

# Supporting patients of all ages who are unwell with coronavirus (COVID-19) in mental health, learning disability, autism, dementia and specialist inpatient facilities

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This document is a compilation of guidance, following recent requests, and has been produced in collaboration with the Royal College of Nursing's Mental Health Programme, the Royal College of Psychiatrists and Unite in Health.

This guidance has been assessed to identify potential equality impacts of the COVID-19 pandemic on people with mental health problems or a learning disability and/or autism. It is acknowledged that people with mental health needs, a learning disability or autism who contract COVID-19 may require reasonable adjustments, and that the COVID-19 pandemic has the potential to affect mental health and wellbeing. Health services must continue to have due regard to their obligation to advance equality under the Equality Act 2010: this includes recognising and factoring-in the vulnerability of different cohorts with protected characteristics including BAME patients; and inequalities in access, experience and outcomes in health services. The [Advancing Mental Health Equalities Toolkit](#) provides support in identifying and addressing mental health inequalities in the round. Partnership working with the voluntary and community sectors is also encouraged to facilitate wrap-around support for vulnerable people, and to maximise engagement with underrepresented groups.

## **Principles**

Throughout this guidance, the term 'provider' refers to providers of inpatient services for people with mental health needs, a learning disability, autism or dementia. This guidance is

applicable to provision of all bed-based care, including acute, intensive care and rehabilitation.

Certain key principles should inform the provision of care to individuals in these settings who are suspected/confirmed to have COVID-19, or who have existing co-morbidities that make them clinically extremely vulnerable/at highest clinical risk if they contract COVID-19 (i.e. individuals who have been advised to [shield](#)):

- People with mental health needs, a learning disability, autism or dementia should receive the same protection and support with managing COVID-19 as other members of the population. This will mean providing additional support, including by making reasonable adjustments to care systems and clinical practice.
- It has previously been recommended that inpatient settings should ‘cohort’<sup>1</sup> patients into those:
  - with confirmed COVID-19
  - without confirmed COVID-19
  - those who require admission and are awaiting a test to confirm whether they have COVID-19

Where an individual is admitted who meets [government criteria for ‘shielding’](#), they should be prioritised for an en-suite facility. Inpatient settings should consider the vulnerabilities of all patients they are caring for, making any reasonable adjustments to care where required.

- Following the [expansion of testing capacity](#), and to support the effective management of COVID-19 in healthcare settings, testing should be expanded to all individuals admitted to inpatient settings. This includes preparing to cohort patients as possible COVID-19 cases who need to be admitted while they await a test result.
- Inpatient settings should reorganise wards/bays/en-suite facilities and staffing arrangements to separate these cohorts of patients, to maximise protection for the maximum number of patients. Specific local arrangements will need to be kept under regular review as the size and gender mix of these cohorts are likely to change over time; see [Managing capacity and demand guidance](#).
- Some basic aspects of physical care for people with suspected or confirmed COVID-19 can be provided in mental health, learning disability, autism or dementia settings.
- When an individual’s needs escalate, they may need to be transferred in a timely way to an acute medical setting. Providers and CCGs should work within existing

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<sup>1</sup> It is recognised that the need to cohort patients under these circumstances may mean that providers breach [current guidance](#) on delivering same-sex accommodation. They should then complete a full assessment of the implications for individuals.

protocols for transfer to an acute setting. These protocols should support joint decision-making and ensure timely transfer and equity of access.

- Some providers will be able to deliver more advanced physical healthcare, depending on their configuration and available resources, including workforce and equipment. Where possible, community and district nursing teams should provide advice, guidance and support virtually.
- Wherever possible we must continue to guard against overly restrictive practice, see corresponding [legal guidance](#);
- Individuals and their families and carers as appropriate should be involved in any key decisions about the patient's care and should be provided with all relevant information in an accessible format.
- Providers are advised to provide refresher physical health training (eg monitoring vital signs and the management of a physically deteriorating patient, or rapid upskilling from neighbouring physical health teams) to all relevant clinical staff so that they can provide some level of physical healthcare for people with COVID-19.

The rest of this document expands on the above key principles and [Table 1](#) gives suggested actions and key considerations for providers when caring for people with suspected/confirmed COVID-19.

## **Managing a suspected or confirmed COVID-19 case**

People with mental health needs, a learning disability, autism or dementia should receive the same protection and support with managing COVID-19 as other members of the population. This includes, where required, rapid access to acute care.

If an individual receiving care and support in an inpatient setting has confirmed or suspected COVID-19, the risk to their health and wellbeing must be assessed and appropriate action taken to provide relevant care and support.

## **Infection control prevention considerations**

Where an individual is suspected or confirmed to have COVID-19, [self-isolation procedures](#) should be followed and they should be tested immediately and regular observations taken. This can support the development of a management and isolation plan. This activity should be carefully planned, managed and communicated to the individual who is required to isolate, to reduce the risk of trauma. Providers should also adopt a trauma-informed approach, with particular consideration of the effects of staff in personal protective equipment (PPE) providing care and support to individuals, recognising the overall aim of reducing trauma.

It is important to notify patients and their relatives if another patient on their ward has tested positive for COVID-19, but in doing so providers should bear in mind the overall need to maintain patient confidentiality. In line with Regulation 20 of the Health and Social Care Act (2008), providers should inform family members or next of kin when a patient, who may be on the same ward as their relatives, is confirmed to have COVID-19. Similarly, family members or next of kin should be informed where adjustments and/or restrictions are being made in line with national guidance about self-isolation for the individual and those who have been in contact with them.

Standard infection control precautions (SICPs) and transmission-based precautions (TBPs) must be used when managing patients with suspected or confirmed COVID-19. Further guidance can be found in [COVID-19 Guidance for infection prevention and control in healthcare settings](#).

Staff should use the [PPE](#) provided by their service for activities that bring them into close personal contact, such as washing, bathing, taking blood and administering medication.

Individuals with confirmed COVID-19 should be isolated as far as possible. If they do not have their own en-suite room, they should be moved to a side ward/bay at the earliest opportunity to reduce the risk of transmission. Where en-suite rooms already exist, providers should move people so that all COVID-19 cases are cohorted in one area. All rooms and individuals should be risk assessed before any individual patient is transferred. For further detail see [Managing capacity and demand guidance](#).

Case-by-case reviews will be required where any patient is unable to follow advice on containment, isolation and testing. Providers should decide the appropriate use of the relevant legal framework for each case, with support from medicolegal colleagues as required. Non-concordance with isolation represents a clear and obvious risk to other people. This should, in the first instance, be conveyed to the patient, helping them to understand the clinical reasons for self-isolation and testing. For further detail, see [Legal guidance](#).

## **Monitoring and clinical management**

Regular observations and key symptom monitoring (ie fever, cough and breathing rate) should be completed and documented. [The National Early Warning Score \(NEWS 2\)](#) may be used to monitor the rate of physiological deterioration in individuals with suspected or confirmed COVID-19 cases. [NEWS2](#) assesses physiological deterioration in these patients when combined with knowledge of the patient's usual presentation while well and the clinical judgement of the attending clinician. [NEWS2](#) is not appropriate for use in those under 16s. Providers are encouraged to use appropriate, validated tools in specific populations, such as

children and adolescents and pregnant women. Additional local tools such as [Stop and Watch](#) and [Restore 2](#) may also be valuable in conjunction with [NEWS2](#), as part of an overall holistic assessment of the individual's care needs.

Individuals should be assessed for pre-existing conditions which would make them high risk if they contract COVID-19 (ie those described in Public Health England's guidance on [vulnerable groups](#) as well as those who have been advised to [shield](#)), as well as their current general physical health, including COVID-19 signs and symptoms. Advice from physical health specialists should be sought where required and arrangements made to obtain advice from a senior physical health physician via telephone. Additional consideration should be given to the known specific contra-indications of medications and their side effects in patients with COVID-19 and other infections. For further guidance refer to information from the [National Association of Psychiatric Intensive Care and Low Secure Units](#).

Patients with a learning disability, autism or dementia and a co-morbid physical health condition may present with additional, softer signs or early indicators of deterioration, eg mood or behaviour changes, becoming unsteady when walking, increasingly tired, sleeping more, restlessness and agitation. These may be harder for the clinician to appreciate and harder for the patient to express. In this situation it would be advisable to speak (where possible) to carers and those most familiar with the individual to assess and note in the patient record for future reference how the person usually presents when well.

In many cases, patients can be safely cared for in their existing mental health, learning disability and autism, dementia and specialist ward, depending on the availability and safety of local facilities and the competence of the staff team in each setting to assess, monitor and intervene in physical healthcare. However, in some circumstances, transfer to a local acute facility may be necessary. Where required, an individual should be transferred at the earliest opportunity. All care and support provided should be in the individual's best interests, with the aim of promoting positive patient experience and outcomes.

Table one below sets out further considerations and suggested actions for patients with different levels of risk and symptom severity. Local areas may wish to develop local escalation frameworks to support clinical decision-making.

**Table 1: Considerations for patients with different levels of risk and symptom severity, and suggested actions**

Risk level	Severity of symptoms	Suggested actions	Key considerations, including resource and workforce implications
1	<b>Individual has mild symptoms</b>	<ul style="list-style-type: none"> <li>Follow self-isolation guidance and reduce the risk of transmission of COVID-19 in hospital settings</li> <li>Where using NEWS2, take a full set of physical observations and calculate a NEWS2 score</li> <li>Testing to be completed as soon as possible where COVID-19 is suspected, in line with national guidance</li> </ul>	<ul style="list-style-type: none"> <li>Explore reopening wards/bays that are currently not used to support effective isolation for patients with confirmed COVID-19. See <a href="#">Managing capacity and demand guidance</a></li> <li>Keep patients in the confirmed COVID-19 cohort away from those who need shielding and ensure that PPE are used.</li> </ul>
2	<b>Individual has moderate symptoms and other factors that make them more susceptible to the effects of COVID-19, eg those identified as ‘vulnerable’ in PHE guidance or those who have been advised to ‘<a href="#">shield</a>’ as per government guidance</b>	<ul style="list-style-type: none"> <li>If a patient scores <math>\geq 3</math> on NEWS2 or is clinically unwell, escalate to the ward doctor</li> <li>A telephone review will determine if an acute transfer is required or if the individual can be appropriately managed in the inpatient setting. Where transfer is required, this should be done at the earliest opportunity</li> <li>Where necessary, the following should only be considered if available locally and competent staff on the ward are competent to deliver them (with cover 24 hours a day): administering intravenous fluids, the use of nebulisers, assessment using NEWS2, oxygen therapy and antibiotics</li> <li>Access support from community health trusts, primary care and local ambulance services where necessary, as well as specialist support for people with a learning disability, autism or dementia</li> </ul>	<ul style="list-style-type: none"> <li>Follow existing provider protocols for obtaining timely medical support from the relevant acute trust to manage co-morbid conditions or symptoms associated with COVID-19</li> <li>Ensure mechanisms are in place to draw advice and guidance from pharmacists, particularly on issues relating to complex physical health presentations and drug interactions</li> <li>Staff should have refresher training in physical health assessment and monitoring (eg on monitoring vital signs and the management of a physically deteriorating patient, or rapid upskilling from neighbouring physical health teams) and delivering relevant physical health interventions</li> </ul>

<p><b>3</b></p>	<p><b>Patient is acutely unwell with severe respiratory symptoms associated with COVID-19</b></p>	<ul style="list-style-type: none"> <li>• If staff are extremely concerned about a patient's clinical condition (eg the patient is scoring <math>\geq 7</math> on <a href="#">NEWS2</a>.) a category 1 or 2 ambulance should be called before contacting the doctor. An immediate ABCDE assessment may also be required</li> <li>• Care should be provided in line with the resource and workforce available</li> <li>• Follow existing processes for patient transfer to an acute facility. See also <a href="#">Guidance for infection prevention and control in healthcare settings</a></li> <li>• If the patient is not breathing, then cardiopulmonary resuscitation should be undertaken (unless the patient has a pre-existing DNACPR). Follow <a href="#">Guidance for infection prevention and control in healthcare settings</a></li> </ul>	<ul style="list-style-type: none"> <li>• Staff should have refresher training in delivering relevant physical health interventions</li> <li>• Some patients detained under the Mental Health Act (including those on Restriction Orders (Sections 41 and 49) ordinarily require escorts when transferred to an acute general hospital. Where this transfer relates to the treatment of COVID-19-related symptoms, it is important that patient, staff and public safety is considered as part of the individual risk assessment, but this must be balanced with the risks in relation to infection control for all those involved. Assessment of the patient's physical presentation will enable appropriate escorting arrangements. This must be planned in conjunction with the acute general hospital's policies. Relevant stakeholders, including the Mental Health Casework Section (MHCS - HMPPS), are developing guidance in relation to these situations and this will be available soon.</li> <li>• Escorting levels should be kept under review and include consideration of known risk factors, in terms of mental health and physical health presentation.</li> </ul>
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## **Patient, family and carer engagement**

Individuals, their families and carers should be involved in any key decisions about the patient's care. Any impact on leave or Care (Education) and Treatment Reviews (C(E)TRs) should be appropriately communicated to the individual and their family. Conversations will inevitably have to take place remotely, rather than face-to-face, and arrangements to support remote visits will need to be put in place. Further guidance can be found on the [NHS Digital website](#). Services should consider providing digital devices to individuals who do not currently own them to make it possible for them to maintain contact with their family. Further detail about C(E)TRs can be found in [Guidance on managing capacity and demand](#). It may also be appropriate to ensure that individuals have access to advice and guidance from an advocate, either digitally or over the telephone.

## **Training requirements and workforce support**

Supporting staff wellbeing will be vital, both in our responsibilities as an employer and as providers of compassionate, safe, quality healthcare. Now more than ever it is important to ensure there are appropriate structures for supervision, reflective practice and peer support. Providers should ensure that staff are appropriately trained to deliver relevant healthcare interventions within their competency and capabilities. As stipulated, where a transfer is required to an acute facility for more specialist care this should be expedited in a timely way.

For further guidance on supporting the workforce, please see the [NHS England and Improvement website](#) and the [NHS Employers website](#). The Royal College of Psychiatrist and developed [COVID-19 guidance for clinicians](#) and the Royal College of Nursing has developed [similar guidance](#).

Providers should urgently review and start training courses to ensure psychiatrists and senior mental health professionals are competent and confident in incorporating certain physical healthcare interventions into a care plan, prescribing the correct treatment and delivering these interventions, as appropriate. The initial priority of training should be to support the broad goal of increasing skills in managing isolation, assessing physical health using NEWS2, and being aware of respiratory distress, hypoxia and shock. Staff should also have refresher training in physical health assessment and monitoring (eg monitoring vital signs and the management of a physically deteriorating patient, or rapid upskilling from neighbouring physical health teams) and delivering relevant physical health interventions.

Support is key as staff may have to engage in conversations, particularly concerning palliative and end-of-life care, that are not part of their usual practice and may have to be had more quickly than usual.



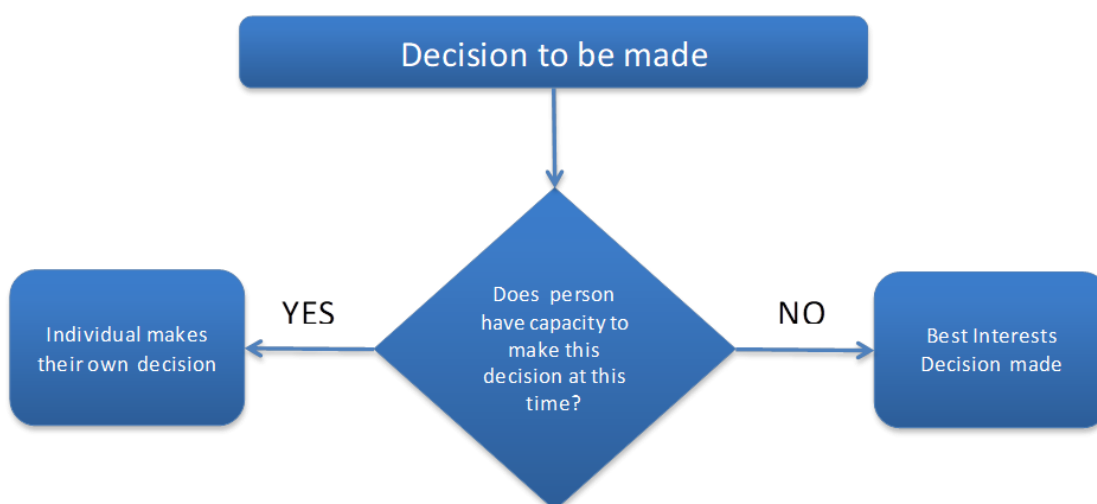
## Palliative care

Where possible, providers should follow existing processes for patient transfer to an acute facility. Guidance on patient transfer can be found in section 6.3 of [Guidance for infection prevention and control in healthcare settings](#).

In some cases, transfer to an acute facility may not be possible, e.g. where an individual has deteriorated significantly and transfer would not be clinically appropriate. Any decision not to transfer an individual to a local acute facility for further treatment should be discussed with the individual, their family and carers, and possibly with the local ethics committee.

DNACPR forms should only be completed in appropriate circumstances where it is in the patient's best interests and when the patient and their family and carers agree. If the person does not have capacity, then a due process of decision-making under the requirements of the Mental Capacity Act (2005) should be completed. Advance care planning guidance is available [here](#).

**No 'blanket' treatment plans across a group of individuals, based on their diagnosis, age or care setting, should be in place.** The legal frameworks of the Mental Capacity Act and General Medical Council guidance on decision-making should continue to be followed. It is crucial that decisions are made on an individual basis even if the predicted outcomes are similar across patient groups. These decisions can be approached in a sensitive and timely way given the current situation.



A 'do not attempt cardiopulmonary resuscitation' (DNACPR) order is purely clinical guidance for a decision in the circumstances of a cardiac arrest, and not for a decision regarding any other clinical interventions. A DNACPR order does not cover decisions about escalation in the context of COVID-19 or an individual's end-of-life care needs.

Regular observation measurement should continue, including NEWS2 testing and food and fluid monitoring. Comfort and pain issues should be regularly reviewed.

Palliative care support and advice should also be sought from specialists via telephone. Providers may wish to consider developing a shared protocol with local services around obtaining advice, guidance and support for the individual concerned. Friends, family and relatives should be consulted on a regular basis. Where appropriate, please refer to the [Clinical guide for the management of palliative care in hospital during the coronavirus pandemic](#).

In line with government guidance on social distancing, conversations with friends and family members should take place remotely, which can be extremely difficult for the patient and their family. Digital technology solutions should be considered as far as possible, eg using video calls to keep people in touch, although for some older people, including older carers, voice calls may be more accessible.

Some mental health and learning disability nurses may not have provided end-of-life care before and may need additional training and support through this.

Guidance for infection prevention and control in healthcare settings should be followed for the deceased. All steps should be taken to clear the area and carry out the required [IPC measures](#).

## **Additional considerations**

### **Specialist eating disorder facilities**

Wards that are compliant with [NICE-guidance](#) can provide NG feeding. Individuals with confirmed or suspected COVID-19 who are receiving NG/PEG feeds need to be managed with the correct PPE equipment in line with [IPC guidance](#) and appropriate training.

Where possible and in line with government guidance, providers should consider providing wrap-around care and intensive support in the community for this vulnerable group of patients.

Providers also need to be mindful that patients with an ED may have a weakened immune system, increasing their susceptibility to the more severe symptoms of COVID-19.

### **Patients in learning disability and autism settings**

Individuals with a learning disability have higher rates of morbidity and mortality than the general population and die prematurely. The third annual LeDeR report in 2019 showed that 41% of people with a learning disability died due to respiratory conditions. There is also a

higher prevalence of diabetes, obesity and being underweight in this group. All of these factors make them more vulnerable to COVID-19.

Clinicians should be mindful of diagnostic overshadowing, when the symptoms of physical ill-health are mistakenly attributed to either a mental health/behavioural problem or as being inherent in the person's learning disability. People with a learning disability have the same illnesses as everyone else but they may present, respond to or communicate symptoms, pain or distress in a very different way from other people. Specialist advice and support from clinical and liaison staff in learning disability and autism teams should be sought if they are not already involved.

Many people with a learning disability, autism or both may be inpatients in hospital settings that are not co-located with general hospitals. Local systems should proactively arrange clear arrangements for advice, support and facilitation of admission and subsequent discharge of patients with suspected or confirmed infection with COVID-19.

For further guidance on providing care for people with a learning disability who have tested positive for COVID-19 can be found on the [NHS England and NHS Improvement website](#).

### **Mother and baby units**

Inpatient perinatal mental health services (mother and baby units (MBUs)) admit women in the later stages of pregnancy and women with their babies up to 12 months of age.

Pregnancy has been identified as a risk factor requiring isolation in the community for 12 weeks. [Self-isolation guidance](#) should also be followed on the MBU, with pregnant women isolated on the unit during this time. This should be actively supported by the obstetric and midwifery services.

All women in the MBU should be supported to develop a COVID-19 management plan, outlining their personal care and support needs should they develop symptoms, in respect of their baby. To help them develop this plan, mothers should be able to access the latest advice and guidance from the [Royal College of Obstetricians and Gynaecologists](#). Partners, co-parents and significant others should be involved in the development of this plan. The important role of the co-parent should be facilitated within service protocols, making full use of technology.

Services should continue to maintain links as needed with social services, health visiting and community services.

## Secure services

An issue specific to the secure services is the need to cohort patients. This is more significant in smaller providers where it may not always be possible to create capacity for COVID-19 positive patients.

In the first instance, providers are encouraged to have a business continuity plan with their partner providers as part of new care models. If changes in security status are required, please refer to the [legal guidance](#) and [Guidance on managing capacity and demand](#).

## People with dementia

Most people with dementia are over 70, have other long-term conditions and are frail, putting them into the particularly vulnerable group to develop complications if infected with COVID-19.

Clinicians involved in screening and treatment should be aware of the additional anxieties people with dementia may experience on admission. It is advisable to allocate additional time for a holistic assessment. Advance care planning (ACP) can be used to identify the wishes and preferences of people with dementia; see [My Future Wishes](#) for further detail. Clinicians should identify if an individual has an ACP or a 'health and welfare power of attorney'. Further detail on ACP can be found on the [NHS England and Improvement website](#).

It may also be necessary to complete a swallowing assessment, to identify any potential swallowing difficulties that may put someone with dementia at increased risk of chest infections or dehydration.

It is important to ensure that all information regarding personal care and support for preventing COVID-19, such as self-isolation and handwashing, are available in accessible formats to ensure that all people with dementia can access it.

Individuals with dementia are much more prone to develop delirium (a confused state) if they become infected. They may also be less able to report symptoms because of communication difficulties. Clinicians should be alert to the presence of signs as well as symptoms of the virus (eg 'look beyond words').

Where required, conversations about end-of-life care should be tailored to reflect expectations in these two situations and [palliative comfort measures offered](#).

If a person with dementia and COVID-19 is imminently close to dying and has symptoms such as breathlessness or severe delirium that are difficult to manage, specialist palliative care support and advice should be sought.

In some cases, people with dementia may have impaired mental capacity. The Mental Capacity Act (2005) provides guidance on assessment of capacity and compliance with legal guidance to act in the individual's best interests.

## Useful resources

- Guidance for the public on the mental health and wellbeing aspects of coronavirus (COVID-19): <https://www.gov.uk/government/publications/covid-19-guidance-for-the-public-on-mental-health-and-wellbeing/guidance-for-the-public-on-the-mental-health-and-wellbeing-aspects-of-coronavirus-covid-19>
- 'e-learning for health' coronavirus resources: <https://www.e-lfh.org.uk/programmes/coronavirus/>
- Public Health England: [easy read guidance on coronavirus](#)
- Public Health England: [advice about the coronavirus \(easy read\)](#)
- Mencap: [a range of easy read guides](#), including self-isolation, social distancing and government guidance.