 m when possible) of more whenever possible, practice hand hygiene, keep your hands away from your face

Scenario	Guidance
Management of a Resident who is identified as a COVID-19 Contact (No symptoms)	<ol style="list-style-type: none"> Such residents should be requested to avoid communal areas and wait in their room for their period of observation (until 14 days after exposure) and until Public Health advice confirms the resident can resume normal activity Residents may go outside if appropriate, alone or accompanied by a staff member maintaining a distance of at least 1m (2m when possible) Staff members who can avoid physical contact and maintain a distance of at least 1 m do not require apron, gloves or mask but should attend to hand hygiene Standard precautions should be used at all times for all patients in particular hand hygiene. Staff members providing direct care should wear plastic apron and gloves as per standard precautions. Surgical masks should be reserved for the care of residents who are coughing and sneezing. Where possible limit time (interventions of 15 mins) and distance exposure(1m) Staff members should monitor at least twice per day and record if the resident has developed symptoms of infection Testing should be considered in residents who develop clinical features consistent with the current case definition (sudden onset of temperature (above 38°C) without other apparent explanation or other relevant symptoms of acute respiratory tract infection Testing for COVID-19 is not indicated in residents with new features of undifferentiated illness or long standing stable cough or shortness of breath for which there is an another clinically apparent cause.



Scenario	Guidance
Management of a resident who develops fever (above 38°C) or symptoms of acute respiratory tract	<ol style="list-style-type: none">1. Such residents should be requested to avoid communal areas and wait in their room until assessed.2. Contact the relevant Person In Charge / ADON/ DON/ Senior Staff member3. Perform a risk assessment by phone with GP/ MO /OOH4. Maintain a strong index of suspicion for likely COVID-19 positive disease in RCF with existing COVID-19 residents and follow isolation protocols accordingly.5. If testing for COVID-19 is required the GP or Medical Officer will arrange testing through the National Ambulance Service home testing service.6. Where COVID-19 is not suspected to be the primary cause of symptoms, and testing is not considered appropriate the resident should avoid communal areas until 48 hours after resolution of respiratory symptoms or fever or until another cause of fever that does not requires specific infection prevention and control precautions is apparent7. Residents may go outside alone if appropriate accompanied by a staff member maintaining a distance of 1m if appropriate8. Staff members providing direct care that requires approach within 1m of the resident in addition to Standard Precautions should wear plastic apron gloves and surgical mask pending confirmation of COVID-19 status9. Staff members who can avoid physical contact and maintain a distance of 1 m do not required apron, mask or gloves but should attend to hand hygiene10. If testing for COVID is considered necessary, then proceed as below regarding suspect COVID-19 case.
Management when testing of a resident for COVID-19 is considered necessary (Suspect Case)	<p>The resident should be considered as a suspect COVID-19 case</p> <ol style="list-style-type: none">1. The resident should avoid communal areas but may go outside alone or accompanied by a staff member maintaining a distance of 1m if appropriate2. Group activities should be suspended pending test results3. Residents should stay in their room as much as possible and minimise contact with other residents pending test results4. Residents should be encouraged to perform hand hygiene and respiratory hygiene and cough etiquette5. Healthcare workers should increase their attention to hand hygiene and respiratory hygiene and cough etiquette6. Visiting should be restricted to absolute necessity (for example end of life care)7. Public health should be informed and testing should be arranged according to the agreed process as quickly as possible8. Care for the resident who is awaiting testing should be delivered by a single nominated person on each shift9. If more than one resident requires testing consider feasibility of having one nominated person on each shift care for those residents awaiting testing

	<ol style="list-style-type: none"> 10. In addition to Standard Precautions, the person caring for the resident should use apron, gloves and a surgical mask when within 1 m of the resident 11. The resident should be encouraged to wear a surgical mask if available or otherwise, if possible, to cover the mouth and nose with a tissue when a staff member is within 1 m 12. In addition to standard precautions if delivering direct care of the resident (close physical contact), contact & droplet precautions should be applied (staff members should wear a gown, surgical mask, and gloves and eye-protection if there is an assessed risk of splashing of blood or body fluids) 13. If the test is reported not-detected management of the resident should be as for other respiratory tract infection
<p>Management if a resident tests positive for COVID-19</p>	<ol style="list-style-type: none"> 1. All group activities should be suspended 2. The resident should avoid communal areas until 48 hours after resolution of symptoms, but may go outside alone if appropriate or accompanied by a staff member maintaining a distance of 1m if appropriate 3. Staff members who can avoid physical contact and maintain a distance of at least 1 m do not require apron, mask or gloves but should attend to hand hygiene 4. Residents should be encouraged to perform hand hygiene and respiratory hygiene and cough etiquette 5. Healthcare workers should increase their attention to hand hygiene and respiratory hygiene and cough etiquette 6. Visiting should be restricted to absolute necessity (for example end of life care) 7. Care for the resident who has tested positive should be delivered by a single nominated person on each shift 8. If more than one resident has tested positive consider feasibility of having one nominated person on each shift care for those residents who have tested positive and any patients awaiting testing 9. In addition to Standard Precautions, staff who are providing direct care need to implement Contact and Droplet precautions (apron, gloves and a surgical mask) when within 1 m of the resident for a brief period to perform a simple task 10. The resident should be encouraged to wear a surgical mask if available or otherwise, if possible, to cover the mouth and nose with a tissue when a staff member is within 1m. 11. If care of the resident requires close physical contact, in addition to Standard Precautions, staff members should wear a gown, surgical mask, and gloves and eye-protection if there is an assessed risk of splashing of blood or body fluids



Scenario	Guidance
Management if more than one resident tests positive for COVID-19 i.e. potential COVID-19 outbreak [Note that this applies where it appears that COVID-19 was acquired while a patient in in the RCF]	Management as per resident tests positive for COVID-19 plus following: <ol style="list-style-type: none">1. Public Health should be informed as soon as possible of all suspected and confirmed outbreaks of COVID-19. (This is a legal obligation)2. HIQA will also require notification (NF02 form)3. A decision to convene an outbreak control team will be agreed between the Residential care facility and Public Health.4. Daily Outbreak Control Team OCT meetings are likely (at least initially) to report on outbreak control measures and updates on potential and confirmed new cases5. Outbreak control measures should be implemented as soon as possible6. Residential care facility staff must ensure that Standard Precautions are reinforced and Droplet and Contact Precautions are implemented immediately, if not already in place7. Identify appropriate area for isolating and cohorting of isolated cases where possible8. Local hospitals and National Ambulance Service notified (in event of anticipated patient transfer) by senior nurse in charge.9. Identified outbreaks should be notified to GP/ MO/ OOH services10. GP / MO and DON to liaise with local treating acute hospital physicians where appropriate in decisions re transfers11. Monitor clinical condition for change and follow national guidance on criteria for hospital admission where this is the ongoing treatment plan12. Care planning should reinforce all infection prevention and control measures to cover eventuality of hospital / other facility transfer13. Consider cancelling non-essential outward movement of residents14. Close the facility to new residents and transfers if possible15. Consider closing the facility to all non-essential visitors

Scenario	Guidance
<p>Death in the residential setting When a resident dies (COVID-19 positive) Coroner Refer to statement from the Coroners Society of Ireland version1. Dated 11/03/2020 http://www.coroners.ie/en/COR/Coroners%20Service%20COVID-19%20110320.pdf/Files/Coroners%20Service%20COVID-19%20110320.pdf Communication of level or risk</p>	<p>Use the HSE guidance documents on Verification and Pronouncement and Death</p> <p>As COVID-19 is a new and emerging pathogen it is understandable that those who will be handling the remains will be concerned and may wish to be made aware of the patient’s infectious status.</p> <p>Embalming</p> <ul style="list-style-type: none"> • Embalming is not recommended. <p>Hygienic preparation</p> <ul style="list-style-type: none"> • Any infection control procedures that have been advised before death must be continued in handling the deceased person after death • Hygienic preparation includes washing of the face and hands, closing the mouth and eyes, tidying the hair and in some cases shaving the face. • Washing or preparing the body is acceptable if those carrying out the task wear long-sleeved gowns gloves , a surgical mask and eye protection if there is a risk of splashing) which should then be discarded. <p>Transporting the deceased person</p> <ul style="list-style-type: none"> • Bodies should be placed in a body bag prior to transportation to the mortuary as this facilitates lifting and further reduces the risk of infection. • A face mask or similar should be placed over the mouth of the deceased before lifting the remains into the body bag. • Those physically handling the body and placing the body into the bag should wear, at a minimum, the following PPE: <ul style="list-style-type: none"> ○ Gloves ○ Long sleeved gown ○ Surgical facemask ○ Pay close attention to washing hands after removal of PPE <p>Once in the hospital mortuary, it would be acceptable to open the body bag for family viewing only. The family should be advised not to kiss the deceased and should clean their hands with alcohol hand rub or soap and water after touching the deceased</p> <p>PPE is not required for transfer once the body has been placed in the coffin</p> <p>See guidance document for funeral directors https://www.hpsc.ie/a-z/respiratory/coronavirus/novelcoronavirus/guidance/funeraldirectorsguidance/Guidance%20Funeral%20Directors%20v1.3.pdf</p>