Hostels for Homeless Patients – COVID-19 Preparedness Work

Dr D Beale 7/4/20 (Westminster)

Building/infrastructure

-Are there posters up in the building about the virus/handwashing/social distancing/shielding/self-isolation?

-Is there alcohol gel in reception area?

-Is there enough and adequate PPE – symptomatic patients will need masks and other PPE needed for staff? Who do they escalate this to if not?

-Do some of the shared areas need cordoning off / would that be possible?

-looking at ratios of rooms to bathrooms in case of large outbreaks such that fewer residents to bathrooms to enable better isolation; is it possible to 'thin out' any eligible residents to 'COVID-PROTECT' type facilities to lighten that load?

-communal areas/banisters/door handles - studies show lots of transmission via hard surfaces as opposed to just through coughing; do residents have responsibility perhaps for their floor's banisters or handles, or similar and use wipes or perhaps staff; do you have gloves/wipes etc for this?

-Who does cleaning of shared areas – including shared bathrooms - could this be done by staff or outside people? Are your cleaning staff 'deep clean' ready and have appropriate protection such that they won't 'pull out' if positive COVID case within? What happens if the cleaning staff levels are depleted?

-Food; is food provided on-site? If catering staff are ill/isolating – how will food be provided? What is the escalation process for this? Is there provision for residents to prepare food or would it need to be takeaway type provision?

-if end-of-life/palliative care medication needs to be stored onsite for on-call visiting clinical team to use, can this be done securely – locked safe?

Staffing

-All 'vulnerable' staff should be shielding/not on frontline

-How are staffing levels? Has COVID affected your staff already? Do you have a business continuity plan for if staffing levels fall dangerously low/hostel has to be unstaffed/how this is escalated - can any residents become 'hostel champions' such that they could help guide others or have responsibilities if staffing levels fall to this level

-Is there anyway of checking in with all residents every day (by phone ideally - does everyone have a phone? If not phones should be sourced ASAP to enable remote checks) for symptom check (how they feel generally, any fever, new cough etc)

- discussions to be had with staff around the traumatic situations that will arise should COVID move swiftly through the hostel; many of the residents will have such significant underlying medical history etc that hospitals would not even accept to transfer them in as they would not ever be put on a ventilator or other assisted ventilation (may result in a lot of end-of-life care needing to be delivered in the hostel - won't be able to even offer home oxygen as smoking in rooms so not safe for any oxygen to be on site).

-should the hostel have so many COVID cases it may become hazardous for staff to remain there, or for health staff to go in regularly (in view of risk of death with excessive viral load/exposure – has happened in care facilities in other affected countries), it may be difficult to deliver palliative care which will again be traumatic for all especially those who know the residents well and will witness difficult scenes; preparing staff for worst case scenario and that very difficult decisions may need to be made for staff's own safety

-How can we support the staff in all this; how are they managing already, counselling or debrief options?

Residents

-Are people social distancing? If not, does there need to be more education?

-Do they understand that their medical conditions make them more vulnerable e.g. “Your health problems could make you more likely to have a severe life-threatening infection should you contract COVID-19” - importance of seriousness of situation to be laid out and shared

-worth noting ALL the COVID-PROTECT sites (which someone may be moved to for their own protection) will be non-smoking rooms but options for sourcing e-cig, or nicotine replacement, or going out for cigarette breaks one at a time, as long as not got any symptoms of COVID (worth broaching this as some people have already been evicted from protection sites re smoking in their rooms due to health and safety/fire hazard)

-medical teams to consider conducting reviews based on frailty scores/medical conditions as per national guidance as preparation re: future appropriateness of transferring to hospital/ringing for emergency services

-thinking about when people become increasingly unwell and for example can't source their own alcohol - who is alcohol dependent (drinking daily to such an extent as to risk withdrawal if they stop) and what is their 'typical day' drinking - how will you source and provide the alcohol such as to keep them safe? Can you keep a record of ‘baseline’ alcohol intake for these drinkers to have to hand?

-Is there a way of 'well' but remotely-working staff isolating to call in or check on people; mobile numbers etc available to those remotely working? And as above, do ALL residents have working mobile phones?

- anyone seeming worryingly unwell ALREADY or who might be nearing end of life who, even without contracting COVID may get sicker over next few weeks; do they need a pre-emptive medical team review for these other issues and ensure any outstanding needs met prior to any possible infection?

-who is on a care package already; what if carers can't come due to their own staffing issues, how to manage needs if this happens – how to escalate and to whom?

-anyone who has care needs who needs us to facilitate/request assessment by social services if not happened yet for whatever reason

-have any residents expressed any advance care wishes about what they do or don't wish to happen if they get very ill? Do we have next of kin details for residents?

-have hostel noticed re reported Class A drug supply reducing; anyone not on a substitution script expressing an interest in going on one?

-Are the drug / alcohol services/other provision helping to get more people onto scripts / how is this working / is there any advocacy needed? What about when someone is symptomatic and cannot pick up their own opiate substitution – can this be delivered (discussion with pharmacy?)- Are services taking this into account when prescribing?

-Procedure re ANYONE who becomes symptomatic and refuses to self-isolate in the appropriate manner – may need to involve health team; assessing capacity/ensuring not acutely delirious – need to make decisions in interests of public health - especially in view of a dozens of medically extremely vulnerable residents around them who have a high likelihood of dying from COVID should they contract it, not to mention risk to staff. Resident will need to leave - what to do thereafter; inform health teams/outreach/rough sleeping commissioners

-Are hostel staff aware of reviewed CPR guidance in community settings and Resus Council guidance – because of risk to the responder; there are no rescue breaths – in a recent document circulated to NW London CCGs’ practices there is also advice NOT to give chest compressions (aerosol-generating and risk too high to responder) – so defibrillator only advised; do hostels have access to one? Can they source one? Do they know where their nearest one in the community is otherwise? Also should place some PPE next to the defibrillator to enable use wherever possible, even at defibrillator stage