Healthcare Improvement Scotland | SIGN Evidence-based clinical guidelines

Scottish Government
Riaghaltas na h-Alba
gov.scot

Coronavirus (COVID-19): guidance on treating patients

Guidance from the Chief Medical Officer (CMO)

COVID-19 position statement:

Presentations and management of COVID-19 in older people in acute care

Date first published: 29/05/2020
Publication date of this version: 01/03/2021
Version number: 2.0

Summary of revisions

Date	Version	Revisions
29/05/2020	1	Original version
01/03/2021	2	Minor editorial changes throughout to improve clarity **Section 2:** addition of rapid testing and screening **Section 3:** additional information on laboratory tests and new section on cognitive assessment and capacity **Section 4:** removal of rehabilitation taking account of fatigue. New sections on 6Ms approach, oxygen therapy, dexamethasone therapy, thromboprophylaxis and rehabilitation **Section 6:** addition that communication with families can reduce concerns for patients **Section 7:** addition to liaise with other services on discharge

Contents

Introduction 1

Recommendations 1

1. Clinical context 3

2. Presentations 4

3. Laboratory testing and bedside observations 5

3.1 Frailty testing – Clinical Frailty Scale (CFS) 5

3.2 Cognitive assessment and capacity 5

4. Management 6

4.1 General considerations 6

4.2 6Ms approach 7

4.3 Oxygen therapy 7

4.4 Dexamethasone therapy 7

4.5 Thromboprophylaxis 7

4.6 Rehabilitation 7

5. Planning ahead 8

6. Family, carers and visiting 9

7. Discharge planning 10

8. Care homes 11

9. Palliation 12

10. Methodology 13

10.1 Updating the guidance 13

10.2 Contributors 13

10.3 Peer review 14

10.4 Editorial review 14

References 15

Introduction

The purpose of this guideline is to provide NHSScotland with advice on presentations and management of COVID-19 in older patients in acute care.

This guideline is for:

- acute care physicians
- emergency medicine physicians
- respiratory physicians
- registered nurses and advanced nurse practitioners
- acute allied health professionals
- geriatricians.

These recommendations have been developed in response to the COVID-19 pandemic situation and so have not followed the standard process used by SIGN to develop guidelines. The recommendations are based on available evidence and expert opinion, with fast expert peer review as assurance.

This guidance will be reviewed and updated as new evidence emerges.

Recommendations

- Older people are less likely to present with cough, fever, or influenza-like illness. Other symptoms or clinical presentations may include:
  - delirium (assess with 4AT)
  - anorexia
  - vomiting or diarrhoea and sometimes abdominal pain
  - low-grade fever or absence of fever
  - fatigue (may be profound and may be confused with hypoactive delirium)
  - falls
  - acute kidney injury.
- Older people may have more than one diagnosis as a cause for their acute illness. Continue to investigate other non-COVID-19 causes of illness, as these may be treatable.
- All patients >65 years should have a frailty assessment on admission using the Clinical Frailty Score (CFS) or other frailty tool. This must be based on functional status two weeks before illness onset and can be used to identify the most vulnerable patients who should be prioritised for Comprehensive Geriatric Assessment.
- Communication between patients and family and loved ones should be promoted through electronic means where possible such as with smartphones or tablets. Regular telephone updates from staff can be helpful.

- An anticipatory care plan should be captured at the earliest practical time point, with a focus on realistic and available options for treatment and symptom management. It should take into account the current illness, previous health status, and 'what matters' to the patient and family.
- Cardiopulmonary resuscitation (CPR) is not suitable for all patients. When it is clear that CPR attempts would not be successful or may be harmful, it is important to discuss this in a sensitive way with the patient and/or their relative/next of kin/power of attorney.
- The management strategy for patients with delirium who wander must take into account the risk to other patients. Placement of patients and appropriate risk assessment is required to ensure the safety of patients is maintained. Cohorting of patients or one-to-one care may be required in some cases. Difficult decisions may need to be made in these situations on the use of pharmacological agents to manage behavioural and psychological symptoms of dementia or symptoms of stress/distress associated with delirium.
- Moving patients within hospitals, especially through non-specialist areas, should be minimised where possible.
- When multiple-occupancy rooms have to be used, cohorting patients may be necessary and local infection control advice should be sought.
- Rehabilitation may need to take account of latent fatigue and focus on both maximising strength and cardiorespiratory endurance.
- For patients being discharged to a care home setting, ensure predischarge liaison and communication with homes is established including timely access to COVID-19 test results.
- Consider Hospital at Home, community nursing or equivalent services during discharge planning where available.
- Discharge planning should take account of the possibility of further unexpected deterioration in symptoms, and patients and carers should be given advice on how and when to access medical support should the patient's condition deteriorate.
- When discharging patients from hospital after COVID-19 illness, assessment of home situations will have to take account of circumstances in relation to vulnerable or shielded carers.
- When discharging to a care home setting it is vital to ensure robust plans are in place and communicated for patients whose symptoms worsen in their care home. Stepdown guidance must be followed.

1. Clinical context

Older people are in the group worst affected by the SARS-CoV-2 pandemic (COVID-19) with 76% of deaths occurring in those aged over 75.[1] While many in this age group may have a mild illness and recover, the presentation and management of illness can be different from younger patients. It is important that each patient is assessed and treated as an individual, and this is especially true for older people with frailty.

2. Presentations

Older people are less likely to present with cough, fever, or influenza-like illness. Instead, other symptoms or clinical presentations may include:

- delirium[2] (assess with 4AT[3])
- anorexia
- vomiting or diarrhoea and sometimes abdominal pain
- low-grade fever or absence of fever
- fatigue (may be profound and may be confused with hypoactive delirium)
- falls
- acute kidney injury.

Patients may present earlier in the disease trajectory (within a few days of symptom onset) and day-to-day variability may be marked. Given this, a repeat swab may be indicated if the initial test result is negative despite the clinical index of suspicion of COVID-19 being high. It may also be indicated if there is a specific concern that the initial swab was poorly taken. Rapid testing and clinical vigilance are key to safely placing a patient in care.

Older people may have more than one diagnosis as a cause for their acute illness. Other non-COVID-19 causes of illness should continue to be investigated as these may be treatable. Screening those over 70 for other conditions on admission to hospital provides an opportunity to recognise people whose symptoms might otherwise be masked. Symptoms of COVID-19 and symptoms of other underlying conditions may be more difficult to recognise in the context of comorbidity with a combination of SARS-CoV-2 infection and other conditions.

3. Laboratory testing and bedside observations

On their own, laboratory tests may not be helpful, but, in the context of a high clinical index of suspicion of COVID-19, may add weight to a diagnosis. In particular, they may clarify that:

- Lymphopenia may be present.
- There may be hypoxia in absence of breathlessness.
- Inflammatory markers may be only modestly elevated.

Chest X-ray may demonstrate bilateral infiltrates.

3.1 Frailty testing - Clinical Frailty Scale (CFS)

All patients >65 years of age should have a frailty assessment on admission using the CFS or other frailty tool. This must be based on functional status two weeks before illness onset and can be used to identify the most vulnerable patients who should be prioritised for Comprehensive Geriatric Assessment (CGA).[4]

The CFS **must not** be used in:

- anyone under the age of 65 or,
- anyone over the age of 65 with long-term disabilities (for example cerebral palsy), learning disability or autism.

For those in whom a CFS assessment is not appropriate, a personalised, holistic and non-discriminatory assessment of their frailty status should be carried out.

A frailty assessment should not be used in isolation to direct clinical decision making. While it will sensitise clinicians to the likely outcomes in groups of patients, clinical decision making with individual patients should be carried out through a holistic assessment, using the principles of shared decision making and non-discrimination.

3.2 Cognitive assessment and capacity

All older patients should routinely have an assessment of cognition using a tool such as the 4AT and should be assessed for capacity. Where patients lack capacity, adults with incapacity guidance should be followed and appropriate forms should be put in place and welfare guardians noted where these exist.

4. Management

4.1 General considerations

Most patients with COVID-19 will not need additional ventilatory or critical care support; however, other symptoms and clinical conditions will arise and should be managed systematically, in keeping with the principles of CGA. Issues to be alert for include:

- acute deconditioning and immobility
- poor nutrition, dehydration and lack of mouth care
- presence of pressure ulcers
- delirium[5]
  - The management strategy for patients who wander must take into account the risk to other patients. Placement of patients and appropriate risk assessment is required to ensure the safety of patients is maintained. Cohorting of patients or 1-to-1 care may be required in some cases. Difficult decisions may need to be made in the use of pharmacological agents to manage behavioural and psychological symptoms of dementia or symptoms of stress/distress associated with delirium. The British Geriatrics Society good practice guide to managing delirium in confirmed and suspected cases of COVID-19 is a helpful resource.[6]
- superimposed bacterial infection
- gastrointestinal (GI) symptoms such as nausea, anorexia, constipation and diarrhoea
- acute kidney injury
- deep vein thrombosis (DVT)/pulmonary embolism (PE).[7]

Rehabilitation may need to take account of latent fatigue and focus on both maximising strength and cardiorespiratory endurance.

General considerations include:

- awareness of the communication impact for patients with hearing or cognitive impairment as use of a face mask or PPE can be an additional barrier
- minimising, where possible, movement of patients within hospitals, especially through non-specialist areas
- seeking local infection control advice when multiple occupancy rooms have to be used and cohorting patients may be necessary. Guidance from Health Protection Scotland provides infection prevention and control measures necessary during the COVID-19 pandemic.[8]

4.2 6Ms approach

A systematic approach to assessment using the 6Ms can be beneficial. Assessments can be carried out in parallel:

- **Medical:** older people may have more than one cause of their acute illness. It remains important to continue to look for other non-COVID-19 causes of illness, as these may be treatable.
- **Medication:** Review the patient's medication. Could any contribute to illness? Do they still need the same medication? Do they need anticipatory prescribing or 'just in case' medications?
- **Mental health:** Are there significant issues needing addressed in relation to mood or cognition? Use the 4AT to assess.
- **Mobility:** Has there been a change in function or mobility? In people >65 years old a frailty assessment using the CFS or other frailty tool may be useful to determine the level of functional change and to tailor appropriate care.
- **Matters to me:** Does the patient have an anticipatory care plan? Have they made their wishes clear in relation to their changing health needs?
- **Me and mine:** Are family and next of kin aware of the situation? Have any welfare attorneys been consulted?

4.3 Oxygen therapy[9]

- Oxygen should be considered if a patient with COVID-19 is hypoxic.
- Give oxygen via nasal cannulae or a mask, aiming for an oxygen saturation of ≥92% and a respiratory rate ≤24/min (or 88% for those with a history of type II respiratory failure).

4.4 Dexamethasone therapy

- Dexamethasone therapy is associated with improved survival and clinical outcomes in people with severe COVID-19 associated with hypoxia.
- Where given, dexamethasone 6 mg once daily should be administered orally for 10 days in keeping with current guidance from the National Institute of Health and Care Excellence (NICE).[10]
- Staff should watch for signs of agitated delirium in patients receiving dexamethasone.

4.5 Thromboprophylaxis

COVID-19 is commonly associated with thromboembolic events. For older people consideration of thromboprophylaxis may be necessary and should be tailored to the potential risks and benefits for an individual patient.

4.6 Rehabilitation

Rehabilitation may need to take account of latent fatigue and focus on both maximising strength and cardiorespiratory endurance. Older people are at high risk of deconditioning in acute illness, which can be easily exacerbated by prolonged bed rest. Staff need to be alert to the risks of deconditioning and consider early mobilisation and an early referral for rehabilitation.[11]

5. Planning ahead

An anticipatory care plan or treatment escalation plan is suitable for all patients to capture their wishes in the face of a changing clinical scenario. Ideally this should be captured at the earliest practical time point, with a focus on realistic and available options for treatment and symptom management. It should take into account the current illness, previous health status, and 'what matters' to the patient and family. It is important to be clear and honest in describing which treatments will work, those that will not work and those which may be harmful. Guidance and advice on anticipatory care planning is available from Healthcare Improvement Scotland.[12]

Support for clinicians in having these conversations is available using the 'RED-MAP framework'.[13]

Cardiopulmonary resuscitation (CPR) is not suitable for all patients. When it is clear that CPR attempts would not be successful or may be harmful, it is important to discuss this in a sensitive way with the patient and/or their relative/next of kin/power of attorney. When conducted sensitively, this discussion can help relatives be better prepared in the event of the death of their relative.

6. Family, carers and visiting

Communication between patients and family and/or loved ones should be supported through electronic means where possible such as with smartphones or tablets. Regular telephone updates from staff can be helpful. Limited visiting can be distressing for patients, but communication with families can help to reduce concerns.

Visiting for patients with dementia who are distressed or patients who are approaching the end of life should be considered as early as possible and PPE made available for visitors following national guidance.[14]

The Scottish Academy of Medical Royal Colleges, Marie Curie and Scottish Care have co-produced guiding principles on visiting dying patients to ensure everyone is treated compassionately and with dignity during the COVID-19 pandemic.[15]

Families may find a diagnosis of COVID-19 infection in their loved one traumatic and may need reassurance and advice on their own self isolation.

7. Discharge planning

- Consider Hospital at Home, community nursing, intermediate care or equivalent, services where available.
- For further information on discharge to care homes, including testing protocols, see Health Protection Scotland advice.[16, 17]
- Support may be required from health and/or social care providers after discharge to enable patients to transition to home.
- Liaise with other services, including social work and social care services, eg care at home, to assess capacity and communicate treatments.
- Discharge planning should take account of the possibility of further unexpected deterioration in symptoms and patients and carers should be given advice on how and when to access medical support should the patient's condition deteriorate.
- When discharging patients from hospital after COVID-19 infection, assessment of home situations will have to take account of circumstances in relation to vulnerable or shielded carers. For more information see Health Protection Scotland advice.[16]

8. Care homes

Every effort should be made to provide care in the most appropriate setting – the acute hospital may not be the most suitable setting for patients entering from care homes. Teams should consider ways to support care homes in their area, following advice from local Care Home Clinical and Care Professional Oversight teams, including local health protection teams.[18]

Ensure predischarge liaison and communication with care homes is established including timely access to COVID-19 test results. For more information see Health Protection Scotland advice.[17]

When discharging to a care home setting it is vital to ensure robust plans are in place and communicated for patients whose symptoms worsen in their care home.

9. Palliation

The Scottish Palliative care guidelines now include additional information on symptom control at end of life in the context of COVID-19.[19]

It is important to note that older people may require lower doses of relevant medication than younger people, and treatment plans should be individualised. Reversible causes of agitation should always be considered such as urinary retention, pain or constipation. Where appropriate, liaise with palliative care teams.

10. Methodology

This guidance has been produced on behalf of the Scottish Government's Chief Medical Officer in response to the COVID-19 pandemic situation and so has not followed the standard process used by SIGN to develop guidelines. The recommendations are based on expert opinion, with rapid expert peer review as assurance.

10.1 Updating the guidance

This guidance will be reviewed if significant new evidence emerges.

10.2 Contributors

Professor Graham Ellis	National Clinical Lead for Older People and Frailty, Scottish Government and Consultant in Elderly Medicine, NHS Lanarkshire
Ms Jan Beattie	Allied Health Professions Lead for Primary Care, Scottish Government
Dr Jennifer Burns	Consultant Physician, Glasgow Royal Infirmary
Dr Patricia Cantley	Consultant Physician, Midlothian Hospital at Home Team, NHS Lothian
Dr Andrew Coull	Consultant in General Medicine, NHS Lothian
Dr Caroline MacInnes	Consultant in Elderly and Stroke Medicine, NHS Lanarkshire
Ms Carolyn McDonald	Chief Allied Health Professions Officer, Scottish Government
Ms Maria McIlgorm	Professional Advisor, Chief Nursing Officer Directorate, Scottish Government
Dr Alan McKenzie	Consultant in Elderly Medicine, Queen Elizabeth University Hospital, Glasgow
Dr Lara Mitchell	Consultant in Elderly Medicine, Queen Elizabeth University Hospital, Glasgow
Ms Diane Murray	Deputy Chief Nursing Officer, Scottish Government
Dr Moray Nairn	Programme Manager, Scottish Intercollegiate Guidelines Network (SIGN)
Dr Suzie Shenkin	Senior Clinical Lecturer, University of Edinburgh and Honorary Consultant, NHS Lothian
Dr Roy Soiza	Honorary Clinical Reader, Institute of Applied Health Sciences, University of Aberdeen
Dr Rowan Wallace	Consultant in Elderly Medicine, University Hospital Crosshouse
Professor Miles Witham	Professor of Trials for Older People, Newcastle University and National Speciality Lead for Ageing, National Institute for Health Research Clinical Research Network

10.3 Peer review

The original version of this document was reviewed by the **Clinical Guidance Cell**.

10.4 Editorial review

As a final quality check, the guideline was reviewed by an editorial group, as follows:

Professor Tom Evans	Professor of Molecular Microbiology, Institute of Infection, Immunity & Inflammation, University of Glasgow and Consultant Infectious Disease Physician, NHS Greater Glasgow & Clyde
Dr Roberta James	Programme Lead, SIGN
Dr Safia Qureshi	Director of Evidence, Healthcare Improvement Scotland

References

1 National Records of Scotland. Deaths involving coronavirus (COVID-19) in Scotland. 9 December 2020. [cited 10 December 2020] Available from URL: https://www.nrscotland.gov.uk/covid19stats

2 Zazzara MB, Penfold RS, Roberts AL, et al. (2020) Probable delirium is a presenting symptom of COVID-19 in frail, older adults: a cohort study of 322 hospitalised and 535 community-based older adults. Age and Ageing, afaa223. Available from URL: https://doi.org/10.1093/ageing/afaa223

3 The 4AT rapid clinical test for delirium. [cited 15 May] Available from URL: https://www.the4at.com/

4 British Geriatrics Society. Comprehensive Geriatric Assessment Toolkit for Primary Care Practitioners.Available from: https://www.bgs.org.uk/resources/resource-series/comprehensive-geriatric-assessment-toolkit-for-primary-care-practitioners

5 Scottish Intercollegiate Guidelines Network (SIGN). Risk reduction and management of delirium. Edinburgh: SIGN; 2019. (SIGN publication no. 157). [cited 19 May 2020]. Available from URL: https://www.sign.ac.uk/sign-157-delirium.html

6 British Geriatrics Society, European Delirium Association, Old Age Psychiatry Faculty (Royal College of Psychiatrists). Coronavirus: Managing delirium in confirmed and suspected cases. [cited 19 May 2020] Available from URL: https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases

7 British Thoracic Society. Guidance on Venous Thromboembolic Disease in patients with COVID-19 (v 3.0). [cited 25 Feb 2021]. Available from URL: https://www.brit-thoracic.org.uk/document-library/quality-improvement/covid-19/bts-guidance-on-venous-thromboembolic-disease-in-patients-with-covid-19/

8 Health Protection Scotland. Novel coronavirus (COVID-19) Guidance for secondary care. Management of possible/confirmed COVID-19 patients presenting to secondary care (v9.9). [cited 9 December 2020]. Available from URL: https://www.hps.scot.nhs.uk/web-resources-container/covid-19-guidance-for-secondary-care/

9 COVID-19 guidance: clinical advice (www.gov.scot)

10 National Institute for Health and Clinical Excellence. COVID-19 prescribing briefing: corticosteriods. [cited 10 December 2020]. Available from URL: https://www.nice.org.uk/guidance/ng159/resources/covid19-prescribing-briefing-corticosteroids-pdf-8839913581

11 http://www.gov.scot/binaries/content/documents/govscot/publications/advice-and-guidance/2020/08/framework-supporting-people-through-recovery-rehabilitation-during-covid-19-pandemic2/

12 Healthcare Improvement Scotland. Anticipatory Care Planning for COVID-19. [cited 21 May 2020]. Available from URL: https://ihub.scot/acp-covid-19

13 Effective Communication for Healthcare. COVID-19: Effective communication for professionals (RED-MAP resources). [cited 9 December 2020]. Available from URL: https://www.ec4h.org.uk/covid-19-effective-communication-for-professionals/

14 Public Health England. COVID-19: infection prevention and control guidance. [cited 9 December 2020]. Available from URL: https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control

15 Academy of Medical Royal Colleges and Faculties in Scotland, Marie Curie and Scottish Care. Patients and Family at the End of Life. [cited 9 December 2020]. Available from URL: https://www.rcpe.ac.uk/sites/default/files/sa_statement_-_patients_and_family_at_end_of_life_care_final_-_updated_september_2020.pdf

16 NHS National Services Scotland. National Infection Prevention and Control Manual. Scottish COVID-19 Infection Prevention and Control Addendum for Acute Settings. [cited 25 Feb 2021]. Available from: http://www.nipcm.hps.scot.nhs.uk/scottish-covid-19-infection-prevention-and-control-addendum-for-acute-settings/

17 Health Protection Scotland. COVID-19: Information and Guidance for Care Home Settings (v 2.1). [cited 25 Feb 2021]. Available from URL: https://hpspubsrepo.blob.core.windows.net/hps-website/nss/2980/documents/1_covid-19-information-and-guidance-for-care-homes.pdf

18 Scottish Government. Coronavirus (COVID 19): enhanced professional clinical and care oversight of care homes. [cited 21 May 2020]. Available from URL: https://www.gov.scot/publications/coronavirus-covid-19-care-home-oversight/

19 Healthcare Improvement Scotland and NHS Scotland. Scottish Palliative Care Guidelines. [cited 21 May 2020]. Available from URL: https://www.palliativecareguidelines.scot.nhs.uk/