FHA Guidelines For
Facility Medical Directors/Physicians
Nurse Practitioners
Response to COVID-19 Pandemic

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A) Non-Outbreak Setting:

1. **Communication amongst Physicians and Nurse Practitioners (NPs):**

a) Facility Medical Director (FMD) will ensure there is a mechanism in place to inform other physicians working at the site and community regarding any new updates in policies and procedures

2. **Communication with Patients and Families:**

a) The goals of care should continue to be reviewed as clinically indicated
b) Ongoing communication to patients and families should occur especially with changes in patient status

3. **Patient visits:**

a) Most Responsible Physicians (MRPs) are advised to provide maintenance care/monitoring of chronic health conditions using a combination of on-site and virtual means, using clinical judgment as to frequency and mode of treatment/surveillance. In a non-outbreak setting some on-site visits are expected, the frequency of which is driven by professional judgment, in collaboration with care home leadership. MRPs supporting multiple homes will ideally arrange their schedule to visit no more than one home on a given day.
b) Clinicians are encouraged to work with care home leadership to familiarize themselves with appropriate modes of providing virtual care (i.e. Doxy.me, telehealth platforms, remote orders) prior to outbreak onset to reduce additional learning burden during a crisis.
c) Urgent medical issues must be addressed promptly, including on-site assessment when clinically indicated.

4. **Resident assessments:**

a) The care team should assess whether routine BP/weights should continue
b) All acute medically necessary assessments should continue as clinically indicated

5. **Medication Reviews:**

a) These should continue to occur at least every 6 months for each patient
b) These should be done remotely off-site via virtual means as much as possible
c) Continue to take the opportunity to review and reduce unnecessary medications or those that are not in line with the goals of care
d) Review medication administration timing to reduce medication passes for each resident

6. **Care conferences and administrative meetings:**

a) These should continue to occur as per your usual schedule
b) These should occur virtually whenever possible

7. Documentation:

a) Complete visits/orders remotely wherever possible and practical to reduce the time spent on-site

b) Ensure virtual and on-site visits are documented and the documentation shared with the care homes clinical record (i.e. via EMR, fax)

8. Hospital Transfers and Essential Medical Appointments:

a) The care team should determine whether off-site medical appointments are necessary and in line with goals of care. If necessary they should be done virtually whenever possible. Transportation of the patient should be done by approved means such as SNT or HandyDART and transport by family should only be done by exception and they are not allowed to transport a patient that is symptomatic of COVID or COVID positive. Refer to the *"Transportation Protocol for Off Site Medical Appointments During COVID-19"*

b) For patients being sent to the Emergency Department, it is preferable that you contact the receiving facility or send a note with the patient to inform the reason for transfer and the goal of the transfer

9. PPE Use:

a) Physicians and NPs must be adherent to the appropriate use of PPE at all times when on-site.

B) In Outbreak Setting:

Once an outbreak has been declared FHA will assign an "Outbreak Response Lead" to your site. This will be the first point of contact to direct any and all questions or concerns regarding the outbreak management. If they do not have the answers to your questions then they should know who to direct your questions and concerns to. If that system fails then please contact our region's FHA Physician Leader for further information.

a) Fraser North: Dr. Nick Petropolis nick.petropolis@fraserhealth.ca
b) Fraser South: Dr. Sandra Derkach sandra.derkach@fraserhealth.ca
c) Fraser East (including Langley): Dr. Ken Dueck ken.dueck@fraserhealth.ca
d) Lead, Pandemic Response: Dr. Anthony Tran anthony.tran@fraserhealth.ca

FHA Regional Triage Intensivist (On-call service)
Should your patient be decompensating and you feel you need some additional treatment advice you can connect with your local FHA Regional Triage Intensivist by calling your local hospital. Please find the hospital below that correlates with the region you work in.

Abbotsford Regional Hospital:	Phone: 604-851-4700
Burnaby Hospital:	Phone: 604-434-4211
Chilliwack General Hospital:	Phone: 604-795-4141
Coquitlam, Port Coquitlam, Port Moody:	
Eagle Ridge Hospital:	Phone: 604-461-2022
Delta Hospital:	Phone: 604-946-1121
Fraser Canyon Hospital:	Phone: 604-869-5656
Langley Memorial Hospital:	Phone: 604-514-6000
Maple Ridge, Pitt Meadows:	
Ridge Meadows Hospital:	Phone: 604-463-4111
Mission Memorial Hospital:	Phone: 604-826-6261
Royal Columbian Hospital:	Phone: 604-520-4253
Surrey Memorial Hospital:	Phone: 604-581-2211
Peace Arch Hospital:	Phone: 604-531-5512

MHO Contact(s)

MHO Daytime contact	Phone: 604-587-3828 *(8:30am-4:30pm Mon-Friday)*
MHO after hours contact:	Phone: 604-527-4806

1. **Communication amongst Physicians and NPs: (Outbreak)**

a) FMD will ensure there is a mechanism in place to inform other physicians working at the site and community that may attend on-site of any outbreaks and updates regarding any new developments

2. **Communication with Patients and Families (Outbreak):**

a) Goals of care conversations should be conducted when clinically appropriate. The care team should evaluate which patients require a review of their goals of care due to a

discrepancy between their designated level of care and their frailty level. These discussions should include a review of the scope of care available in the care home.

b) If possible the Physician/NP at the time of COVID-19 diagnosis should contact the family to review the diagnosis and goals of care. Delegation of this task to other health care providers can occur if the care team deems appropriate.
c) Families should be informed of significant changes in resident status.

3. Patient visits: (Outbreak)

a) Provide patient care remotely/virtually as much as possible. Determine a regularly scheduled time to call nursing staff/residents to review medical conditions under treatment and new issues that arise.
b) FMD should organize Physicians and NPs to ensure one clinician is available for necessary on-site assessments for residents. When possible designated a single "on-site clinician" per day or per week to provide in-person assessments on an as-needed basis. Collaborate with facility clinical leadership to develop a model that works for providers and staff such as a daily vs weekly rotation.
c) If after a remote/virtual visit is conducted and it is determined that an on-site visit is necessary, one should delegate whenever possible, the on-site visit to the "on-site clinician" of the day/week. There should be a direct communication between the patient's physician/nurse practitioner and the "on-site clinician" for all requests.
d) The designated on-site clinician should coordinate with nursing staff to efficiently visit residents needing direct assessment. Ensure COVID-19 negative residents are seen first, followed by suspected COVID-19 residents and COVID-19 positive residents last.
e) Physicians and NPs working in multiple care homes will ideally not visit other homes on the same day as the outbreak site or schedule the outbreak site visit for the last visit of the day whenever possible.

4. Resident assessments: (Outbreak)

a) Non-essential resident assessments such as routine BP/weights should be stopped
b) All acute medically necessary assessments should continue as clinically indicated

5. Medication Reviews: (Outbreak)

a) These should be done proactively when able to reduce number of medications and medication passes to reduce nursing staff demands
b) Remotely off-site via virtual means as much as possible
c) Continue to take the opportunity to review and reduce unnecessary medications or those that are not in line with the goals of care
d) Review medication administration timing to reduce medication passes for each resident

6. Care conferences and administrative meetings: (Outbreak)

a) Determine whether or not non-essential services can safely continue through the use of technology.
b) Resident care conferences and medication reviews should be conducted remotely through the appropriate use of telehealth services if the care team has the capacity to

do so. Some sites may elect to suspend these services until a later time if resources do not allow for safe conduct to occur.

7. Documentation: (Outbreak)

a) Complete visits/orders remotely wherever possible and practical to reduce the time spent on-site
b) Ensure virtual and on-site visits are documented and the documentation shared with the care homes clinical record (i.e. via EMR, fax)

8. Hospital Transfers and Essential Medical Appointments: (Outbreak)

a) Appointments should be rescheduled when possible. Transportation of the patient can ONLY be done by approved means such as SNT or HandyDART. Refer to the *"Transportation Protocol for Off Site Medical Appointments During COVID-19"*
b) If the medical appointment is determined to be necessary the care team MUST contact the Emergency Department or the accepting site to inform them of the reason for transfer and ensure they are willing and able to accept the patient before transferring them.

9. PPE Use: (Outbreak)

a) Physicians and NPs must be adherent to the appropriate use of PPE at all times when on-site.

10. COVID-19 treatment algorithms: (Outbreak)

a) *"Clinical Decision Pathway COVID-19 in LTC Residents"*
b) *"CTC Antimicrobial and immunomodulatory therapy in adult patients with COVID-19"*
c) *"Pre-Printed Orders for Confirmed or Presumed COVID-19 in LTC"*

COVID-19 Physician Recommendations Summary Table

	Non-Outbreak	Outbreak
Communication amongst Physicians and NP's:	• FMD will ensure a mechanism for communication of information for general updates	• FMD will ensure a mechanism for communication of information regarding outbreak updates
Communication with Patients and Families:	• Review GOC as needed and communicate changes to family	• Review GOC as needed and communicate changes to family
Patient visits:	• Combination of virtual and on-site visits for preventative care • on-site visits should occur when needed	• Virtual as much as possible • Assign "on-site clinician" of the day or week • See those with suspected COVID/COVID positive last • Go to outbreak sites at end of the day
Resident assessments:	• Routine vitals can occur if deemed clinically appropriate	• Do vitals only when necessary
Medication Reviews:	• Every 6 months • Reduce meds/passes when possible • Virtually when able	• Proactively do medication reviews virtually to reduce medication administrations and passes
Care conferences and administrative meetings:	• Virtually whenever able	• Virtually if the team has clinical capacity • May want to cancel if resources need reallocation
Documentation:	• Off-site when able and share documentation with the care homes	• Off-site when able and share documentation with the care homes
Hospital Transfers and Essential Medical Appointments:	• Refer to the *"Transportation Protocol for Off Site Medical Appointments During COVID-19"* • Contact the ED or provide a note when able	• Refer to the *"Transportation Protocol for Off Site Medical Appointments During COVID-19"* • You ***MUST*** Contact the ED or transfer site to ensure they are able and willing to accept patient
PPE Use:	• Use at all times in all settings	• Use at all times in all settings

	Non-Outbreak	Outbreak
COVID-19 treatment algorithms:	• N/A	• *"Clinical Decision Pathway COVID-19 in LTC Residents"* • *"CTC Antimicrobial and immunomodulatory therapy in adult patients with COVID-19"* • *"Pre-Printed Orders for Confirmed or Presumed COVID-19 in LTC"*

COVID-19 Physician Resources

Most of the following resources can be found at the following link:
https://www.fraserhealth.ca/employees/clinical-resources/coronavirus-information/ltc-al-il/resources#.X7daXGhxePo

The “Long-Term Care, Assisted Living COVID-19 Resource Toolkit” which every care home leadership team should be aware of and utilizing to direct their planning and prevention strategies as well as outbreak management is also found on that site. Please familiarize yourself with this resource if you are a FMD. The site is updated regularly and some content may be removed if no longer relevant or as new information is available.

Summary of reference documents:

BCCDC COVID Testing Guidelines

HOW YOU CAN SLOW THE SPREAD OF COVID-19

Take care of others by taking care of yourself
Wash your hands, don't touch your face, and stay home if you are sick.

Stay at Home and Physically Distance
Stay at home whenever you can. Maintain 2 meters distance from those outside of your household.

COVID-19: Adult Viral Testing Guidelines for British Columbia

September 17, 2020 – For Healthcare Providers

Guidelines for COVID-19 testing in BC are periodically reviewed and updated based on COVID-19 epidemiology, seasonality, public health measures in place, testing capacity, and our evolving understanding of test performance in clinical settings. As a result, BC guidelines may differ from other national or provincial guidelines.

At this time in BC, there are low levels of community transmission of COVID-19. As BC society continues to re-open, and there are changes in the level of interactions between people in the population, early detection and management of COVID-19 cases and their contacts is a critical public health strategy for maintaining low levels of transmission in BC. There is also capacity to expand testing beyond current levels.

Accordingly, at this time providers are recommended to have a low threshold for testing symptomatic individuals for COVID-19 infection.

Guidance for COVID-19 Testing by Nucleic Acid Tests (NATs)

1. **Test all individuals with new symptoms compatible with COVID-19, however mild.**

The symptoms most commonly found with COVID-19 infection include:

- Fever
- Chills
- Cough*
- Shortness of breath
- Runny nose
- Sore throat
- Loss of sense of smell or taste
- Headache
- Fatigue
- Diarrhea
- Loss of appetite
- Nausea and vomiting
- Muscle aches

*Or exacerbation of chronic cough.

Less common symptoms of COVID-19 infection include stuffy nose, conjunctivitis (pink eye), dizziness, confusion, abdominal pain, and skin rashes or discoloration of fingers or toes.

Clinical judgement remains important in the differential diagnosis and work-up of individuals presenting with these symptoms (e.g., people with allergies). For more information on the diagnosis and management of COVID-19 infection, please refer to the clinical guidelines on the BCCDC website.

2. **It is particularly important to test symptomatic individuals who:**

   - Are residents or staff of long-term care facilities
   - Require admission to hospital or are likely to be admitted
   - Are healthcare workers
   - Are contacts of a known case of COVID-19
   - Are travellers who in the past 14 days returned to BC from outside Canada, or from an area with higher infection rates within Canada
   - Are residents of remote, isolated, or Indigenous communities
   - Live in congregate settings such as work-camps, correctional facilities, shelters, group homes, assisted living and seniors' residences
   - Are homeless or have unstable housing
   - Are essential service providers, such as first responders.

3. **COVID-19 testing is not recommended for asymptomatic individuals.**

Routine COVID-19 screening of asymptomatic people is not recommended in BC (e.g., in schools, prior to surgery or other procedures, in hospitals or healthcare settings, as a condition of employment or for travel).

4. **Medical Health Officers may recommend testing as part of public health investigations.**

Medical Health Officers may recommend testing for individuals who are part of a public health investigation of a case, cluster or an outbreak, regardless of symptom profile.

Note: In May the Provincial Health Officer temporarily removed the requirement for licensed practical nurses to have a client-specific order prior to performing nasopharyngeal swabs if being done as part of a screening program approved by a Medical Health Officer.

Guidance on Specimen Collection and Labelling

Specimen Collection

Collect a **Nasopharyngeal (NP) Swab** using the instructions provided in this video "How to perform a nasopharyngeal swab". Note the instructions for donning and doffing of personal protective equipment (PPE). https://youtu.be/m8r4es548uQ (produced by UBC ENT and Providence Healthcare)

Use the swab/collection device provided by your institution. The following swabs are currently validated and are available for use in BC:

- YOCON Virus Sampling Kit
- VWR Starplex Multitrans Collection Kit
- Roche cobas™ PCR Dual Swab Sample Kit†
- Columbia Plastics Swab Kit
- Copan swab with red top tube*
- Hologic Aptima Unisex Swab Specimen Collection Kit**

† These swabs have limited availability.
* These swabs are currently restricted to pediatric collections
** DO NOT use the orange packaged Hologic Aptima Multitest swabs for NP collection

For hospitalized patients and/or patients with evidence of lower respiratory tract disease, collect a lower respiratory tract sample (e.g., sputum, endotracheal aspirate, bronchoalveolar lavage, etc.) in a sterile screw-top container **in addition to a nasopharyngeal swab.**

**Use with care when inserting into the nasopharyngeal cavity, as these swabs may cause mild trauma. Gently insert only as far as possible, and avoid forcing against resistance. Inserting approximately 2-3 cm will allow swabbing of the mid-turbinate area. In this case, swab bilateral mid-turbinates using a single swab to optimize sampling quality.

Specimen Labelling

All specimens (cylindrical tube) must have an attached label with:

- Patient name
- PHN or Date of Birth (DOB)
- Specimen type (e.g., NP swab)
- Date & time of collection

Please add one of the following codes to the specimen label:

- **HCW1** – Health Care Worker – Direct Care
- **HCW2** – Health Care Worker – Non Direct Care
- **LTC** – Long Term Care Facility
- **OBK** – Outbreaks, clusters or case contacts
- **HOS** – Hospitalized
- **CMM** – Community or Outpatient, including Urgent and Primary Care Centres
- **CGT –** People living in congregate settings such as work-camps, correctional facilities, shelters, group homes, assisted living and seniors' residences.
- **TREEPL –** Tree planters
- **SCHOOL –** People attending school in-person including students, teachers and support staff

Please submit each specimen in an individual, sealed biohazard bag. Include a paper requisition which clearly states the patient information, the ordering physician, and the test name (COVID-19 NAT).

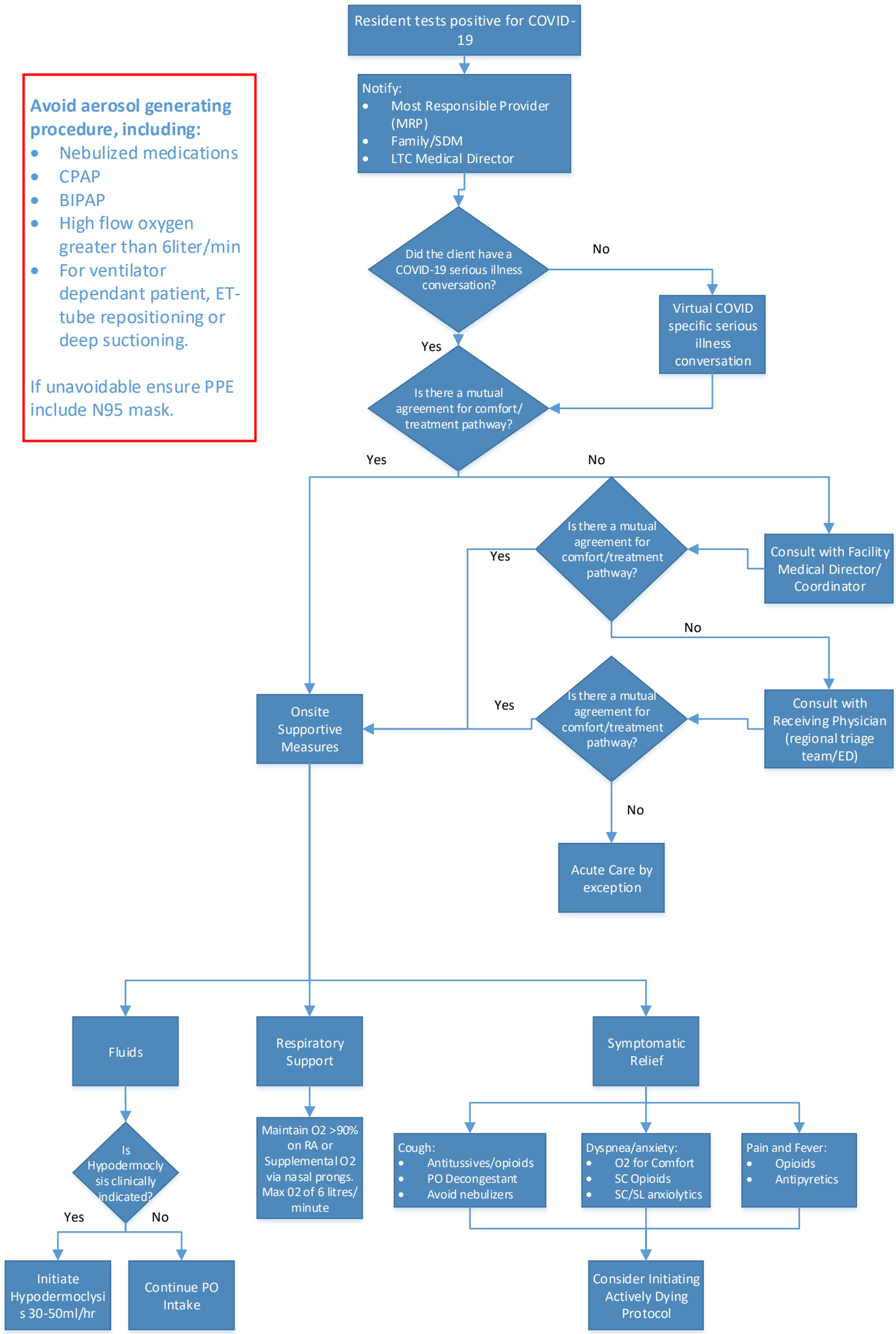
Please refer to the BCCDC Public Health Laboratory eLab Handbook under COVID-19 test for specimen requirements. http://www.elabhandbook.info/phsa/

Paper Requisitions are available here: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Forms/Labs/VI%20Req.pdf

Clinical Decision Pathway in LTC Residents

Clinical Decision Pathway COVID-19 in LTC Residents

This algorithm assumes Public Health Authorities are involved and are coordinating outbreak in facility, and is meant to aid clinicians to manage care of residents with COVID-19 LTC.



CPR for COVID in LTC

November 17, 2020

Uncommon Practice: Cardio Pulmonary Resuscitation (CPR) in Long-Term Care (CPR – C2)

CPR is not attempted on a resident who has suffered an unwitnessed cardiac arrest. Please ensure families are aware that CPR will not be initiated for a non-witnessed arrest.

WITNESSED ARREST ONLY (The following applies to ALL cases of CPR administration for the duration of the COVID-19 pandemic due to risk of inadvertent COVID-19 transmission)

1. Call 911.
2. Keep the resident in the same room.
3. If required, clear space by moving other residents out of the area. If not possible to remove other residents, apply procedure mask to them.
4. Staff must wear the required PPE: eye protection (face shield/goggles), procedure mask, gown and gloves.
5. Apply a procedure mask to the resident.
6. Start COMPRESSIONS ONLY, NO ventilations.
7. If resident is on droplet precautions and/or ventilations are initiated by the code team or BC Ambulance Service, then all team members must wear a N95 respirator in addition to eye protection, gowns and gloves.

For resources on Aerosol Generating Procedures (AGP) see:

http://fhpulse/quality_and_patient_safety/infection_control/novel_coronavirus/FH%20Aerosol%20Generating%20Procedures%20(AGP)%20SOP%20%5brev%20Mar%2024%5d.pdf

Note most residents are frail and vulnerable and M1-M3 DNR.

Preventative proactive conversations should occur to ensure all residents have updated goals of care documented and the Medical Orders Scope of Treatment reflects the wishes and preferences of the resident. Included in the conversation are explanations of COVID-19 and possible outcomes of a COVID-19 confirmed diagnosis.

Source Information: Acute Care AGP, Consultation with Emily Boorman CNS Critical Care, LTC Physician COVID-19 Task Force, FH Infection Prevention and Control

CTC Antimicrobial and immunomodulatory therapy in adult patients with COVID-19

British Columbia COVID-19 Therapeutics Committee (CTC) Clinical Practice Guidance for

Antimicrobial and Immunomodulatory Therapy in Adult Patients with COVID-19

SUMMARY
last updated July 14th, 2020

Recommendations in this document apply to patients > 18 years of age. For details including special populations, refer to the complete summary document.

There is limited clinical evidence to guide antiviral therapy for patients with COVID-19.

Specialist consultation (e.g., Critical Care, Infectious Disease, Hematology, or Rheumatology) is recommended if any investigational treatment is offered to a patient with COVID-19 outside of approved clinical trials. Informed consent should be obtained from the patient or the substitute decision maker.

SEVERITY OF ILLNESS	ANTIVIRAL THERAPY Unless otherwise specified, recommendations include antivirals alone or in combination	ANTIBACTERIAL THERAPY	IMMUNOMODULATORY THERAPY	OTHER THERAPEUTICS
Critically Ill COVID-19 Patients *Hospitalized, ICU-based* Patients requiring mechanical ventilatory and/or vasopressor/inotropic support	**Chloroquine** or **Hydroxychloroquine** is **not** recommended for the treatment of COVID-19 **Lopinavir/ritonavir** is **not** recommended outside of approved clinical trials **Remdesivir*** is **not** recommended outside of approved clinical trials. Remdesivir shortened time to clinical recovery but failed to show any survival benefit in the ACTT-1 trial. Remdesivir is currently not approved by Health Canada. **Ribavirin/Interferon** is **not** recommended outside of approved clinical trials	**Ceftriaxone 1-2 g IV q24h x 5 days** is recommended if there is concern for bacterial co-infection (alternative for severe beta-lactam allergy: moxifloxacin 400 mg IV q24h x 5 days) **Azithromycin 500 mg IV q24h x 3 days** is recommended if atypical bacterial infection is suspected (not required if on moxifloxacin) De-escalate on the basis of microbiology results and clinical judgment	**Dexamethasone 6 mg IV/PO q24h for up to 10 days** is **strongly recommended** (RECOVERY trial), unless higher doses are indicated**. If Dexamethasone is not available, methylprednisolone 30 mg IV q24h is the preferred alternative. **Tocilizumab** or **sarilumab** is **not** recommended outside of approved clinical trials; where clinical trials are not available, expert consultation is recommended (Infectious Diseases, Hematology, Rheumatology)	**Enoxaparin 30 mg SC q12h** is **suggested** for VTE prophylaxis **ACE inhibitors** and **ARBs** should not be discontinued solely on the basis of COVID-19 **NSAIDs** should not be discontinued solely on the basis of COVID-19
Severely Ill COVID-19 Patients *Hospitalized, ward-based, long-term care* Patients requiring supplemental oxygen therapy	**Chloroquine** or **Hydroxychloroquine** is **not** recommended for the treatment of COVID-19 **Lopinavir/ritonavir** is **not** recommended outside of approved clinical trials **Remdesivir*** is **not** recommended outside of approved clinical trials. Remdesivir shortened time to clinical recovery but failed to show any survival benefit in the ACTT-1 trial. Remdesivir is currently not approved by Health Canada. **Ribavirin/Interferon** is **not** recommended outside of approved clinical trials	Antibacterial therapy is **not** routinely recommended outside of approved clinical trials unless other indications justify its use (e.g., suspected bacterial co-infection in COVID-19 positive patients)	**Dexamethasone 6 mg IV/PO q24h for up to 10 days** is **recommended** (RECOVERY trial), unless higher doses are indicated**. If Dexamethasone is not available, methylprednisolone 30 mg IV q24h or prednisone 40 mg PO q24h are the preferred alternatives. If dexamethasone supplies are limited, they should be reserved for critically ill patients. **Tocilizumab** or **sarilumab** is **not** recommended outside of approved clinical trials	**Enoxaparin 30 mg SC q12h** should be **considered** for VTE prophylaxis in severely ill hospitalized patients **ACE inhibitors** and **ARBs** should not be discontinued solely on the basis of COVID-19 **NSAIDs** should not be discontinued solely on the basis of COVID-19
Mildly Ill COVID-19 Patients *Ambulatory, outpatient, long-term care* Patients who do not require supplemental oxygen, intravenous fluids, or other physiological support	**Chloroquine** or **hydroxychloroquine** (with or without azithromycin) is **not** recommended outside of approved clinical trials **Lopinavir/ritonavir** is **not** recommended outside of approved clinical trials **Remdesivir*** is **not** recommended outside of approved clinical trials. Remdesivir shortened time to clinical recovery but failed to show any survival benefit in the ACTT-1 trial. Remdesivir is currently not approved by Health Canada. **Ribavirin/Interferon** is **not** recommended outside of approved clinical trials	Antibacterial therapy is **not** routinely recommended outside of approved clinical trials unless other indications justify its use (e.g., suspected bacterial co-infection in COVID-19 positive patients)	**Corticosteroids** are **not** recommended outside of approved clinical trials unless otherwise indicated** **Tocilizumab** or **sarilumab** is **not** recommended outside of approved clinical trials	**ACE inhibitors** and **ARBs** should not be discontinued solely on the basis of COVID-19 **NSAIDs** should not be discontinued solely on the basis of COVID-19
Prophylaxis Patients with known COVID-19 exposure	**Chloroquine** or **hydroxychloroquine** is **not** recommended for prophylaxis in patients with known COVID-19 exposure			

** Currently unavailable in Canada*
*** e.g., asthma exacerbation, refractory septic shock, history of chronic steroid use, obstetric use for fetal lung maturation*

This document is dynamic and addresses key therapeutic areas of concern for clinicians. The complete and most up-to-date version of the guidelines is available at http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care/clinical-care/treatments

Vancouver Coastal Health — Promoting wellness. Ensuring care.
fraserhealth — Better health. Best in health care.
Provincial Health Services Authority — Province-wide solutions. Better health.
Providence Health Care — How you want to be treated.
island health
Interior Health — Every person matters
northern health — the northern way of caring
British Columbia Ministry of Health
BC Patient Safety & Quality Council — Working Together. Accelerating Improvement.
First Nations Health Authority — Health through wellness

Donning and Doffing PPE Guidelines

COVID-19

COVID-19 Donning and Doffing PPE Guidance for Extended Mask and Eye Protection for Long-Term Care, Assisted Living, and Mental Health and Substance Use Facilities

These donning and doffing PPE procedures are interim guidance based on the Keeping You Informed Memo (COVID-19 Extended Wear PPE in LTC and MHSU).
Perform only absolutely necessary AGPs to reduce the need for N95 respirators. When performing AGPs, please refer to the FH Aerosol Generating Procedures Standard Operating Procedure.

1.

- Health care providers (HCP) must perform hand hygiene to start
- HCP will put on a surgical/procedure mask and eye-protection (goggles or face-shield) at the beginning of their shift on a LTC, AL, or MHSU Resident care unit.
- Clean hands

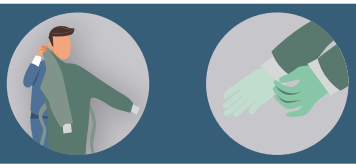
2.

- Avoid touching eye-protection or surgical/procedure mask
- Immediately clean your hands if mask or eye-protection is touched
- If mask becomes damp/damaged/visibly soiled or is difficult to breath through, remove and discard mask, clean hands and apply a new mask

If Resident is deemed to have respiratory symptoms, Droplet Precautions are required; proceed to Step 3.
If the Resident is asymptomatic (no Droplet Precautions), follow routine practices and proceed to Step 5.

3.

- After cleaning hands, put on a long-sleeved gown and gloves.
- Put on gloves
- Provide care as per routine protocols



4.

- Prior to the immediate exit of the Client's home (a minimum of 2 meters from the Resident), remove gloves
- Clean hands
- Remove gown and discard in the regular garbage if disposable
- Proceed to step 5
- Clean hands

5.

- Exit the Resident room
- Clean hands
- Continue wearing surgical/procedure mask and eye-protection between all Resident interactions
- It is not necessary to remove masks or eye-protection when going from room to room or while working on the resident care unit

6.

- Discard mask and clean hands prior to eating/drinking during breaks or if it becomes damaged/damp/visibly soiled or difficult to breath through
- Clean hands

7.

- Remove and clean eye-protection equipment as per cleaning and disinfection instructions at end of shift
- Clean hands
- Discard mask at end of shift
- Put on clean eye-protection and a new mask when returning to the unit or repeat steps 1-7 as needed
- Clean hands

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End-of-Life Symptom Management COVID-19

Symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside of the ICU

adapted from BC Centre for Palliative Care Guidelines* with input from Palliative Care MDs & pharmacists. Thank you to all who contributed!

BEFORE enacting these recommendations PLEASE identify patient's LEVEL OF INTERVENTION these recommendations are consistent with: DNR, no ICU transfer, comfort-focused supportive care

Suggested tools to assist with conversation:
From Seattle MDs: COVID-19 Conversation Tips (http://bit.ly/SeattleVitalTalkCOVID19)
Serious Illness Conversation Guide (http://bit.ly/SeriousIllnessConversationGuide)
Communicating Serious News (UpToDate; requires login http://bit.ly/CommunicatingSeriousNews)

All below are STARTING doses. COVID-19 symptoms may advance quickly. Be prepared to escalate dosing.

Consider dose ranges to give frontline staff capacity for urgent clinical decision-making as needed.

Patient NOT already taking opioids ("opioid-naive")

OPIOIDS
(ALL relieve dyspnea & can be helpful for cough - *codeine is not recommended*)

Opioids help relieve acute respiratory distress & agitation, contribute to energy conservation

Begin at low end of range for frail elderly

Start with PRN *but* low threshold to advance to q4h / q6h scheduled dosing: Avoid PRN = "Patient Receives Nothing"

MORPHINE
2.5 - 5 mg PO ***OR*** 1 - 2 mg SQ / IV
q1h PRN *(SQ / IV can be q30min PRN)*,
if >6 PRN in 24h, MD to review

HYDROMORPHONE
0.5 - 1 mg PO ***OR*** 0.25 - 0.5 mg SQ / IV
q1h PRN *(SQ / IV can be q30min PRN)*,
if >6 PRN in 24h, MD to review

If using >6 PRNs in 24h, consider dosing at q4h REGULARLY *(consider q6h for frail elderly)* *AND* continue a PRN dose

PLEASE TITRATE UP AS NEEDED

Also consider (see guidelines):*
PO solution for cough
eg. dextromethorphan, hydrocodone
antinauseant eg. metoclopramide SQ
laxative eg. PEG / sennosides

Patient already taking opioids

Continue previous opioid, **consider increasing by 25%**

To manage breakthrough symptoms: **Start opioid PRN at 10% of total daily (24h) opioid dose**

Give PRN: **q1h PRN if PO, q30min if SQ**

See guideline for conversion between opioids*

For further assistance including telephone support please contact your local Palliative Care team

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FOR ALL PATIENTS: OTHER MEDICATIONS

Opioids are the mainstay of dyspnea management, these can be helpful adjuvants

For associated anxiety:
LORAZEPAM
0.5 - 1 mg SL q2h PRN,
initial order: max 3 PRN / 24h,
MD review when max reached
consider q6-12h regular dosing

For severe SOB / anxiety:
MIDAZOLAM
1 - 4 mg SQ q30min PRN,
initial order: max 3 PRN / 24h,
MD review when max reached

MAY REQUIRE MUCH MORE
consider q4h regular dosing or continuous infusion if available

For agitation / restlessness:
METHOTRIMEPRAZINE
2.5 - 10 mg PO / SQ q2h PRN,
initial order: max 3 PRN / 24h,
MD review when max reached
consider q4h regular dosing
can also be given buccally

Respiratory secretions / congestion near end-of-life

Advise family & bedside staff: not usually uncomfortable, just noisy, due to patient weakness / not able to clear secretions

Consider glycopyrrolate 0.4mg SQ q4h PRN ***OR***
atropine 1% (ophthalmic drops) 1 - 2 drops SL q4h PRN

If ? fluid overload consider furosemide 20mg SQ q2h PRN & monitor response

Engage with your team to ensure comfort is the priority as patients approach end of life. Please ensure written orders reflect this. Unmanaged symptoms at time of death will add to distress of patients, family members & bedside staff.

These recommendations are for reference and do not supercede clinical judgement.
Please adapt as needed for appropriate use in your population.

We have attempted to decrease complexity to allow barrier-free use in multiple settings.

Evidence supports that appropriate opioid doses do not hasten death in other conditions like COPD or advanced cancer; reassess dosing as patient's condition or level of intervention changes.

Latest version of this document: *(online updates may be slightly delayed)* http://bit.ly/LatestCOVIDSxDoc

***BC Centre for Palliative Care Guidelines** http://bit.ly/BCCentreSymptomManagementGuidelines

Version: 2020 Mar 25. Recommendations compiled collaboratively with input from a team of BC Palliative Care MDs, pharmacists & allied health. Feedback to katie.mcaleer@gmail.com

Essential Visitors Protocol

Version	Date	Comments / Changes
1.0	FINAL	Initial Clinical Protocol Released
2.0	Month Year	Revision

1. PURPOSE

- Support decision making about whether a requested visit is an essential visit.
- Support documentation of the decision made regarding essential visit approval or denial
- Support the identification of the parameters of the essential visit
- Provide requirements of necessary steps that must be taken to ensure the essential visit is conducted safely.

2. SCOPE

Applies to registered Assisted Living and licensed Long Term Care within the geographical borders of Fraser Health.

3. BACKGROUND

As per the May 19, 2020 Ministry of Health Policy Communique 2020-01: Infection Prevention and Control for Novel Coronavirus (COVID-19) a broad definition of essential visits are those which can include but are not limited to:

- Visits for compassionate care, including critical illness, palliative care, hospice care, end of life, and Medical Assistance in Dying;
- Visits paramount to the patient/client's physical care and mental well-being, including:
    - Assistance with feeding;
    - Assistance with mobility;
    - Assistance with personal care;
    - Communication assistance for persons with hearing, visual, speech, cognitive, intellectual or memory impairments;
    - Assistance by designated representatives for persons with disabilities, including provision of emotional support;
    - Visits for supported decision making; and
- Visits required to move belongings in or out of a client's room.
- Police, correctional officers and peace officers accompanying a patient/client for security reasons.

In a majority of cases family members or friends will be the individuals identified as the essential visitor. However, according to the Communique it is appropriate to utilize existing registered volunteers if they are providing an essential service.

The BCCDC/MOH *Interim Guidance for Infection Prevention and Control for Covid-19 in Long Term Care and Seniors Assisted Living (May 19, 2020*) provides guidance regarding practices for sites and visitors to follow when on site.

4. DEFINITIONS

Essential visit: Essential visits are necessary visits directly related to resident/tenant care needs. It must be determined that the absence of the visitor and/or replacement of visitor by staff is contributing to recognizable harm to resident/tenant's physical care and/or mental wellbeing.

Actively Dying: Death anticipated as imminent (i.e. within next 1-2 weeks), resident/tenant is bed bound AND taking minimal oral nutrition and Goals of care are established through discussions with resident/tenant/ substitute decision maker and are documented. MOST form has been completed to support care of resident/tenant.

5. RELEVANT RESOURCES

BCCDC Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim Guidance for Long-Term Care and Seniors Assisted Living

May 19 2020 Ministry of Health Policy Communique 2020-01

Actively Dying Protocol: Caring for Residents in Final Days (Residential Care). Section 4.1 Page 4 of 14.
http://fhpulse/clinical_resources/clinical_policy_office/Lists/CDST%20Library/DispForm.aspx?ID=52

6. APPLICATION PARAMETERS and REQUIREMENTS

The guiding principles on which this protocol was developed are:

- To ensure public and staff safety is maintained, society protects itself against the risk of serious harm and protects the lives and wellbeing of vulnerable residents/tenants
- To advance the wellbeing of residents/tenants based on their values and beliefs
- To ensure the goals of the visitation policy are justified and consistent across facilities
- To work collaboratively, compassionately and transparently in making decisions
- To ensure flexibility in making decisions
- To protect the lives of vulnerable residents/tenants and prevent avoidable morbidity and mortality (saving life, preventing disease)

Consistent with the principles, essential visits will be permitted for any registered Assisted Living or licensed Long Term Care home which is not on COVID-19 outbreak. In the event that a site is on COVID-19 outbreak then essential visits will be allowed only for actively dying residents/tenants; one visitor per resident/tenant per day.

To apply this protocol for essential visitor attendances:

- Each facility must identify a lead who will ensure that the essential visitor policy is followed and that the application of this protocol is understood.
- Each site must keep a log of visitors who attend the site- the time they arrived and the time they departed. This supports contact tracing if required at any point, and may be requested by the Health Authority or Ministry of Health for informational purposes.
  (NOTE: BC CDC reference document Appendix B Visitor sign in sheet for a sample visitor log * *requires adaptation to include time in and time out)*
- Each site must document and log all essential visit requests and identify which are accepted and which are denied.

7. ASSESSMENT

Facility/Site Assessment

Before assessing individual essential visit requests, the facility/site must assess their capacity to support essential visits based on facility operations, staffing and physical space, and prepare their site to support the visitors (e.g. physical cueing, screening, instructions re PPE and distancing, etc.).

Identify the number of essential visits that can be accommodated based on:

- physical environment and ability to maintain physical distancing
- staff resources to support and monitor screening at entry
- provision of, and instruction in, necessary PPE

Schedule visits considering:

- total number of visits per day
- visiting times
- duration of visit
- frequency of essential visits for a single resident/tenant

Resident/Tenant Assessment

The decision to allow an essential visit should be made with the primary focus being the care needs of the resident. An essential visit is a necessary visit directly related to resident/tenant care needs as identified in the care plan.

The individual or substitute decision maker (if the individual is not capable) and involved family must be actively consulted as part of determining the visit as essential.

Components to Assessing an Essential Visit

COVID-19 STATUS OF FACILITY		
Is the LTC/AL facility COVID-19 free?	☐ YES	☐ NO
If YES continue If NO 1 essential visitor for an actively dying resident/tenant. Review exception process in section 11 of protocol		
PURPOSE OF VISIT		
Does the visit meet one or more of the essential visit categories as per MOH policy? If yes, which one (s)?	☐ YES	☐ NO

• Visits for compassionate care, including critical illness, palliative care, hospice care, end of life, and Medical Assistance in Dying;
• Visits paramount to the patient/client's physical care and mental well-being, including:
  • Assistance with feeding;
  • Assistance with mobility;
  • Assistance with personal care;
  • Communication assistance for persons with hearing, visual, speech, cognitive, intellectual or memory impairments;
  • Assistance by designated representatives for persons with disabilities, including provision of emotional support;
  • Visits for supported decision making; and
• Visits required to move belongings in or out of a client's room.
• Police, correctional officers and peace officers accompanying a patient/client for security reasons.
	☐
	☐
	☐
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		☐

Does the visit directly relate to the resident /tenant's care plan?	☐ YES	☐ NO
Is the resident/tenant's need being adequately met through staff? – review clinical evidence to identify how well the need is being met, or not and be prepared to share objective findings.	☐ YES	☐ NO
Has the resident/tenant and family provided input into how adequately the care needs are being met, and how a visitor might address any gap?	☐ YES	☐ NO
Has there been discussion with key care team members, such as: most responsible physician, operational leader, social worker (if available) with care team confirmation about the importance of the proposed essential visit in meeting the resident/tenant's care needs?	☐ YES	☐ NO
Have other possible alternatives been ruled out as ineffective: - Family visits by telephone, Skype/Zoom, window visits - Recreational therapy specific to individual needs	☐ YES	☐ NO

CLINICAL EVIDENCE SUPPORTING ESSENTIAL VISITS:

Essential visits should be provided:

- ***When clinical indicators are demonstrating a decline in function that can be attributed to the absence of the visitor***
- ***When replacement of visitor by staff result in harm to resident/tenant's physical care and/or mental wellbeing***
- ***When resident/tenant require assistance by a visitor to support essential decision making***

Examples demonstrating a change related to the absence of an essential visitor:

- Residents/tenants who have previously had consistent visits for meal assist- and changes are notable decline in appetite and intake,
- Residents/tenants who previously had consistent visits for personal care- and changes noted are resistive behaviour and declining personal care assistance (e.g. now recognizable skin breakdown)
- Residents/tenants who previously had consistent visits for mobilization- and changes noted are increased falls due to deconditioning
- Residents/tenants who previously had consistent visits sensitive to language or cultural factors- changes noted are signs of depression, withdrawal, changes in mood, or resistive behaviour
- Residents/tenants who display (new since Covid-19 pandemic) one or more indicators of depressed, sad or anxious mood which are not easily altered by attempts to "cheer up", console, or reassure the resident
- Residents/tenants who require assistance to adequately plan and complete advanced care planning decisions (power of attorney or representation agreements)

Is there sufficient clinical evidence to support an essential visit? Include rationale below.	☐ YES	☐ NO

ESSENTIAL VISITOR ASSESSMENT		
Facility/site must ensure that the essential visitor agrees and is capable of the following:		
- Being available frequently and consistently to reasonably meet the care need	☐YES	☐NO
- Family member willing to stay home if ill (including new mild symptoms) and be screened upon entrance when arriving for a visit	☐YES	☐NO
- Perform hand hygiene, practice respiratory etiquette, wear required PPE and maintain physical distancing practices	☐YES	☐NO
- To travel directly between the entrance and the resident/tenant's room, and do not deviate to other locations with the site	☐YES	☐NO
PROCEED WITH ESSENTIAL VISIT if all answers are YES		

8. IMPLEMENTATION:

As per British Columbia Centre for Disease Control Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim Guidance for Long-Term Care and Seniors Assisted Living May 19, 2020
See Pages 6 and 7

- All visitors entering the facility must be actively screened on every visit for signs and symptoms of all gastrointestinal and respiratory infections, including COVID-19
- All visitors with symptoms identified via screening must NOT enter the facility.
- All visitors on self-isolation in accordance with Public Health directives must NOT enter the facility.
- All visitors must sign-in when entering the facility
- All visitors must be capable of complying with appropriate precautions, including infection prevention and control measures. If not, the visitor must be excluded from visiting.
- All visitors must be instructed on how to put on a surgical/procedure mask.
- All visitors must be instructed on how to practice respiratory etiquette, hand hygiene and physical distancing (i.e., maintaining at least two meters of physical distance from others at all times).
- Provide all visitors with handouts and information about COVID-19, including the need for visitor restrictions during the pandemic.
- All visitors should limit the time they spend in the facility by visiting the resident/tenants room or suite directly upon arrival and exiting the building immediately following their visit.

Establish a Consistent and Fair Application of Essential Visit Guidelines

Facilities must ensure a transparent process for residents/tenants/substitute decision makers to identify and document:

- how and when a resident/tenant would benefit from an essential visit
- the designated visitor(s) to conduct the essential visit
- frequency of visits
- duration of essential visitor "approval"

- rationale if the visit is not deemed essential

The requestor should be provided with an opportunity to have the decisions reviewed by the facility and be provided a clear justification of the decision. If the requestor is not satisfied, they can request a formal review of a decision through the Patient Care Quality Office (1-877-880-8823; email pcqoffice@fraserhealth.ca.)

9. DOCUMENTATION

- Documentation should be completed as per standard practice for site.
- Documentation must include the essential visit assessment checklist
- **All** essential visitor requests must be logged -including those that are accepted and those that are denied
- As identified in the Section 6 Application Parameters and Requirements a log of essential visitors is required including (First and Last Name, Email, Phone number, Date, Time they arrived, Time they departed)
    - Retain visitor logs for up to 120 days

10. EVALUATION AND MONITORING

LTC-AL-IL Coordination Centre will monitor feedback on process from facilities and families and residents/tenants and adjust/revise as indicated

Provider survey will be distributed in 1 month to evaluate application of protocol.

11. EXCEPTION PROCESS

If your site is in outbreak, document if there is a request for an essential visit outside of current standard of 1 essential visitor for an actively dying resident/tenant. The outbreak site's Emergency Operations Centre in consultation with Public Health and/or Fraser Health Infection, Prevention and Control Service will consider exceptions.

12. REFERENCES

BCCDC Infection Prevention and Control for Novel Coronavirus (COVID-19): Interim Guidance for Long-Term Care and Seniors Assisted Living

May 19 2020 Ministry of Health Policy Communique 2020-01

Actively Dying Protocol: Caring for Residents in Final Days (Residential Care). Section 4.1 Page 4 of 14. http://fhpulse/clinical_resources/clinical_policy_office/Lists/CDST%20Library/DispForm.aspx?ID=5

13. APPENDICES (TBD)

Exemption to Quarantine Act for Compassionate Reasons

Background:

The Government of Canada recently introduced a process to enable entry for travellers into Canada and limited release from mandatory quarantine for compassionate reasons. This process includes sign off by a licensed health professional and, where applicable, sign off by a site/service administrator. For more information, visit: Government of Canada - COVID-19: Compassionate entry for travellers and limited release from quarantine

Purpose:

The purpose of this document is to:

- provide guidance for the consistent interpretation and application of the process within Fraser Health
- ensure a fair and equitable process is applied consistently for all potential visitors
- ensure the safety of patients/residents/clients as well as staff and medical staff
- ensure the process is applied in a way that will improve the quality of life of patients/residents/clients and provide culturally safe care
- support infection prevention strategies to minimize risk of COVID-19 spread throughout society

Scope:

The guidance provided in the document applies to all Fraser Health settings.

Definitions:

Actively Dying: A person for whom death is anticipated as imminent (i.e. within next 1-2 weeks)

Critically Ill: A person whose conditions are life-threatening and who requires comprehensive care and constant monitoring.

Compassionate Reasons: The Government of Canada will consider applications for those needing to:

- be present during the final moments of life for a loved one or to provide support or care to someone who is critically ill.
- provide care to a person who has a medical reason as to why they require support
- attend a funeral or end of life ceremony.

Essential Visit: As defined by the BC Ministry of Health, essential visits include, but are not limited to:

- visits for compassionate care, including critical illness, palliative care, hospice care and Medical Assistance in Dying.
- visits paramount to the patient/client's physical care and mental well-being, including:
    - assistance with feeding
    - assistance with mobility
    - assistance with personal care

- communication assistance for persons with hearing, visual, speech, cognitive, intellectual or memory impairments
- assistance by designated representatives for persons with disabilities, including the provision of emotional support
- visits for supported decision making
- visits for pediatric care, labour and delivery

Licensed Health Professional: An authorized health professional, licensed to practice in British Columbia, including physicians, registered nurses, licensed practical nurses, and allied health professionals.

Site/Service Administrator: For the purpose of signature of the Government of Canada Site Administrator form, *Site/Service Administrator* will be defined as the Executive Director, Site Medical Director, or Director of Clinical Operations for Fraser Health facilities/services and Director of Care for contracted facilities.

Guidelines checklist:

- ☐ **Appropriate Licensed Health Professional**: The health professional signing off has appropriate familiarity with the patient/resident/client situation.
- ☐ **Communication**: The health professional signing off (if not the MRP) has communicated the request with MRP and appropriate members of the care team.
- ☐ **Timeline:** It is reasonably foreseeable that travel timelines will allow the purpose of the visit could be achieved.
- ☐ **Consent:** The patient/resident/client has consented to visit OR decision aligns with patient wishes according to the judgment of a substitute decision-maker OR visit is in the best interest of the patient/resident/client
  - The visitation by the individual should align with patient/resident/client values and beliefs.
- ☐ **Essential Visitor Policy:** The visit meets both the MoH essential visitor policy definitions as well as requirements specific for visitors to that facility/service area, including any requirements for facilities or units in Outbreak or visiting COVID positive patients/residents/clients (see *Appendix A* for links to the visitor policies).
  - The federal process is meant to respect provincial and health authority requirements.
- ☐ **Informed choice**: The visitor understands the risks involved to all those affected by the decision.
  - All potential visitors should have the risks of the visit explained before authorization is provided, including the risk of COVID transmission to the patient, to the family, to health care providers and to the broader community. Travellers who are coming from locations with a high prevalence of COVID infection should be requested to exercise extra care and discretion in their decision-making and adherence to infection control measures.
- ☐ **Screening:** Visitor meets screening requirements at time of request and agrees to do so upon presenting to facility
- ☐ **Personal Protective Equipment (PPE):** Appropriate PPE will be available for the visitor.
  - Medical grade PPE is required for all visitors who have been exempted from the quarantine restriction.

- **Agreement to comply with instructions and safety measures:** The visitor is willing and able to comply with requirements during visit (e.g. PPE, directly enter/exit facility, hand hygiene, two-metre physical distancing from others wherever possible, expectation for self-isolation when not visiting)

Process:

Licensed Health Professional Sign Off

Review by the licensed health professional who has appropriate familiarity with the patient/resident/client situation to confirm that the reason for the visit meets one of the following criteria outlined in the Government of Canada process:

- To be present during the final moments of life for a loved one or to provide support or care to someone who is critically ill;
- To provide care to a person who has a medical reason as to why they require support;
- To attend a funeral or end of life ceremony.

Obtain sign off by licensed health professional.

Site/Service Administrator Sign Off

Request to facility via patient/client/resident or decision maker to unit/facility/service area.

The designated unit/facility/service area lead assesses:

- If the sign off by the licensed health professional is completed (if not complete, facilitate the steps above);
- If the applicant meets screening criteria at time of request;
- If the applicant meets essential visit policy criteria.
- Review visit requirements for safety measures during visit and applicant agreement to follow safety measures.

Submit for sign off to site/service administrator prior to travel. Maintain copy for reference upon arrival. A copy should be kept in the patient/client's chart.

Provide letter to visitor confirming expectations for visit.

Add visitor to approved visitor list for the facility. Ensure arrangements and communication about the visit are made with unit according to site-specific visitor processes.

Note: Additional precautions required for the visitor due to the quarantine exception (e.g. medical grade PPE; potential need for alternate visit location) must be communicated. Additional consideration should be given to the location of the visit to maintain two-metre distance with other patients/residents/clients, particularly if the facility has multi-bed rooms.

At the time of visit(s), review expectations and process with visitor. The visitor should be met at the facility entrance and escorted at all times.

Decision Making Resources/Support:

If decision maker not available: make best reasonable decision in interest of the patient/resident/client.

If uncertainty or disagreement about the visit, initiate a clinical ethics consultation request clinical ethics consultation request for same day response. (NOTE: Only available to Fraser Health locations at this time.)

References:

Government of Canada - COVID-19: Compassionate entry for travellers and limited release from quarantine

Ministry of Health Policy Communique - May 19, 2020

Appendix A:

Long-Term Care, Assisted Living COVID-19 Resource Toolkit

Family Presence Policy - Guideline for Essential Visits in Acute Care during COVID-19

LTC Resident Transfers COVID19

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LONG-TERM CARE – Transfers of Residents during COVID-19

NOTE: Transfers to LTC from Assisted Living or from another LTC home require 14 days isolation/droplet precautions post arrival

Transfers for Essential Medical Appointments

Resident with serious medical condition. Serious Illness & Goals of Care Conversation with MRP*, Resident & Family

Resident to continue with essential medical appointment (e.g. renal dialysis)

Use **FH COVID-19 Screening Process for LTC, MHSU, AL & Other Residential Settings.** Confirm medical appointment/ transportation with receiving institution & ensure all aware if resident is symptomatic

Urgent Transfers to Emergency Department

Resident has an acute event (e.g. fracture). Serious Illness & Goals of Care Conversation with MRP*, Resident & Family

MRP* determines that acute care is required & contacts receiving ED physician. Sending & receiving physicians discuss transfer of resident

Transfer approved

Transfer declined.

Inform ED of transfer prior to resident's arrival. Ensure Ambulance Services & receiving institution are aware if resident is symptomatic

Transfers to Higher Level of Care

ACT receives a transfer request to higher level of care (BSTN, Enhanced/Vent Unit, Tertiary OAMH)

ACT & care home consult with CNS to identify solutions to support resident in place

Unable to mitigate resident care needs in current environment

Able to mitigate resident care needs

Resident remains in current LTC facility

ACT confirms COVID-19 status of resident with sending & receiving care home.

Prepare resident for transfer. Apply surgical/procedural mask on symptomatic resident if tolerated

Upon resident return or arrival to care home, screen **using COVID-19 Screening Process for LTC, MHSU, AL & other Residential Settings**

* MRP also refers to On-Call Designate

Notify MRP* if resident becomes symptomatic/symptoms worsen.

Long-Term Care-Assisted Living-Independent Living Coordination Centre Updated: [August 27, 2020]

Management strategies for wandering and restlessness in COVID19 positive patients with dementia

Management strategies for wandering and restlessness in COVID-19 positive patients with dementia

Dr. Atul Nanda, MBBS, FRCPC | Lead Physician for Geriatric Psychiatry in Long-Term Care

April 23, 2020

Background

- Wandering is not an uncommon symptom in patients with cognitive impairment
- Majority of these patients are usually redirectable and manageable
- It can be a major risk for spreading COVID-19 to other residents and care staff
- Treatment of these patients can be challenging for physicians and healthcare team
- There are multiple contributing factors to restlessness and wandering
- Currently there is limited evidence for symptomatic treatments in dementia
- Non pharmacological approaches should be considered the mainstay of therapy, complemented by psychotropic medications only when unavoidable
- Agitation is defined as ill-defined spectrum of abhorrent hyperactive motor behavior such as wandering
- It is accompanied by emotional distress and excess emotional disability
- Worse in evening hours - “sundowning”

Assessment

- Causes
  - Modifiable factors: unmet needs, acute medical problems, knowledge about the condition, caregiver distress, over/under stimulation, lack of routine, caregiving quality, caregiving quantity, caregiving knowledge, family dynamics
  - Unmodifiable factors: medical comorbidities, stage of dementia, type of dementia, brain changes, genetic makeup, personality, life history, infrastructure of care facility
- Describe and measure assessment of wandering and restlessness
  - When and how severe
  - Associated with depression
  - Emotional dysregulation and insomnia
  - Safety issues
  - Any triggers
  - Family dynamic
- Analyze - what do we know about the patient, and what could be contributing
  - Medical, psychological, or social factors

Ethical considerations

- Key ethical principles that constitute values to be considered
  - Harm principle - a society has the right to protect itself from harm (real or threatened) and government is justified in intervening and possibly infringing on rights of the individual to protect the community from harm
  - Autonomy - maintaining individual autonomy
  - Maintain patient privacy and confidentiality
  - Everyone matters equally but not everyone may be treated the same
  - Least resistive means to be used
  - Everyone working together

- Proportionality - measures that are implemented, especially restrictive ones, should be proportional to the level of threat and risk
- All decisions and procedures need to be fair and transparent in managing patients with COVID-19

Values in tension: Respect vs. The harm principle

- When possible, individual liberties and preferences should be respected
- In pandemic settings, individual rights including whether to practice physical distancing do not supersede public health safety concerns.

Risk/benefit analysis

- Public safety - minimize the net harm to public
- Care provider safety and wellbeing - minimize risk to the healthcare providers including moral distress
- Expose as few people to COVID-19 patients as possible
- Justifiable decision-making
- Established core value and practices for COVID-19 consistent with provincial, federal, and health authorities decisions

Non-pharmacological management

- Mainstay of the treatment
- Need creative and novel approach to avoid spreading transmission of COVID-19
- Patients who cannot register, or have lost the ability to comprehend, are not able to follow orders - they will need to be isolated
- Treatment approach depends on the stage of dementia
- Treatment approach also depends on addressing modifiable risk factors
- Non pharmacological approach is based on least restrictive approach, but mindful of risk of harm to others and caregivers
- Patients may react fearfully/increased anxiety as a result of countertransference from the care provider (if you are anxious, they become anxious, if you are fearful, they become fearful)
- Patient may become frightful/have increased anxiety when they don't understand why their caregivers are dressed oddly, with masks/gloves/gowns/faceshields etc.
- Environment of long term care (e.g. high tension, hyperalertness, increased anxiety will rub off on the patients)
- Reduced patience from the caregivers will trigger behavioral disturbance
- Sometimes, redirection and distraction, if not done patiently, can trigger more aggressive behaviour
- Become mindful of what is being displayed on TV, as it should not transfer increased fear and anxiety
- Caregivers to become extra vigilant of their own hygiene and sanitizing habits
- Avoid leaving contaminated PPE where patients can reach
- Encourage and monitor patient hand hygiene
- Monitor what patients may have touched, and immediately clean the surfaces
- Try sanitizing the patients hand as if providing a hand massage
- If patient allows, try putting a mask when he or she is in common areas

- When patient is in their room, close the doors and monitor through monitoring device or regular checkups
- Try and provide regular exercise
- Sensory stimulation and music therapy can be helpful
- Encourage virtual family visits via technology like FaceTime, Skype, Zoom, etc.
- Should continue even when pharmacological interventions are used

Pharmacological management

- Frequently provided but carries the risk of serious side effects
- Most of the medications are not approved
    - Antipsychotics are off label
    - Multiple morbidities and polypharmacy complicate the use of pharmacotherapy
    - Baseline ECGs should have been done (if feasible)
    - Carefully assess risk/benefit
    - Psychotropics should be for a limited time
    - Initiate low dose, titrate slowly to lowest effective dose
    - Continue to monitor target symptoms like wandering and restlessness
    - Use for shortest period of time
    - Evaluate side effects or the effectiveness
- Cholinesterase inhibitors/memantine
    - Some evidence it may be helpful
- Antidepressants
    - For affective symptoms and anxiety
    - Most commonly used
    - SSRI is reasonable choice, particularly citalopram (monitor QTc)
    - As effective as atypical neuroleptics
    - Tricyclic antidepressants not recommended because of anticholinergic side effects
- Antipsychotics
    - Atypical neuroleptics are first choice
    - Risperidone and aripiprazole are most commonly used
    - Effective in treating psychotic symptoms, agitation and aggressive behavior
    - Risperidone 0.125mg-2mg per day
    - Aripiprazole 1mg-10mg per day
    - Typical antipsychotics like haldol, loxapine etc. not recommended for this behavior
    - Side effects to be kept in mind - anticholinergic, orthostatic hypotension, seizures, EPS, sedation, QTc prolongation, increased risk of CVA, increased mortality
    - Evidence of quetiapine efficacy is mixed - has favorable side effect profile (sedation, lack of EPS), hence used often
        - Dosage can be 12.5mg-200mg per day
- Benzodiazepine
    - Lacks efficacy
    - Associated with sedation, dizziness, falls, worsening of cognition, paradoxical reaction, respiratory depression
- Other medications
    - Anticonvulsants - minimal effectiveness
    - Zopiclone/zolpidem - same as benzodiazepine

Conclusion

- An individualized treatment plan is needed
- A therapeutic decision tree should be established, taking into account a patient's individual and environmental risk
- Psychosocial treatment is pivotal, combining different non-pharmacological approaches is the first choice
- Pharmacological treatment can be added if required
- Regular assessment, close monitoring, discontinuing medications that become inappropriate
- Even with optimal management, sometimes the symptoms will not disappear completely and will remain challenging for all involved

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Pre-Printed Orders for Confirmed or Presumed COVID-19 in LTC

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Regional Pre-Printed Orders for
COVID-19 Confirmed or Presumed
Long-Term Care (LTC)

DRUG & FOOD ALLERGIES

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

- Review Advance Care Planning documents (ACP) Record, Advance Directive, Representation Agreements, Identification of Substitute Decision Maker (SDM) List
- Initiate or engage in conversations (utilize Serious Illness Conversation Guide (SICG SDM COVID-19)), document on ACP Record
- Update MOST with resident & SDM based on above
- If a transfer to acute care is recommended by the MRP, MRP to call receiving ER physician to discuss and accept transfer before calling EHS. Resident to wear a surgical/procedure mask during transportation.

INFECTION PREVENTION AND CONTROL:
- Cohort and isolate (with droplet precautions) all residents with suspected or confirmed COVID-19.
- Ensure staff have reviewed proper donning and doffing techniques
- Stop all Aerosol Generating Procedures (AGP) including nebulized medications, CPAP, nocturnal BiPAP and high flow oxygen for all residents in the facility unless deemed clinically essential.
- Start nocturnal oxygen instead of CPAP treatment. If nocturnal BiPAP use is essential, the resident should be in a private room, on airborne precautions.

MONITORING:
- Vital signs (BP, HR, RR, O_2, Temperature) once daily and as clinically required
- Monitor resident's clinical status, symptoms, and comfort twice per shift
- Use O_2 PRN up to 6 L/min via Nasal Prong to maintain an O_2 sat of 92% or greater
- If on O_2 6 L/min via Nasal Prong and resident unable to maintain an O_2 sat greater than 92%, continue O_2 at 6 L/min and start medications to support comfort with shortness of breath (see page 2, shortness of breath section).

MEDICATIONS:

ANALGESICS AND ANTIPYRETICS:
- Treat fever only if presenting with associated discomfort:
- **acetaminophen** 650 mg PO/rectal Q6H PRN for pain/fever

Select one of the following:

☐ Maximum **acetaminophen** from all sources 4000 mg per 24 hours

OR

☐ Maximum **acetaminophen** from all sources 2000 mg in 24 hours (advanced liver disease)

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#

DRUG & FOOD ALLERGIES

• **Mandatory** ☐ **Optional: Prescriber check (✓) to initiate, cross out and initial any orders not indicated.**

SHORTNESS OF BREATH:

☐ **HYDROmorphone** 0.5 mg PO Q4H PRN

AND/OR

☐ **HYDROmorphone** 0.25 mg subcutaneous Q4H PRN

OR

☐ **HYDROmorphone** _____

If comfort needs are not met despite PRN opioid use, MRP to:

- Adjust the opioid dose if resident is already receiving scheduled narcotics and/or if comfort needs are not met despite PRN opioid use.
- Consider addition of regularly scheduled opioid in addition to PRN if shortness of breath persists.
- Review goals of care if resident is unable to maintain O_2 sat and is experiencing increased respiratory distress.
- Initiate actively dying protocol if appropriate.

CORTICOSTEROID:

☐ **dexamethasone** 6 mg PO daily for 10 days to be started if one of the following criteria is met:

- If resident is requiring supplemental O_2 to maintain O_2 saturation 92% or above.

OR

- If the resident is on baseline O_2 with increasing O_2 requirements.

(Please note that is expert consensus based on data from acute care settings)

☐ Discontinue **dexamethasone** if no longer requiring supplemental O_2 or back to baseline O_2 for 24 hours.

ANTIBIOTICS:

- Antibiotics not recommended for outpatients with COVID-19 who do not require supplemental oxygen.
- Consider antibiotics if suspected bacterial co-infection, rapidly increasing supplemental oxygen requirements, or evidence of sepsis.

☐ **azithromycin** 500 mg PO daily x 3 days (caution if prolonged QTc)

AND ONE OF:

☐ **amoxicillin-clavulanate** 500 mg-125 mg PO TID x 5 days if eGFR greater than or equal to 30 mL/min

☐ **amoxicillin-clavulanate** 500 mg-125 mg PO BID x 5 days if eGFR less than 30 mL/min

OR

IF SEVERE PENICILLIN ALLERGY:

☐ **MOXIfloxacin** 400 mg PO daily x 5 days (addition of azithromycin not necessary)

Date (dd/mm/yyyy)	Time	Prescriber Signature	Printed Name and College ID#

Serious Illness COVID-19 Guide

SERIOUS ILLNESS CONVERSATION GUIDE

A CONVERSATION TOOL FOR CLINICIANS
Adaptation for COVID-19

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The purpose of this scripted guide is to discuss potential outcomes of possible COVID-19 infection with at risk adults prior to a health crisis, including the elderly, those with chronic conditions (eg. heart/lung/renal disease, diabetes) or immunocompromised patients (eg. cancer, HIV/AIDS, transplant recipients). The intention is to open up dialogue and to introduce possible limitations to critical care interventions - eg. they may not be a candidate for ventilation, or for transfer to hospital. It is not intended to be a conversation to convince patients/clients to change their MOST status. This guide is to learn more about patients.

CONVERSATION FLOW	GUIDED SCRIPT
1. ***Set up the conversation*** • Introduce purpose • Prepare of future decisions • Ask permission	"I'd like to talk with you about COVID-19 and what may be ahead for you and your care. I would also like to hear from you about what is important to you so that we can make sure we provide you with the care you want if you get sick with COVID-19 - **is this okay?**"
Transition conversation to Step 2. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
2. ***Assess COVID-19 understanding and preferences***	"What is your **understanding** about COVID-19 and how it is affecting at risk people?" "How much **information** would you like from me about COVID-19 and what is likely to be ahead if you get sick with it?" "How are you **coping** during this time of uncertainty?"
Transition conversation to Step 3. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
3. ***Share prognosis*** • Share prognosis • *Caution: purpose is not to provide patient education* • Frame as a "wish...worry" "hope ... wonder" statement • Allow silence, explore emotion	"I want to share with you our current **understanding** of COVID-19 and how it affects people at risk, specifically those like you with _____ (specific health condition(s), eg. heart/lung/renal disease, cancer, diabetes, etc.)." "COVID-19 is a virus that spreads through contact with liquid droplets when someone coughs or sneezes, often entering through our eyes, nose or throat if you are in close contact. We know that it is particularly serious for vulnerable people, especially for those who have other health problems. It can also cause other very severe problems." "It can be difficult to predict what will happen if you get sick with COVID-19. I **hope** it would not be severe and that you will continue to live well at _____ (current place of residence: home, assisted living, long term care, etc.)." "But I'm **worried** that as an adult with other health problems, you could get sick quickly and that you are at risk of dying. I think it is important for us to prepare for that possibility."
Transition conversation to Step 4 by allowing for silence. Consider exploring emotion. Refer to SIC Clinicians Reference Guide for more scripted language on common difficult responses (Eg. tears, anger, denial). **March 26, 2020**	

SERIOUS ILLNESS CONVERSATION GUIDE

A CONVERSATION TOOL FOR CLINICIANS
Adaptation for COVID-19
Cont'd

CONVERSATION FLOW	GUIDED SCRIPT
4. *Explore key topics* • Meaning • Fears and worries • Sources of strength • Family/People that matter • Best care	"What is **most important** to you right now? What means the most to you, and gives your life **meaning?"** "What are your biggest **fears and worries** about the future and your health?" "What gives you **strength** as you think about the future?" "How much does your **family/people that matter to you** know about your priorities and wishes?" "Is there anything else that we need to know about you so that we can give you the **best care possible?"**
Transition conversation to Step 5. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
5. *Reassurance*	"We want you to know that **our priority is to ensure that you are cared for and comfortable** if you become sicker. Regardless of the medical treatments that you get or do not get, your health care team will always provide treatments to help make you feel better. So it is important to let us know if you get a new cough, fever, shortness of breath or other signs that your health is changing. We will continue to support you as best we can to get the right help for you."
Transition conversation to Step 6. Utilize paraphrasing and demonstrate empathy to let them know they've been heard.	
6. ***Close the conversation*** • Summarize what you've heard • Make a recommendation within your scope of practice • Check in with patient • Affirm commitment ****Refer to Serious Illness Clinician Reference Guide for additional help with recommendations (page 18)****	"I've heard you say that _____ is really important to you. Keeping that in mind, and what we know about COVID-19 and your current health, I **recommend*** that we.... Focus: **Wellbeing** — "Talk again in a few days, to reassess where you are at." Focus: **Illness** — "Talk with your primary care providers." "Make plans for care at home." Focus: **Support System** — "Talk to your family/those that matter to you/including your Substitute Decision Makers." Focus: **Help** — "Get you more information about risks and benefits regarding specific critical care treatments (e.g. restarting your heart or using a breathing machine)." "How does this seem to you?" " I know this is a scary time for all of us. We will do everything we can to help you through this."

7. ***Document your conversation on the ACP Record and fax if non-acute setting. Communicate with primary care providers. Store in Greensleeve if paper charts are used in your setting.***

8. ***Communicate with key clinicians.***

March 25, 2020

Serious Illness Care Program

Reference Guide for Clinicians: COVID-19 Adaptation

The Serious Illness Care Program is a well-established method of how to engage in meaningful discussions with patients and families. In regular circumstances, clinicians are encouraged to attend a 3-hour training session, & read through the 20 pg companion guide. In the current climate, we recognize this isn't possible for most clinicians.

If you need to start using this guide right now – please read this page.

Principles

- You will not harm your patient by talking about their illness and the importance of planning
- Anxiety is normal for both patients and clinicians during these discussions. It is important to acknowledge and validate the emotion(s) in order to move forward
- Patients want and need the truth about prognosis to make informed decisions
- The purpose of this conversation is **not** to establish a new MOST status, if the discussion naturally flows in this direction, explore this in your recommendations.

The order of the questions and the language is chosen very specifically. Patients are very accepting if you explain that you will be reading off the page and following the guided script: *"I may refer to a Conversation Guide, just to make sure that I don't miss anything important."*

Practices

- ✓ Give a direct, honest prognosis about the risk of COVID-19 for your patient's condition to the best of your knowledge, within your own scope of practice
- ✓ Allow silence as time permits
- ✓ Acknowledge and explore emotion as it occurs. Do not just talk about facts and procedures
- ✓ Make a recommendation. In these distressing times, patients & families need to hear your professional opinion.
- ✓ Listen more than you talk.
- ✓ Avoid premature reassurance, instead align with the patients in ***hoping*** things may improve
- ✓ Focus on patient-centred goals and priorities not medical procedures
- ✓ Do not offer a menu of interventions, especially those that are not clinically beneficial
- ✓ Use the wish, worry, wonder framework…
  - **I wish** allows for aligning with the patient's hopes.
  - **I worry** allows for being truthful while sensitive.
  - **I wonder** is a subtle way to make a recommendation.

"I hear you saying you know it is important to do some planning and also that you worry this process will be overwhelming."

"I know this is hard to talk about, but I'd like to see if we can clarify a couple of things about what your worries are about the future."

"I can see how strong you are and how important your family is. I think there is a lot we can do to help you all prepare for the future."

"I wish we weren't in this situation, but I worry that if you got sick with COVID-19 with your other health problems, you would not survive an ICU admission. I wonder if we can take this opportunity to ensure you and your family are prepared."

Resources

- Healthcare Provider Serious Illness Resources
- Clincian Reference Guide: Strategies for Common Scenarios
- Public Advance Care Planning Resources

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Transportation Protocol for Off Site Medical Appointments during COVID-19

Version	Date	Comments / Changes
1.0	October 2020	Initial Clinical Protocol Released

PURPOSE

This protocol for essential off-site medical appointments during the Coronavirus (COVID-19) pandemic will provide guidance to Long-Term Care (LTC) and Assisted Living (AL) Teams (e.g. Most Responsible Practitioners (MRPs), Nurses, Director of Care (DOC), AL Clinical Lead etc.), residents/tenants, and families on:

- How to determine if an off-site medical appointment is necessary;
- How to minimize the risk of COVID-19 exposure and transmission during residents'/tenants' transportation to an essential off-site medical appointment and;
- How to proceed with safe transport of a resident/tenant to an essential off-site medical appointment.

1. BACKGROUND

Approximately 8 in 10 COVID-19-related deaths in Canada have occurred in LTC[4]. A strong body of literature confirms that COVID-19 adds many new risks to the health of older adults. As the pandemic has spread quickly around the globe, it has become increasingly clear that people over the age of 70 with underlying chronic medical conditions are most at risk of a serious or fatal illness after contracting COVID-19. In addition, these same people living in congregate LTC and Assisted Living (AL) settings are at greater risk still due to their daily care needs[2].It is important for protective measures to be sustained even during residents'/tenants' temporary absences from the home to protect LTC/AL residents/tenants from COVID-19 (e.g. for essential off-site medical appointments).

A palliative approach to care in LTC continues during the COVID-19 pandemic and contributes to the decision-making into whether or not a medical appointment is essential for a resident/tenant.

2. DEFINITIONS

Designated family member: The identified person as per the resident's/tenant's care plan.

Essential medical appointment: A medical appointment the resident/tenant must attend in order to enable resolution of an urgent, episodic medical issue, decrease the need for an ER visit or hospitalization, or if delaying the appointment could lead to serious harm.

Family: Defined as whoever the resident/tenant identifies as being important, or identifies as being his or her family, including blood relations, partners, neighbours, and/or friends (Fraser Health, 2016).

Representative: A person named by a capable adult in a Representation Agreement to make health care decisions on behalf of the adult if they become incapable[5].

Third party medical transportation: Non-Fraser Health transportation service available for people who are medically stable (i.e. HandyDART and SN Transfer).

3. RELATED RESOURCES

Medical Orders for Scope of Treatment and Advance Care Planning – Clinical Policy

Long-Term Care, Assisted Living COVID-19 Resource Toolkit

Integrating a Palliative Approach to Care in Long-Term Care – Clinical Practice Guideline

4. APPLICATION PARAMETERS

This protocol applies to staff and residents/tenants in Fraser Health LTC and AL Affiliated and Owned & Operated care homes.

For any essential off-site medical appointment, there will be communication as far in advance as possible of the appointment between the resident/tenant, and family (or substitute decision maker) and health care team (e.g. Most Responsible Practitioners (MRPs), Nurses, Director of Care (DOC) etc.).

5. ASSESSMENT

Determine whether the appointment is consistent with the resident's/tenant's goals of care and clinically necessary. Refer to the Long-Term Care, Assisted Living COVID-19 Resource Toolkit in the section titled Admissions and Transfers: Essential Medical Appointments and the section titled Clinical Practice Resources: Serious Illness Conversation.

What is considered an essential medical appointment?

In order to support decision-making related to resident/tenant health and safety, prior to allowing off-site health related visits, the following questions should be considered and discussed amongst the care team to determine if the visit is essential.

	No	**Yes**
Can the appointment be done virtually OR the health issue(s) be managed by the MRP or by an existing staff member?		
Can the appointment be provided on-site, instead of off-site?		
If answered YES to any of the questions do not proceed with off-site visit. If answered No, proceed to next questions.		

	No	**Yes**
Would the medical appointment enable resolution of an acute and/or urgent episodic medical issue? (e.g. worsening wounds, foot care which if left untreated would result in infection or further burden of care, broken tooth)		
Would the service reduce the immediate or very near-future need for an ER visit or hospitalization?		
Would delaying the appointment lead to increased morbidity and/or serious harm for the resident/tenant?		
If answered Yes to the questions above then proceed with off-site essential medical appointments.		

Fraser Health's LTC/AL residents/tenants are routinely screened for signs and symptoms of COVID-19 a minimum of two times per day (Fraser Health COVID-19 Screening Process for Long-Term Care, 2020).

In addition, care providers need to follow the appropriate set of procedures below depending on the results of the screening for off-site medical appointments.

6. INTERVENTIONS

When transporting an asymptomatic resident/tenant:

a) Recommended method: If it is determined that the appointment should go ahead, it is recommended that resident/tenant be transported by an approved third party transportation company in order to ensure proper infection prevention control measures are followed.

b) Transporting by Family Member: If transport of the resident/tenant by a family member is deemed appropriate and necessary, the following procedures should be reviewed with the resident/tenant and family member in advance of the appointment.

- The designated family member must be capable of complying with appropriate precautions, including infection prevention and control measures.
- The designated family member is responsible for contacting the medical clinic in advance to determine what additional guidelines should be followed during the clinic appointment.
- The designated family member will be actively screened by the care home staff at the entrance for all signs and symptoms of COVID-19 prior to being allowed to transport the resident/tenant. The nurse will document the outcome of the family member screening on the resident/tenant health record.
- If the designated family member is identified with symptoms via screening, the screener staff will inform the leadership at the care home and they must NOT be allowed to transport the resident/tenant.
- Only the designated family member may be involved in transporting the resident/tenant if possible, but an exception can be made if that family member is not suited to provide the transportation (i.e. does not have a driver's license, is not physically able to assist the resident/tenant in and out of the vehicle)
- No other individuals other than the designated family member and the resident/tenant should be in the vehicle.
- The resident/tenant MUST be transported directly to the appointment and back to the care home/AL site. No additional stops should be made.

Designated family member transporting a resident/tenant to an essential off-site appointment must be instructed:

- On how to practice respiratory etiquette, hand hygiene and physical distancing as appropriate (i.e. maintaining at least 2 metres distance from others at all times).
- That both the resident/tenant and designated family member should wear a mask at all times when possible.
- To sign in and out when leaving and returning to the LTC/AL site.
- That the vehicle used for transport should be wiped down with disinfectant prior to transporting a resident/tenant.

The resident/tenant should wash hands and change clothes upon return to the home.

When transporting a symptomatic resident/tenant:

- Symptomatic residents/tenants should have their appointments rescheduled whenever possible. This includes residents/tenants who have been tested for COVID-19 and are awaiting results as well as those who test positive.
- If the appointment is absolutely necessary (e.g. dialysis), the receiving site (e.g. dialysis clinic) must be notified that the resident/tenant is symptomatic and swab results pending and follow additional steps required to safely accommodate the resident/tenant and protect others at the clinic (e.g. re-scheduling the resident's/tenant's appointment to end of day).
- A symptomatic resident/tenant should be:
  - Prepared for transfer by applying a surgical/procedural mask if tolerated
  - Transported via an approved third party transportation company only
  - On Droplet Precautions upon return to the home.

- Family members are **NOT** permitted to transport residents/tenants who are symptomatic, have a swab result pending, or are COVID-19 positive.

7. EDUCATION

Resident/Tenant and Family Member

- Be aware of and follow the instructions to minimize risks of COVID-19 exposure and transmission

Staff

- Be familiar with the Essential Off-site for Medical Appointment Transportation Protocol
- Provide resident/tenant and family members with credible resources on COVID-19, such as the ones provided by the BC Centre for Disease Control (link below) and/or Fraser Health.

8. DOCUMENTATION

- The assessment findings and interventions will be communicated to all the healthcare team members and documented on the resident's/tenant's health record as well as in the care plan.
- Staff will follow the care homes'/AL's process and documentation required for residents/tenants going off-site.

9. CLINICAL OUTCOMES

Through the consistent use of this protocol, it is anticipated that rates of COVID-19 will not increase among residents/tenants of Fraser Health Long-Term Care and Assisted-Living Affiliated and Owned & Operated care homes who attend essential off-site medical appointments.

Health care team members (e.g. MRP, DOC, nurse, AL Clinical Lead) at the care home/AL site will be equipped to determine if an off-site medical appointment is necessary and be able to minimize the risk of COVID-19 exposure and transmission during resident/tenant transportation to appointments.

10. REFERENCES

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What to do with - One Positive COVID Case

Checklist – One (or more) Positive COVID-19 Test Results (Client and/or Staff)

Outbreak Detection and Confirmation	
☐	Notify **Public Health** of any clients (and/or staff) with respiratory or gastrointestinal symptoms (Phone 604-949-7296)
☐	Maintain separate **report and tracking** lists of symptomatic staff and/or clients (see Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form). submit daily via Fax: 604-587-4418
Symptomatic Clients or Confirmed Case	
☐	Post **Droplet Precautions** signage at the door of the affected clients (see Droplet Precautions Poster)
☐	**Isolate** the client in their room
☐	Obtain a **nasopharyngeal (NP) swab** specimen for any symptomatic clients. • The swab should be obtained as soon as possible and sent to a lab for COVID-19 testing. • Ensure labelling of all requisitions with "LTC" to ensure prioritized **testing**
☐	Place a **PPE**, hand hygiene and disinfectant wipes station and laundry hamper outside the symptomatic clients' rooms for the use of staff entering and leaving the room. Place disinfectant wipes outside the room
☐	Continue with extended **surgical/procedural mask and eye-protection** when in common resident/tenant areas. Additionally, wear **gloves and gowns** when providing care for clients on Droplet precaution or when indicated by routine practices
☐	Provide **care** to asymptomatic clients first, then to the confirmed positive COVID-19 client(s)
☐	Ask the client to wear a **surgical/procedural mask** if anyone will be entering their room
☐	Implement COVID **care plan**
☐	Continue to ensure **proactive goals of care** conversations are occurring and client MOST is up to date. Ensure facility (and Medical Director, their delegate, or Most Responsible Provider) is aware and involved in ongoing conversations related to client's goals of care
☐	Ensure that ongoing **serious illness conversations** are occurring as appropriate with Substitute Decision Maker, and goals of care are aligning with management
☐	Consider **cohorting** COVID-19 positive clients – Applicable to LTC only
All Clients	
☐	**Isolate and implement droplet** for any symptomatic clients
☐	**Isolate** all clients on the same floor or neighbourhood as the confirmed positive COVID-19 clients (or where staff worked), to the best extent possible
☐	Implement **droplet precautions** throughout floor/unit/neighbourhood where clients are located or staff and client are epidemiologically linked or interact
☐	Serve **meals** to all clients in-room via tray service (serve confirmed clients last) • If in-room meal service not possible, serve asymptomatic group first in common dining area AND clean dining area particularly high touch areas when finished THEN serve symptomatic/confirmed clients. Maintain physical distancing as much as possible
☐	Continue **symptom checks** for all clients twice daily

☐	Continue with extended **surgical/procedural mask and eye-protection** when on client units. Additionally, wear **gloves and gowns** when providing care for clients on Droplet precaution or when indicated by routine practices
☐	Minimize contact between clients on affected floors/units/wards with unaffected areas through **isolation, discontinuing group activities, physical distancing measures**
☐	Remind clients of **hand hygiene and respiratory etiquette**
☐	**Close** the affected floor/unit/ward from other areas as possible
☐	Ensure ongoing discontinuation of **group activities** and cancel all **client gatherings**
☐	Continue **physical distancing** and avoid clients gathering in common areas
☐	Ensure ongoing cancellation or rescheduling of all **non-urgent appointments** that do not risk the health or well-being of clients
☐	Complete**,** as directed by Public Health, COVID-19 **testing** for other clients of the floor, regardless of reported symptoms • Note mild symptoms in client or atypical/unusual symptoms for assessment and/or testing
Symptomatic Staff	
☐	**Exclude** staff from work • Staff with respiratory or new gastrointestinal symptoms should be excluded from the facility and present to an assessment centre for testing. This includes support staff (e.g. food services, housekeeping, maintenance) working in any site. • **Home isolation** of the staff member for 10 days from the onset of symptoms or until symptom resolution, whichever is longer. A dry cough may persist for several weeks, so a dry cough alone does not warrant continuation of self-isolation
☐	Ensure staff **notify** supervisor/manager
☐	Arrange for **testing**
☐	**Notify** Facility Medical Director
Staff	
☐	**Cohort** staff assignment. Staff working with symptomatic clients avoid working with clients who are well
☐	**Restrict** staff throughout facility (no staff coverage between units/floors)
☐	Active Screening 2 x per shift: Beginning and during shift for all staff. Screen staff for: symptoms (i.e. fever, new or worsening cough, new or worsening shortness of breath, sore throat, and nausea /vomiting and diarrhea); travel outside of Canada, and/or; contact with confirmed COVID-19 case. TIPS: ACTIVE SCREENING of all staff: follow BC CDC guidelines for screening at beginning of shift and during shift. Staff screening of each other must occur and it must be documented during their shift. **FH Screeners can be deployed in an outbreak situation and screening will occur 2 x shift beginning and during shift.**
☐	Confirm facility staff are not actively **working at another site** • If staff are dually employed, staff should be asked to only work at one facility throughout the duration of the outbreak
☐	**Return to Work** • Staff infected with COVID-19 can return to work 10 days after the onset of symptoms or until symptom resolution. A dry cough may persist for several weeks, so a dry cough alone does not warrant continuation of self-isolation. Public Health will provide this information during routine follow-up. Encourage supervisors to follow-up with individual staff members 10 days after a positive test for psychosocial supports.

Facility	
☐	Activate **site** Emergency Operations Centre **(EOC)** with *at a minimum* the Director of Care, the Facility Medical Director (if applicable) and the FH assigned site EOC lead.
☐	Post COVID-19 **outbreak signage** throughout the facility on doors, desk, boards, etc.
☐	Close entire facility to **admissions**
☐	Continue **enhanced cleaning** of floor and/or neighbourhood (consider facility) • 2x/day cleaning throughout the facility including high-touch surfaces (door knobs, faucets in bathrooms, common areas, dining rooms, gyms, recreational therapy rooms, shared equipment). • Use 0.5% accelerated hydrogen peroxide wipes or bleach wipes
☐	Continue to ensure adequate **supply** of PPE, swabs, and hand hygiene materials
☐	Alert regular **PPE** supplier that additional hand hygiene products, gloves, gowns, eye protection, and surgical/procedural masks may be required
☐	Increase restriction on **visitors** to no visitors, unless by special exception for actively dying clients by facility management. Visitor must be screened negative for symptoms.
☐	Ensure **delivery staff** (e.g. linens, food and nutrition, supply management) deliver first to the unaffected units before progressing to affected unit
☐	Dedicate **housekeeping** cart to the outbreak unit
☐	Avoid **garbage and soiled linens** traversing from the affected unit through other units; take directly to holding areas/loading dock
Communicate	
☐	Provide **communication** to facility staff, clients, and families using standardized letters that are provided by Public Health. These letters cannot be altered, but can be attached to a separate letter from the facility. FH Patient Care Quality Office (PCQO) will attend to notify families by phone.
☐	Notify non-facility staff, professionals, and service providers of the **outbreak** and the inability to visit the facility
☐	Discuss **outbreak** with Public Health daily to implement additional outbreak control measures as directed
☐	Maintain separate **report and tracking** lists of symptomatic staff and/or clients (see Public Health Tool 27: Resident Illness Report and Tracking Form or Public Health Tool 28: Staff Illness Report and Tracking Form), submit daily via Fax: 604-587-4418
☐	Encourage diligence in **hand washing** and use of alcohol hand sanitizer for all visitors/clients/staff

Remdesivir for COVID-19 in Long Term Care (LTC)

COVID-19

Date: November 19, 2020 KEEPING YOU INFORMED

Remdesivir for COVID-19 in Long Term Care (LTC)

What is happening?
Remdesivir is an antiviral agent approved by Health Canada for the treatment of COVID-19. A Federal supply of remdesivir has been distributed to the provinces since October 2020. On November 10, 2020, the Provincial Remdesivir Review and Advisory Working Group met and expanded use of remdesivir to select patients outside of clinical trials.

At this time, remdesivir is not available for individuals with COVID-19 in Fraser Health LTC facilities.

Why?
The evidence of clinical benefit for remdesivir remains controversial. Currently published literature does not show any mortality benefit nor reduction in need for mechanical ventilation. The primary benefit shown is reduced duration of illness. There is potentially reduction in hospital length of stay, but uncertainty remains around this outcome. There is no evidence that remdesivir reduces infectivity or spread of COVID-19 outbreaks in facilities.

Remdesivir supply is limited to that provided by the Federal government. In light of limited drug supply, remdesivir should be used to maximize both individual and system-wide benefit. Reduced duration of illness and potentially length of stay would be most beneficial in those requiring acute care admission.

Individuals with COVID-19 can continue to receive treatments with established mortality benefit in LTC facilities (e.g., supplemental oxygen and dexamethasone). Transfer to acute care for remdesivir is **strongly discouraged** given the lack of mortality benefit.

For more information contact Dr. Akber Mithani or Dr. Kevin Afra