AGENDA ITEM
2.2.11

QUALITY & SAFETY COMMITTEE

COVID-19 RELATED MORTALITY IN CARE HOMES- SUMMARY DOCUMENT OF WORK SO FAR (TO FEBRUARY 2021)

Date of meeting	18/05/2021
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Dr Gareth Jordan Clinical Director Dr Ron Barr PCSU Dr David Miller AMD Primary Care
Presented by	Dom Hurford Assistant Medical Director, Quality & Safety and Clinical Efficiency
Approving Executive Sponsor	Executive Medical Director
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
(Insert Name)	(DD/MM/YYYY)	Choose an item.

ACRONYMS	

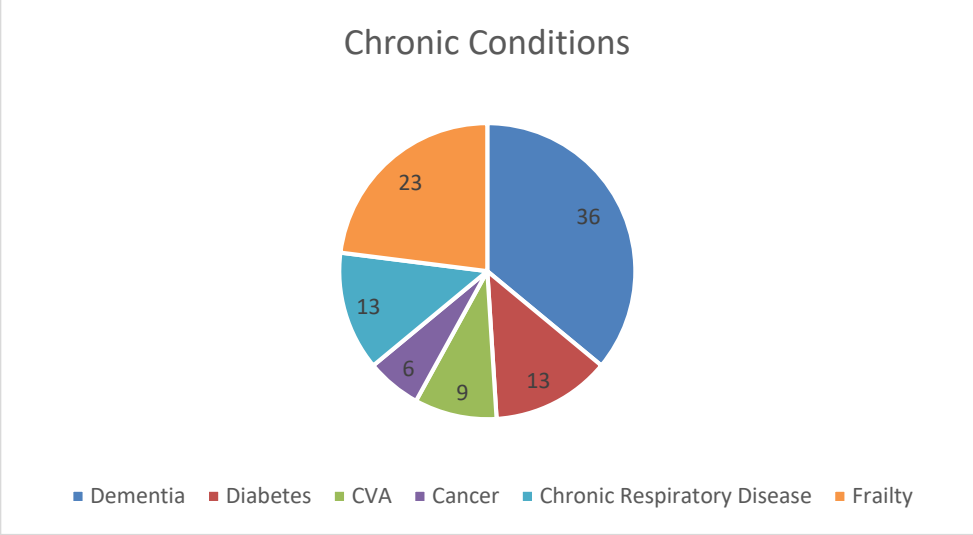
1. SITUATION/BACKGROUND

- Primary Care (PC) was asked by Gold Command (May 2020) to conduct wider reviews of deaths in a Care Home setting relating to COVID-19.
- Members of the review team include: Primary Care (PC) Clinical Director in GP, Primary Care Support Unit (PCSU) representative and further GP with an interest in this area. The Assistant Medical Director Primary Care (AMD PC) is supporting the process.
- All GP practices & Local Medical Committee (LMC) were made aware of the review and were asked to submit all known COVID-19 deaths (Death Certificate indicated COVID-19) to a secure NHS joint email account.
- Database updated weekly and cases sent to reviewers.
- Aim: review all deaths, a significant majority of these have now been completed.
    - Awaiting further data and access to clinical notes from some practices, as such cases may potentially rise.
- Communities across Rhondda Cynon Taf, Merthyr and Bridgend have experienced very high rates of COVID-19 which has caused a significant number of deaths in our elderly population, including in Care Homes.
- Welsh Government requires notification of all COVID-19 related deaths to Public Health Wales and Health Boards.
    - We have been charged with replicating this for Care Homes in respect of COVID-19 related deaths.
    - Key to this process is implementing learning in preparation for further surges.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

- Of data analysed 56 patients from 6 practices were reviewed. Three quarters of these were form the first wave.
- As such this shows learning from the first wave and implementing that learning.
- End of life care /just in case medications were prescribed in 82 % of patients.
- Do Not Attempt CPR (DNACPR) status was formally recorded in notes reviewed in 89 % of cases.
- It is noticeable that the patients in this early pandemic cohort received an average of primary care contacts per resident of between 2.75-4.75. Many practices showed early adoption of video consultation to supplement house calls and phone calls.
- The care of the patients had followed a treatment pathway in line with the COVID-19 Community Respiratory Framework.

Graph shows co-morbidities of our COVID-19 patients.



ACP / DNACPR status

- No inappropriate CPR was undertaken.
- 89% of patients had a CPR status discussion ***documented*** prior to their acute illness.
- 89% with DNACPR ***documented***
- 11% of patients had an ACP (Advance Care Plan) ***documented*** in place prior to the last acute illness before death.
- 62.5% of notes had ceiling of treatment discussions ***documented*** between health professionals and relatives.
- These are all improving figures.

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Learning Points raised:

- The guidance regarding swabs for residents and staff has evolved in the pandemic. Pre-discharge swabs now occur as does regular testing of staff and residents of care and nursing homes, at the time this was not official guidance/available.
- Availability of lateral flow testing for health professionals visiting care settings is a recent welcome resource
- Reviewing and recording ACP documentation may be desirable in mitigation. The new Care Home Direct Enhanced service will support this. Anecdotally this has also been identified by a neighbouring health board as an area to improve.
- Improvement in documentation regarding ceiling of treatment discussions would be useful going forward.

- CTMUHB has provided practical support to care home colleagues e.g. observation equipment for our care homes, attend anywhere remote consultation, District Nursing colleagues support in EOLC and offering outreach ACP etc. Further CTMUHB's enhanced service GMS for care homes should further support care home colleagues. Going forward we may want to look at publicising CTMUHB wellbeing staff support to include our care home colleagues
- CTMUHB should consider up skilling district nursing colleagues in being able to confirm death to ease Out Of Hours visits to do this.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	There are no specific quality and safety implications related to the activity outined in this report.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	Safe Care
Equality impact assessment completed	Not required
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Well-being Objectives	Provide high quality, evidence based, and accessible care

5. RECOMMENDATION

5.1 The Committee are being asked to **NOTE** the above findings