Nursing Home Guidance RE Coronavirus

Treatment for Covid19 is supportive as there is currently no cure. If sent to hospital, most care home occupants would be unlikely to be eligible for escalated care; they are therefore likely to be sent back. Please bear this in mind with the increased cases of all ages going into hospital with Corona virus. Those over age 80 years are most at risk of contracting this infection hence are extremely vulnerable if sent to hospital for a different reason due to the high mortality at this age.

The average life expectancy for a resident in a nursing home is 9 -30 months so consider the Gold Standard Framework question: Would you be surprised if this person died within the next year?

In order to address the challenge of coronavirus in B&D, the following guidance is suggested to help ensure care for residents is planned and supportive:

1. All residents to be registered with a GP doing a weekly telephone triage + video consultation if needed.
2. If face -to-face consultation is required, full Personal Protective Equipment (PPE) to be worn (separate one for each patient with adequate disposal in between)
3. All residents to have Advance Care Plans (ACP) documented in their notes on arrival if from hospital and within 48 hours if admitted from another site.
4. Documentation of the ACP on the Co-ordinate My Care (CMC).
5. Where CMC not possible to upload on-line, a printed paper version of ACP at the front of the notes.
6. ACP updated to include:
    i. Resuscitation status
    ii. Preferred place of care
    iii. Preferred place of death
    iv. Ceiling of care – PEACE document
    v. Details of an Advanced Directive to Refuse Treatment
    vi. Details of Next of Kin with Resident's permission, documented ACP discussion and decisions shared with them or MDT if no NoK
7. Ensure planned relevant prescribing eg. Rescue packs for COPD, enough prn (as required) medications to last the weekend, regular medications line up appropriately to minimise ad hoc requests
8. Palliative care arrangements to be in place eg. Medications for End of Life + authorization forms, family informed, funeral company
9. Review and postpone any routine visits eg. Hospital outpatients
10. Any uncertainty about care and potential transfer MUST be discussed with the Care Home manager and GP. Please use the attached form to record clinical findings in order to discuss the case with the GP.
11. Nursing staff to do Verification of Death on-line training if possible and supported by the Care Home management. Currently care homes call the Dr about a death. From now, GP verifies this as an expected death and advises the nurses to verify (form attached). Dr has the option of visiting the home to verify the death themselves.
12. Involve family or next of kin early and keep them informed about the actions taken to look after their loved ones.

- **Advance Care Planning** is the process of discussions about the future and future wishes of patients and is done in anticipation of future deterioration.
- A care plan can be made with or without capacity and covers any aspect of health and social care and is orientated towards immediate needs, preferences, goals of care
- The GP is legally the senior responsible clinician for patients in the community
- They have joint responsibility for undertaking, documenting & communicating the ACP discussion/ decisions with the MDT.Capacity is defined as the ability to make a decision or give consent to a particular act.