Evidence Search Service
Results of your search request

Risk from Covid-19 for people working in the domiciliary care provision

ID of request: 24745
Date of request: 14th August, 2020
Date of completion: 28th August, 2020

If you would like to request any articles or any further help, please contact: Isatou N'jie at Isatou.N'Jie@nelft.nhs.uk

Please acknowledge this work in any resulting paper or presentation as: Evidence search: Risk from Covid-19 for people working in the domiciliary care provision. Isatou N'jie. (28th August, 2020). ILFORD, UK: Aubrey Keep Library and Knowledge Service.

Sources searched
(0)
BMJ (1)
Care Quality Commission (CQC) (2)
Department of Health and Social Care (DHSC) (2)
EMBASE (13)
Faculty of Occupational Medicine (FOM) (1)
Health Protection Scotland (HPS) (1)
MEDLINE (21)
National Institute for Health and Care Excellence (NICE) (1)
Regulation and Quality Improvement Authority (1)
Runnymede Trust (1)
Skills for Care (3)
The Health Foundation (2)
Thurrock Clinical Commissioning Group (CCG) (1)
UK Government (4)

Date range used (5 years, 10 years): 2015-2020
Limits used (gender, article/study type, etc.): English, Adults
Search terms and notes (full search strategy for database searches below):

The search strategy can be found at the end of the report.

For more information about the resources please go to: http://www.nelft.nhs.uk/library .

Summary of Results

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A thorough search was conducted on high-level evidence sources including NICE HDAS, UK Government websites and other grey literature sources. The search did not find any specific data on domiciliary worker ethnicity in Thurrock and found few resources on using AGPs in home care. I have included relevant articles and guidance on the topic which you may find useful. Here are key titles you may want to first look at:

- Coronavirus (COVID-19): provision of home care https://www.gov.uk/government/publications/coronavirus-covid-19-providing-home-care/coronavirus-covid-19-provision-of-home-care

- COVID-19: adult social care risk reduction framework https://www.gov.uk/government/publications/coronavirus-covid-19-reducing-risk-in-adult-social-care/covid-19-adult-social-care-risk-reduction-framework

- COVID-19 prevalence survey: domiciliary care staff in England https://www.gov.uk/government/publications/covid-19-prevalence-survey-domiciliary-care-staff-in-england

- A summary of the adult social care sector and workforce in Thurrock 2018/19 https://www.skillsforcare.org.uk/adult-social-care-workforce-data/Workforce-intelligence/documents/Local-authority-area-summary-reports/Eastern/Thurrock-Summary.pdf

Contents

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The state of health care and adult social care in England 2018/19

Department of Health and Social Care (DHSC)
COVID-19: Our Action Plan for Adult Social Care (V 1.0)

Faculty of Occupational Medicine (FOM)
Risk Reduction Framework for NHS Staff at risk of COVID-19 infection

Runnymede Trust
Over-Exposed and Under-Protected: The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain.

Skills for Care
The size and structure of the adult social care sector and workforce in England
Workforce intelligence summary: domiciliary care services in the adult social care sector 2018/2019.
A summary of the adult social care sector and workforce in Thurrock 2018/19.

The Health Foundation
The adult social care workforce in London
Adult social care and COVID-19: Assessing the impact on social care users and staff in England so far

Thurrock Clinical Commissioning Group (CCG)
Coronavirus (COVID-19)

UK Government
COVID-19 prevalence survey: domiciliary care staff in England

C. Original Research

1. Case for continuing community NIV and CPAP during the COVID-19 epidemic
2. Coronavirus Disease Pandemic (COVID-19): Challenges and a Global Perspective.
3. COVID-19 Preparedness in US Home Health Care Agencies
4. Covid-19: excess all cause mortality in domiciliary care
5. Expanding frontiers of risk management: care safety in nursing home during COVID-19 pandemic.
6. Experiences of Home Health Care Workers in New York City during the Coronavirus Disease 2019 Pandemic: A Qualitative Analysis
7. Fabry disease during the COVID-19 pandemic. Why and how treatment should be continued.
8. Health and Economic Outcomes of Home Maintenance Allergen Immunotherapy in Select Patients with High Health Literacy during the COVID-19 Pandemic: A Cost-Effectiveness Analysis During Exceptional Times
9. Home Care for Cancer Patients During COVID-19 Pandemic: The Double Triage Protocol
10. Home medical nutrition during SARS-CoV-2 pandemic - A position paper.
11. Home monitoring for COVID-19
12. Home-based Testing for SARS-CoV-2: Leveraging Prehospital Resources for Vulnerable Populations.
13. Impact of home quarantine on physical activity among older adults living at home during the COVID-19 pandemic: Qualitative interview study

14. Intergenerational Relationships, Family Caregiving Policy, and COVID-19 in the United States
15. Keeping people with epilepsy safe during the COVID-19 pandemic.
16. Management of Aerosol during Noninvasive Ventilation for Patients with Sleep-Disordered Breathing: Important Messages during the COVID-19 Pandemic.
17. Management Strategies for People Experiencing Sheltered Homelessness during the COVID-19 Pandemic: Clinical Outcomes and Costs.
18. Non-hospitalized Adults with COVID-19 Differ Noticeably from Hospitalized Adults in Their Demographic, Clinical, and Social Characteristics
19. Pulse Oximetry for Monitoring Patients with COVID-19 at Home: Potential Pitfalls and Practical Guidance.
20. Report of five nurses infected with severe acute respiratory syndrome coronavirus 2 during patient care: case series.
21. Review of Burden, Clinical Definitions, and Management of COVID-19 Cases.
22. The effect of social distance measures on COVID-19 epidemics in Europe: an interrupted time series analysis.
23. The Hydra-Headed Coronaviruses: Implications of COVID-19 for Homeopathy
24. The impact of the COVID-19 pandemic on the emotional well-being and home treatment of Belgian patients with cystic fibrosis, including transplanted patients and paediatric patients
25. The invisible workforce during the COVID-19 pandemic: Family carers at the frontline.
26. Transmission and risk factors of OF COVID-19.
27. Treating Hematologic Malignancies During a Pandemic: Utilizing Telehealth and Digital Technology to Optimize Care.
28. Urgent need for individual mobile phone and institutional reporting of at home, hospitalized, and intensive care unit cases of SARS-CoV-2 (COVID-19) infection.
29. Using Telemedicine and Infographics for Physician-Guided Home Drain Removal.
30. Video calls for reducing social isolation and loneliness in older people: A rapid review
31. Vitamin D can be effective on the prevention of COVID-19 complications: A narrative review on molecular aspects
32. [COVID-19: care at home or in hospital? Considerations in primary care].
33. [Ethical approach to the issue of confinement of the elderly in the context of the COVID-19 pandemic: Prevention of frailty versus risk of vulnerability].
34. [HOME CARE AND COVID-19. BEFORE, IN AND AFTER THE STATE OF ALARM].
35. [The CoViD-19 epidemic is posing entirely new problems for home cancer care services.]

D. Search History

A. National and International Guidance

Department of Health and Social Care (DHSC)

Coronavirus (COVID-19): provision of home care (2020)

Available online at this link

The guidance below has been informed by discussions with provider representative groups and many of the webinars that have been held to provide support to organisations working in health and social care during the coronavirus response. It will be reviewed and updated as further feedback is received and as the government and other agencies continue to refresh guidance.

Health Protection Scotland (HPS)

COVID-19 - guidance for domiciliary care (Version 1.41) (2020)

Available online at this link

This guidance is to support those working in domiciliary care settings to give advice to their staff and users of their services about COVID-19. This includes registered providers, social care staff, local authorities and care staff who support and deliver care to people in their own homes (including supported living settings).

National Institute for Health and Care Excellence (NICE)

Home care: delivering personal care and practical support to older people living in their own homes: NICE guideline [NG21] (2015)

Available online at this link

his guideline covers the planning and delivery of person-centred care for older people living in their own homes (known as home care or domiciliary care). It aims to promote older people's independence and to ensure safe and consistently high quality home care services.

Regulation and Quality Improvement Authority

RQIA Provider Guidance 2019-20 Domiciliary Care Agencies (Northern Ireland) (2020)

Available online at this link

Available online at this link

The Regulation and Quality Improvement Authority (RQIA) is the independent body that regulates and inspects the quality and availability of Northern Ireland's health and social care (HSC) services.

UK Government

COVID-19: how to work safely in domiciliary care in England (2020)

Available online at this link

A resource for those working in domiciliary care providing information on the use of personal protective equipment (PPE).

COVID-19: personal protective equipment use for aerosol generating procedures (2020)

Available online at this link

Guidance on the use of personal protective equipment (PPE) for aerosol generating procedures (AGPs).

Coronavirus (COVID-19): provision of home care (2020)

Available online at this link

The document brings together guidance for social care staff, registered providers, local authorities and commissioners who support and deliver care to people in their own homes in England.

B. Institutional Publications

Care Quality Commission (CQC)

COVID-19 Insight Report: state of care: focus on adult and social care (2020)

Available online at this link

Available online at this link

The data used in this document are a combination of CQC data and publicly available data from Office for National Statistics and Public Health England. (includes data on ethnicity)

The state of health care and adult social care in England 2018/19 (2019)

Available online at this link

Available online at this link

Annual assessment of health care and social care in England. The report looks at the trends, shares examples of good and outstanding care, and highlights where care needs to improve. (section on workforce inequality and data)

Department of Health and Social Care (DHSC)

COVID-19: Our Action Plan for Adult Social Care (V 1.0) (2020)

Available online at this link

This action plan sets out our approach for all settings and contexts in which people receive adult social care. This includes people's own homes, residential care homes and nursing homes, and other community settings – it applies to people with direct payments and personal budgets, and those who fund their own care. It supports the response services for the people who rely on technology-enabled care and monitoring services. Our action plan will support care providers, the care workforce, unpaid carers, local authorities and the NHS in their ongoing hard work to maintain services and continue to provide high quality and safe social care to people throughout the pandemic.

Faculty of Occupational Medicine (FOM)

Risk Reduction Framework for NHS Staff at risk of COVID-19 infection (2020)

Available online at this link

Runnymede Trust

Over-Exposed and Under-Protected: The Devastating Impact of COVID-19 on Black and Minority Ethnic Communities in Great Britain. (2020)

Available online at this link

Available online at this link

The survey, (conducted by the Runnymede Trust and ICM in June 2020), illuminates why BME groups are at greater risk from Covid-19: they are more likely to be working outside their home, more likely to be using public transport, more likely to be working in key worker roles, less likely to be protected with PPE and more likely to live in multigenerational, overcrowded housing, so much less able to self-isolate and shield.

Skills for Care

The size and structure of the adult social care sector and workforce in England (2020)

Available online at this link

This report provides the most up-to-date and comprehensive overview of the size and structure of the adult social care sector and workforce in England.

Workforce intelligence summary: domiciliary care services in the adult social care sector 2018/2019. (2019)

Available online at this link

This report provides a summary of the adult social care workforce within domiciliary care services and includes Skills for Care's workforce estimates. Across England there were 9,400 domiciliary care services registered with CQC as at September 2018. These care providing locations had an estimated workforce of 520,000. Around 505,000 of these roles were within the independent sector, with 19,000 in local authorities.

A summary of the adult social care sector and workforce in Thurrock 2018/19. (2019)

Available online at this link

The information within this summary has been produced by Skills for Care using the National Minimum Data Set for Social Care (NMDS-SC).

The Health Foundation

The adult social care workforce in London (2020)

Available online at this link

Greater diversity and heavy reliance on zero-hours contracts and domiciliary care differentiate the capital's care workforce.

Adult social care and COVID-19: Assessing the impact on social care users and staff in England so far (2020)

Available online at this link

Our analysis on the scale of the impact of COVID-19 on social care in England during the first phase of the pandemic

Thurrock Clinical Commissioning Group (CCG)

Coronavirus (COVID-19) (2020)

Available online at this link

This page has information on the coronavirus outbreak and links to some of most important websites for keeping informed.

UK Government

COVID-19 prevalence survey: domiciliary care staff in England (2020)

Available online at this link

This pilot study provides the first estimate of the extent of COVID-19 infections among domiciliary care workers in England.

C. Original Research

1. **Case for continuing community NIV and CPAP during the COVID-19 epidemic**
   Baker J.G. Thorax 2020;75(5):368.

   Available online at this link

   Available online at this link

   Available online at this link

2. **Coronavirus Disease Pandemic (COVID-19): Challenges and a Global Perspective.**
   Malik Yashpal Singh Pathogens (Basel, Switzerland) 2020;9(7):No page numbers.

   The technology-driven world of the 21st century is currently confronted with a major threat to humankind, represented by the coronavirus disease (COVID-19) pandemic, caused by the severe acute respiratory syndrome, coronavirus-2 (SARS-CoV-2). As of now, COVID-19 has affected more than 6 million confirmed cases and took 0.39 million human lives. SARS-CoV-2 spreads much faster than its two ancestors, SARS-CoV and Middle East respiratory syndrome-CoV (MERS-CoV), but has low fatality rates. Our analyses speculate that the efficient replication and transmission of SARS-CoV-2 might be due to the high-density basic amino acid residues, preferably positioned in close proximity at both the furin-like cleavage sites (S1/S2 and S2') within the spike protein. Given the high genomic similarities of SARS-CoV-2 to bat SARS-like CoVs, it is likely that bats serve as a reservoir host for its progenitor. Women and children are less susceptible to SARS-CoV-2 infection, while the elderly and people with comorbidities are more prone to serious clinical outcomes, which may be associated with acute respiratory distress syndrome (ARDS) and cytokine storm. The cohesive approach amongst researchers across the globe has delivered high-end viral diagnostics. However, home-based point-of-care diagnostics are still under development, which may prove transformative in current COVID-19 pandemic containment. Similarly, vaccines and therapeutics against COVID-19 are currently in the pipeline for clinical trials. In this review, we discuss the noteworthy advancements, focusing on the etiological viral agent, comparative genomic analysis, population susceptibility, disease epidemiology and diagnosis, animal reservoirs, laboratory animal models, disease transmission, therapeutics, vaccine challenges, and disease mitigation measures.

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3. **COVID-19 Preparedness in US Home Health Care Agencies**
Shang J. Journal of the American Medical Directors Association 2020;21(7):924-927.

Objectives: In the United States, home health agencies (HHAs) provide essential services for patients recovering from post-acute care and older adults who are aging in place. During the COVID-19 pandemic, HHAs may face additional challenges caring for these vulnerable patients. Our objective was to explore COVID-19 preparedness of US HHAs and compare results by urban/rural location.
Design(s): Cross-sectional study. Setting/Participants: Using a stratified random sample of 978 HHAs, we conducted a 22-item online survey from April 10 to 17, 2020.
Method(s): Summary statistics were computed; open-ended narrative responses were synthesized using qualitative methods.
Result(s): Similar to national data, most responding HHAs (n = 121, 12% response rate) were for-profit and located in the South. Most HHAs had infectious disease outbreaks included in their emergency preparedness plan (76%), a staff member in charge of outbreak/disaster preparedness (84%), and had provided their staff with COVID-19 education and training (97%). More urban HHAs had cared for confirmed and recovered COVID-19 patients than rural HHAs, but urban HHAs had less capacity to test for COVID-19 than rural HHAs (9% vs 21%). Most (69%) experienced patient census declines and had a current and/or anticipated supply shortage. Rural agencies were affected less than urban agencies. HHAs have already rationed (69%) or implemented extended use (55%) or limited reuse (61%) of personal protective equipment (PPE). Many HHAs reported accessing supplemental PPE from state/local resources, donations, and do-it-yourself efforts; more rural HHAs had accessed these additional resources compared with urban HHAs. Conclusions/Implications: This survey reveals challenges that HHAs are having in responding to the COVID-19 pandemic, particularly among urban agencies. Of greatest concern are the declines in patient census, which drastically affect agency revenue, and the shortages of PPE and disinfectants. Without proper protection, HHA clinicians are at risk of self-exposure and viral transmission to patients and vulnerable family members.
Copyright © 2020 AMDA - The Society for Post-Acute and Long-Term Care Medicine

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4. **Covid-19: excess all cause mortality in domiciliary care**
Glynn 2020;370:m2751.

Piccininni and colleagues show the importance of using excess all cause mortality to measure the impact of covid-19.1 This approach has drawn attention to the shocking rates of covid-19 related deaths in care homes. But domiciliary care remains neglected.

Available online at this link

5. **Expanding frontiers of risk management: care safety in nursing home during COVID-19 pandemic.**

Scopetti Matteo International journal for quality in health care : journal of the International Society for Quality in Health Care 2020;:No page numbers.

BACKGROUNDNursing homes provide long-term care and have residential-oriented hospitalizations characterized by medical, nursing, and social-care treatments for a typically geriatric population. In the current emergency phase, the problem of infections in residential structures for the elderly is taking on considerable importance in relation to the significant prevalence rates of COVID-19.SAFETY IMPROVEMENT STRATEGIESPrevention and control measures for SARS-CoV-2 infection in nursing homes should be planned before a possible outbreak of COVID-19 occurs and should be intensified during any exacerbation of the same. Each facility should identify a properly trained contact person-also external-for the prevention and control of infections, who can refer to a multidisciplinary support committee and who is in close contact with the local health authorities. The contact person should collaborate with professionals in order to prepare a prevention and intervention plan that considers national provisions and scientific evidence, the requirements for reporting patients with symptoms compatible with COVID-19, the indications for the management of suspected, probable or confirmed cases of COVID-19.DISCUSSIONAdequate risk management in residential structures implies the establishment of a coordination committee with dedicated staff, the implementation of a surveillance program for the rapid recognition of the outbreaks, the identification of suitable premises and equipment, the application of universal precautions, the adaptation of care plans to reduce the possibility of contagion among residents, the protection of operators and staff training initiatives.

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6. **Experiences of Home Health Care Workers in New York City during the Coronavirus Disease 2019 Pandemic: A Qualitative Analysis**
Sterling M.R. JAMA Internal Medicine 2020;:No page numbers.

Importance: Home health care workers care for community-dwelling adults and play an important role in supporting patients with confirmed and suspected coronavirus disease 2019 (COVID-19) who remain at home. These workers are mostly middle-aged women and racial/ethnic minorities who typically earn low wages. Despite being integral to patient care, these workers are often neglected by the medical community and society at large; thus, developing a health care system capable of addressing the COVID-19 crisis and future pandemics requires a better understanding of the experiences of home health care workers.
Objective(s): To understand the experiences of home health care workers caring for patients in New York City during the COVID-19 pandemic.
Design, Setting, and Participant(s): From March to April 2020, a qualitative study with 1-to-1 semistructured interviews of 33 home health care workers in New York City was conducted in partnership with the 1199SEIU Home Care Industry Education Fund, a benefit fund of the 1199 Service Employees International Union United Healthcare Workers East, the largest health care union in the US. Purposeful sampling was used to identify and recruit home health care workers.
Main Outcomes and Measures: Audio-recorded interviews were professionally transcribed and analyzed using grounded theory. Major themes and subthemes were identified.
Result(s): In total, 33 home health care workers employed by 24 unique home care agencies across the 5 boroughs of New York City participated. Participants had a mean (SD) age of 47.6 (14.0) years, 32 (97%) were women, 21 (64%) were Black participants, and 6 (18%) were Hispanic participants. Five major themes emerged: home health care workers (1) were on the front lines of the COVID-19 pandemic

but felt invisible; (2) reported a heightened risk for virus transmission; (3) received varying amounts of information, supplies, and training from their home care agencies; (4) relied on nonagency alternatives for support, including information and supplies; and (5) were forced to make difficult trade-offs in their work and personal lives.
Conclusions and Relevance: In this qualitative analysis, home health care workers reported providing frontline essential care, often at personal risk, during the COVID-19 pandemic. They experienced challenges that exacerbated the inequities they face as a marginalized workforce. Interventions and policies to better support these frontline health care professionals are urgently needed..
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7. **Fabry disease during the COVID-19 pandemic. Why and how treatment should be continued.**
Politei Juan Molecular genetics and metabolism 2020;130(4):227-229.

Fabry disease is an X-linked disease due to a deficiency of the lysosomal enzyme alpha-galactosidase A. Clinical symptoms in classically affected males include acroparesthesia, anhydrosis and angiokeratoma, which may present during childhood followed by cardiac, cerebral and renal complications. Even though pulmonary involvement is not widely appreciated by clinicians, an obstructive lung disease is another recognized component of Fabry disease. Coronavirus Disease-19 (COVID-19), caused by the SARS-CoV-2 virus was labeled as a global pandemic and patients with Fabry disease can be considered at high risk of developing severe complications. The impact of COVID-19 on patients with Fabry disease receiving enzyme replacement therapy is still unknown. Many patients who receive treatment in the hospital experienced infusion disruptions due to fear of infection. Effects of temporary treatment interruption was described in more detail in other lysosomal storage diseases, but the recommencement of therapy does not fully reverse clinical decline due to the temporary discontinuation. When possible, home-therapy seems to be the most efficient way to maintain enzyme replacement therapy access during pandemic. Sentence take-home message: Home-therapy, when possible, seems to be the most efficient way to maintain enzyme replacement therapy access during pandemic in patients with Fabry disease.

Available online at this link

8. **Health and Economic Outcomes of Home Maintenance Allergen Immunotherapy in Select Patients with High Health Literacy during the COVID-19 Pandemic: A Cost-Effectiveness Analysis During Exceptional Times**
Shaker M.S. Journal of Allergy and Clinical Immunology: In Practice 2020;8(7):2310.

Background: Allergen immunotherapy (AIT) is safe and effective but is typically administered under strict clinic observation to mitigate the risk of a systemic reaction to immunotherapy (SRIT). However, in the setting of the global coronavirus disease 2019 pandemic, alternative care models should be explored.
Objective(s): To evaluate the cost-effectiveness of home immunotherapy self-administration (HITSA) in a highly idealized circumstance for provision of maintenance AIT in a shelter-in-place or other scenarios of unforeseen reduction in nonessential medical services.
Method(s): Markov modeling was used to compare in-office clinic AIT in selected patients using cohort analysis and

microsimulation from the societal and health care perspectives.
Result(s): Assuming similar SRIT rates, HITSA was found to be a cost-effective option with an incremental cost-effectiveness ratio of $44,554/quality-adjusted life-year when considering both incremental epinephrine autoinjector costs and coronavirus disease 2019 risks. Excluding epinephrine autoinjector costs, HISTA dominated other options. However, outside of pandemic considerations, HITSA was not cost-effective (incremental cost-effectiveness ratio, $198,877,286) at annual epinephrine autoinjector costs above $287. As the incremental HITSA SRIT rate increased above 15%, clinic AIT was the most cost-effective strategy. Excluding both pandemic risks and risk of motor vehicle accident fatality from round-trip clinic transit, clinic AIT dominated other strategies. Clinic AIT was the more cost-effective option at very high fatality relative risk for HITSA or at very low annual risk of contracting coronavirus disease 2019.
Conclusion(s): Under idealized assumptions HITSA can be a safe and cost-effective option during a global pandemic in appropriately selected patients provided home rates of SRIT remain stable.
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9. **Home Care for Cancer Patients During COVID-19 Pandemic: The Double Triage Protocol**
Porzio G. Journal of Pain and Symptom Management 2020;60(1):No page numbers.

Patients with cancer have an increased risk of developing severe forms of coronavirus disease 2019, and patients with advanced cancer who are followed at home represent a particularly frail population. Although with substantial differences, the challenges that cancer care professionals have to face during a pandemic are quite similar to those posed by natural disasters. We have already managed the oncological home care service in L'Aquila (middle Italy) after the 2009 earthquake. With this letter, we want to share the procedures and tools that we have started using at the home care service of the Tuscany Tumor Association during the coronavirus disease 2019 pandemic.
Copyright © 2020 American Academy of Hospice and Palliative Medicine

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10. **Home medical nutrition during SARS-CoV-2 pandemic - A position paper.**
Matras Przemyslaw Clinical nutrition ESPEN 2020;38:196-200.

BACKGROUNDThe severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) is the cause of a worldwide rapidly spreading illness, Coronavirus Disease 2019 (COVID-19). Patients fed enterally and parenterally at home are exposed to the same risk of infection as the general population, but more prone to complications than others. Therefore the guidance for care-givers and care-takers of these patients is needed.METHODSThe literature search identified no relevant systematic reviews or studies on the subject. Therefore a panel of 21 experts from 13 home medical nutrition (HMN) centres in Poland was formed. Twenty-three key issues relevant to the management of SARS-CoV-2 infection or COVID-19 in the HMN settings were identified and discussed. Some statements diverge from the available nutrition, surgical or ICU guidelines, some are based on the best available experience. Each topic was discussed and assessed during two Delphi rounds

subsequently. Statements were graded strong or weak based on the balance between benefit and harm, resource and cost implications, equity, and feasibility.RESULTSthe panel issued 23 statements, all of them were graded strong. Two scored 85.71% agreement, eleven 95.23%, and ten 100%. The topics were: infection control, enrolment to HMN, logistics and patient information.CONCLUSIONSthe position paper present pragmatic statements for HMN to be implemented in places without existing protocols for SARS-CoV-2 pandemic. They represent the state of knowledge available at the moment and may change should new evidence occurs.

Available online at this link

11. **Home monitoring for COVID-19**
Medina M. Cleveland Clinic journal of medicine 2020;:No page numbers.

Cleveland Clinic recognized the importance of mitigating community transmission of COVID-19 by keeping people at home. Patient-care activities quickly pivoted to remote touches, preserving continuity through a variety of digital and telephonic modalities. As the number of confirmed cases grew, standardizing home-based care became critical to managing high-risk patients, moderating the risk of exposure for healthcare workers, and reducing the amount of community spread through appropriate education on home-based care for exposed or infected individuals. This novel, team-based approach to caring for patients with COVID-19 incorporates a self-monitoring app for patient engagement, monitors symptoms for early intervention, and promotes a holistic view of care.
Copyright © 2020 The Cleveland Clinic Foundation. All Rights Reserved.

Available online at this link

12. **Home-based Testing for SARS-CoV-2: Leveraging Prehospital Resources for Vulnerable Populations.**
Goldberg Scott A. The western journal of emergency medicine 2020;21(4):813-816.

INTRODUCTIONExpanded testing for SARS-CoV-2 is critical to characterizing the extent of community spread of COVID-19 and to identifying infectious cohorts. Unfortunately, current facility-based testing compounds shortcomings in testing availability, neglecting those who are frail or physically unable to travel to a testing facility.METHODSWe developed an emergency medical service (EMS)-based home testing and evaluation program, leveraging existing community EMS resources. This program has kept vulnerable populations out of the emergency department, reduced cost, and improved access to care.RESULTSOur EMS-based testing program can test approximately 15 homebound patients per day. Through April 2020 our program had performed 477 home-based tests. Additionally, we have recently undertaken several mass testing operations, testing up to 900 patients per testing site.CONCLUSIONFacility-based SARS-CoV-2 testing requires that a patient physically present to a facility for a nasopharyngeal swap to be collected. Unfortunately, access may be limited for patients that are homebound, chronically ill, or without a means of private transportation. By leveraging existing EMS infrastructure in new ways, our community has been able to keep almost 500 vulnerable patients in their home. Using EMS, we can strengthen the healthcare system's response to the evolving COVID-19 pandemic and support at-risk populations, including those that are underserved, homebound, and frail.

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Available online at this link

13. **Impact of home quarantine on physical activity among older adults living at home during the COVID-19 pandemic: Qualitative interview study**
Goethals L. Journal of Medical Internet Research 2020;22(5):No page numbers.

Background: Older adults and those with pre-existing medical conditions are at risk of death from severe acute respiratory syndrome coronavirus 2 (SARS CoV-2). In this period of quarantine, one of the reasons for going out is physical activity. This issue is important, as the impact of a sedentary lifestyle might be lower for children and young adults, but is far more severe for older adults. Although older adults need to stay at home because they have a higher risk of coronavirus disease (COVID-19), they need to avoid a sedentary lifestyle. Physical activity is important for older adults, especially to maintain their level of independence, mental health, and well-being. Maintaining mobility in old age is necessary, as it may predict loss of independence in older adults.
Objective(s): Our first objective was to evaluate the impact of this quarantine period on physical activity programs and on the physical and mental health of older adults. Our second objective was to discuss alternatives to physical activity programs that could be suggested for this population to avoid a sedentary lifestyle.
Method(s): We conducted a qualitative survey using semistructured interviews with professionals (managers in charge of physical activity programs for older adults and sports trainers who run these physical activity programs) from the French Federation of Physical Education and Voluntary Gymnastics (FFPEVG) and older adults participating in a physical activity program of the FFPEVG. We followe d a common interview guide. For analysis, we carried out a thematic analysis of the interviews.
Result(s): This study suggests that the COVID-19 epidemic has affected, before quarantine measures, the number of seniors attending group physical activity programs in the two study territories. In addition, despite the decline in their participation in group physical activities before the quarantine, older adults expressed the need to perform physical activity at home. There is a need to help older adults integrate simple and safe ways to stay physically active in a limited space. A national policy to support older adults for physical activity at home appears essential in this context.
Conclusion(s): Given the results of our study, it seems necessary to globally communicate how important it is for older adults to maintain physical activity at home. We are concerned about the level of independence and mental health state of older adults after the end of quarantine if there is no appropriate campaign to promote physical activity among them at home.
Copyright © 2020 Luc Goethals, Nathalie Barth, Jessica Guyot, David Hupin, Thomas Celarier, Bienvenu Bongue.

Available online at this link

Available online at this link

14. **Intergenerational Relationships, Family Caregiving Policy, and COVID-19 in the United States**
Stokes J.E. Journal of aging & social policy 2020;32(4):416-424.

Families and intergenerational relationships are important sources of risk for COVID-19 infection, especially for older adults who are at high risk of complications from the disease. If one family member is exposed to the virus they could serve as a source of transmission or, if they fall ill, the resources they provide to others could be severed. These risks may be especially heightened for family members who work outside the home and provide care, or for those family members who care for multiple generations. Policies have the potential to help families bear the burden of these decisions. This essay argues that policies that address health, employment, and other social issues have implications for families, and that policies aimed at families and caregivers can affect the health, employment, and the general well-being of the nation.

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15. **Keeping people with epilepsy safe during the COVID-19 pandemic.**
French Jacqueline A. Neurology 2020;94(23):1032-1037.

OBJECTIVESTo provide information on the effect of the coronavirus disease of 2019 (COVID-19) pandemic on people with epilepsy and provide consensus recommendations on how to provide the best possible care for people with epilepsy while avoiding visits to urgent care facilities and hospitalizations during the novel coronavirus pandemic.METHODSThe authors developed consensus statements in 2 sections. The first was "How should we/clinicians modify our clinical care pathway for people with epilepsy during the COVID-19 pandemic?" The second was "What general advice should we give to people with epilepsy during this crisis? The authors individually scored statements on a scale of -10 (strongly disagree) to +10 (strongly agree). Five of 11 recommendations for physicians and 3/5 recommendations for individuals/families were rated by all the authors as 7 or above (strongly agree) on the first round of rating. Subsequently, a teleconference was held where statements for which there was a lack of strong consensus were revised.RESULTSAfter revision, all consensus recommendations received a score of 7 or above. The recommendations focus on administration of as much care as possible at home to keep people with epilepsy out of health care facilities, where they are likely to encounter COVID-19 (including strategies for rescue therapy), as well as minimization of risk of seizure exacerbation through adherence, and through ensuring a regular supply of medication. We also provide helpful links to additional helpful information for people with epilepsy and health providers.CONCLUSIONThese recommendations may help health care professionals provide optimal care to people with epilepsy during the coronavirus pandemic.

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16. **Management of Aerosol during Noninvasive Ventilation for Patients with Sleep-Disordered Breathing: Important Messages during the COVID-19 Pandemic.**
Pirzada Abdul Rouf Sleep and vigilance 2020;:1-6.

With the advent of COVID-19 infection and its rapid spread, preventive strategies are being developed worldwide, besides following the universal infection control guidelines. Prevention of spread through aerosol generation is one of the essential strategies in this

regard, particularly for patients with sleep-disordered breathing at home and during hospital admission. Aerosols are produced, at home and in health care facilities, by natural processes and aerosol-generating procedures. To address this impinging problem, aerosol-generating procedures, like non-invasive ventilation (NIV), are to be handled meticulously, which might warrant isolation and sometimes device/interface modifications.

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17. **Management Strategies for People Experiencing Sheltered Homelessness during the COVID-19 Pandemic: Clinical Outcomes and Costs.**
Freedberg Kenneth A. medRxiv : the preprint server for health sciences 2020;:No page numbers.

IMPORTANCEApproximately 356,000 people stay in homeless shelters nightly in the US. These individuals are at high risk for COVID-19.OBJECTIVETo assess clinical outcomes, costs, and cost-effectiveness of strategies for COVID-19 prevention and management among sheltered homeless adults.DESIGNWe developed a dynamic microsimulation model of COVID-19. We modeled sheltered homeless adults in Boston, Massachusetts, using cohort characteristics and costs from Boston Health Care for the Homeless Program. Disease progression, transmission, and clinical outcomes data were from published literature and national databases. We examined surging, growing, and slowing epidemics (effective reproduction numbers [Re] 2.6, 1.3, and 0.9). Costs were from a health care sector perspective; time horizon was 4 months.SETTING & PARTICIPANTSSimulated cohort of 2,258 adults residing in homeless shelters in Boston.INTERVENTIONSWe assessed combinations of daily symptom screening with same-day polymerase chain reaction (PCR) testing of screen-positive individuals, universal PCR testing every 2 weeks, hospital-based COVID-19 care, alternate care sites [ACSs] for mild/moderate COVID-19 management, and moving people from shelters to temporary housing, compared to no intervention.MAIN OUTCOMESInfections, hospital-days, costs, and cost-effectiveness.RESULTSCompared to no intervention, daily symptom screening with ACSs for those with pending tests or confirmed COVID-19 and mild/moderate disease leads to 37% fewer infections and 46% lower costs when Re=2.6, 75% fewer infections and 72% lower costs when Re=1.3, and 51% fewer infections and 51% lower costs when Re=0.9. Adding universal PCR testing every 2 weeks further decreases infections in all epidemic scenarios, with incremental cost per case prevented of $1,000 (Re=2.6), $27,000 (Re=1.3), and $71,000 (Re=0.9). In all scenarios, moving shelter residents to temporary housing with universal PCR testing every 2 weeks is most effective but substantially more costly than other options. Results are most sensitive to the cost and sensitivity of PCR testing and the efficacy of ACSs in preventing transmission. Conclusions & Relevance: Daily symptom screening and ACSs for sheltered homeless adults will substantially decrease COVID-19 cases and reduce costs compared to no intervention. In a surging epidemic, adding universal PCR testing every 2 weeks further decreases cases at modest incremental cost and should be considered.

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18. **Non-hospitalized Adults with COVID-19 Differ Noticeably from Hospitalized Adults in Their Demographic, Clinical, and Social Characteristics**
Bergquist S.H. SN Comprehensive Clinical Medicine 2020;:No page numbers.

The characteristics of patients with coronavirus disease 2019 (COVID-19) have primarily been described in hospitalized adults. Characterization of COVID-19 in ambulatory care is needed for a better understanding of its evolving epidemiology. Our aim is to provide a description of the demographics, comorbidities, clinical presentation, and social factors in confirmed SARS-CoV-2-positive non-hospitalized adults. We conducted a retrospective medical record review of 208 confirmed SARS-CoV-2-positive patients treated in a COVID-19 virtual outpatient management clinic established in an academic health system in Georgia. The mean age was 47.8 (range 21-88) and 69.2% were female. By race/ethnicity, 49.5% were non-Hispanic African American, 25.5% other/unknown, 22.6% non-Hispanic white, and 2.4% Hispanic. Nearly 70% had at least one preexisting medical condition. The most common presenting symptoms were cough (75.5%), loss of smell or taste (63%), headache (62%), and body aches (54.3%). Physician or advanced practice provider assessed symptom severity ranged from 51.9% mild, 30.3% moderate, and 1.4% severe. Only eight reported limitations to home care (3.8%), 55.3% had a caregiver available, and 93.3% reported initiating self-isolation. Care needs were met for 83.2%. Our results suggest the demographic and clinical characteristics of COVID-19 illness in non-hospitalized adults differ considerably from hospitalized patients and warrant greater awareness of risk among younger and healthier individuals and consideration of testing and recommending self-isolation for a wider spectrum of clinical symptoms by clinicians. Social factors may also influence the efficacy of preventive strategies and allocation of resources toward the SARS-CoV-2 pandemic.
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19. **Pulse Oximetry for Monitoring Patients with COVID-19 at Home: Potential Pitfalls and Practical Guidance.**
Luks Andrew M. Annals of the American Thoracic Society 2020;:No page numbers.

During the ongoing COVID-19 pandemic, reports in social media and the lay press indicate that a subset of patients are presenting with severe hypoxemia in the absence of dyspnea, a problem unofficially referred to as "silent hypoxemia." To decrease the risk of complications in such patients, one proposed solution has been to have those diagnosed with COVID-19 but not sick enough to warrant admission monitor their arterial oxygenation by pulse oximetry at home and present for care when they show evidence of hypoxemia. While the ease of use and low cost of pulse oximetry makes this an attractive option for identifying problems at an early stage, there are important considerations with pulse oximetry about which patients and providers may not be aware that can interfere with successful implementation of such monitoring programs. Only a few independent studies have examined the performance of pocket oximeters and smart phone-based systems but the limited available data raise questions about their accuracy, particularly as saturation falls below 90%. There are also multiple sources of error in pulse oximetry that must be accounted for including rapid fluctuations in measurements when the PaO2 falls on the steep portion of the dissociation curve, data acquisition problems when pulsatile blood flow is diminished, accuracy in the setting of severe hypoxemia, dyshemoglobinemias and other problems. Recognition of these issues and careful counseling of patients about the proper means for measuring their oxygen saturation and when to seek assistance can help ensure successful implementation of needed monitoring programs.

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20. **Report of five nurses infected with severe acute respiratory syndrome coronavirus 2 during patient care: case series.**
Gheysarzadeh A. New microbes and new infections 2020;36:100694.

The high prevalence of coronavirus disease 2019 (COVID-19) has received much attention all over the world. Nurses are in the first line of defence against severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) and are placed in a high-risk situation. This study aimed to report on infection with SARS-CoV-2 during patient care among nures in the Mostafa Khomini Hospital, Ilam, Iran. In this hospital 125 nurses were enrolled in the COVID-19 centre. Five out of 125 nurses (4%) who enrolled in the COVID-19 infection centre, developed COVID-19. They were first positive by real-time PCR but the CT scan was positive for only one of them. None of the infected nurses were hospitalized and all of them preferred to quarantine at home and receive the necessary care and treatment (oseltamivir, azithromycin and lopinavir/ritonavir). This study showed that, regardless of self caring, the nurses were exposed to the virus, because at the start of the SARS-CoV-2 outbreak in Iran, there was no special protection against this infection, so the nurses were placed at risk. This study also reported that receiving the necessary care and treatment at home was a good experience for nurses and can be used in some cases.

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21. **Review of Burden, Clinical Definitions, and Management of COVID-19 Cases.**
McArthur Laura The American journal of tropical medicine and hygiene 2020;103(2):625-638.

Our understanding of SARS-CoV-2, the virus responsible for coronavirus disease 2019 (COVID-19), its clinical manifestations, and treatment options continues to evolve at an unparalleled pace. This review sought to summarize the key literature regarding transmission, case definitions, clinical management, and the burden of COVID-19. Our review of the literature showed that SARS-CoV-2 was mainly transmitted via inhalation of respiratory droplets containing the virus and had a mean incubation period of 4-6 days. The commonly reported symptoms were fever (75.3% ± 18.7%) and cough (62.6% ± 17.7%) across the spectrum of clinical disease-mild, moderate, severe, and critical, but with the disease phenotype varying with severity. Categorization of these cases for home care or hospital management needs to be defined, with risk stratification accounting for the age of the patient and the presence of underlying comorbidities. The case definitions varied among countries, which could have contributed to the differences in the case fatality rates among affected countries. The severity and risk of death due to COVID-19 was associated with age and underlying comorbidities. Asymptomatic cases, which constitute 40-80% of COVID-19 cases are a considerable threat to control efforts. The presence of fever and cough may be sufficient to warrant COVID-19 testing, but using these symptoms in isolation will miss a proportion of cases. A clear definition of a COVID-19 case is essential for the management, treatment, and tracking of clinical illness, and to inform the quarantine measures and social distancing that can help control the spread of SARS-CoV-2.

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22. **The effect of social distance measures on COVID-19 epidemics in Europe: an interrupted time series analysis.**
Vokó Zoltán GeroScience 2020;42(4):1075-1082.

Following the introduction of unprecedented "stay-at-home" national policies, the COVID-19 pandemic recently started declining in Europe. Our research aims were to characterize the changepoint in the flow of the COVID-19 epidemic in each European country and to evaluate the association of the level of social distancing with the observed decline in the national epidemics. Interrupted time series analyses were conducted in 28 European countries. Social distance index was calculated based on Google Community Mobility Reports. Changepoints were estimated by threshold regression, national findings were analyzed by Poisson regression, and the effect of social distancing in mixed effects Poisson regression model. Our findings identified the most probable changepoints in 28 European countries. Before changepoint, incidence of new COVID-19 cases grew by 24% per day on average. From the changepoint, this growth rate was reduced to 0.9%, 0.3% increase, and to 0.7% and 1.7% decrease by increasing social distancing quartiles. The beneficial effect of higher social distance quartiles (i.e., turning the increase into decline) was statistically significant for the fourth quartile. Notably, many countries in lower quartiles also achieved a flat epidemic curve. In these countries, other plausible COVID-19 containment measures could contribute to controlling the first wave of the disease. The association of social distance quartiles with viral spread could also be hindered by local bottlenecks in infection control. Our results allow for moderate optimism related to the gradual lifting of social distance measures in the general population, and call for specific attention to the protection of focal micro-societies enriching high-risk elderly subjects, including nursing homes and chronic care facilities.

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23. **The Hydra-Headed Coronaviruses: Implications of COVID-19 for Homeopathy**
Waisse S. Homeopathy 2020;:No page numbers.

Successful homeopathic prescriptions are based on careful individualization of symptoms, either for an individual patient or collectively in the case of epidemic outbreaks. The ongoing COVID-19 pandemic was initially represented as a severe acute respiratory illness, with eventual dramatic complications. However, over time it revealed to be a complex systemic disease with manifestations derived from viral-induced inflammation and hypercoagulability, thus liable to affect any body organ or system. As a result, clinical presentation is variable, in addition to variations associated with several individual and collective risk factors. Given the extreme variability of pathology and clinical manifestations, a single, or a few, universal homeopathic preventive Do not split medicine(s) do not seem feasible. Yet homeopathy may have a relevant role to play, inasmuch as the vast majority of patients only exhibit the mild form of disease and are indicated to self-care at home, without standard monitoring, follow-up, or treatment. For future pandemics, homeopathy agencies should prepare by establishing rapid-response teams and efficacious lines of communication.
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24. **The impact of the COVID-19 pandemic on the emotional well-being and home treatment of Belgian patients with cystic fibrosis, including transplanted patients and paediatric patients**
Havermans T. Journal of Cystic Fibrosis 2020;:No page numbers.

Background: Little is known about the impact of COVID-19 on patients with cystic fibrosis (CF), despite being considered a high-risk group. This study explored the early impact of COVID-19 on the emotional well-being of patients and self-reported changes in their home therapy since the start of the pandemic.
Method(s): Adult patients with CF, lung-transplanted (LTX) CF patients and parents of children with CF completed an online questionnaire, securely linked to their medical files. The questionnaire covered the emotional impact of the pandemic, changes in CF and LTX treatment, changes in health-protecting behaviours and CF-related concerns, and their perception of their COVID-19 status.
Result(s): The response rate was 63% (80 CF, 66 LTX and 73 parents). A wide range of illness severity was included. None of the respondents had contracted COVID-19 and all strictly followed the social distancing rules. There was evident psychological impact, with many reporting increased stress, fear and worry about CF and the future. Changes in treatment were positive, including more physiotherapy for adults and better-quality nebulizing. Changes in routine were reported, such as different treatment timing. Adult patients and parents had cancelled their CF appointments more often since the start of the pandemic.
Conclusion(s): The initial psychological impact of COVID-19 was evident. The impact on home treatment was reassuringly small. Psychological care is needed for patients suffering prolonged psychological impact, and CF teams need to contextualize the information that patients and parents receive from the media and support them to balance the perceived risk with true risk.
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25. **The invisible workforce during the COVID-19 pandemic: Family carers at the frontline.**
Phillips Dominique HRB open research 2020;3:24.

This is an open letter to acknowledge the essential and increasingly challenging role unpaid family carers are playing in the COVID-19 pandemic. The letter is written by members of the CAREWELL team, a HRB-funded project that aims to promote health and self-care behaviours among working family carers. Family carers provide care to family and friends in the community who need support due to old-age, disability and chronic illness. In many cases, family carers are supporting those who are considered most at risk in this pandemic meaning carers must reduce their own risk of infection in order to protect their dependent family members. The temporary reduction of some home care services, as well as school and creche closures, means that family carers are providing increased levels of care with little or no support. At a time when both worlds of work and care have been dramatically transformed, we wish to shed light on those who are currently balancing paid employment with a family caregiving role. We argue that there is much to be learned from the recent work restrictions that could benefit employees, including working family carers, beyond this pandemic. We also wish to build on the potential positives of a transformed society and encourage policy makers and employers to focus on what is currently being implemented, and to identify which measures could be used to create a bedrock of policies and practices that would offer robust and effective support to family carers. It is hoped that family carers will receive greater recognition for the significant role they play in society, providing essential care and alleviating the strain on health and social care systems, both during and post the COVID-19 pandemic.

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26. **Transmission and risk factors of OF COVID-19.**
Miller Ryan Cleveland Clinic journal of medicine 2020;:No page numbers.

SARS-CoV-2, the virus that causes COVID-19, is transmitted through respiratory secretions and saliva. The virus can also live for short periods of time (1 to several hours) on fomites such as doorknobs, handrails, and tables. Aerosolization of the virus can occur during procedures including bronchoscopy, endotracheal intubation, and administration of nebulized treatments. Asymptomatic shedding of the virus does occur and may account for up to 60% of cases. Risk factors for a more severe course of COVID-19 include age 65 and older, living in a nursing home or long term care facility, chronic lung disease, and others.

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27. **Treating Hematologic Malignancies During a Pandemic: Utilizing Telehealth and Digital Technology to Optimize Care.**
Binder Adam F. Frontiers in oncology 2020;10:1183.

In late January 2020, Severe Acute Respiratory Syndrome Coronavirus-2 (SARS CoV-2) was reported as an outbreak in Wuhan, China. Within 2 months it became a global pandemic. Patients with cancer are at highest risk for both contracting and suffering complications of its resultant disease, Coronavirus 19 (COVID-19). Healthcare systems across the world had to adapt quickly to mitigate this risk, while continuing to provide potentially lifesaving treatment to patients. Bringing care to the home through the use of telehealth, home based chemotherapy, and remote patient monitoring technologies can help minimize risk to the patient and healthcare workers without sacrificing quality of care delivered. These care models provide the right treatment, to the right patient, at the right time, in the right place. Whether these patient-centered models of care will continue to be embraced by key stakeholders after the pandemic remains uncertain.

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28. **Urgent need for individual mobile phone and institutional reporting of at home, hospitalized, and intensive care unit cases of SARS-CoV-2 (COVID-19) infection.**
McCullough Peter A. Reviews in cardiovascular medicine 2020;21(1):1-7.

Approximately 90 days of the SARS-CoV-2 (COVID-19) spreading originally from Wuhan, China, and across the globe has led to a widespread chain of events with imminent threats to the fragile relationship between community health and economic health. Despite near hourly reporting on this crisis, there has been no regular, updated, or accurate reporting of hospitalizations for COVID-19. It is known that many test-positive individuals may not develop symptoms or have a mild self-limited viral syndrome consisting of fever, malaise, dry cough, and constitutional symptoms. However some individuals develop a more fulminant syndrome including viral pneumonia, respiratory failure requiring oxygen, acute respiratory distress syndrome requiring mechanical ventilation, and in substantial fractions leading to death attributable to COVID-19. The pandemic is evolving in a clustered, non-

inform fashion resulting in many hospitals with preparedness but few or no cases, and others that are completely overwhelmed. Thus, a considerable risk of spread when personal protection equipment becomes exhausted and a large fraction of mortality in those not offered mechanical ventilation are both attributable to a crisis due to maldistribution of resources. The pandemic is amenable to self-reporting through a mobile phone application that could obtain critical information on suspected cases and report on the results of self testing and actions taken. The only method to understand the clustering and the immediate hospital resource needs is mandatory, uniform, daily reporting of hospital censuses of COVID-19 cases admitted to hospital wards and intensive care units. Current reports of hospitalizations are delayed, uncertain, and wholly inadequate. This paper urges all the relevant stakeholders to take up self-reporting and reporting of hospitalizations of COVID-19 as an urgent task in combating this devastating pandemic.

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29. **Using Telemedicine and Infographics for Physician-Guided Home Drain Removal.**
Go Beatrice C. OTO open 2020;4(2):2473974X20933566.

ObjectiveMeasures to decrease hospital length of stay and outpatient visits are crucial during the coronavirus disease 2019 (COVID-19) pandemic. Physician-guided home drain removal presents a potential opportunity for mitigating viral spread and transmission.MethodsA prospective case series on patients undergoing major head and neck surgery with Jackson-Pratt drain placement was conducted. Patients were shown an infographic detailing drain care and removal at preoperative assessment and prior to discharge. At a 1-week follow-up telemedicine visit, patients were instructed to remove the drain under physician guidance. Patients were assessed 7 days after to determine complication rate and satisfaction.ResultsTwenty-five patients were enrolled with 100% patients undergoing successful drain removal at home with caregiver support. There were no complications reported at the 7-day postdrain removal time point, and overall patient satisfaction was high.DiscussionInfographics and telemedicine are 2 synergistic strategies to guide safe and effective home drain removal.Implications for PracticeThis study demonstrates how telemedicine and an infographic can be effectively used in physician-guided home drain removal. During a time like the COVID-19 pandemic, innovative measures are necessary to curb transmission and infection rates. We propose a unique and replicable yet safe solution to limit unnecessary exposure and encourage other surgical providers to adopt a similar strategy.

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30. **Video calls for reducing social isolation and loneliness in older people: A rapid review**
Noone C. Cochrane Database of Systematic Reviews 2020;5:1-40.

Background The current COVID-19 pandemic has been identified as a possible trigger for increases in loneliness and social isolation among older people due to the restrictions on movement that many countries have put in place. Loneliness and social isolation are consistently identified as risk factors for poor mental and physical health in older people.

Video calls may help older people stay connected during the current crisis by widening the participant's social circle or by increasing the frequency of contact with existing acquaintances. Objectives The primary objective of this rapid review is to assess the effectiveness of video calls for reducing social isolation and loneliness in older adults. The review also sought to address the effectiveness of video calls on reducing symptoms of depression and improving quality of life. Search methods We searched CENTRAL, MEDLINE, PsycINFO and CINAHL from 1 January 2004 to 7 April 2020. We also searched the references of relevant systematic reviews. Selection criteria Randomised controlled trials (RCTs) and quasi-RCTs (including cluster designs) were eligible for inclusion. We excluded all other study designs. The samples in included studies needed to have a mean age of at least 65 years. We included studies that included participants whether or not they were experiencing symptoms of loneliness or social isolation at baseline. Any intervention in which a core component involved the use of the internet to facilitate video calls or video conferencing through computers, smartphones or tablets with the intention of reducing loneliness or social isolation, or both, in older adults was eligible for inclusion. We included studies in the review if they reported self-report measures of loneliness, social isolation, symptoms of depression or quality of life. Two review authors screened 25% of abstracts; a third review author resolved conflicts. A single review author screened the remaining abstracts. The second review author screened all excluded abstracts and we resolved conflicts by consensus or by involving a third review author. We followed the same process for full-text articles. Data collection and analysis One review author extracted data, which another review author checked. The primary outcomes were loneliness and social isolation and the secondary outcomes were symptoms of depression and quality of life. One review author rated the certainty of evidence for the primary outcomes according to the GRADE approach and another review author checked the ratings. We conducted fixed-eKect meta-analyses for the primary outcome, loneliness, and the secondary outcome, symptoms of depression. Main results We identified three cluster quasi-randomised trials, which together included 201 participants. The included studies compared video call interventions to usual care in nursing homes. None of these studies were conducted during the COVID-19 pandemic. Each study measured loneliness using the UCLA Loneliness Scale. Total scores range from 20 (least lonely) to 80 (most lonely). The evidence was very uncertain and suggests that video calls may result in little to no diKerence in scores on the UCLA Loneliness Scale compared to usual care at three months (mean diKerence (MD) -0.44, 95% confidence interval (CI) -3.28 to 2.41; 3 studies; 201 participants), at six months (MD -0.34, 95% CI -3.41 to 2.72; 2 studies; 152 participants) and at 12 months (MD -2.40, 95% CI -7.20 to 2.40; 1 study; 90 participants). We downgraded the certainty of this evidence by three levels for study limitations, imprecision and indirectness. None of the included studies reported social isolation as an outcome. Each study measured symptoms of depression using the Geriatric Depression Scale. Total scores range from 0 (better) to 30 (worse). The evidence was very uncertain and suggests that video calls may result in little to no diKerence in scores on the Geriatric Depression Scale compared to usual care at three months' follow-up (MD 0.41, 95% CI -0.90 to 1.72; 3 studies; 201 participants) or six months' follow-up (MD -0.83, 95% CI -2.43 to 0.76; 2 studies, 152 participants). The evidence suggests that video calls may have a small eKect on symptoms of depression at one-year follow-up, though this finding is imprecise (MD -2.04, 95% CI -3.98 to -0.10; 1 study; 90 participants). We downgraded the certainty of this evidence by three levels for study limitations, imprecision and indirectness. Only one study, with 62 participants, reported quality of life. The study measured quality of life using a Taiwanese adaptation of the Short- Form 36-question health survey (SF-36), which consists of eight subscales that measure diKerent aspects of quality of life: physical function; physical role; emotional role; social function; pain: vitality; mental health; and physical health. Each subscale is scored from 0 (poor health) to 100 (good health). The evidence is very uncertain and suggests that there may be little to no diKerence between people allocated to usual care and those allocated to video calls in three-month scores in physical function (MD 2.88, 95% CI -5.01

to 10.77), physical role (MD -7.66, 95% CI -24.08 to 8.76), emotional role (MD -7.18, 95% CI -16.23 to 1.87), social function (MD 2.77, 95% CI -8.87 to 14.41), pain scores (MD -3.25, 95% CI -15.11 to 8.61), vitality scores (MD -3.60, 95% CI -9.01 to 1.81), mental health (MD 9.19, 95% CI 0.36 to 18.02) and physical health (MD 5.16, 95% CI -2.48 to 12.80). We downgraded the certainty of this evidence by three levels for study limitations, imprecision and indirectness.
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31. **Vitamin D can be effective on the prevention of COVID-19 complications: A narrative review on molecular aspects**
Shiravi A.-A. International journal for vitamin and nutrition research. Internationale Zeitschrift fur Vitamin- und Ernahrungsforschung. Journal international de vitaminologie et de nutrition 2020;:1-13.

The widespread COVID-19 pandemic has been, currently, converted to a catastrophic human health challenge. Vitamin D (VD) and its metabolites have been used as a palliative treatment for chronic inflammatory and infectious diseases from ancient times. In the current study, some molecular aspects of the potential effects of VD against COVID-19 side-effects have been discussed. An arguable role in autophagy or apoptosis control has been suggested for VD through calcium signaling at the mitochondrial and ER levels. 1,25(OH)2D3 is also an immunomodulator that affects the development of B-cells, T-cells, and NK cells in both innate and acquired immunity. The production of some anti-microbial molecules such as defensins and cathelicidins is also stimulated by VD. The overexpression of glutathione, glutathione peroxidase, and superoxide dismutase, and down-regulation of NADPH oxidase are induced by VD to reduce the oxidative stress. Moreover, the multi-organ failure due to a cytokine storm induced by SARS-CoV2 in COVID-19 may be prevented by the immunomodulatory effects of VD. It can also downregulate the renin-angiotensin system which has a protective role against cardiovascular complications induced by COVID-19. Given the many experimental and molecular evidences due to the potential protective effects of VD on the prevention of the COVID-19-induced morbidities, a VD supplementation is suggested to prevent the lethal side-effects of the infection. It is particularly recommended in VD-deficient patients or those at greater risk of serious or critical effects of COVID-19, including the elderly, and patients with pre-existing chronic diseases, especially those in nursing homes, care facilities, and hospitals.

32. **[COVID-19: care at home or in hospital? Considerations in primary care].**
Harskamp R. E Nederlands tijdschrift voor geneeskunde 2020;164:No page numbers.

COVID-19 is a treacherous disease, in which infected patients who appear to fare well can deteriorate rapidly, mostly due to respiratory failure. For general practitioners (and other first-line responders), a clinical evaluation at any given time merely provides a snapshot of the patient's condition. Therefore, frequent monitoring is warranted in at-risk patients. However, there is no one-size-fits-all approach for monitoring, treatment and referral decisions. This is particularly the case in patients with advanced age. In this article, through the use of case examples, we aim to provide guidance when facing difficult management decisions in patients with (suspected) COVID-19.

33. **[Ethical approach to the issue of confinement of the elderly in the context of the COVID-19 pandemic: Prevention of frailty versus risk of vulnerability].**
Piccoli M. Ethics, medicine, and public health 2020;14:100539.

COVID-19 pandemic particularly affects older people and exposes them to a higher risk of mortality. Containment, social distancing and isolation measures have been implemented to limit viral transmission. While there is a clear rationale for reducing the contagiousness of the infection through this means, the adverse consequences of this social isolation, especially for this heterogeneous, aged and frail people, are difficult to apprehend. In particular, the disruption of the usual support and care ecosystems at home or in institutions may paradoxically increase the frailty of these people and lead to adverse events we wanted to avoid. On the other hand, the risk of a decrease in the older person's empowerment regarding his or her own health and social life decisions requires particular vigilance to prevent the risk of societal ageism. Regarding this population in particular, a possible conflict of values between individual and collective protection on one hand and respect for autonomy and independence on the other hand could exist. This article proposes an ethical reflection on the issue of containment of frail ageing people, based on medical ethics principles, in order to open up positive approaches of vulnerability that guarantee respect for the dignity of the person and equity in care access.

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34. **[HOME CARE AND COVID-19. BEFORE, IN AND AFTER THE STATE OF ALARM].**
Ramón Martínez Riera José Enfermeria clinica 2020;:No page numbers.

In Spain, Home Care as a fundamental tool of Primary Health Care, has had uneven development both before and during the COVID-19 pandemic, although it initially played a relevant role in the control and monitoring of infected people and their families. However, at no time it was used the desirable community perspective and community participation throughout the process as it has been successfully done in other settings. Subsequently, with the closure of health centers, it ceased to be provided in some autonomous communities, when all the attention was transferred to the hospital setting. This exacerbated hospital-centrism, to the detriment of PHC and Home Care, is showing a high contagion in healthcare professionals. The circulation of professionals in the hospitals, where the main focus of infection is concentrated, and from these to their homes is a clear risk factor. In addition, we must not forget that Home Care is of special importance for the care of people with terminal illnesses or very advanced chronic diseases (dementia, COPD ...), although always taking into account recommendations tending to extreme precautions for infection for professionals, family and caregivers. This can be adapted to the pandemic situation by using tools that digital health offers (telephone care, video calls ...). Finally, it would be very interesting that, once the crisis was over, research was carried out that allowed the incorporation of people who have been treated by the health service during the pandemic, through the technique called public participation in research projects.

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35. **[The CoViD-19 epidemic is posing entirely new problems for home cancer care services.]**
Porzio Giampiero Recenti progressi in medicina 2020;111(4):257-258.

We report on the protocol adopted by the Oncological Home Care Service of the Tuscany Cancer Association during the CoViD-19 pandemic. Based on the experience in home cancer care gained during the 2009 earthquake, we have developed strategies to ensure continuity of care, non-abandonment and protection of operators. In this context, the double triage protocol plays a central role, aimed at identifying patients at risk for CoViD-19 infection and rationalizing home access. we describe the protocol and present the preliminary data.

Opening Internet Links

The links to internet sites in this document are 'live' and can be opened by holding down the CTRL key on your keyboard while clicking on the web address with your mouse

Full text papers

Links are given to full text resources where available. For some of the papers, you will need an **NHS OpenAthens Account**. If you do not have an account you can register online.

You can then access the papers by simply entering your username and password. If you do not have easy access to the internet to gain access, please let us know and we can download the papers for you.

Guidance on searching within online documents

Links are provided to the full text of each document. Relevant extracts have been copied and pasted into these results. Rather than browse through lengthy documents, you can search for specific words as follows:

Portable Document Format / pdf / Adobe
Click on the Search button (illustrated with binoculars). This will open up a search window. Type in the term you need to find and links to all of the references to that term within the document will be displayed in the window. You can jump to each reference by clicking it.

Word documents
Select Edit from the menu, the Find and type in your term in the search box which is presented. The search function will locate the first use of the term in the document. By pressing 'next' you will jump to further references.

D. Search History

	Source	Criteria	Results
1.	EMBASE	COVID-19 OR Covid19 OR coronavirus* OR Coronavirinae OR "corona virus" OR "2019-nCoV" OR "human coronavirus" OR "respiratory syndrome related coronavirus" OR ((Wuhan OR novel) ADJ5 coronavirus).ti,ab OR (human ADJ coronavirus).ti,ab OR ("human influenza" OR "influenza virus" OR "influenza pandemic").ti,ab OR exp *"CORONAVIRUS 229E, HUMAN"/ OR exp *"CORONAVIRUS NL63, HUMAN"/ OR "severe acute respiratory syndrome coronavirus 2" OR "SARS-CoV-2" OR	100705

	Source	Criteria	Results
		"SARS-CoV" OR "SARS Coronavirus" OR "SARS Virus" OR exp *"CORONAVIRUS OC43, HUMAN"/	
2.	EMBASE	(risk* OR danger* OR transmi*).ti,ab	3797305
3.	EMBASE	exp *RISK/	313387
4.	EMBASE	(2 OR 3)	3826869
5.	EMBASE	("adult social care" OR "domiciliary care" OR "home care").ti,ab	21850
6.	EMBASE	exp *"HOME CARE"/	36694
7.	EMBASE	(care* ADJ3 home*).ti,ab	44713
8.	EMBASE	(5 OR 6 OR 7)	67803
9.	EMBASE	(1 AND 4 AND 8)	65
10.	EMBASE	("care home*").ti,ab	5110
11.	EMBASE	9 NOT (10)	46
12.	EMBASE	11 [DT 2015-2020] [English language] [Languages English] [Human age groups Adult 18 to 64 years OR Aged 65+ years]	19
13.	EMBASE	("aerosol generating procedure*" OR AGPs OR "Continuous positive airway pressure" OR CPAP OR BPAP OR BiPAP OR "Bilevel Positive Airway Pressure" OR nebuli?er*).ti,ab	30558
14.	EMBASE	exp *"POSITIVE END EXPIRATORY PRESSURE"/	16181
15.	EMBASE	exp *"BIPAP DEVICE"/	17
16.	EMBASE	exp *AEROSOL/	22467
17.	EMBASE	exp *NEBULIZER/ OR exp *"AEROSOL GENERATOR"/	2671
18.	EMBASE	(13 OR 14 OR 15 OR 16 OR 17)	60390
19.	EMBASE	(1 AND 8 AND 18)	2
20.	Medline	COVID-19 OR Covid19 OR coronavirus* OR Coronavirinae OR "corona virus" OR "2019-nCoV" OR "human coronavirus" OR "respiratory syndrome related coronavirus" OR ((Wuhan OR novel) ADJ5 coronavirus).ti,ab OR (human ADJ coronavirus).ti,ab OR ("human influenza" OR "influenza virus" OR "influenza pandemic").ti,ab OR exp *"CORONAVIRUS 229E, HUMAN"/ OR exp *"CORONAVIRUS NL63, HUMAN"/ OR "severe acute respiratory syndrome coronavirus 2" OR "SARS-CoV-2" OR "SARS-CoV" OR "SARS Coronavirus" OR "SARS Virus" OR exp *"CORONAVIRUS OC43, HUMAN"/	94635
21.	Medline	(risk* OR danger* OR transmi*).ti,ab	2691029
22.	Medline	exp *RISK/	37390
23.	Medline	(21 OR 22)	2701706
24.	Medline	("adult social care" OR "domiciliary care" OR "home care").ti,ab	18420
26.	Medline	(care* ADJ3 home*).ti,ab	38726
27.	Medline	exp *"HOME CARE SERVICES"/	33868
28.	Medline	(24 OR 26 OR 27)	59710
29.	Medline	("care home*").ti,ab	3962
30.	Medline	28 NOT (29)	55748

	Source	Criteria	Results
31.	Medline	(20 AND 23 AND 30)	61
32.	Medline	31 [DT 2015-2020] [Human age groups Young adult OR Adult OR Middle Aged OR Aged OR Aged,80 and over] [Languages English]	8
33.	Medline	("aerosol generating procedure*" OR AGPs OR "Continuous positive airway pressure" OR CPAP OR BPAP OR BiPAP OR "Bilevel Positive Airway Pressure" OR nebuli?er*).ti,ab	18100
34.	Medline	exp *"CONTINUOUS POSITIVE AIRWAY PRESSURE"/	4597
35.	Medline	exp *"NEBULIZERS AND VAPORIZERS"/	5568
36.	Medline	(33 OR 34 OR 35)	23290
37.	Medline	(20 AND 30 AND 36)	1