# MANAGEMENT OF PEOPLE WITH COVID-19 WHO ARE OLDER AND LIVING WITH FRAILTY AND/OR COGNITIVE IMPAIRMENT

NATIONAL CLINICAL EVIDENCE TASKFORCE
COVID-19

**FORMS OF GUIDANCE**

Evidence-Based Recommendation **(EBR)**
Consensus Recommendation **(CBR)**
Practice Point **(PP)**

Types of EBRs: RECOMMENDATION FOR USE; RECOMMENDATION AGAINST USE; CONDITIONAL RECOMMENDATION FOR USE; CONDITIONAL RECOMMENDATION AGAINST USE

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Overarching principles of care

## GENERAL PRINCIPLES

Ensure multidisciplinary collaboration amongst the health and social/community care teams within the decision-making process when managing people with multimorbidity, cognitive impairment and functional decline.
**PP** [Taskforce/WHO]

Early specialist advice should be considered in older people living with frailty and/or with cognitive impairment. **PP** [Taskforce]

Maintain activity and minimise deconditioning by providing allied health and rehabilitation interventions by health professionals wearing PPE. Appropriate health professionals may include physiotherapists, occupational therapists, speech pathologists, dietitians, social workers and exercise physiologists.
**PP** [Taskforce]

## GOALS OF CARE

Identify if the patient has an advance care directive or plan. If yes, reaffirm prior decision. **PP** [Taskforce]

Ensure early discussion with the patient around goals of care, which may include active disease-directed care. If the patient has a legal guardian for medical decision-making, they should be contacted. **PP** [Taskforce]

Respect priorities and preferences and take these into account where possible when deciding on and communicating the care plan. **PP** [Taskforce]

Undertake a clinical assessment to determine expected prognosis, taking into account COVID-19 illness and underlying conditions.
**PP** [Taskforce]

## MEDICATION MANAGEMENT

Reaffirm a clear indication for each medication and minimise polypharmacy. Where possible, administer medication at a frequency that aligns with the delivery of other patient care.
**PP** [Taskforce]

### Older people living with frailty and/or cognitive impairment

This population includes older people (usually > 65 years) with impairments of physical, cognitive and/or physiological function, or who have frailty. Frailty is a multifaceted syndrome that includes physical impairments and higher susceptibility to disease. Comorbidities are often present, such as cerebrovascular disease, dementia, heart failure and chronic lung disease [Hilmer 2017].

This guidance can be applied in all settings where these individuals receive care, including in hospital, aged care facilities, and at home.

## COMMUNICATION

Establish a timely and ongoing regular line of communication, with a nominated healthcare decision-maker or family/carers. **PP** [Taskforce]

Visiting restrictions should be included in care planning discussions to enable patients and families to make informed decisions. **PP** [Taskforce/ANZSPM]

Minimise sensory impairment (e.g. hearing aids available and working, glasses available, and utilise other augmentative and alternative communication (AAC) devices such as communication boards, electronic communication devices). **PP** [Taskforce]

Ensure cultural and spiritual/religious practices that are part of the person's wishes are identified, prioritised and observed/facilitated, where possible. Remember that those with sensory impairments may not be able to hear or use lip reading to assist in understanding if carers are wearing face masks. Consider the use of written communication tools (e.g. clipboards) in the room, or digital tools if outside the room without face masks (e.g. video tablets, two-way radios). **PP** [Taskforce/ANZSPM]

Respiratory distress and a diagnosis of COVID-19 will likely cause high levels of anxiety and distress. There may be worsening of pre-existing mental health conditions. **PP** [SA Health]

Communicate with patients and support their mental wellbeing to help alleviate any anxiety or fear they may have about COVID-19.
**PP** [NICE]

Specific aspects of care

## ACTIVE DISEASE-DIRECTED CARE

Older people are at high risk (on age alone, with or without other risk factors) and should have early, active treatment with the most effective therapy tolerated. **PP** [Taskforce]

If goals of care include active disease management, refer to

- MANAGEMENT OF ADULTS WITH SEVERE TO CRITICAL COVID-19 Clinical Flowchart
- RESPIRATORY SUPPORT FOR ADULTS WITH SEVERE TO CRITICAL COVID-19 Clinical Flowchart
- DRUG TREATMENTS FOR ADULTS WITH COVID-19 Clinical Flowchart

Treat potentially reversible causes of symptoms (e.g. delirium), such as urinary retention, pain or constipation and prevent and/or treat these causes. Manage gastrointestinal symptoms as per usual care. **PP** [ANZSPM]

Recognise that treatment may be required for other illnesses, not only for COVID-19. **PP** [Taskforce]

Specific aspects of care

## MANAGING BREATHLESSNESS OR COUGH

### GENERAL TREATMENT

Non-pharmacological measures to manage breathlessness should be considered; these include positioning, relaxation techniques, wiping the face with cool wipes, reducing room temperature. **PP** [Scottish Palliative Care Guidelines]

For further advice go to The Australian & New Zealand Society of Palliative Medicine.

For management of the symptoms of breathlessness or cough, use opioids as per usual care. Consider the addition of a benzodiazepine (for example midazolam) if breathlessness persists. **PP** [Taskforce]

For further advice go to The Australian & New Zealand Society of Palliative Medicine.

### COVID-19 SPECIFIC

Avoid fans and nebulised medications due to potential for aerosol generation. **PP** [Taskforce/ANZSPM]

## MANAGING DELIRIUM, ANXIETY AND AGITATION

### GENERAL TREATMENT

For non-pharmacological prevention and management of delirium and agitation, follow guidance as per usual care. **PP** [Taskforce]

For further advice go to SIGN delirium guidelines and ACSQHC delirium clinical standard.

For pharmacological prevention and management of delirium and agitation, follow guidance as per usual care. **PP** [Taskforce]

For further advice go to SIGN delirium guidelines and ACSQHC delirium clinical standard.

### COVID-19 SPECIFIC

Delirium may be the sole presenting symptom in some patients. **PP** [Taskforce/ANZSPM]

Prevention of delirium, as per usual practice, is critical. In people with COVID-19, delirium can increase risk to other patients and staff as it may impact on the person's capacity to understand and follow infection control measures and maintain isolation. **PP** [Taskforce]

Early detection of delirium to allow timely treatment requires regular screening. Delirium usually has multiple causes or contributing factors, and other aetiologies other than COVID-19 should be also considered. **PP** [Taskforce]

There are other additional factors that can promote anxiety, distress and agitation of patients, including clinicians wearing PPE, isolation and limitation of visitors. **PP** [ANZSPM]

If possible, optimise environment (within infection control restrictions):

- manage in a low-stimulus environment
- provide support with sleep hygiene
- use reorientation strategies (e.g. clock, calendar, radio, room board etc.)
- avoid unnecessary patient movement between wards/rooms.

**PP** [ANZSPM]

Escalation of care

When considering treatment options, take into account individual decision-making around goals of care. This includes decisions around proceeding to more invasive forms of ventilation, transfer to ICU and cardiopulmonary resuscitation. **PP** [Taskforce/ANZSPM]

The net clinical benefit for each patient should be considered on a case-by-case basis, as older people with frailty and/or cognitive impairment may have reduced benefit and increased potential for harms when escalating treatment. **PP** [Taskforce]

**Refer to**

- MANAGEMENT OF ADULTS WITH SEVERE TO CRITICAL COVID-19 Clinical Flowchart
- RESPIRATORY SUPPORT FOR ADULTS WITH SEVERE TO CRITICAL COVID-19 Clinical Flowchart

Decisions around proceeding to more invasive forms of ventilation should be discussed with the patient or their healthcare decision-maker or family/carers. **PP** [Taskforce]

If a person has symptoms such as breathlessness or delirium that are difficult to manage, and/or is imminently dying, specialist palliative care support and advice should be sought. **PP** [Taskforce/SIGN]

**Refer to**

- MANAGEMENT OF PEOPLE WITH COVID-19 WHO ARE RECEIVING PALLIATIVE CARE Clinical Flowchart

Ongoing care

Recognise that ongoing care may be required for some patients who present with post-acute COVID-19 signs and symptoms. **PP** [Taskforce]

For assessment of symptoms and signs that are described by people with post-acute COVID-19, refer to

- CARE OF PEOPLE AFTER COVID-19 Clinical Flowchart


**Sources**

**ANZSPM -** The Australian & New Zealand Society of Palliative Medicine Inc. (ANZSPM) Guidance - palliative care in the COVID-19 context.

**ACSQHC -** Australian Commission on Safety and Quality in Health Care (ACSQHC). Delirium Clinical Care Standard. 2021.

**Hilmer SN, Gnjidic D.** Prescribing for frail older people. Aust Prescr. 2017;40(5):174-178. doi:10.18773/austprescr.2017.055

**NICE -** The National Institute for Health and Care Excellence (NICE). COVID-19 rapid guideline: managing COVID-19 [NG191].

**NHS Scotland -** Scottish Palliative Care Guidelines. Supportive and Palliative Care Temporary Guideline. End of Life Care Guidance when a Person is Imminently Dying from COVID-19 Lung Disease. Updated 16 March 2021.

**SA Health** - Commission on Excellence and Innovation in Health. Guide to non-pharmacological interventions in the palliative care of persons deteriorating and dying with COVID-19. May 2020.

**SIGN -** Scottish Intercollegiate Guidelines Network (SIGN). COVID-19 position statement: Presentations and management of COVID-19 in older people in acute care. Version 2.0, 1 March 2021.

**SIGN -** SIGN157: Risk reduction and management of delirium. A national clinical guideline. March 2019.

**Taskforce –** Current guidance from the National COVID-19 Clinical Evidence Taskforce.

**WHO -** World Health Organization (WHO). Living guidance for clinical management of COVID-19**.**