

CARE OF  
COVID-19 POSITIVE RESIDENTS  
IN  
RESIDENTIAL AGED CARE FACILITIES



Southern Metro Region Palliative Care Consortium  
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Version 1

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- ❖ These guidelines are an adaptation of documents developed by NHS UK and are not considered proprietary works of the Southern Metro Region Palliative Care Consortium.

*Clinical guide for the management of palliative care in hospital during the coronavirus pandemic  
Keeping the care in healthcare*

27 March 2020, Version 1

<https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0081-Speciality-guide-Palliative-care-and-coronavirus-FINAL-02.04.20.pdf>

Accessed 6 April 2020

- ❖ The appendices have been developed by the SMRPCC 2020

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## Guidance Notes

This guide has been developed to assist aged care facilities in providing care to residents who have tested positive to COVID-19.

We acknowledge the significant impact the coronavirus (COVID-19) is having on the aged care sector communities and individuals across the world, especially older people and those who are vulnerable. You all are at the forefront of this evolving situation.

We recognize that you will currently be experiencing significant stress and increased demands in your workplace and your priorities will be to your residents, yourselves and your loved ones. At this time, we also acknowledge the need for continuing to provide excellent communication and palliative care in your facility.

This includes not only responding to the symptoms the resident may be experiencing but also considering the emotional, social and spiritual needs of your resident and their loved ones.

It is critical for all facilities to adhere to the State's guidance on the reporting and infection control management as identified at the Department of Health and Human Services web page ...

<https://www.dhhs.vic.gov.au/aged-care-sector-coronavirus-disease-covid-19>

AND

The Australian Department of Health web page ...

<https://www.health.gov.au/news/health-alerts/novel-coronavirus-2019-ncov-health-alert/coronavirus-covid-19-advice-for-the-health-and-aged-care-sector>

Ensure you are checking the website daily.

The most important recommendation for all facilities and staff is that preventing infection of COVID-19 in your facility is every person's responsibility. All staff must be educated in standard, droplet and contact precautions, safe use (donning and removal) of personal protective equipment (PPE) and access to sufficient equipment in order to do their job safely.

Leadership at the facility must be aware of infection control strategies and the process of reporting and responding to a COVID-19 infection.

**All residential aged care facility managers should subscribe to the Chief Health Officer alerts and the Coronavirus update newsletter via the department's website ...**

<https://www.dhhs.vic.gov.au/health-services-and-general-practitioners-coronavirus-disease-covid-19>

COVID-19 Infection Prevention and Control for Residential Care Facilities

<https://www.health.gov.au/sites/default/files/documents/2020/04/coronavirus-covid-19-guidelines-for-infection-prevention-and-control-in-residential-care-facilities.pdf>

## Communication

It is critical to keep the lines of communication open with the following groups:

- residents and their representatives
- your own staff including your executive management
- the support services who provide onsite clinical support including GPs, Residential In-Reach Teams, Community Palliative Care providers
- both state and federal health departments for news and updates

See ...

<https://www.health.gov.au/resources/collections/coronavirus-covid-19-resources-for-health-professionals-including-aged-care-providers-pathology-providers-and-healthcare-managers>

(Scroll down to Aged Care Workforce)

### Residents and Representatives

Having information accessible for residents or their representatives is critical. This may include having information available in community languages.

See the resources page for a range of resources that may assist you in communicating with residents and their representatives.

#### IT to assist with communication

- There are a range of free services that can be used including:
  - Skype, Facetime, Messenger video calls, Zoom, Microsoft Teams
- Smart TVs can be used for video calling if connected to mobile phones/ tablets/ laptops. You can even get a webcam to attach to the TV in order to enhance communication between residents and their loved ones.

*Cleaning of phones/ tablets: Remember that equipment will need to be thoroughly cleaned between use.*

Please email me if you want any further information of IT based services to help you keep your residents and families connected ([Jane.Newbound@smrpcc.org.au](mailto:Jane.Newbound@smrpcc.org.au))

#### See the Resources page for links to resources that may be of assistance including:

- COVID19 information in community languages
- Having difficult conversations
- Information for carers or individuals with a diagnosis of Dementia

## Advance Care Directives and Goals of Care forms

Many of you may have heard the suggestion to review the Advance Care Directives or 'Goals of Care' forms of your residents.

It is important to remember that 'Goals of Care' are documents that have medical practitioner involvement in the decision making.

Frequently we ask the question "If you were unwell would you want us to transfer you to hospital". We need to reframe this question.

What we need to do at this point is the following:

- Review the contact details for every resident's representative and determine who is the medical decision maker for each resident.
- Provide information to residents or their representatives (medical decision makers) about the pandemic. The information provided should be appropriate for the resident's cognitive ability or in their preferred language.
- Whilst family and loved ones may want 'everything' done for the resident, it is important to reinforce the following:
  - this is a virus and we don't have a cure for it
  - all care will be provided to ensure your loved one is kept as comfortable as possible
  - we can get doctors from the community and the hospital to visit the resident here at the facility and we will be guided by them
  - we can provide care to treat the symptoms that the resident may experience
  - we know that the virus is very serious for our Elders, but it's important to note that many people do recover
- Answer their questions or find information for them that will provide answers.
- For some residents it may be best to refer to a "bad virus that's worse than the flu and causes pneumonia".
- Explain that "lots of people are very unwell and are going to hospital". Therefore, "the doctors and hospitals think the safest place for residents at this time is the aged care facility". It's also the reason why there haven't been many visitors.
- If someone is unwell, the doctors from the community and hospital will come out to visit (your GPs and residential in-reach teams)
- If it is needed, the resident will be transferred to the hospital for treatment and, if possible, transferred back to the nursing home quickly.
- "We can look after you here" needs to be reinforced.
- "Staff may need to wear gowns and masks to make sure you are kept safe and don't get the virus ... Sorry we know it looks a scary"
- **For residents without a cognitive deficit and for their medical decision makers, you will need to discuss the residents COVID-19 status in relation to the resident's current medical condition.**
- Recognise and acknowledge the disruption and distress the resident may be experiencing.
- Review every residents spiritual and cultural needs associated with their Advance Care Directives.

This time is about reassuring residents and representatives that basic care will be ongoing and, if needed, you can get people out to help you.

Decisions about the location of care after a COVID-19 diagnosis will be made by the resident’s medical practitioner and the health services in your region.

**Keep the communication lines with your GPs and residential in-reach teams open and active. They are your best resource at this stage. This is a dynamic and evolving situation and every situation will need to be managed as it arises.**

**See Appendix A: Advance Care Directives – Which Form Do I Use?**

It is important to note if you already have an Advance Care Directive or ‘Goals of Care’ form in your clinical documentation system, continue to use your forms.

## Presentation of COVID-19

Information about the presentation of COVID-19 in the aged care community is limited, however recent United States experiences revealed the following in a 130-bed long term care facility in Washington State.

Group	Number COVID19 positive	Transferred to Hospital	Deceased
Residents	101 (7 residents had no symptoms identified)	55	34
Staff	50	3	0
Visitors	16	8	1

See the link below for further details of the outbreak:

Residential Aged Care Communiqué Volume 15 Special Issue 1.2 April 2020,

<https://www.thecommuniques.com/post/copy-of-residential-aged-care-communiqué-volume-15-special-issue-1-2-april-2020>

**It is important to note a significant number of residents were cared for in the facility and a significant number of residents recovered from the virus.**

A resident with COVID-19 may present with the following symptoms:

- temperature of 37.5 C or higher although some aged persons may not present with a temperature
- new and/or persistent cough
- shortness of breath
- general indicators the resident is unwell including:
  - lethargy, decline in function, falls or increased confusion

**It is important to note that residents may present with atypical symptoms or be asymptomatic.**

The resident should be assessed by a medical practitioner as soon as possible and appropriate infection control precautions implemented immediately that COVID-19 is suspected.

## Goals of care

The treatment of patients suffering from coronavirus may be orientated towards:

- supportive measures – *e.g.*, provision of fluids and/or oxygen
- targeted treatment – *e.g.*, provision of antibiotics to treat bacterial pneumonia
- organ support – *e.g.*, ventilator support, dialysis, *etc.*

It is important to remember that most people with coronavirus will survive and recover.

For those who are dying because of coronavirus and/or who do not wish to have active or invasive treatments, the switch in focus to high quality, compassionate, palliative care at the end of their life is equally important.

## Treatment escalation planning

In the context of the coronavirus pandemic, decisions about further treatment escalation or shifting the focus to palliative care will need to take place rapidly. It may not be possible to have joint discussions involving the patient, those close to them and the clinicians because:

- **the resident may have become ill and deteriorated very quickly, so they may not be able to fully participate in the decision-making**
- **the residents may not have decision making capacity**
- **the resident's family and those closest to them may not be able to be present because of facility infection control procedures, or they may be in self-isolation or looking after family members who are ill.**

Conversations with the patient's family may well have to take place remotely. They are likely to be anxious and shocked by what has happened. These are not easy conversations to have but it is important that honest and timely conversations do take place.

Referral to community-based palliative care services or residential in-reach teams may be necessary

- to assist the provision of care
- with managing poorly controlled symptoms or
- to assist with the communication/ support of family

## Symptom Management

The most common symptoms of coronavirus that require attention are:

- breathlessness
- cough
- fever
- delirium/ restlessness
- pain

## Care of the dying patient

Despite the challenging circumstances of the coronavirus pandemic, it is important not to lose sight of the important elements of holistic care of the dying person. This includes:

- effective communication including clear decision-making
- adequate pain and symptom management
- opportunity to prepare for death, including emotional and spiritual support (chaplains and faith leaders may play an important role here)
- support for those close to the dying person, including the ability to keep in touch via phone or virtual communication (e.g., Skype, Facetime, WhatsApp)

Personal protective equipment (PPE) will need to be used by those visiting or attending to the dying person. As far as possible, try to make the immediate environment as conducive as possible to a peaceful and dignified death.

## In the event of death

Where coronavirus has been confirmed, or if the patient has been tested and no results are available yet, they will need to be treated as high risk when they die. Full PPE should be worn for performing physical care after death.

An appropriately trained professional must complete the verification of death using PPE and maintaining infection control measures. The appropriate doctor then completes the medical certificate or cause of death certificate as soon as possible. The funeral parlour needs to be advised of COVID-19 status when arranging retrieval and they will provide body bags for the deceased person.

Coordination of support for the bereaved family and those close to the patient should be managed by the facility and where necessary families should be guided to appropriate resources to manage their grief: (Lifeline. Beyond Blue, Australian Centre for Grief and Bereavement, GPs for a Mental Health Care Plan and psychology services).

**Medications to be prescribed as per [Anticipatory Medicines; State-wide Guidance for Victoria](#)  
OR via your approved local protocols:**

[https://www.bettersafercare.vic.gov.au/sites/default/files/2020-03/GUIDANCE\\_Anticipatory%20medicines%20FINAL.pdf](https://www.bettersafercare.vic.gov.au/sites/default/files/2020-03/GUIDANCE_Anticipatory%20medicines%20FINAL.pdf)

**NOTE: There is anecdotal but limited clinical evidence on the use of Ibuprofen in COVID-19 cases. It is recommended to avoid usage until further evidence has been identified.**

# Breathlessness

Breathlessness is the subjective sensation of discomfort with breathing and is a common cause of major suffering in people with acute, advanced and terminal disease. Treatment of underlying causes of dyspnoea should be considered and optimised where possible. Both COVID-19 and non-COVID-19 conditions (e.g., advanced lung cancer, lymphangitis carcinomatosa, SVCO, etc) may cause severe breathlessness/distress toward end of life.

**Nebulisers and room fans should be avoided to prevent risks of aerosolising the virus. If this cannot be avoided, then full airborne infection control precautions must be implemented**  
**Leave resident's spacer in their room between use.**

## Reversible Causes

- both COVID-19 and non-COVID-19 conditions may cause severe distress or breathlessness towards the end of life
- check blood oxygen levels

**Residents requiring inhaled medications should have this delivered via metered dose inhalers and spacers**

## Non-Pharmacological

- positioning (sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward) SOOB where possible, mobilising
- Deep breathing exercises, side lying and frequent turning
- relaxation techniques
- reduce room temperature
- cool the face by using a cool flannel or cloth, reassurance

**Portable fans are not recommended for use**

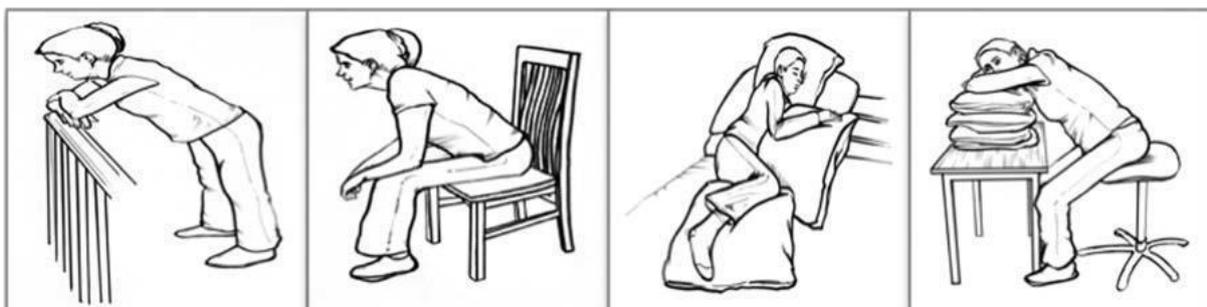
## Medication

- oxygen (no evidence of benefit in the absence of hypoxaemia)
- opioids may reduce the perception of breathlessness

**Consider the use of ...**

- **Morphine (or alternative opiate)**
- **Midazolam**
- **Anxiolytic**

...if severe/end of life: morphine sulphate injection via CSCI or intermittent S/C injection as per guidelines



Forward lean 1

Forward lean 2

Adapted forward lean for lying

Adapted forward lean for sitting

# Cough

Cough is a protective reflex response to airway irritation and is triggered by stimulation of airway cough receptors by either irritants or by conditions that cause airway distortion.

## Reversible Causes

To minimise the risk of cross-transmission:

- cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping and blowing the nose
- dispose of used tissues promptly into clinical waste bin used for infectious or contaminated waste
- clean hands with soap and water, alcohol hand rub or hand wipes after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions

## Non-Pharmacological

- humidify room air (if you have a humidifier)
- oral fluids/ offer frequent sips
- honey and lemon in warm water
- suck cough drops/hard sweets if appropriate (low risk of aspiration)
- elevate the head when sleeping
- avoid smoking

## Medication

- simple linctus 5-10mg PO QID if ineffective
- codeine linctus 30-60mg PO QID  
*or*
- morphine sulphate immediate release solution 2.5mg PO 4 hourly
- if severe/end of life: morphine sulphate injection via CSCI or intermittent S/C injection as per guidelines



Teach residents, staff and visitors about cough etiquette.

Correct use of PPE to protect residents, staff and visitors from infection. Consider need for residents to wear mask

**Standard, Droplet and Contact Precautions**

# Delirium

Delirium is an acute confusional state that can happen when someone is ill. It is a SUDDEN change over a few hours or days and tends to vary at different times of day. People may be confused at times and then seem their normal selves at other times. People who become delirious may start behaving in ways that are unusual for them - they may become more agitated than normal or feel more sleepy and withdrawn. People with dementia are more prone to becoming delirious

## Non-Pharmacological

- identify and manage the possible underlying cause or combination of causes
- ensure effective communication and reorientation (for example, explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- consider involving family, friends and carers to help with this
- ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk
- avoid moving people within and between wards or rooms unless absolutely necessary
- ensure adequate lighting
- recognise that care being delivered in full PPE may be frightening for some residents, reassure +++++

## Medication

Oxygen (if resident is hypoxic)

Medications used for the management of delirium may include

- Clonazepam (oral or injectable)
- Midazolam (injection)

If the resident's symptoms are not relieved discuss options with palliative care or residential in-reach teams.

Frequent assessment and active management of symptom is required to minimise the distress experienced by the resident.

Continuous Sub Cutaneous Infusion may need to be considered for consistent regular medication delivery.

Management of this symptom, which is distressing for both relatives and staff (patients are usually unaware of what they are doing at this time) can be troublesome. Through use of the medications above, titrated appropriately, this can usually be managed effectively.

Prevention of delirium is better than cure, so meticulous adherence to delirium prevention strategies (orientation, prevention of constipation, management of hypoxia, pain *etc*) is essential.

**This is a significant symptom of COVID-19 and must be actively managed**

# Pyrexia (Fever)

Fever is when a human's body temperature goes above the normal range of 36–37° Centigrade. It is a common medical sign. As the body temperature goes up, the person may feel cold until it levels off and stops rising.

## Is it fever?

Significant fever is defined as a body temperature of:

- 37.5°C or greater (oral)
- 37.2°C or greater (axillary)
- 37.8°C or greater (tympanic)
- 38°C or greater (rectal)

Associated signs and symptoms:

- shivering
- shaking
- chills
- aching muscles and joints
- other body aches

## Non-Pharmacological

- reduce room temperature
- wear loose clothing
- cool the face by using a cool flannel or cloth
- oral fluids
- avoid alcohol

**Portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent**

## Medication

### paracetamol 1-gram QID

- can be given as tablet or liquid
- when the resident is nil orally, PR suppositories to be prescribed

**There is some conjecture over the use of NSAIDs such as ibuprofen and are therefore not recommended for use**

Paracetamol works as both a mild analgesic and an antipyretic medication. Ensure that it is ordered for all residents receiving end of life care for COVID-19 or other conditions producing a febrile response (pneumonia, influenza, septicaemia etc.) **NSAIDs are not recommended for use.**

# Resources

## • Communication

- [COVID-19 information in languages other than English](#)

The [Centre For Cultural Diversity in Ageing](#) have compiled all the translated COVID-19 links in to one place. This includes links to both state and federal resources

- [COVID-19: Having Difficult Conversations](#)

There are a couple of web pages to have a look at ...

- o [Vital Talk](#) have developed some resources specifically developed for use in this pandemic including short videos hosted by [Vimeo](#) as guidance including *Family Phone Goodbye* and *COVID Goals of Care*
- o ... and the document [COVID Ready Communication Playbook](#)
- o Vital Talk website: [www.vitaltalk.org](http://www.vitaltalk.org)

- [Fraser Health](#)

[Serious Illness Care Program – COVID-19 update](#) have produced a brief document that gives you some scripted questions and responses. It's a great starting point.

- [Dementia Australia](#)

Tips for carers and individuals with a dementia diagnosis  
Dementia Australia website: <https://www.dementia.org.au/>

## • Anticipatory Guide

- New Victorian based document detailing recommended 'anticipatory medications' for use in end of life care:

[https://www.bettersafecare.vic.gov.au/sites/default/files/2020-03/GUIDANCE\\_Anticipatory%20medicines%20FINAL.pdf](https://www.bettersafecare.vic.gov.au/sites/default/files/2020-03/GUIDANCE_Anticipatory%20medicines%20FINAL.pdf)

- ELDAC

<https://www.eldac.com.au/>

- CareSearch – COVID-19 and Residential Aged Care

<https://www.caresearch.com.au/caresearch/tabid/5974/Default.aspx>

- End of Life Essentials – Click on Education Modules and enrol in your preferred subjects.

<https://www.endoflifeessentials.com.au/tabid/5126/Default.aspx>

- PalliAged – practice tips, tools and resources

<https://www.palliaged.com.au/tabid/4248/Default.aspx>

- Syringe Driver Education – see navigation pane on left side of page.

<https://www.health.qld.gov.au/cpcrc/subcutaneous/home>

- You Tube Syringe driver – excellent basic video describing syringe driver set up.

<https://www.youtube.com/watch?v=Safi7imeEdQ>

- BD Saf T Intima

- o Insertion video

<https://www.youtube.com/watch?v=BpMUPQ21eEo>

- o Care and Insertion Guide, Opioid Conversion, Terminal Phase Respiratory Secretions.

<https://www.emrpcc.org.au/clinical-guidelines>



## Appendices

### Appendix 1:

ACD's – What Form Do I Use?

Available for download from [https://smrpcc.org.au/wp-content/uploads/2019/03/ACP\\_which-documents\\_resource.pdf](https://smrpcc.org.au/wp-content/uploads/2019/03/ACP_which-documents_resource.pdf)

### Appendix 2:

Care Plan Prompts for COVID-19 positive Residents in RACFs



## Advance Care Directives: What Form Do I Use?

When entering a permanent residential facility, ALL residents with capacity should be offered an opportunity to complete an Advance Care Directive. If the resident lacks capacity to complete an Advance Care Directive, others who know them well can record what is known of the person's preferences and values on a different type of form (this form is not an Advance Care Directive).

In addition, **EVERY** resident should have a Goals of Care – Medical Treatment Order form (or similar) completed by their doctor

If a resident enters your facility with a completed Advance Care Directive or other Advance Care Planning document, please place a copy of this in their file. DO NOT transcribe the details on to one of the facility forms. Check that all the information is current and relevant (date and ask the person to re-sign the document). Note, that if a person has completed an Advance Care Directive and has then lost capacity to make their own medical decisions, that Advance Care Directive cannot be changed, nor should anyone else re-sign it.

Form Name	Who is it for?	Where do I get it?
<b>Goals of Care – Medical Treatment Order</b>	<b>EVERYONE</b> – every resident who enters a care home should have a Goals of Care – Medical Treatment Order form completed by their GP in consultation with the resident and / or their Medical Treatment Decision Maker.	<a href="http://www.nh.org.au/resources-for-people-who-lack-capacity-to-undertake-advance-care-planning/">www.nh.org.au/resources-for-people-who-lack-capacity-to-undertake-advance-care-planning/</a> Click on 'Generic Goals of Care' under Medical Treatment Plan
<b>Advance Care Directive for Adults Values Directive section</b>	Individuals who have capacity to communicate their own preferences and values for future medical treatment, should they lose medical decision-making capacity	<a href="http://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms">www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms</a> Click on 'Advance Care Directive for Adults'
<b>Advance Care Directive for Adults Instructional Directive section</b>	Individuals who have capacity for medical decision making and want to consent to or refuse specific treatment in advance for a time when they might lose medical decision-making capacity. – <b>remember</b> if a resident has completed an instructional directive, this is binding consent or refusal, and cannot be overridden by the Medical Treatment Decision Maker or other family.	<a href="http://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms">www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms</a> Click on 'Advance Care Directive for Adults'
<b>Advance Care Directive for Adults for Someone Completing Signing On Your Behalf</b>	Individuals who have cognitive capacity but may not have the physical capacity to complete a written document. The individual directs their nominated person to complete the form identifying their preferences and values	<a href="http://www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms">www2.health.vic.gov.au/hospitals-and-health-services/patient-care/end-of-life-care/advance-care-planning/acp-forms</a>
<b>Preferences and Values Form for Another Person</b>	Individuals who do not have the cognitive capacity to complete their own Advance Care Directive. May be completed by their Medical Treatment Decision Maker or others who know them well.	Northern Health Advance Care Planning and Office of the Public Advocate websites have information for the person completing the form on behalf of the individual. <a href="http://www.nh.org.au/resources-for-people-who-lack-capacity-to-undertake-advance-care-planning/">www.nh.org.au/resources-for-people-who-lack-capacity-to-undertake-advance-care-planning/</a>

## Basic Care Guide COVID-19: RACFs

Issue	Requirement
<p><b>Contact Details</b></p>	<p>Check each resident’s contact details and ensure they are up to date and accessible. Where possible get email addresses and ensure you have a ‘list/ database’ to enable mass emails of relevant information, facility updates and newsletters to families of your loved one.</p>
<p><b>Advance Care Directive/ Goals of Care</b></p>	<p>Identify the Medical Treatment Decision Maker for each person. Identify their preferred method of communication. If you are unsure, see the following link:  <a href="https://www.publicadvocate.vic.gov.au/medical-consent/identifying-the-medical-treatment-decision-maker">https://www.publicadvocate.vic.gov.au/medical-consent/identifying-the-medical-treatment-decision-maker</a></p> <ul style="list-style-type: none"> <li>- Make sure the resident or their representatives is informed about COVID-19.</li> <li>- If your facility has access to its own Advance Care Directives (ACD) or Goals of Care (GOC) form continue to use these. If not see Appendix A: ACDs – What form do I use?</li> <li>- Review the ACD or GOC to ensure everyone is ‘on the same page’.</li> <li>- Decisions about location of care will be made by medical practitioners and health services when needed.</li> <li>- Residents with COVID-19 may decline rapidly and it may be difficult to include all parties with regard to decision making at a critical time.</li> </ul>
<p><b>Oxygen Therapy</b></p>	<p>Residents with COVID-19 may require oxygen therapy. <b>It is only of benefit if the resident is hypoxic.</b></p> <p><b>Do you have oxygen cylinders/ equipment and/ or oxygen concentrators onsite?</b></p> <ul style="list-style-type: none"> <li>- How many nasal prongs, masks, tubing and/ or extension tubing do you have?</li> </ul> <p><b>Do you have a fingertip pulse oximeter and spare batteries?</b></p> <ul style="list-style-type: none"> <li>- Available at medical supplies businesses, Kogan, Ebay and Gumtree (\$30 to \$50) + batteries</li> </ul> <p><b>Do you know how to clean this equipment appropriately?</b></p> <p>Care should include:</p> <ul style="list-style-type: none"> <li>- checking the equipment each shift to ensure functioning</li> <li>- sufficient supply of bottled oxygen (if using)</li> <li>- check of tubing, prongs/ mask. Wash prongs/ mask daily and replace if worn/ broken/ leaking</li> <li>- concentrators must have filters washed at least weekly</li> <li>- 4/24 checks of pressure areas including nose, cheeks, ears</li> <li>- mouth care +++ (oxygen therapy dries out mucosa) and frequent sips of fluid</li> <li>- assess and record resident’s tolerance and response to therapy in progress notes</li> <li>- medical practitioners are to record flow rates and reportable levels (pO2)</li> </ul>

Issue	Requirement
<p><b>Spiritual/ Cultural Needs</b></p>	<ul style="list-style-type: none"> <li>- Identify if the resident has specific spiritual or cultural needs associated with death and dying. Where possible honour these requests.</li> <li>- Arrange for 'remote' communication if needed with spiritual leaders in your community (phone, tablet or computer)</li> </ul>
<p><b>Pain</b></p>	<p>The cause of the pain experienced may be from multiple sources. Consider the following:</p> <ul style="list-style-type: none"> <li>- lung or chest pain from pneumonia or from excessive coughing</li> <li>- pre-existing conditions (such as arthritis)</li> <li>- being bed bound/ immobile</li> <li>- general aches and pain caused by the infection</li> </ul> <p>Every resident should have QID Paracetamol ordered (Tablet/ Liquid/Suppository)  Opiate medication may be required to manage pain.  Pain should be assessed 4/24 at a minimum and more frequently if the symptom is not responding to the usual treatment... <b>Remember Go Low, Go Slow but Go Regular</b> with regard to administration of analgaesics.</p> <p><b>Assess the resident's response to the treatment and document. Respond immediately if the analgaesic has been ineffective.</b></p> <p>Use air mattresses, pillows/ wedges and repositioning etc to assist with keeping the resident comfortable.  Work closely with your GPs, In-Reach and Palliative Care Services.</p>
<p><b>Breathlessness</b></p> <p><b>Do not use nebulisers as this may aerosolise the virus. Use metered aerosol inhalers and spacers. Keep the spacer in the resident's room to prevent cross contamination. If nebulisers are needed, full airborne precautions need to be implemented.</b></p>	<p>Many residents with COVID-19 will experience severe breathlessness or 'air hunger'  Positioning is critical in maintaining comfort and optimising respiratory function.  Treatment options may include</p> <ul style="list-style-type: none"> <li>- Positioning – do your beds have knee breaks (turn the bed into a chair) and do your staff know how to use them?</li> <li>- Consider SOOB where possible, mobilising if resident has mild to moderate disease, side lying with frequent turns (2-4/24) to facilitate better lung function. Elevate head of bed</li> <li>- Oxygen therapy if hypoxic. Oxygen may be administered via nasal prongs or mask. You may have to be assessing the persons oxygen levels and increasing the dose of oxygen accordingly. GPs need to provide guidance on this. <b>Do you have a fingertip pulse oximeter?</b></li> <li>- Opiate and other medication as prescribed</li> <li>- May require anxiolytics if agitated.</li> </ul> <p>Morphine (or other opiate analgesics) are not just for pain and are effective treatments for relieving the symptom of breathlessness.</p>

Issue	Requirement
<p><b>Fever</b>  <b>Do not use fans in the room as this may aerosolise the virus.</b></p>	<p>Paracetamol for all residents (unless contraindicated then alternative should be considered)  Cool sponges  Frequent personal hygiene  Loose clothing/ remove excessive bed clothes</p>
<p><b>Cough</b></p>	<p>COVID-19 positive residents will usually have a new and/ or persistent cough.  Consider the following</p> <ul style="list-style-type: none"> <li>- Frequent sips of fluid</li> <li>- If appropriate offer 'cough drops' or hard sweets to suck (consider cognitive and swallowing ability)</li> <li>- Simple cough syrups/ honey and lemon drinks</li> <li>- Opiate based medication to suppress cough (codeine linctus/ Ordine etc)</li> <li>- Regular subcutaneous opiate medication if unable to tolerate oral medication</li> </ul> <p><b>Report on sputum production and colour as this may indicate an additional respiratory bacterial infection which can be treated by antibiotics if appropriate</b></p>
<p><b>Delirium/ Restlessness</b></p>	<p>COVID-19 positive residents are more likely to experience delirium.  Safety is critical at this point as some residents may experience a significant increase in confusion.</p> <ul style="list-style-type: none"> <li>- Falls prevention strategies to be implemented.</li> <li>- If the resident is agitated/ confused they are more likely to attempt to get out of bed or wander (therefore ↑ risk of falls, self-injury or infection transmission)</li> </ul> <p>Delirium is a serious symptom which must be actively managed.</p> <ul style="list-style-type: none"> <li>- Reassure, reinforce, reorient</li> <li>- Treat reversible causes - ↓ oxygen levels, infection, dehydration where possible, prevent constipation and pain.</li> <li>- If needed the resident may require 1:1 care until settled</li> <li>- Medications as prescribed by the medical practitioner</li> </ul> <p><b>Report the resident's response to medication administered and if it is not effective, communicate with your medical practitioner immediately. You must actively manage this symptom!</b></p>

Issue	Requirement
<b>Mouth Care</b>	What products are to be used and how frequently? Consider the following <ul style="list-style-type: none"> <li>- Mouth wash – what product are you using (remember no alcohol)</li> <li>- Jumbo swabs (do you have enough in the facility for a number of residents?)</li> <li>- Lip balms</li> <li>- Mouth moisturisers (saliva replacement gels and sprays such as Biotene)</li> <li>- Sips of fluid where possible</li> <li>- To be done at least 4/24 and more frequently if required</li> </ul>
<b>Nutrition and Hydration</b>	Whilst residents are able to eat and drink, they should be offered foods and fluids of preference <ul style="list-style-type: none"> <li>- Sips of fluids or small food offerings may be tolerated better by some residents</li> <li>- If no longer tolerating or able to eat and drink, increase mouth care frequency as needed</li> <li>- Oral intake may provoke coughing. Monitor closely for aspiration.</li> </ul>
<b>Elimination</b>	Monitor output every shift Bowel <ul style="list-style-type: none"> <li>- Constipation must be treated</li> <li>- More likely if opiates being used and resident is dehydrated</li> <li>- If not treated can lead to bowel obstruction or significant pain</li> <li>- Untreated constipation can cause an ↑ restlessness/ delirium symptoms</li> </ul> Urine <ul style="list-style-type: none"> <li>- Potential for urinary retention thus an ↑ in pain or restlessness/ delirium symptoms</li> </ul>
<b>Communication</b>	Residents <ul style="list-style-type: none"> <li>- May be scared or fearful</li> <li>- Reassurance +++++</li> <li>- Demonstrate PPE to residents to allow them to become familiar with it</li> <li>- Keep them informed of updates</li> <li>- Emotional support ++ while facility is in lockdown and where possible facilitate remote communication with loved ones</li> </ul> Representatives <ul style="list-style-type: none"> <li>- Ensure you have the correct contact details</li> <li>- Ensure the Medical Treatment Decision Maker is identified</li> <li>- Use technology to assist with communication</li> <li>- Use mass emails/ newsletters to keep loved one educated and updated</li> <li>- Encourage family members to write letters. cards and supply photos</li> </ul>

Issue	Requirement
<p><b>Communication (cont)</b></p>	<p>Staff</p> <ul style="list-style-type: none"> <li>- Use technology to assist with communication (memo's, emails and text messages)</li> <li>- Education of the infection control precautions and use of PPE may need to be repeated frequently to reinforce the need for stringent adherence to the recommendations</li> <li>- Remind staff not to attend if unwell – how is your facility screening staff?</li> <li>- Education on specific care needs (syringe drivers/ symptom assessment/ or any basic care needs)</li> <li>- <b>CARE PLANS</b> – clear, concise, relevant to the individual resident</li> </ul> <p><b>HANDOVER</b></p> <ul style="list-style-type: none"> <li>- all staff to be involved in the resident care to be given appropriate handover</li> <li>- COVID-19 status to be conveyed to all staff in the facility and any visiting health professionals</li> <li>- Specific care needs and requirements for residents must be easily available/ accessible information</li> </ul>
<p><b>Personal Hygiene and Skin Care</b></p>	<p><b>Personal Hygiene</b></p> <ul style="list-style-type: none"> <li>- Residents are usually febrile so will require basic hygiene measures including clothing changes depending on their level of sweating. A full sponge may be needed 2 to 3 times per day. In addition, cool face cloths will be needed to assist with comfort.</li> <li>- Change the bed clothing as frequently as is needed. Don't forget pillowcases.</li> </ul> <p>Skin Care</p> <ul style="list-style-type: none"> <li>- Residents are at very high risk of developing pressure areas.</li> <li>- Use alternating surface mattresses (air mattress), wedges and pillows to assist with repositioning.</li> <li>- Keep skin folds clean and dry. Frequent hygiene may be required if sweating.</li> <li>- Use barrier creams when performing hygiene</li> <li>- Frequent repositioning (for respiratory function and skin care)</li> <li>- Check continence aids at least 4/24 and replace as needed. Skin at high risk of excoriation from urine exposure. Use barrier cream in skin folds.</li> <li>- If using oxygen – check pressure areas including nose, cheeks, ears, chin.</li> <li>- Check pressure areas at each turn/ reposition and report any changes, pressure areas, tears etc.</li> </ul>
<p><b>Documentation</b></p>	<ul style="list-style-type: none"> <li>- Reinforce to all staff the importance of documenting all care provided. Is this done in the progress notes or another form?</li> <li>- Are you using a recognised End of Life Care Pathways? If not consider implementing one. (<a href="https://metrosouth.health.qld.gov.au/raceolcp">https://metrosouth.health.qld.gov.au/raceolcp</a>)</li> <li>- Guidance or recommendations by your health care professionals MUST be followed.</li> </ul>