# COVID-19 MANAGEMENT PLAN IN RESIDENTIAL AGED CARE FACILITIES (RACF)

**Ministry of Health Malaysia**
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# Summary of Recommendations

1. A single positive case of COVID-19 in RACF required immediate action to be taken to curb the spread of the infection, hence preventing the outbreak.

2. A structured pathway for assessment, triaging and managing RACF outbreak allows better outcome for the residents infected with COVID-19 involved:
   - RACF providers
   - Public Health team
   - Primary Health Care Clinical team: Health clinic/ Private Health Care Provider
   - Hospital Clinical team: Geriatricians and/or Palliative Physician and/or Pharmacist

3. There are three criteria that determine the plan of management:

   **Criteria 1**: MANAGE AT RACF/CAC/ Mobile CAC
   - CFS 6 or less + CATEGORY 2* (Refer to COVID-19 Hospital Admission ANNEX 2)

   **Criteria 2**: FOR IMMEDIATE ADMISSION TO HOSPITAL
   - CFS 6 or less + CATEGORY 3 and above
   - Any other reason for admission e.g., clinical dehydration, hypotension, tachycardia, uncontrolled medical condition e.g., angina

   **Criteria 3**: MANAGE AS PALLIATIVE CARE IN RACF
   - CFS 7 or more AND
   - Advanced care plan not for active resuscitation/hospitalization OR
   - Already in active phase of dying e.g., gasping, poor GCS, mottled skin, hypotension & hypoxia

4. Clear communication with RACF operator and residents' next of kin is very important in ensuring positive outcome of the management

## INTRODUCTION

The COVID-19 pandemic has resulted in devastating number of mortalities amongst residents of the Residential Aged Care Facility (RACF) around the globe. Older age, frailty and multiple co-morbidities put them at highest risk of developing severe illness requiring hospitalization as well as intensive or high dependency care management. Being in a congregated space and the communal style of living and challenges to adhere to physical distancing resulted in rapid and accelerated transmission and spread of the disease amongst the residents as well as the carer of the residential aged care. The international data prior to massive vaccination roll out in the USA and European countries in December 2020 showed that older people living at RACFs comprise of 47% of all mortalities from COVID-19 which exceeds 1.4 million deaths.

This guideline aims to provide a management plan for the RACFs, public health authority and clinical team to work together to plan, prepare and respond to COVID-19 outbreaks.

The RACFs involved are from both the public and private sectors where there are staffs to provide personal care and/or health care. This includes:

- nursing homes (dependent residents)
- residential homes (largely independent residents)
- long-stay hospital wards and rehabilitation hospitals
- other accommodation e.g., retirement villages, sheltered accommodation

Pertinent considerations in preparing this guideline with regards to RACFs in Malaysia are:

- RACFs are not designed to be like hospitals, therefore, with limited facility to practice infection control
- A large number of residents in a confined area
- A limited background in healthcare and/or limited experience in clinical skills as well as infection control and Personal Protective Equipment (PPE) use
- working and living arrangements that involve shared use of equipment and spaces
- residents who may not be capable of complying with isolation and infection control - measures

## OBJECTIVES

1. To provide appropriate COVID-19 management plan for residents and providers in Residential Aged Care Facility
2. To coordinate the care between Residential Aged Care Facility (RACF) with public health, primary health care and hospital team.

## TEAM MEMBERS FROM MINISTRY OF HEALTH

1. **DISTRICT HEALTH OFFICE (PKD):**
   a. District Health Officer (DHO)
   b. Public Health Physician
   c. Medical & Health Officer (M&HO)
   d. Environmental Health Officer

2. **PRIMARY HEALTH CARE CLINICAL TEAM (KLINIK KESIHATAN/ PRIVATE HEALTH CARE PROVIDER):**
   a. Family Medicine Specialist (FMS) / Private Health Care Provider (e.g. General Practitioner)
   b. Medical Officer (MO)
   c. Pharmacist
   d. Paramedic

3. **HOSPITAL CLINICAL TEAM**
   a. Geriatrician
   b. Palliative Physician
   c. Medical Officer (MO)
   d. Paramedic
   e. Pharmacist

## DEFINITION OF EXPOSURE AND OUTBREAK

1. **Residential aged care facility COVID-19 exposure is defined as:**
   - Any case of COVID-19 in staff, residents or a visitor at the facility during their infectious period that does not meet the definition of an outbreak.

2. **A residential aged care facility COVID-19 outbreak is defined as:**
   - Two or more residents of a residential care facility who have been diagnosed with COVID-19 via RTK-Ag or PCR test within 5 days and has been onsite at the residential aged care facility at any time during their infectious period.

## ROLES AND RESPONSIBILITIES

### 1. RESIDENTIAL AGED CARE FACILITIES (RACF)

a. The provider is required to comply with Public Health Orders, Health and Safety requirements and infection control in their facility.
b. The provider should ensure all the residents and the staffs of RACF are vaccinated and boostered.
c. The provider is responsible to do COVID-19 testing for the residents and staffs in the RACF during the outbreak (based on risk assessment by PKD).

d. The provider should identify suitable isolation area for positive and close contact (residents and staffs) in the RACF.
e. The positive and close contact (residents and staffs) should be isolated or cohorted at specific area.
f. The provider should inform the PKD immediately once COVID-19 positive case identified.
g. The provider should ensure all the necessary equipment for home assessment are available e.g pulse oximeter, thermometer, blood pressure machine, PPE, hand sanitiser etc.
h. The provider is responsible to do vital signs and warning signs checklist monitoring (HAT) for the RACF residents and staffs (APPENDIX 7A, 7B).
i. The provider is responsible to update daily results of monitoring to the RACF Primary Health Care Clinical Team.
j. The provider should ensure all the staffs are trained in wearing appropriate PPE, sanitisation and disinfection.
k. The provider should arrange suitable transportation when there is a need.

## 2. DISTRICT HEALTH OFFICE (PKD)

a. To contact the provider for risk assessment of the residents and prepare a line listing.
b. To do initial inspection and risk assessment of the RACF.
c. To supervise close contact screening, cohorting the positive case and facilitating the residents to get the Home Surveillance Order (HSO) and Release Order (RO).
d. To facilitate transportation (Rapid Response Team, RRT) for those RACF residents and staff who need admission.
e. To support and liaise with NGOs to facilitate care at the RACF.
f. To facilitate vaccination for those who have not received vaccination in the RACF.

## 3. PRIMARY HEALTH CARE CLINICAL TEAM (KLINIK KESIHATAN/ PRIVATE HEALTH CARE PROVIDER)

a. To assess residents and staff at the RACF (assessing the negatively tested residents followed by positively tested residents).
b. To provide management plan for residents and staff remaining in the care facility including reviewing the Home Assessment Tools (HAT)
c. Primary Health Care Clinical team may consult geriatrician or Hospital Clinical team for COVID-19 case with multiple comorbidities/ complications or decision for palliative care if needed.

## 4. HOSPITAL CLINICAL TEAM:

a. Receive consultation from Primary Health Care Clinical team regarding management plan of COVID-19 in the RACF.
b. Provide management plan for residents and staff following consultation from Primary Health Care Clinical Team on a case-to-case basis including the decision to visit the RACF for further evaluation and management.

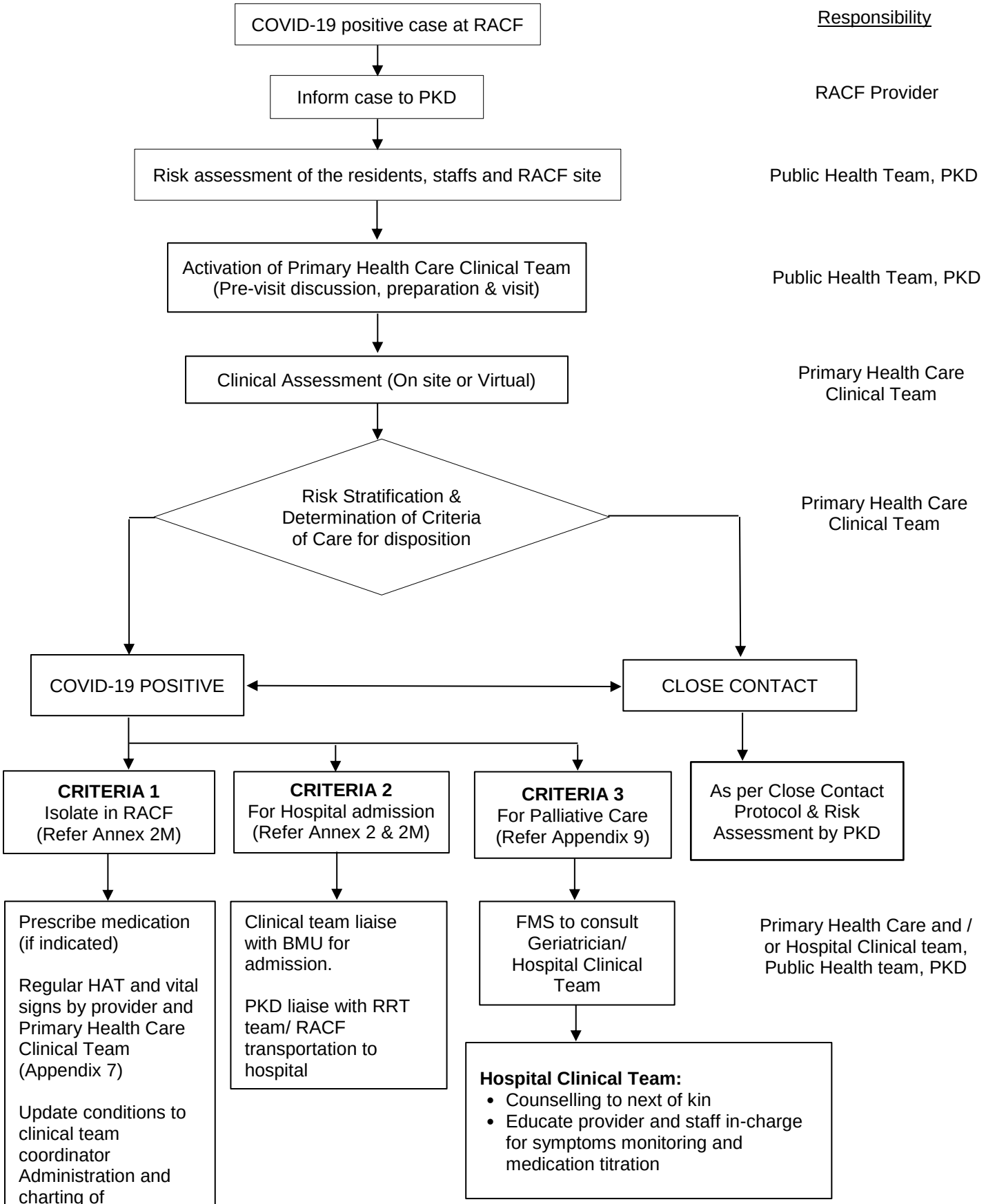
c. Communicate with the next-of-kin of any terminally ill resident for the aim of management including providing palliative care (consumables and medications) in RACF.
d. Supplying medication(s) that is(are) not available in Health Clinic following consultation from Primary Health Care Clinical Team if needed.

**TERM OF REFERENCE**

| **Team Member** | **Roles** |
|---|---|
| Public Health Physician | • Coordinator<br>• Risk assessment and infection prevention and control (IPC) measures at the RACF<br>• Risk assessment of the residents and line listing<br>• Communication between *Bilik Gerakan*, CAC and RACF clinical team |
| Medical & Health Officer (Public Health Officer) | • Assist Public Health Physician<br>• Risk assessment and IPC measures at the RACF<br>• Risk assessment of the residents and line listing<br>• Communication between *Bilik Gerakan*, CAC and RACF clinical team |
| Environmental Health Officer | • On site risk assessment and IPC measures at the RACF<br>• Issue of Home Surveillance Order (HSO) and Release Order (RO)<br>• Communication between *Bilik Gerakan*, CAC and RACF clinical team<br>• Provide supervisory advice on sanitation and dead body management (if required –refer to Annex 20a) |
| Family Medicine Specialist | • Coordinator for Primary Health Care Clinical team<br>• On site assessment* and clerking (*if required)<br>• Prescribing medications<br>• Communication with *Bilik Gerakan*, CAC, PKD, Geriatrician, Hospital Clinical Team<br>• Update family members about patient's condition<br>• Liaise with BMU for hospital admission (if indicated) |
| Geriatrician | • Coordinator for Hospital Clinical Team<br>• Liaise with BMU for hospital admission (if indicated)<br>• Provide consultation to PKD or Primary Health Care Clinical team regarding management plan of COVID-19<br>• Provide consultation on COVID-19 case with multiple comorbidities/ complications or decision for palliative care<br>• On site assessment* and clerking (*if required) |

| | |
|---|---|
| Palliative Physician | • Coordinator for Hospital Clinical Team (Palliative Care)<br>• Provide consultation to PKD or Primary Health Care Clinical team regarding management plan of COVID-19<br>• Provide consultation on COVID-19 case with multiple comorbidities/ complications or decision for palliative care<br>• Liaise with BMU for hospital admission (if indicated)<br>• On site assessment* and clerking (*if required) |
| Medical Officer | • Monitoring residents and staffs in the RACF<br>• Assist Family Medicine Specialist or Geriatrician or Palliative Care Physician<br>• Documentation of clerking sheet in hard copy or soft copy |
| Paramedics | • Assist in patient care<br>• Assist in transferring residents or staffs to hospital (if needed) |
| Pharmacist (Hospital) (For further details, please refer Appendix 1) | • Preparation of prescribed medication and Dangerous Drugs (DD)<br>• To counsel PIC about medication administration<br>• Assess for drug-drug interaction |
| Pharmacist (Health Clinic) | • Assist Primary Health Care Clinical Team in preparation for PPE and medications required |
| **TEAM A at Inside RACF - Dirty area:** | • Clerking (Appendix 6)<br>• Vital signs<br>• 1-min-Sit to Stand Test (SST) (if indicated)<br>• Perform physical examination<br>• Takes image of clerking sheet and send to Team B |
| **TEAM B: Outside RACF - Clean area:** | • To get collateral history<br>• To document in soft copy |

# FLOW CHART FOR COVID-19 MANAGEMENT AT THE RACF



## CRITERIA FOR COVID-19 MANAGEMENT AT THE RACF

**CRITERIA 1**: *CFS 6 or less + COVID-19 category
(Refer COVID-19 Hospital Admission ANNEX 2)
•Cat 1 and 2a
•Clinically stable

→ Isolation at RACF

**CRITERIA 2**: *CFS 6 or less + COVID-19 category
(Refer COVID-19 Hospital Admission ANNEX 2)

- Any other reason for admission e.g., clinical dehydration, hypotension, tachycardia, uncontrolled medical condition e.g., angina

→ Hospital Admission

**CRITERIA 3**: *CFS 7 or more AND
Advanced care plans not for active resuscitation or **hospitalization

Already in active phase of dying e.g., gasping, poor GCS, mottled skin, hypotension & hypoxia

→ Palliative Care

Note:
The provider will inform the Primary Health Care Clinical team if any resident or staff deteriorates and requires admission as per assessment done. The Primary Health Care Clinical Team will arrange for hospital admission.

* Refer Appendix 9, Clinical Frailty Scale (CFS)

**Decision made after communicating with the caregiver

## ENDING OF ISOLATION PRECAUTION AND RELEASE OF CASE

Refer Annex 2 to those who fulfilled the requirement for Release Order.

## FULL REPORT OF THE OUTBREAK

Will be done by PKD and Primary Health Care Clinical Team coordinator of the RACF affected.

## DEATH IN THE NURSING HOME DURING OUTBREAK:

All deaths due to Covid-19 in the RACF must follow Annex 20a Guidelines (*Pengurusan Kematian COVID-19 di Luar Hospital dan Merentas Negeri)*

## REFERENCES


1. CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia, 15 February 2022, https://www.health.gov.au/resources/publications/cdna-national-guidelines-for-the-prevention-control-and-public-health-management-of-covid-19-outbreaks-in-residential-care-facilities-in-australia

2. Chen, Angela T et al. "Long-Term Care, Residential Facilities, and COVID-19: An Overview of Federal and State Policy Responses." *Journal of the American Medical Directors Association* vol. 21,9 (2020): 1186-1190. doi:10.1016/j.jamda.2020.07.001

3. Comas-Herrera A, Ashcroft E and Lorenz-Dant K. (2020) *International examples of measures to prevent and manage COVID-19 outbreaks in residential care and nursing home settings*. Report in LTCcovid.org, International Long-Term Care Policy Network, CPEC-LSE, 11 May 2020, https://ltccovid.org/2020/05/02/new-report-international-examples-of-measures-to-prevent-and-manage-covid-19-outbreaks-in-residential-care-and-nursing-home-settings/
4. CDC Updates COVID 19 Guidance for Nursing Homes, https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-home-long-term-care.html

5. Guidance on Covid-19 for the care of older people and people living in long-term care facilities, other non-acute care facilities and home care, WHO, https://apps.who.int/iris/handle/10665/331913

6. Covid-19 Outbreak Management. Preparing and responding – Guidance for Residential Aged Care Facilities in Queensland. Queensland Health, https://www.health.qld.gov.au/__data/assets/pdf_file/0025/1004677/racf-covid19-outbreak-management-guidelines.pdf

7. Australian Government Department of Health, Managing A Covid19 Outbreak in Residential Aged Care, https://www.health.gov.au/node/18602/managing-a-covid-19-outbreak-in-residential-aged-care

**APPENDIX 1**

## ROLE AND RESPONSIBILITIES OF PHARMACIST (HOSPITAL CLINICAL TEAM) IN RESIDENTIAL AGED CARE FACILITY (RACF) IN COVID 19 OUTBREAK

### PRE-VISIT:

1. To gather and document patient details, comorbidities, medication profile, CFS, symptoms and PCR status and may document into RACF Patient Medication Profile (Appendix 2) if time permits.
2. To prepare medications to be brought to the RACF:
    a. Medications for symptoms control
    b. Medication for End-of-Life care
    c. Other required for COVID-19 specific medications for individualized person based on comorbidities
3. To prepare suitable and simple documentation according to the legal requirements for dangerous drug (DD)
4. To prepare and bring sufficient RACF Medication Administration Charts (Appendix 3), RACF Medication Schedule (Appendix 4), RACF Stock Movement Checklist (Appendix 5) and clerking sheets (Appendix 6)
5. To prepare convenient and understandable labelled medications envelopes in advance. (*can prepare coloured symbols/pictograms if necessary
6. To prepare non-medical items (e.g., PPE, consumables) Blood Pressure Machine and SPO2 monitoring device and simple stationaries (e.g. scissors, markers) to be brought along
7. If time permits, to do medication history tracing via communication with the RACF manager and other sources (e.g., Health Clinic) prior to the visit
8. Attending Pre-visit MDT meeting for last preparation

### DURING VISIT:

1. Ideally, 2 pharmacists allocated for 25 residences should be present at the site:

<u>Pharmacist A: Attending to the affected patient at dirty area in PPE</u>

1. Items to bring in:
    a. Pen
    b. Pre-filled RACF Medication Administration Chart
    c. Patient List
2. Quick medication history review via interview with resident /PIC or appointment book/card
3. Document other medications taken by patients into RACF Medication Administration Chart

4. Communicate the plans as decided by the attending doctors in Team A to Team B and Pharmacist B
5. To fill in the medication administration chart as per physician's plan and educate the resident/PIC on the use of it
6. Brief and immediate medication counselling on the medications prescribed either to patient /manager
7. Reminder about bringing all documentation and medications if patient is admitted

Pharmacist B: Standby pharmacist at clean area

1. To receive and immediately carry out plans as decided by physicians in Team A (STAT OR CONTINUE supply of medications)
2. To prepare, label, and pack the medications as per the plan.
3. To monitor stock movement during the visit to track the usage of drugs for future visit reference
4. To be able to respond to medication queries by physician in Team A

**POST-VISIT:**

1. To do a post-mortem and prepare a report on the visit and stock movement of medications and potential areas for improvement
2. To complete RACF Medication Review documentation
3. To follow up regularly with the manager about the patient's clinical condition and if any medication needed
4. Follow up visit on PRN basis after discussion with the primary team

## APPENDIX 2

# RACF PATIENT MEDICATION PROFILE / RACF PROFIL UBAT PESAKIT

***MEDICATION REVIEW BY RACF VISITING PHARMACIST***
***Cov19RCAFgpsig/Jul2021***

**MEDICATION REVIEW REPORTING**

**(A) PATIENT INFORMATION & PRESENTATION**

| | | | |
|---|---|---|---|
| **Patient's Name :**<br>**Identification Number (IC) :** | | **Name of Facility:**<br>**Contact Number (Carer/Patient) :** | |
| **DOD COVID PNEUMONIA:** | **Past Medical History :**<br>DM/ HPT/ IHD/ Dyslipidemia/ CKD/ Liver D / Dementia<br>Others:_____ | **Diagnosis:**<br>COVID19 Pneumonia<br>☐Category :<br>☐CFS :<br>☐Palliative date: | **HISTORY OF DRUG ALLERGY/ADVERS DRUG EVENT:** |
| **NG Tube :**<br><br>**Patient under follow up :** | | **COVID-19 Vaccination status**<br>Dose 1 :<br>Dose 2 : | |

**(B) SOURCE OF MEDICATION HISTORY**

☐ Patient Own Medication ☐ PHIS ☐ Interview with Patient /Carer (relationship)_____
☐ Interview CP : ☐ Medication album identification ☐ GP /Others :_____

**(C) MEDICATIONS RECONCILLIATION**

| **PLEASE SPECIFY CLINIC / PRIMARY CARE THAT PRESCRIBED EACH MEDS OR PLEASE STATE IF OTC** | **MEDICATION LIST** *(All medications prior to current review including TCM/over-the counter medications/ supplement/vitamins as well as new medications upon discharge)* | | | **STATUS OF MEDICATIONS UPON REVIEWING**<br>**C** : continue<br>**DC** : discontinue<br>**WH** : withold | **DESCRIBE CHANGES MADE / PLAN** |
|---|---|---|---|---|---|
| | Name and strength | Dose | Frequency | | |
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**Pharmacist (Chop/Sign)**

***MEDICATION REVIEW BY RACF VISITING PHARMACIST***
***Cov19RCAFgpsig/Jul2021***

| **(D) PHARMACEUTICAL CARE ISSUES** | | |
|---|---|---|
| **Mark ✓Issues** | **Describe findings of your issues identified.** | **Personalized Care Plan / Follow up findings** |
| **Symptomatic Tx**<br>☐ Antipyretic<br>☐ Cough Syrup<br>☐ Antihistamine | | |
| **Steroid**<br>☐ Dexamethasone / Prednisolone<br>☐ PPI<br>☐ Vitamin D | | |
| ☐ **Anticoagulation** | | |
| ☐ **Antibiotic** | | |
| **Palliative**<br>☐ Morphine / Fentanyl patch<br>☐ Others | | |

| **(E) MEDICATIONS COUNSELING PROVIDED (√)** | | | |
|---|---|---|---|
| | **Steroid : to complete the course** | | **Fentanyl patch : date to patch and to replace** |
| | **PPI : to take before meal** | | **Proper administration for crushing medication** |
| | **Anticoagulant:** | | **To bring all meds and record on meds if admitted to hospital** |
| | **Morphine : dose titration** | | **Others:** |

| **(F) SUBSEQUENT FOLLOW-UP** | |
|---|---|
| ☐ **Hospital :**<br>Date:<br>☐ **GP / Clinic :**<br>Date:<br>☐ **Pharmacy**<br>Date: | **Follow up Notes :** |

| **1. Pharmacist signature and stamp**<br><br>**Date:** | **2. Pharmacist signature and stamp**<br><br>**Date:** |
|---|---|

**APPENDIX 3**

**RACF MEDICATION ADMINISTRATION CHART /**
**CARTA PEMBERIAN UBAT DI FASILITI**

***RESIDENT* / NAMA RESIDEN :**

***ID* / IDENTITI PENGENALAN :**

***BED or ROOM* / KATIL atau BILIK :**

***NG TUBE or PEG TUBE*/ PENGGUNAAN TIUB PEMAKANAN ENTERAL ATAU PEG: YA / TIDAK**

| ***DATE START*** **Tarikh Mula** | ***MEDICATION*** **Ubat** | ***TIMES*** **Masa Pemberian** | **1** | **2** | **3** | **4** | **5** | **6** | **7** | ***INDICATION/DETAILS*** **Penerangan tujuan dan cara pemberian Ubat** |
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*Reviewed by Doctor* / Doktor: *Pharmacist* / Pegawai farmasi: *Date*/ Tarikh:

## APPENDIX 4

### RACF MY MEDICATION SCHEDULE / JADUAL UBAT SAYA

*NAME* / NAMA :

*ID* / IDENTITI PENGENALAN :

*BED or ROOM* / KATIL atau BILIK :

*NG TUBE or PEG TUBE* / PENGGUNAAN TIUB PEMAKANAN ENTERAL ATAU PEG: YA / TIDAK

| ***Medication Prescribed Upon Review for COVID 19 /***<br>***Drug / Dose / frequency***<br><br>**Ubat yang diberikan oleh doctor bagi rawatan COVID 19**<br>**Nama ubat / Dose / Frekuensi** | ***Mark the dosing regimen accordingly /***<br>**Tandakan dos yang diperlukan mengikut masa pemberian** | | |
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*Reviewed by Doctor* / Doktor: *Pharmacist* / Pegawai farmasi *Date* / Tarikh

## APPENDIX 5

### SENARAI UBAT DAN KONSUMABEL

| Medication | Quantity | Remarks | Visit | Stock Balance |
|---|---|---|---|---|
| ***ORAL*** | | | | |
| Tab Dexamethasone 4mg | 15 x 10's | Prepack [8mg OD X 5 days] | | |
| Tab Pantoprazole 40mg | 10 x 7's | Prepack [40mg OD X 5 days]<br>Sodium Bicarbonate 16.8g x 3 pack<br>Empty Bottle 120ml x 2<br>Instruction on preparation of Syrup pantoprazole for patients on NG TUBE | | |
| Tab Paracetamol 500mg | 20 x 10's | Prepack<br>[ 2 strips – labelled as 1g TDS] | | |
| Tab Prednisolone 5mg | 5 x 10's | | | |
| Tab Loratadine 4mg | 10 x 10's | Prepack<br>[ 1 strip – labelled as 10mg OD] | | |
| Tab Bromhexine 8mg | 10 x 10's | Prepack<br>[2 strips – labelled 8mg TDS] | | |
| Tab Haloperidol 1.5mg | 1 x 30's | For restless and agitated patients | | |
| Tab Risperidone 1mg | 2 x 10's | | | |
| Syrup Benadryl | 10 bottles | Please prescribed short term, alternative Mist Expectorant Ipencuanha | | |
| ORS | 1 box | Prepack [5 each] | | |
| ***DD item*** | | | | |
| Tab Clonazepam 0.5mg | 10 x 10's | | | |
| Fentanyl Patch 25mcg / day | 2x 5's | For patients who are palliated with RR>25<br>Use lowest dose of 12.5mcg/hour | | |
| Syrup Morphine 10mg / 5 ml | 2 x 120mls | Empty bottle -30ml x 5<br>To supply in small quantity<br>Syrup Morphine labels | | |
| ***Injection*** | | | | |
| IV Bromhexine 4ml/ml | 2 x 10's | | | |
| IV Esomeprazole 40mg | 5 | If there is IV<br>Pantoprazole shortage | | |
| SC Enoxaparin 40mg | 6's | Can increase as prescribed by physician | | |

| | Quantity | Remarks | Visit | Stock Balance |
|---|---|---|---|---|
| ***PPE*** | | | | |
| Surgical Mask | 10 | | | |
| KN95 / N95 | 5 s | | | |
| Full PPE | 5 set | Hood, N95, Apron, Gloves, Face shield, Shoe cover, Isolation Gown | | |
| Face Shield | 5 | | | |
| Gloves | 1 box | | | |

| | Quantity | Remarks | Visit | Stock Balance |
|---|---|---|---|---|
| Plastic Apron | 10 | | | |
| Hand Sanitizer 70% | 1 | | | |
| Yellow Plastic for disposable items | 5 | | | |

| ***CONSUMABLE ITEM*** | | | | |
|---|---|---|---|---|
| Alcohol swab | 20 pieces | | | |
| IV Drip NaCl 0.9% | 5 | | | |
| IV Cannula 20G (Pink) | 5 | | | |
| IV infusion line set | 5 | | | |
| Syringe 10 ml | 5 | | | |
| Syringe 3 ml | 10 | | | |
| Syringe needle | 5 | | | |
| Micropore | 1 | For administration Syr Morphine | | |
| Tegaderm | 1 pack | | | |

| ***Others*** | | | | |
|---|---|---|---|---|
| BP Machine | 1 | | | |
| $SPO^2$ Monitoring Device | 1 | | | |
| Scissor | 1 | | | |
| Marker Pen | 1 | | | |
| Pen | 5 | | | |
| Medication's envelope | As per required | | | |
| Envelope according to dosing regime | 10 set | | | |
| Tablet / syrup medication labels | As per needed | | | |
| COVID-19 RACF clerking sheets | 30 | | | |
| COVID-19 RACF Observation forms | 30 | | | |
| COVID-19 RACF Medication Administration Chart | 30 | | | |
| COVID-19 Medication Schedule Chart | 20 | | | |
| Memo | 10 | | | |

**APPENDIX 6**

# COVID-19 RESIDENTIAL AGED CARE FACILITY CLERKING SHEET

**NAME OF FACILITY :**
**NAME OF RESIDENT :**
**IC / PASSPORT :**
**DATE :**

| | |
|---|---|
| **PAST MEDICAL HISTORY** | |
| **MEDICATIONS** | |
| **CFS SCORE** | |
| **SYMPTOMS** | |
| **EXAMINATION** | |
| **VITALS** | TEMPERATURE:<br>HR: RR:<br>BP: SPO2: |
| **INVESTIGATION RESULTS:** | |
| **MANAGEMENT** | |
| **IF PALLIATION, INFORMED** | ○ NURSING HOME PROPRIETER<br>○ FAMILY |
| **SIGNATURE** | |

**APPENDIX 7A (VERSI MELAYU)**

# COVID-19 RESIDENTIAL AGED CARE FACILITY DAILY MONITORING

**NAMA FASILITI :**
**NAMA PENGHUNI :**
**KAD PENGENALAN / PASSPORT :**

| | | | |
|---|---|---|---|
| HARI | HARI | HARI | HARI |
| TARIKH | TARIKH | TARIKH | TARIKH |
| SIMPTOM<br>○ DEMAM<br>○ BATUK<br>○ SUSAH NAFAS<br>○ LESU<br>○ CIRIT<br>○ MUNTAH<br>○ LAIN-LAIN | SIMPTOM<br>○ DEMAM<br>○ BATUK<br>○ SUSAH NAFAS<br>○ LESU<br>○ CIRIT<br>○ MUNTAH<br>○ LAIN-LAIN | SIMPTOM<br>○ DEMAM<br>○ BATUK<br>○ SUSAH NAFAS<br>○ LESU<br>○ CIRIT<br>○ MUNTAH<br>○ LAIN-LAIN | SIMPTOM<br>○ DEMAM<br>○ BATUK<br>○ SUSAH NAFAS<br>○ LESU<br>○ CIRIT<br>○ MUNTAH<br>○ LAIN-LAIN |
| PEMAKANAN<br>(APA YANG DIMAKAN?) | PEMAKANAN<br>(APA YANG DIMAKAN?) | PEMAKANAN<br>(APA YANG DIMAKAN?) | PEMAKANAN<br>(APA YANG DIMAKAN?) |
| MINUM<br>(APA YANG DIMINUM?) | MINUM<br>(APA YANG DIMINUM?) | MINUM<br>(APA YANG DIMINUM?) | MINUM<br>(APA YANG DIMINUM?) |
| SUHU BADAN | SUHU BADAN | SUHU BADAN | SUHU BADAN |
| NADI | NADI | NADI | NADI |
| TEKANAN DARAH | TEKANAN DARAH | TEKANAN DARAH | TEKANAN DARAH |
| PERNAFASAN/MINIT | PERNAFASAN/MINIT | PERNAFASAN/MINIT | PERNAFASAN/MINIT |
| TAHAP OKSIGEN | TAHAP OKSIGEN | TAHAP OKSIGEN | TAHAP OKSIGEN |
| KELIRU<br>○ YA<br>○ TIDAK | KELIRU<br>○ YA<br>○ TIDAK | KELIRU<br>○ YA<br>○ TIDAK | KELIRU<br>○ YA<br>○ TIDAK |
| KOMEN LAIN | KOMEN LAIN | KOMEN LAIN | KOMEN LAIN |

**APPENDIX 7B (ENGLISH VERSION)**

# COVID-19 RESIDENTIAL AGED CARE FACILITY DAILY MONITORING

**NAME OF FACILITY :**
**NAME OF RESIDENT :**
**IC / PASSPORT :**

| | | | |
|---|---|---|---|
| DAY | DAY | DAY | DAY |
| DATE | DATE | DATE | DATE |
| SYMPTOM<br>○ FEVER<br>○ COUGH<br>○ SHORT OF BREATH<br>○ DIARRHOEA<br>○ VOMITING<br>○ OTHERS | SYMPTOM<br>○ FEVER<br>○ COUGH<br>○ SHORT OF BREATH<br>○ DIARRHOEA<br>○ VOMITING<br>○ OTHERS | SYMPTOM<br>○ FEVER<br>○ COUGH<br>○ SHORT OF BREATH<br>○ DIARRHOEA<br>○ VOMITING<br>○ OTHERS | SYMPTOM<br>○ FEVER<br>○ COUGH<br>○ SHORT OF BREATH<br>○ DIARRHOEA<br>○ VOMITING<br>○ OTHERS |
| DIET & APPETITE<br>(WHAT IS EATEN?) | DIET & APPETITE<br>(WHAT IS EATEN?) | DIET & APPETITE<br>(WHAT IS EATEN?) | DIET & APPETITE<br>(WHAT IS EATEN?) |
| HYDRATION<br>(WHAT WAS DRANK?) | HYDRATION<br>(WHAT WAS DRANK?) | HYDRATION<br>(WHAT WAS DRANK?) | HYDRATION<br>(WHAT WAS DRANK?) |
| TEMPERATURE | TEMPERATURE | TEMPERATURE | TEMPERATURE |
| HEART RATE | HEART RATE | HEART RATE | HEART RATE |
| BLOOD PRESSURE | BLOOD PRESSURE | BLOOD PRESSURE | BLOOD PRESSURE |
| RESPIRATORY RATE | RESPIRATORY RATE | RESPIRATORY RATE | RESPIRATORY RATE |
| OXYGEN LEVEL | OXYGEN LEVEL | OXYGEN LEVEL | OXYGEN LEVEL |
| ALERT<br>○ YES<br>○ NO | ALERT<br>○ YES<br>○ NO | ALERT<br>○ YES<br>○ NO | ALERT<br>○ YES<br>○ NO |
| OTHER COMMENTS | OTHER COMMENTS | OTHER COMMENTS | OTHER COMMENTS |

## APPENDIX 8

### Palliative Care Management for Criteria 3 patients undergoing RACF based care

### Roles and responsibility of clinician/ palliative medicine specialist and geriatrician

1. To assess and anticipate problems that may be encountered by patient during RACF based care.
2. To prescribe appropriate medications in the appropriate route to control symptoms and also PRN medication in anticipation of escalating symptoms or crisis.
3. To provide necessary advice to Person-in-Charge (PIC) to handle problems and support the PIC to care for patients at RACF
4. To visit RACF to review patient as needed or scheduled.

### Roles and responsibility of Person-in-Charge (PIC) of patients undergoing RACF based palliative care

1. To monitor patients on a daily basis and also whenever necessary if patient becomes distressed.
2. To follow instructions / give medications regularly as prescribed by the clinician/ palliative medicine specialist.
3. To provide PRN medications when patients have worsening of symptoms
4. To contact clinician / palliative medicine specialist if unable to manage worsening symptoms.
5. To document monitoring and administration of medications for patients. Also to document calls to clinician and advice provided.

## Clinical Frailty Scale*

**1 Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

**2 Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

**3 Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

**4 Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

**5 Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

**6 Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

**7 Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

**8 Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

**9. Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

**Scoring frailty in people with dementia**

The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.



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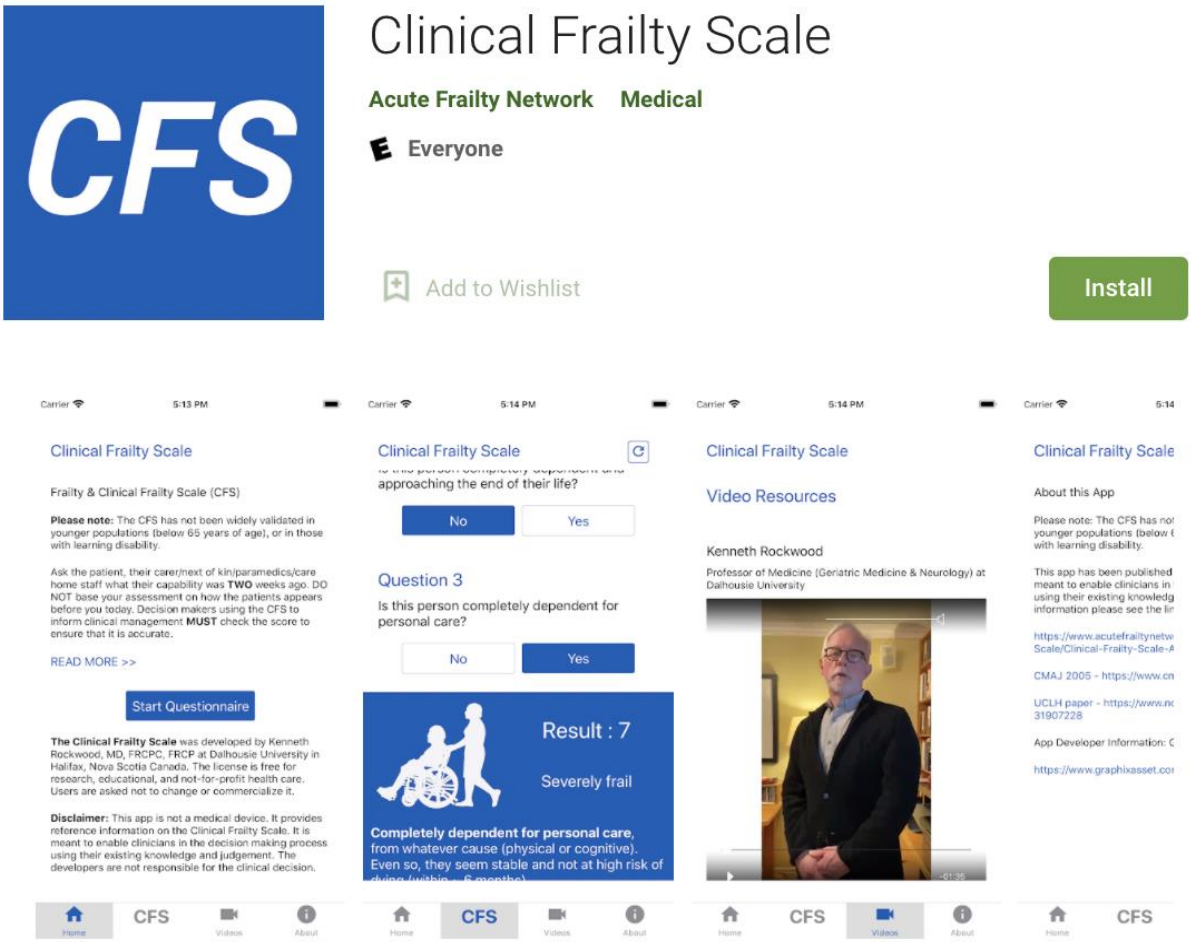


CFS (Clinical Frailty Scale) has been created to help health care professionals quickly identify frailty in people over the age of 65, it is a reliable predictor of outcomes in the urgent care context and is a useful decision support tool.