

# Lessons learned in providing effective care for older residents in long-term care homes affected by COVID-19

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***2020 SHS/UHN COVID-19 SPECIAL GERIATRICS INSTITUTE EDUCATION DAY***

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# DISCLOSURE AND FINANCIAL SUPPORT

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# A FEW WORDS ABOUT LANGUAGE

- Will use neutral terms like “**older adults**” and “**older Canadians**”, and avoid terms connoting negative stereotypes
  - e.g. “seniors” and “elders/elderly”
- Will avoid catastrophic terms to describe demographic changes
  - e.g. “tidal wave”, “rising tide”, “silver tsunami”

## Instead of These Words and Cues:

## Try:

“Tidal wave,” “tsunami,” and similarly catastrophic terms for the growing population of older adults	Talking affirmatively about changing demographics: “As Americans live longer and healthier lives . . . ”
“Choice,” “planning,” “control,” and other individual determinants of aging outcomes	Emphasizing how to improve social contexts: “Let’s find creative solutions to ensure we can all thrive as we age . . . ”
“Seniors,” “elderly,” “aging dependents,” and similar “other-ing” terms that stoke stereotypes	Using more-neutral (older people, Americans) and inclusive (“we” and “us”) terms
“Struggle,” “battle,” “fight,” and similar conflict-oriented words to describe aging experiences	The Building Momentum metaphor: “Aging is a dynamic process that leads to new abilities and knowledge we can share with our communities . . . ”
Using the word “ageism” without explanation	Defining ageism: “Ageism is discrimination against older people due to negative and inaccurate stereotypes . . . ”
Making generic appeals to the need to “do something” about aging	Using concrete examples like intergenerational community centers to illustrate inventive solutions

# A FEW WORDS ABOUT LANGUAGE

- “The term “informal” suggests “casual, unstructured, unofficial care—pleasant but not essential”; today’s caregivers would tell you they find this term invalidating and that there is absolutely nothing “informal” or unessential about the care they provide”

**Table 1. Terms to Use When Describing Caregiving**

Caregiving role	Terms to be avoided	Less optimal terms	Preferred terms
Provide care primarily because of a <i>personal</i> relationship. They are usually next of kin (spouses, children, or other relatives) but may sometimes be friends or neighbors.	<p><i>“Informal caregiver”</i></p> <p>Family caregivers may find this term insulting and invalidating, and it is an inaccurate description of the complex tasks performed by today’s caregivers.</p>	<p><i>“Care partner”</i> or <i>“Carer”</i></p> <p>In North America, these terms do not clearly distinguish family caregivers from paid care providers.</p>	<p><i>‘Family caregiver’</i></p> <p><i>“Family/Friend caregiver”</i></p> <p><i>“Unpaid caregiver”</i></p>
Provide care primarily because of a <i>financial</i> relationship. They may be licensed or unlicensed home care workers (home health aides, nursing assistants, registered nurses).	<p><i>“Formal caregiver”</i></p> <p>By labeling paid care providers as formal, this necessarily suggests that family caregivers are informal.</p>	<p><i>“Professional caregiver”</i></p> <p>By contrasting family caregivers with “professional” caregivers, it may suggest that family caregivers are less competent. Certainly, paid care providers should be professional in their duties, but the compound term “professional caregiver” should be avoided.</p>	<p><i>“Home care worker”</i></p> <p><i>“Professional home care worker”</i></p> <p><i>“Paid caregiver”</i></p> <p><i>“Care provider”</i></p> <p><i>“Healthcare professional”</i></p>

# OUTLINE

1. Epidemiology of COVID-19 in long-term care homes
2. Clinical assessment and triage of residents with confirmed or suspected COVID-19 infection
3. Active medical management of residents with COVID-19
4. Palliative care of residents with COVID-19
5. Preventing and managing the “collateral damages” of COVID-19 in long-term care homes
6. Our hospital’s multi-phase emergency response to a long-term care home experiencing a COVID-19 outbreak



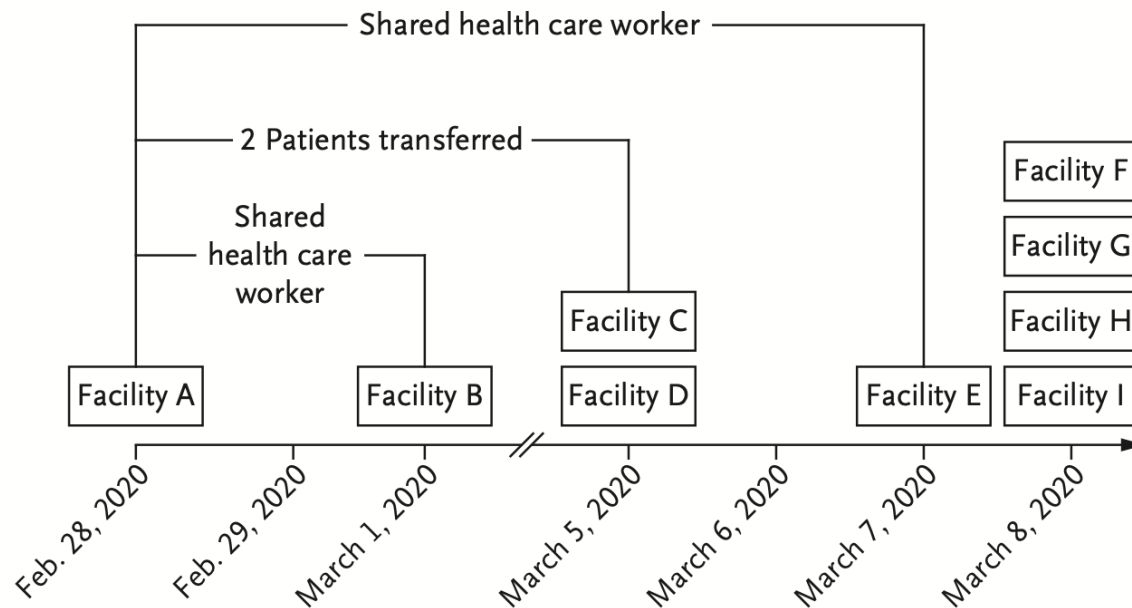
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# EPIDEMIOLOGY OF COVID-19 IN LTC

- LTC residents are at high risk of contracting SARS-CoV-2:
  - Congregant living
  - Exposure to staff (and visitors)
  - Challenges with physical distancing and hand hygiene





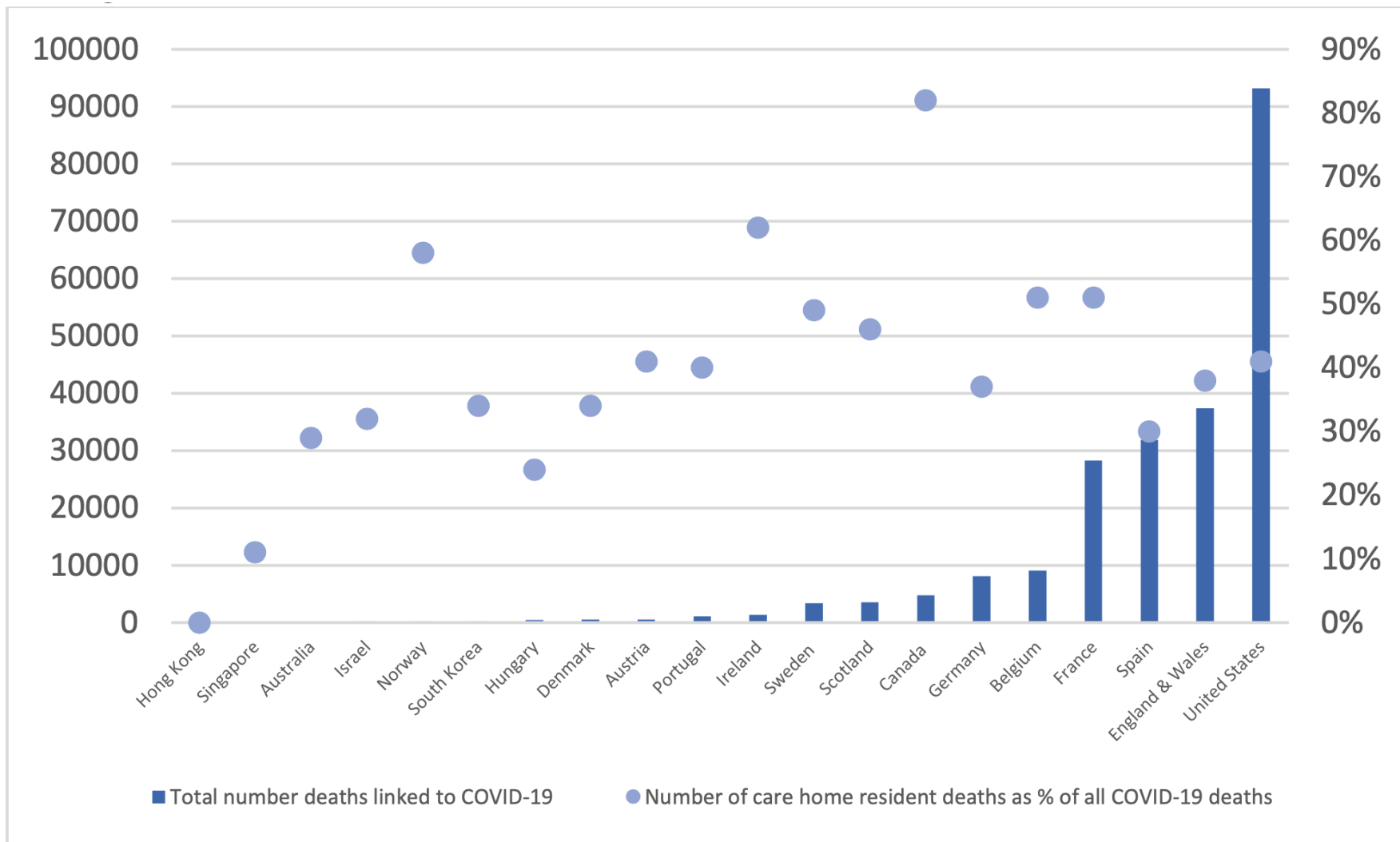
# EPIDEMIOLOGY OF COVID-19 IN LTC

- LTC residents are at increased risk of COVID-19 morbidity and mortality:
  - Advanced age (immunosenescence)
  - Multimorbidity
- Case fatality rates ~25-35%





# EPIDEMIOLOGY OF COVID-19 IN LTC



# EPIDEMIOLOGY OF COVID-19 IN LTC

## CANADIAN SUMMARY



CANADIAN JURISDICTION	Total Cases	Total Deaths	Total Homes	Homes Affected	% of Homes Affected	Resident Cases	Staff Cases	% of all Resident Cases	Resident Deaths	Staff Deaths	% of all Resident Deaths
Alberta	7579	152	350	58	17%	550	302	11%	116	0	76%
British Columbia	2783	168	392	38	10%	311	181	18%	93	0	55%
Manitoba	308	7	261	5	2%	4	2	2%	2	0	29%
New Brunswick	164	2	468	2	0%	16	9	15%	2	0	100%
Newfoundland and Labrador	261	3	125	1	1%	1	0	0%	0	0	0%
Northwest Territories	5	0	9	0	0%	0	0	0%	0	0	
Nova Scotia	1061	62	134	13	10%	265	123	37%	57	0	92%
Nunavut	0	0	5	0	0%	0	0		0	0	
Ontario	34532	2604	1396	435	31%	6545	3065	28%	2016	8	78%
Prince Edward Island	27	0	39	0	0%	0	0	0%	0	0	
Québec	54383	5340	2215	562	25%	10251	6079	30%	4409	8	83%
Saskatchewan	708	13	402	3	1%	4	4	1%	2	0	15%
Yukon	11	0	5	0	0%	0	0	0%	0	0	
<b>CANADA</b>	<b>101822</b>	<b>8351</b>	<b>5801</b>	<b>1117</b>	<b>19%</b>	<b>17947</b>	<b>9765</b>	<b>27%</b>	<b>6697</b>	<b>16</b>	<b>80%</b>

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# CLINICAL ASSESSMENT OF RESIDENTS

- Any resident with any of the following “**typical** symptoms” should be considered for testing for COVID-19:
  - Fever (temperature of 37.8°C or greater)
  - New or worsening cough
  - Shortness of breath (dyspnea)
  - Sore throat
  - Difficulty swallowing
  - New olfactory or taste disorder(s)
  - Nausea/vomiting, diarrhea, abdominal pain
  - Runny nose, or nasal congestion – in absence of underlying reason for these symptoms such as seasonal allergies, post nasal drip, etc.

# CLINICAL ASSESSMENT OF RESIDENTS

- Any resident with any of the following “**atypical** symptoms” should be considered for testing for COVID-19:
  - Unexplained fatigue/malaise/myalgias
  - Delirium (acutely altered mental status and inattention)
  - Unexplained or increased number of falls
  - Acute functional decline
  - Exacerbation of chronic conditions
  - Chills
  - Headaches
  - Croup
  - Conjunctivitis

# CLINICAL ASSESSMENT OF RESIDENTS

- **Potential signs of COVID-19:**

**Other signs of COVID-19 can include:**

- Clinical or radiological evidence of pneumonia

**Atypical signs can include:**

- Unexplained tachycardia, including age specific tachycardia for children
- Decrease in blood pressure
- Unexplained hypoxia (even if mild i.e. O<sub>2</sub> sat <90%)
- Lethargy, difficulty feeding in infants (if no other diagnosis)

# CLINICAL ASSESSMENT OF RESIDENTS

Age and Ageing 2020; 1–2  
doi: 10.1093/ageing/afaa068

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## CASE REPORT

# Atypical presentation of COVID-19 in a frail older person

HUI SIAN TAY<sup>1</sup>, ROWAN HARWOOD<sup>1,2</sup>

Journal of the  
American Geriatrics Society



Letter to the Editor | [Free Access](#)

## Typically Atypical: COVID -19 Presenting as a Fall in an Older Adult

Richard E. Norman MD✉, Nathan M. Stall MD, Samir K. Sinha MD

First published: 28 April 2020 | <https://doi.org/10.1111/jgs.16526> | Citations: 2

SECTIONS



PDF



TOOLS



SHARE



# CLINICAL TRIAGE OF RESIDENTS

## A COVID-19 Pandemic Assessment and Triage Tool:

### 1. Respiratory status:

- Hypoxia: pulse oximeter saturation level <90-92% on room air
- Tachypnea: respiratory rate >16-20 breaths per minute

### 2. Cardiovascular status:

- Tachycardia: heart rate >100 beats per minute
- Hypotension: systolic blood pressure <100-120 mmHg<sup>2</sup>

### 3. Mental status

- Impaired level of consciousness
- Delirium (abrupt and fluctuating change in cognition, inattention and either disorganized thinking or altered level of consciousness)<sup>3</sup>

### 4. Decreased oral intake

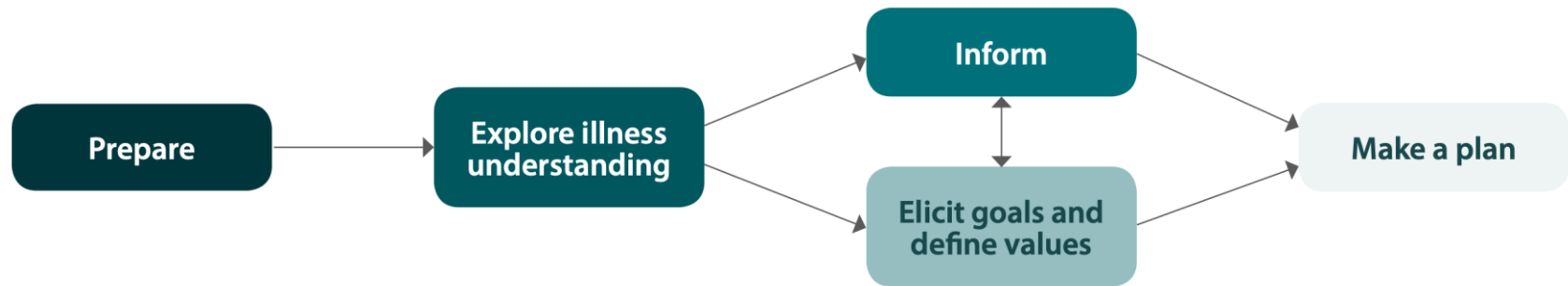
### 5. Functional impairment

- Deterioration in mobility
- Deterioration in the performance of activities of daily living

### 6. Staff or family concerns

- Any concerning change in baseline status

# ESTABLISHING GOALS OF CARE



1. Introduce yourself and discussion
2. Explore illness understanding
3. Provide information
4. Respond to emotions
5. Explore values and goals, including previous discussions during care planning
6. Make recommendations for management (based on values discussion)
7. Discuss visitor policy
8. Confirm management plan

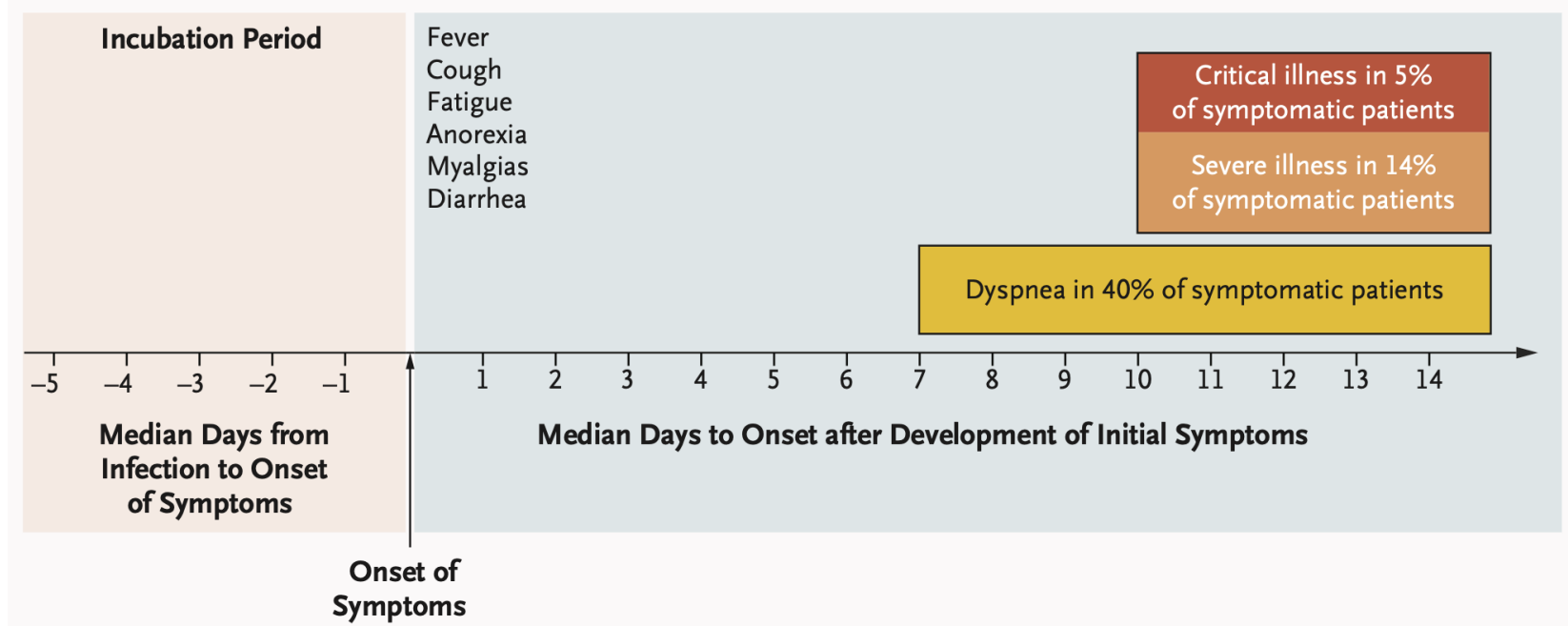


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# CLINICAL COURSE AND RISK FACTORS



- **Risk factors for severe COVID-19:**

Older age

Chronic lung disease

Cardiovascular disease

Diabetes mellitus

Obesity

Immunocompromise

End-stage renal disease

Liver disease



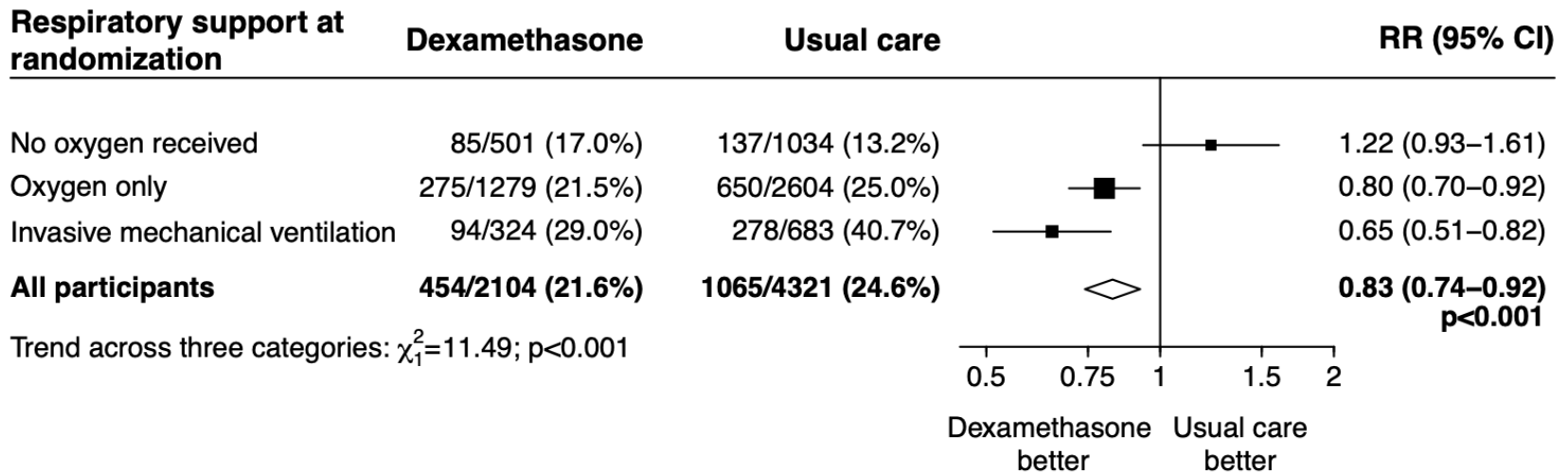
# MEDICAL MANAGEMENT OF COVID-19

## *No evidence-based therapies for treatment of COVID-19 authorized for use in Canada*

- Low flow supplemental oxygen (1-6 L/minute)
- Hydration with hypodermoclysis (30-60 cc/hr)
- Symptom management (e.g. fever and pain)
- Empiric antibiotics should not be given
- Medications should be reviewed
  - Chronic therapies (e.g. antihypertensives and psychotropics) may need to be held
- Be vigilant for thromboembolism, especially in severe disease

# DEXAMETHASONE FOR COVID-19

- RECOVERY Trial (not yet peer-reviewed)
  - Randomized controlled open label trial comparing the effect of dexamethasone (6 mg/day, either PO or IV, for up to 10 days) to usual care for COVID-19 on 28-day mortality
  - Included 6,425 patients admitted to 176 UK hospitals
  - Majority of trial participants were <70 years of age



# OUTLINE

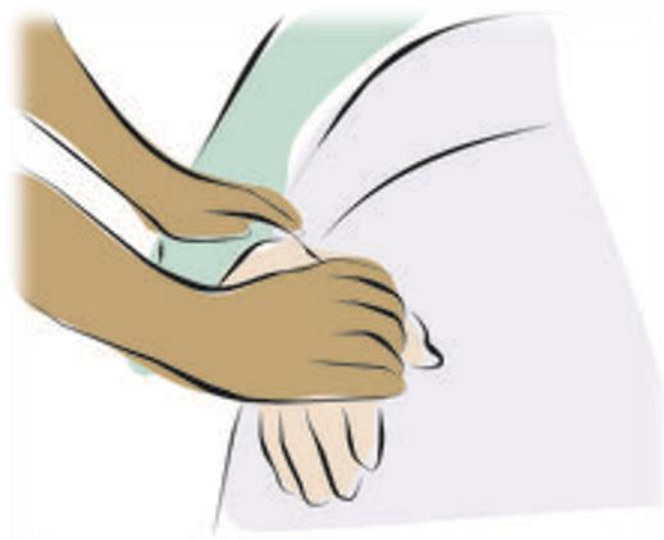
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# PALLIATIVE CARE

- General principles:
  - Residents with COVID-19 have a large symptom burden
  - Need for clear and open communication with residents and families
- Common COVID-19 end-of-life symptoms:
  - Dyspnea
  - Respiratory congestion
  - Pain
  - Nausea
  - Delirium



# PALLIATIVE SYMPTOM MANAGEMENT

- Stockpile comfort medications, symptoms management kits, and equipment to deliver medications (e.g. subcutaneous cannulae and pumps)

**Table 1: Suggested contents of a symptom management kit and recommended starting doses for patients with severe coronavirus disease 2019\***

Symptom	Treatment	Recommended starting order	Quantity for kit
Pain or dyspnea	Hydromorphone 2 mg/mL	0.5–1.0 mg subct q30min p.r.n.†	10 vials
Nausea or delirium	Haloperidol 5 mg/mL	1 mg subcut q2h p.r.n.‡	10 vials
Sedation	Midazolam 5 mg/mL	1–2 mg subcut q15min p.r.n.§	10 vials
Secretions	Scopolamine 0.4 mg/mL	0.4 mg subcut q4h p.r.n.	10 vials
Fever	Acetaminophen 650 mg suppositories	Administer q6h PR p.r.n.	10 vials
Urinary retention	Foley catheter 16 French	Insert catheter p.r.n.	1 kit
Dry mouth	Mouth swabs	Mouth care q.i.d. and p.r.n.	10 swabs

Note: PR = per rectum, p.r.n. = as needed, q4h = every 4 hours, q6h = every 6 hours, q15min = every 15 minutes, q30min = every 30 minutes, q.i.d. = 4 times per day, subct = subcutaneous.

\*Adapted with permission from the Champlain Palliative Symptom Management Medication Order Form – Long-term Care.

†May start at 0.25 mg in a patient who is opioid naive, frail or older.

‡Relative contraindication in Parkinson disease.

§Higher doses can be used for refractory dyspnea.

# COMMUNICATION

## When Sharing Medical Information:

- Speak slowly, pause frequently
- Speak in plain English (no medical words)
- Check frequently for understanding
- Provide time for processing
- Ask them to repeat back what they heard

## When Responding to Emotions:

### Do:

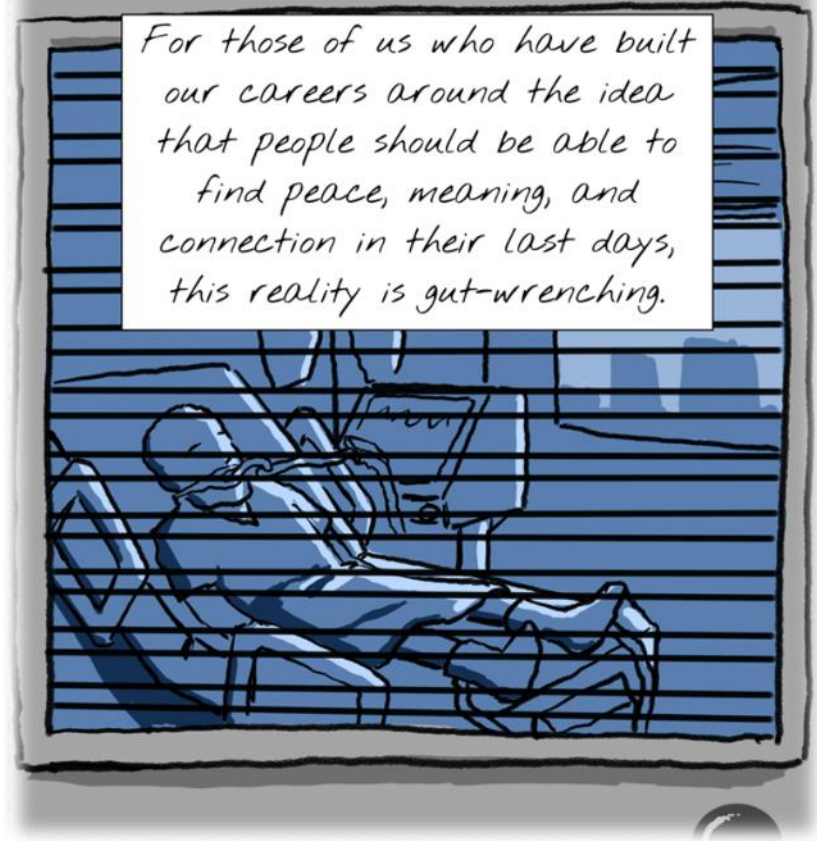
- ✓ Allow them to happen
- ✓ Acknowledge them
- ✓ Respond openly and honestly
- ✓ Use silence
- ✓ Use "I wish" statements

### Do Not:

- ✗ Move on until the emotions settle
- ✗ Offer premature or empty reassurances
- ✗ Backpedal

*In the midst of this outbreak, people are dying in relative isolation from their family and friends.*

*For those of us who have built our careers around the idea that people should be able to find peace, meaning, and connection in their last days, this reality is gut-wrenching.*



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# THE “CONFINEMENT SYNDROME”



JAMDA

journal homepage: [www.jamda.com](http://www.jamda.com)



Letter to the Editor

## Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2)-Related Deaths in French Long-Term Care Facilities: The “Confinement Disease” Is Probably More Deleterious Than the Coronavirus Disease-2019 (COVID-19) Itself

To the Editor:

To date, coronavirus severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) has infected 2.2 million people and has killed more than 150,000.<sup>1</sup> The population groups most susceptible to severe and fatal coronavirus disease-2019 (COVID-19) are older adults and those with chronic underlying chronic medical disorders. The residents of long-term care facilities (LTCFs) typically combine those 2 features and are, thus, particularly at risk. In France, 9.4% of the population is over age 75 years and nearly 600,000 people currently reside in LTCFs for older dependent individuals. To date, more than 60% of the French LTCFs have reported at least 1 case of COVID-19 among their residents.

Estimated overall mortality among patients with COVID-19 is 10% in France but reaches up to 30% in LTCFs. There are, however, substantial differences in mortality rates between the different LTCFs.<sup>2</sup> What explains these differences?

We intervened in 1 LTCF located in the Southern Île-de-France region that had registered more than 24 deaths related to COVID-19 among the 140 residents in 5 days. No acute respiratory distress syndrome was observed, and mortality was mainly due to hypovolemic shock. Most of the victims had been left alone in their rooms for confinement settings for many days without help because of the lack of protective masks and the work overload for caregivers affected by a 40% staff absenteeism rate. The dependent residents were confined and no longer received the usual assistance for drinking and eating. In addition, general practitioners

stopped their physical examination visits, limiting their interventions to telemedicine, which proved unsuitable whenever feasible at all.

With appropriate resources lacking, the “disease linked to confinement” thus proved more fatal than COVID-19 itself. We did not observe this phenomenon in other LTCFs where healthcare staff and physicians were physically present in full force.

A task force team intervened as soon as the fifth death was reported. Adapted infusion to restore hydroelectrolytic balance as well as oxygen therapy per World Health Organization guidelines led to a rapid improvement of this high mortality trend.<sup>3,4</sup>

Disproportionate mortality because of COVID-19 in LTCFs is not a fatality. Continuous provision of pragmatic medicine and wellness care will limit the devastating impact of this infection in dependent older people.

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# THE “CONFINEMENT SYNDROME”

- **Collateral damages:**
  - Dehydration and malnutrition
  - Physical and functional decline
  - Exacerbation of chronic medical conditions and mental health disorders
  - Cognitive decline and delirium
  - Worsening of responsive behaviors
  - Loneliness and social isolation
  - Psychological distress, depression and anxiety

## Family reeling as senior dies of malnutrition, not COVID-19, inside long-term care home



Pietro Bruccoleri's daughters say they were stopped from removing him from the home before his death



Chris Glover - CBC News

Posted: June 09, 2020

Last Updated: June 09, 2020



UNIVERSITY OF  
TORONTO



*J Am Med Dir Assoc. 2020 May 3;S1525-8610(20)30354-6.*





# PSYCHOSOCIAL SUPPORT FOR STAFF

*For us, this pandemic means being ready to support hard-working colleagues as they face risks to their own health on top of the emotional toll that overstrained resources, death, and tough conversations can bring to us all.*





# PSYCHOSOCIAL SUPPORT FOR CAREGIVERS AND STAFF

- Increased caregiver and staff needs for psychosocial support
  - Caring for vulnerable and dying residents, navigating rapidly changing IPAC guidance, and worrying about their own health and safety

## Strategies to help you cope



**Accept and validate your feelings**, understanding that stress and anxiety are normal during challenging times.



**Recognize what's within your control** and focus on those factors to try to mitigate the stress.



**Remember that this is temporary** and will pass.



**Take care of your health** by eating and sleeping well, exercising, and meditating.



**Make time for yourself** with activities you enjoy that are free from COVID-19-related topics.



**Stay connected** with family, friends, and colleagues while still practising physical distancing.



**Reach out for help** by talking to your supervisor or seeking professional support.



**Monitor your substance use** and pay attention to what triggers it.

- Follow *Canada's Low-Risk Alcohol Drinking Guidelines*.
- Follow *Canada's Lower-Risk Cannabis Use Guidelines*.



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# “COVID-19 SWAT TEAMS”

- The Government of Ontario asked hospitals to develop and deploy specialized “COVID-19 SWAT teams” to provide additional staffing, IPAC, occupational health and operational support to nursing homes

## Newsroom

News Release

### Ontario Takes Immediate Steps to Further Protect Long-Term Care Residents and Staff During COVID-19 Outbreak

Response includes increased testing, COVID-19 SWAT teams, and additional PPE

April 22, 2020 1:45 P.M. | [Office of the Premier](#)

TORONTO — The Ontario government is making progress on the implementation of the *COVID-19 Action Plan for Protecting Long-Term Care Homes* to help stop and contain the spread of COVID-19 in the province's long-term care homes. The government has introduced more aggressive testing, screening, and surveillance, deployed specialized teams from hospitals, public health and the home care sector, recruited additional frontline staff, and increased personal protective equipment.



# OUR HOSPITAL PARTNERSHIP

**Journal of the  
American Geriatrics Society**



Brief Report |  [Free Access](#) |

## **A Hospital Partnership with a Nursing Home Experiencing a COVID -19 Outbreak: Description of a Multiphase Emergency Response in Toronto, Canada**

Nathan M. Stall MD , Carolyn Farquharson RN, MN, ENCC, Chris Fan-Lun BScPhm, Lesley Wiesenfeld MD, MSc(SM), Carla A. Loftus RN, MN, Dylan Kain MD, Jennie Johnstone MD, PhD, Liz McCreight BA, Russell D. Goldman MD, MPH, Ramona Mahtani MD ... [See fewer authors](#) 

First published: 22 May 2020 | <https://doi.org/10.1111/jgs.16625>

# PHASE 1: FIRST 72 HOURS

**Table 1: Environmental scan, team-building and immediate response (first 72 hours)**

- 1. An environmental scan of clinical expertise, staffing, supplies and equipment needs**
  - Securing direct access to geriatric medicine, palliative care and IPAC clinicians.
  - Evaluating current and projected nursing home staffing shortages.
  - Determining the PPE stockpile, supply chain and expected burn rate.
  - Assessing shortages and expected needs for medical equipment and medications.
  
- 2. Immediate Infection Prevention and Control assessment**
  - Reviewing the outbreak line list and plotting its epidemiological curve.
  - Risk assessment to understand any gaps in IPAC measures and procedures.
  
- 3. SARS-CoV-2 testing of the remaining residents at the nursing home**
  - Widespread SARS-CoV-2 nasopharyngeal swabbing.
  
- 4. Team building: establishing a clinical and operations team**
  - Members of the hospital team included senior leadership, administrators, nurses and clinicians in geriatrics, palliative care, psychiatry, pharmacy and IPAC. The full list of team members, roles and responsibilities is detailed in *Appendix 1*.
  
- 5. Decanting of 15 nursing home residents to the acute care hospital**
  - The nursing home and hospital agreed to decant 15 residents who were receiving end-of-life care or who would benefit from acute care medical management.

# STRUCTURE OF CLINICAL AND OPERATIONS TEAM

## Hospital-Based Clinical and Operations Team

Team members

### Clinical team

- Geriatrician
- Palliative care physician
- Geriatric psychiatrist
- Geriatric pharmacist
- Nursing director
- CNS palliative care

### IPAC team

- Medical director of IPAC
- IPAC fellow
- Director of IPAC
- Director of housekeeping

### Health Human Resources team

- VP of Human Resources & Occupational Health & Safety
- VP Professional Practice
- CNS geriatric psychiatry

### PPE Supply team

- VP and Senior Director level leadership

Roles and responsibilities

- Establish the infrastructure for the provision of virtual care
- Clinical triage and assessment of nursing home residents
- Goals of care discussions and advance care planning
- Active medical management
- High-quality palliative care
- Optimize medications and streamline administration
- Psychiatric support and care for nursing home residents
- Psychosocial support for frontline nursing home staff
- Ensure access to medical equipment, drugs and supplies (i.e., vital sign monitors, palliative medications, oxygen compressors)

- IPAC risk assessment, review of outbreak line list and plotting epidemiological curve
- Coordination of outbreak management with the local Public Health Unit
- Education and training around IPAC, PPE and outbreak housekeeping procedures
- Direct SARS-CoV-2 testing and results reporting
- Lead the strategy for terminal room cleans, cohorting and resident room changes (based on COVID-19 testing results)
- Work with occupational health and the local Public Health Unit to organize screening of asymptomatic

- Assess the staffing availability and create a strategy to support optimal ratios of staff to nursing home residents
- Lead the process of redeploying unionized and hospital-based RN and RPNs to the nursing home to help with staffing
- Connect with nursing home staff away from work for any reason (i.e., illness, caregiving responsibilities, fear) to assess their wellbeing, provide support, and begin the plan for staff to return to work (if appropriate)
- Provide orientation, training, and staff scheduling for redeployed nurses as well as on-site support

- Assess supply chain of PPE and calculate utilization/burn rate
- Ensure continuous access to PPE by redistributing PPE from the hospital to the nursing home and by supporting the nursing home's escalating requests to the provincial government for additional PPE



# PHASE 2: NEXT 7 DAYS

**Table 2: Details about the early phase response (next 7 days)**

- 1. Establishing the infrastructure for the provision of virtual care**
  - Telehealth (videoconferencing and remote access to the electronic medical record) was used to reduce staff exposure to SARS-CoV-2 and minimize the PPE burn rate.
  
- 2. Clinical triage of the remaining residents in the home**
  - Medically unwell and end-of-life residents were rapidly identified by chart review and by a screening tool we developed for the nursing home staff (see *Appendix 2*).
  - The clinical team virtually rounded with an on-site registered practice nurse (RPN) on residents, prioritizing those who were potentially medically unwell or end-of-life.
  
- 3. Goals of care discussions for residents determined to be unwell or end-of-life**
  - Goals of care conversations were had with all nursing home residents (and their family members/proxies) identified as being medically unwell or end-of-life.
  - Decisions were made about active vs. medical management, and transfer to the acute care hospital vs. remaining in the nursing home.
  
- 4. Provision of active medical management within the nursing home**
  - STAT and in-home laboratory and imaging services were organized.
  - Hypoxic residents were given low-flow oxygen therapy (maximum of 5L/minute).
  - Volume contracted residents were rehydrated using subcutaneous hypodermoclysis.
  - A geriatrician and palliative care physician were available 24/7 staff to respond to any clinical concerns or emergency situations.



# PHASE 2: NEXT 7 DAYS

## 5. Provision of high-quality palliative care within the nursing home

- Residents identified as being end-of-life and wishing to remain within the nursing home for comfort care were assessed on at least a daily basis via virtual care.
- We helped ensure an adequate supply of comfort care and subcutaneous medications.

## 6. IPAC training for frontline staff

- Several on-site training sessions focusing on modes of transmission of COVID-19, point of care risk assessment, PPE selection, and donning and doffing procedures.

## 7. Ongoing IPAC interventions

- Additional SARS-CoV-2 testing.
- Room changes and terminal cleans.
- Enhanced environmental cleaning and disinfection.
- Setting up donning and doffing stations, increasing access to PPE and hand hygiene.

## 8. Occupational Health

- The Occupational Health team worked with IPAC, the local Public Health Unit and the nursing home to connect with and support staff away from work for any reason (illness, caregiving responsibilities, or fear) and determine a plan for return to work.

# PHASE 3: STABILIZATION AND TRANSITION PHASE

**Table 3: Details about the stabilization and transition phase**

- 1. Deployment of hospital-based nurses to alleviate staffing shortages**
  - The hospital redeployed 1 clinical nurse specialist, 4 registered nurses, and 7 registered practice nurses for a 4-week assignment at the nursing home.
- 2. Pharmacist intervention for nursing home residents**
  - Medication administration schedules were consolidated and streamlined to minimize staff exposure and PPE burn rate.
  - Comprehensive medication reviews to optimize medication safety and resident care.
- 3. Psychiatric support for nursing home residents**
  - Geriatric psychiatry consultations to residents with new mental health concerns and reassessment and optimization of treatment plans for those with pre-existing mental illness and cognitive impairment.
- 4. Psychosocial support for the nursing home staff**
  - The hospital psychiatry group offered one-on-one and group-based counselling.
- 5. Stabilizing IPAC interventions within the nursing home**
  - Screening all asymptomatic staff and clearing residents who had recovered from COVID-19 based on symptom onset.
  - Ongoing support around PPE selection, donning and doffing, and environmental cleaning, to ensure a continued safe environment for staff.
- 6. Transitioning of medical care back to the nursing home staff and physicians**
  - Coaching and empowering the nursing home staff to monitor and manage geriatric and palliative syndromes as well as pursue goals of care conversations.
  - The nursing home's family physicians started joining virtual rounds, and eventually began rounding independently using the newly established virtual care infrastructure.

# Lessons learned in providing effective care for older residents in long-term care homes affected by COVID-19

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