Dear Colleagues,

The changes to society and to our practice forced on us by COVID-19 over the last few days or so are profound – easily comparable to being put into a state of war. As old age psychiatrists we are on the front line. Most of us have a leadership role and will be responsible for adopting the changes needed to protect and support our patients, teams and ourselves.

As many of you will know, Krish and I have been working to put together some general principles that our members may find helpful as well as inputting directly into the College who are linking with NHSE. The College has published some guidance, which amalgamates all the official government guidance so far, covering the community and inpatients and care homes settings. The current College guidance can be found here https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/guidance-for-psychiatrists-and-other-professionals-working-in-mental-health-settings-(covid-19)

The official government guidance so far is not specifically directed at older adults with mental health issues, but a lot applies to us. We recommend services follow official guidance in a way that works for the circumstances of their own particular local situation bearing in mind that guidance can vary between the different home nations and for different service settings.

More and more official guidance is coming online all the time. We suggest you check frequently whether there is any new advice that has been published for your area or service setting and judge for yourselves its relevance for the circumstances of your own staff and patients.

You can find some specific helpful advice on how to help the older adults cope with stress during the COVID-19 outbreak on page 11 of the link below https://www.epi-win.com/sites/epiwin/files/content/attachments/2020-03-11/MHPSS%20COVID19%20Briefing%20Note%202%20March%202020-English.pdf

However as much of the official guidance is not aimed specifically at older adults with mental health issues, we have put together an added list of specific, practical, suggestions for consideration by Old Age Psychiatry services as part of your planning. These however are just our suggestions and although they are informed by our study of the official guidance, **they are NOT official guidelines**.

Inpatient older adults

- Where time allows take steps to update the knowledge and skills of staff relating to physical health.

- Check care plans reflect any updated lasting power of attorney documentation and advance care decisions.

- If there are multiple inpatient sites, try to avoid internal movement of patients and as far as possible of staff.

- There are clear NHSE guidelines on visiting by family and friends to protect patients and staff, and these should be reflected in your locally agreed policies and procedures, which should be followed. However, be mindful of the psychological impact for both patients and the families. Consider facilitating alternate ways of communicating including use of mobile phones or video facilities.

- In particular, decisions about visits during an end of life situation should be made on a case by case basis and take into account the potential negative psychological impact if the visit does not happen and should include careful screening of the visitors.

- Staff, other patients in our inpatient units, family and carers may experience trauma when deaths occur to their patients or if other staff are severely impacted. They are likely to need support. Ensure that teams recognise this risk and are provided with appropriate support and you may wish to consider doing after death reviews with staff (such as what went well, what did not go so well).

Hospital environment

- Where possible, try to move patients with mental health presentations away from high-risk areas such as the emergency department or medical assessment areas.

- Patients with suspected or actual infection (and their relatives), may find it highly distressing to be in an intensive care environment, and cared for by staff taking precautionary measures. These experiences may have psychological and emotional repercussions long after recovery from the physical illness. Consider what can be done to make the environment less threatening and more familiar. Try to reduce the number of investigations, if at all possible.

- Try and ensure that the care staff are aware of non-pharmacological ways to address distressed behaviour.

- Older people will often be at increased risk of delirium. Staff should be encouraged to consider risk reduction strategies early on (nutrition, hydration, constipation and pain etc). Together with the BGS we have produced guidance in relation to delirium which can be found on the Faculty website (https://www.rcpsych.ac.uk/members/your-faculties/old-age-psychiatry/news-and-resources) under Our Reports and Resources and on the BGS website https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases

- Your management plan (both non-pharmacological and pharmacological) should consider all the relevant factors, including risk to others. You may have to consider earlier pharmacological intervention if the situation warrants to reduce the risk of further transmission of infection to others.

Older Adults in the Community

- It is essential to have a plan to safely meet the needs of patients in the community that potentially may need a home visit. A flow chart is included on the website.

- Patients at home with dementia may find it distressing when their care arrangements have to be altered or they are required to self isolate. Try to see that they are given information in an understandable way, which addresses their concerns and provides comfort. This is likely to take extra time. For those with more severe dementia consider using simple reminder notes or pictures.

- Older people might be put at particular risk due to the social distancing (or reduced visits from hard-pressed social services). Consider what can be done to protect them by encouraging collaboration from local health, social care and third sector agencies. Seek support from friends/family using regular phone calls and technologies if possible such as WhatsApp and Skype. Encourage them to help enrich the persons' environment if possible such as learning a new thing. For those with mild dementia consider self-help such as relaxation and exercise. Older carers also may be particularly negatively impacted by the social isolation and are very likely themselves to need increased support.

- You may wish to have to consider delaying drug changes if drug monitoring cannot happen such as a patient may need to remain on lower dose of cholinesterase inhibitors for longer.

- Consider contingency plans for ECT, MHA assessments, lithium and clozapine monitoring. You may also wish to consider discussing with your legal team about the potential inability to do any S49 work due to staff shortages.

- Consider putting in place systems to ensure the ability to respond rapidly to appropriate adjustments of care packages.

China was the first country to cope with this virus and you might useful the video from Professor Wang of the Chinese Society of Geriatric Psychiatry as well as an English language version of the Society's action plan on managing patients with dementia and COVID-19:
https://www.youtube.com/watch?v=zM6cd1QSSFo

https://www.alz.co.uk/sites/default/files/pdfs/MHPSS-Key%20messages-EN-min.pdf

Whilst this link is for an article from the USA Journal of Geriatric Emergency medicine it summarises the impact on older people and has a useful set of key points in Table 1 and a leaflet for patients Appendix 2

https://gedcollaborative.com/wp-content/uploads/2020/03/JGEM-COVID-19-in-Older-Adults.pdf

Using technology

With more emphasis on home working and on remote communication, it is more important than ever to consider how we use technology.

NHSX (the new name for NHS Digital) in England has put out some advice regarding the use of other communication/consultation tools in relation to information governance when using them with colleagues and patients. You can find it at https://www.nhsx.nhs.uk/key-information-and-tools/information-governance-guidance.

Make sure your service is aware of the advice by NHSX regarding the use of communication / consultation tools in relation to information governance when using them with colleagues and patients.

- Ensure the communication means that you use are suitable for the purpose of a confidential discussion. Maintain a dedicated clinical account, if you use the platform socially as well as professionally.

- Take contact details early in the proceedings, so that you can re-establish contact if the connections or technology fail and agree who will contact whom in the event of a lost connection.

- Consider the volume of loudspeakers and suggest that the patient does the same, emphasising confidentiality.

- Consider the environment beyond your video camera. Do you look professional? Be particularly careful using video or still photos outside an office, e.g. in your living room or bedroom. Are there photographs/books/posters visible that you would not have in a consulting room?

- In order to establish eye contact, you need to look at the camera, not at the eyes of the person you are interviewing.

New Changes to Mental Health Act Legislation

You will have heard that (at the time of writing) the Government is intending to pass emergency legislation including provisions that particularly affect our speciality. This is likely to be passed by the time that you read this. Here is the full link to the proposed changes
https://publications.parliament.uk/pa/bills/cbill/58-01/0122/cbill_2019-20210122_en_11.htm#sch7

The key provisions affecting us have been helpfully (and quickly) summarised by one of our Faculty members Dr Gemski as follows:

- Applications for S2 or S3 admissions can be made with one medical recommendation alone, if the AMHP considers that complying with the requirement for two medical recommendations is impracticable or would involve undesirable delay. Practitioner must be Section 12 approved (and does not need prior knowledge of the patient).

- No change otherwise to the S2 / S3 criteria & requirements.

- Similar provision for the forensic sections (36, 37, 38, 45, 47, 48) and timescale for transfer under S 47 increased to 28 days from 14 days.

- Any registered medical practitioner can detain in hospital under Section 5(2) – not just practitioner in charge of treatment – if complying with the requirement for report to be done by practitioner in charge is impracticable or would involve undesirable delay.

- Duration of detention under Section 5(2) increased to 120 hours from 72 hours.

- Duration of detention under Section 5(4) increased to 12 hours from 6 hours.

- Approved clinician in charge can certify S58 medical treatment after 3 months, if complying with the requirement for a (SOAD) certification is impracticable or would involve undesirable delay.

- S58 certificate can be given after consulting with 1 consultee rather than 2 (not a nurse or doctor) if consulting with 2 is impracticable or would involve undesirable delay.

- Duration of detention under Section 136 increased to 36 hours from 24 hours.

Staffing and staff welfare

As part of business continuity planning, an old age psychiatric team should consider what service it can deliver with reduced staff numbers and how it will cope with various scenarios. In particular:

- Consultants and team leaders/managers need to have clear lines of delegation in case they are incapacitated.

- Consider if the team can adopt social distancing measures to limit gatherings of the whole team?

- Consider delaying research, audit and training events to free up clinical resource but be mindful of training needs of staff if they move from community to inpatient to support the service. Consider partnering inexperienced workers with their more experienced colleagues. The buddy system helps to provide support, monitor stress and reinforce safety procedures.

- Discuss with your local voluntary and third sectors organisation including willing members of public (university students, volunteers, retired staff) who can provide

support if resources are depleted.

- Plan how you will look after your personal physical and emotional wellbeing. These several months are going to be very testing times and we need resilience to maintain our wellbeing. Think about using your friends, family social network and peers to get support. It is important you are taking regular comfort breaks, adequate nutrition and hydration. There are several resources available to use to help with mindfulness, meditation etc. For example www.unmind.com have given free access to all NHS staff to use their online resources. There are some downloadable posters on wellbeing from this site https://www.ics.ac.uk/ICS/Education/Wellbeing/ICS/Wellbeing.aspx?hkey=92348f51-a875-4d87-8ae4-245707878a5c.

- Discuss with your employer if there are facilities that you can access if you were to stay away from home. Develop a psychological safe environment where you can provide and seek support from your colleagues. If in doubt please ask your peers, colleagues and provide support and supervision when colleagues come to you. This is the time to break artificial barriers and work together to keep both staff and patients safe.

Conclusion

If you have any examples of protocols or best practice documents for old age services that you want to share with colleagues please can you send to Kitti so we can put on the website so that we can disseminate good practice quickly.

We wish you all the best at a very challenging time for our patients, staff and services. Above all please remember to look after your own health.

Amanda and Krish

20 March 2020
Faculty of Old Age Psychiatry