

20. Caring for older people with COVID-19

Older age has been reported as a risk factor for increased mortality in those affected by COVID-19. Other risk factors that have been reported are: smoking, diabetes, hypertension, cerebrovascular disease, cancer and chronic lung disease. Since older people are often affected by these conditions as well, they are potentially at the highest risk for fatality. Those with frailty are one of the most vulnerable populations. Refer to the WHO guidance *Integrated care for older people (ICOPE)* ([197](#)) for person-centred and coordinated model of care.

- ✔ **We recommend that older people be screened for COVID-19 at the first point of access to the health system, be recognized promptly if they are suspected to have COVID-19 and treated appropriately according to established COVID-19 care pathways. This should occur in all settings where older people may seek care; included but not limited to facility-based emergency units, primary care, prehospital care settings and LTCFs.**

Remark:

Older patients may present with atypical symptoms (including delirium) of COVID-19 (see Table 1); health workers should take this into account during the screening process.

- ✔ **Identify if there is an advance care plan for patients with COVID-19 (such as desires for intensive care support) and respect their priorities and preferences. Tailor the care plan to be in line with patients' expressed wishes and provide the best care irrespective of treatment choice.**
- ✔ **We recommend a review of medication prescriptions to reduce polypharmacy and prevent medicine interactions and adverse events for those being treated with COVID-19.**

Remarks:

1. Older people are at greater risk of polypharmacy, as a result of newly prescribed medications, inadequate medication reconciliation, and a lack of coordination of care, all of which increases the risk of negative health consequences. If medications are prescribed for mental and neurological manifestations of COVID-19 in older adults, this should be done with extreme caution given the increased susceptibility to drug side-effects and drug interactions with other prescribed medications.
2. Over 20% of adults over 60 years have pre-existing mental or neurological conditions for which they may already be taking medications before infection ([198](#)). If a person has a previously diagnosed mental or neurological condition and is already on medications, consider how these medications (or withdrawal from them) may affect their COVID-19 symptoms. Stopping or adjusting the dosage of medications in people with COVID-19 are decisions that require careful risk-benefit analyses and when possible, consultation with a specialist is advised.

- ✓ **Ensure multidisciplinary collaboration among community workers, physicians, nurses, pharmacists, physiotherapists, occupational therapists, social workers, mental health and psychosocial providers and other health care professionals in the decision-making process to address multimorbidity and functional decline (197).**

Remarks:

1. Physiological changes with age lead to declines in intrinsic capacity such as malnutrition, cognitive decline, depressive symptoms, and those conditions interact at several levels. These interactions require an integrated approach to the screening, assessment and management of older people (197).
2. Hearing and vision impairments become more prevalent among older adults and may pose a communication barrier, especially when masks prevent lip reading and decrease vocal clarity. Cognitive decline may also need to be considered when communicating with older patients. Such impairments should be identified early so that health workers involved in their care can adjust their communication accordingly (199).
3. Older people who experience COVID-19, including those admitted to ICU and/or treated with protracted oxygen therapy and bed rest, are more likely to experience pronounced functional decline and require coordinated rehabilitation care after acute hospitalization (see Chapter 17: Rehabilitation for patients with COVID-19).
4. Ensure that chronic infections are diagnosed and treated appropriately in older people. Other infections such as TB may mimic or co-exist with COVID-19 and therefore pass unrecognized, causing increased mortality (38, 39, 41).

21. Palliative care and COVID-19

Palliative care is a multifaceted, integrated approach to improving the quality of life of adults and paediatric patients and their families facing the problems associated with life-threatening illness such as COVID-19. Palliative care focuses on prevention and relief of suffering by means of early identification, assessment and treatment of physical, psychosocial and spiritual stressors. Palliative care includes but is not limited to end-of-life care (200). Palliative interventions should be integrated with curative treatment (200). Basic palliative care, including relief of dyspnoea or other symptoms and social support, should be practised by all doctors, nurses, social workers and others caring for persons affected by COVID-19 (200, 201). Refer to the WHO guide *Integrating palliative care and symptom relief into responses to humanitarian emergencies and crises* (200).

- ✓ **We recommend to identify, in all patients with COVID-19, if they have an advance care plan for COVID-19 (such as desires for intensive care support) and respect their priorities and preferences to tailor the care plan and provide the best care irrespective of treatment choice.**
- ✓ **Palliative care interventions should be made accessible at each institution that provides care for persons with COVID-19.**

Remarks:

1. All interventions described in Appendix 3 should be accessible at each institution that provides care for persons with COVID-19. Efforts should be made to assure accessibility of interventions at home (200).
2. Palliative care includes but is not limited to end-of-life care. Palliative interventions should be integrated with curative treatment. Basic palliative care, including relief of dyspnoea or other symptoms and social support, should be practised by all doctors, nurses, social workers and others caring for persons affected by COVID-19.
3. In hospitals, palliative care does not require a separate ward or department. Palliative care can be provided in any setting.
4. Consider opioids and other pharmacologic and non-pharmacologic interventions for relief of dyspnoea that is refractory to treatment of the underlying cause and/or as part of end-of-life care (202). The narrow therapeutic margin of opioids in the management of dyspnoea requires that opioids are prescribed in accordance with evidence-based treatment protocols and that patients are closely monitored to prevent negative unintended effects due to inappropriate use of opioids. Providers should reference their institutional standards regarding the potential use of opioids for dyspnoea in patients with COVID-19.

22. Ethical principles for optimum care during the COVID-19 pandemic

Ethics are central to the clinical care of COVID-19 patients in the same way that ethics pertains to all patients. Clinical care involves using clinical expertise to do what is best for patients within a relationship of care. This section provides a brief introduction to some of the ethical considerations that are important to remember in the context of COVID-19 (203, 204).

Ethical considerations that affect all persons affected by COVID-19

Equal moral respect: Every person is equally valuable. Treatment and care decisions should be based on medical need and not on irrelevant or discriminatory features such as **ethnicity, religion, sex, age, disability or political affiliation**. Patients with similar health problems or symptoms must receive equal treatment and care. Showing moral respect means involving patients and their caregivers in decision-making to the greatest extent possible, explaining options and limitations in treatment.

Duty of care: Every patient is owed the best possible care and treatment available in the circumstances. Even when resources need to be rationed during a crisis, health care professionals and frontline workers have a duty of care to promote their patients' welfare within available resources. Health care professionals and frontline workers are also owed a duty of care. In this regard, appropriate PPE for health care professionals and frontline workers should be provided to promote their safety and well-being. This is a benefit to them but also to the whole of society by ensuring that they are available to support the clinical response for as long as possible.

Non-abandonment: It follows from consideration of equal moral respect and duty of care, that no person in need of medical care should ever be neglected or abandoned. Care will

extend to families and friends of patients and options to maintain communication with them should be explored. Palliative care must be accessible for all patients with respiratory failure for whom ventilatory support will be withheld or withdrawn.

Protection of the community: Appropriate IPC should be in place, respected and enforced. Such actions protect patients, health care professionals and the community. During a pandemic the focus should be on both clinical care for patients and the promotion of public health.

Confidentiality: All communications between patient and clinician must remain confidential except in the case of compelling public health concerns (e.g. contact tracing and surveillance etc.) or other accepted justifications for breach of confidentiality. Private individual information must be kept secure unless it is a justified breach.

- ✔ **We recommend that hospitals and health systems at local, regional, national and global level plan prepare and be ready to surge clinical care capacity (staff, structure, supplies and systems) in order to be able to provide appropriate care of all COVID-19 patients and maintain essential health services (33, 205).**
- ✔ **Allocation of scarce resources: We recommend that each institution should establish a plan for what to do in situations of resource scarcity to cover the allocation or access to critical medical interventions (such as oxygen, intensive care beds and/or ventilators). Such a plan should establish a clear overall aim.**
- ✔ **Decision-making regarding allocation: Part of planning for scarcity is ensuring that a fair system of decision-making for allocation is in place.**

Remarks:

1. Personnel familiar with the medical triage criteria and allocation protocols, who are distinct from the clinical treating team are one option. Allocation decisions should be done according to the established plan and regularly reviewed. If necessary, there should be a reallocation of a resource that was previously allocated where it is not proving beneficial.
2. For example, the aim might be to ensure the best possible use of limited resources based upon chosen medical criteria. Triage criteria should seek to balance medical utility and equity, and ease of implementation. The same criteria should be applied for all patients with similar levels of need, regardless of COVID-19 status.

- ✔ **We recommend that it be clear when decision-making will move from routine allocation to pandemic allocation, so that institutions do not move too soon to restrict access in anticipation of possible future scarcity that might not arise.**

Remarks:

1. It should be clear what the “tipping point” is to change to pandemic allocation (e.g. a declaration by a ministry of health, or hospitals reaching ICU bed and ventilator capacity). This should take into account maximizing surge clinical capacity.
2. Whatever method is chosen should be subject to a fair process, such as using the following procedural principles:

- **Inclusiveness:** Input should be obtained from the most affected population(s).
- **Transparency:** The mechanism should be easily accessible and understandable at an elementary school level and in all major languages in the institution's catchment area.
- **Accountability:** A mechanism should be available to review the application of an approved triage protocol, or requests to review a particular decision, in light of novel or updated clinical information or other concerns.
- **Consistency:** Allocation principles should be applied consistently.



We recommend that caregivers should be:

- **Given access to adequate training in caregiving, including IPC.**
- **Given access to appropriate and adequate PPE.**
- **Exempted from travel restrictions that would preclude caring for the patient.**
- **Be given access to psychological, social and spiritual care, and also to respite and bereavement support as needed.**

Remark:

Caregivers are at risk for the same types of psychological, social and spiritual distress as patients. They are also at risk for becoming infected. Basic mental health and psychosocial support should be provided for all caregivers by asking them about their needs and concerns, and addressing them (206).

23. Reporting of death during the COVID-19 pandemic



We recommend the use of emergency ICD codes as outlined in the *International guidance for certification and coding of COVID-19 as cause of death* (208). As there are six types of coronaviruses, we recommended not to use “coronavirus” in place of COVID-19.

Remarks:

1. The primary goal is to identify all deaths due to COVID-19. A death due to COVID-19 is defined for surveillance purposes as a death resulting from a clinically compatible illness, in a probable or confirmed COVID-19 case, unless there is a clear alternative cause of death that cannot be related to COVID-19 disease (e.g. trauma). There should be no period of complete recovery from COVID-19 between illness and death. A death due to COVID-19 may not be attributed to another disease (e.g. cancer) and should be counted independently of pre-existing conditions that are suspected of triggering a severe course of COVID-19.
2. Specification of the causal sequence leading to death in Part 1 of the certificate is important. For example, in cases when COVID-19 causes pneumonia, sepsis and acute respiratory distress; then pneumonia, sepsis and acute respiratory distress should be included, along with COVID-19, in Part 1. Certifiers should include as much detail as possible based on their knowledge of the case, from medical records, or about laboratory testing (207).