COVID-19
Guiding Document on Long-Term Care
Communication & Symptom Guidelines

Preamble:
As a novel highly infectious virus, we have to learn from our colleagues as to best practice to reduce the burden of disease and impact on limited health care resources. Physical distancing from potential contacts and handwashing remain the best options for managing the spread of this virus. Long-term care (LTC) residents are generally elderly, frail, have multiple co-morbidities, or are immunocompromised which puts them into the highest risk population for mortality.

Furthermore, many of the LTC residents are Comfort Care or Medical Care with no heroic intervention thus making them ineligible for ICU admission, a resource which will be greatly stressed in the middle of this pandemic.

Action Plan:
Taking these facts into consideration, the following are recommended:

1) Personal Care Homes (PCHs) should limit the number of physical visits from clinicians (physician or nurse practitioner):
   a. Each PCH should identify one clinician to visit only once per week at a set time and that clinician will cover the entire home for urgent in-person assessments;
   b. PCHs should provide a clear schedule of which clinician is responsible for the weekly on-site visit, what time they will visit, and a mechanism to inform the clinician of each patient that has an urgent need to be seen;
   c. PCHs can choose to have a single clinician cover the home for several weeks in a row for “on-site visits” if they choose;
   d. The clinician who is responsible for the weekly on-site visit should travel directly from their home to the PCH to reduce risks of community contamination; and should not be working across health care facilities, and should not be concurrently providing care to COVID-19 positive patients (i.e. in-patient care);
   e. The clinician who is responsible should only take what they need to make rounds (i.e. properly cleaned stethoscope, pen, phone) and not other bags/items that can be potential vectors of infection; these should be appropriately cleaned between patients;
   f. The remaining clinicians for the PCH should continue to “round” on their own patients through a virtual presence. This can be done at a pre-set time or on a case by case basis. All routine, non-urgent, follow-up, lab tests, and such should go to the regular attending physician for management through telephone/fax communication or to manage through a virtual video consultation. Any patients that require a physical assessment that cannot be completed by the available nursing on site, should be put forward to the identified On-Site Clinician for the week.
2) **Every patient that requires transfer to hospital should first be triaged by a physician/nurse practitioner.**

   a. Emergency, Urgent Care, and Hospital resources will be strained during the pandemic. Only transfers that cannot be managed in PCH should be sent for evaluation. The triaging clinician should evaluate:
      i. Is this transfer appropriate?
      ii. Can the resident stay in the PCH with additional medical management and be seen by the on-site clinician urgently this week for further assessment?
      iii. Is this resident ACP C or palliative and can be best managed in PCH?
      iv. Is this resident ACP M with no heroic interventions, which can be best managed in PCH?
      v. Is this a resident with possible COVID-19 infection and showing rapid decline, discuss with family in regards to keeping resident at PCH (see resources below for talking points)?
      vi. If imaging is required, in Winnipeg it can be done by the Mobile X-ray Service/ portable X-ray (where available) in the next 1-2 days (i.e., all X-rays can be done except skull, spine, and abdomen). This service not available in all regions or in all PCHs.

   b. The triaging clinician should contact the hospital and speak to the EMO for each transfer.

   c. Each PCH should provide to each floor/unit a listing of call order (and contact numbers) for any transfers to ensure that each transfer has been triaged. The order should be:
      i. During regular hours, Attending physician, if no call back then:
      ii. On-call physician, if no call back then:
      iii. Medical Director for the PC , if no call back then:
      iv. For WRHA, LTC Medical Director, Dr Gilles Pinette
         For other RHAs, Chief Medical Officer

**RESOURCES:**

Available information should be used support conversations with residents and their families (in the event of transfer or proactively beforehand):

- There is no current medical treatment beyond supportive care for COVID-19;
- Supportive care includes assistance with feeding, fever control, oxygen if needed, subcutaneous medications if unable to swallow or take meds orally, and in some rare instances, hypodermoclysis to avoid dehydration;
- In many cases, supportive care can be provided more effectively in the care home, provided by staff who know the resident rather than in a hospital environment;
- For those residents who may go on to develop respiratory failure, consideration should be given to when care needs to focus on the provision of comfort to ease suffering at the end of life.
In Winnipeg - X-ray Mobile Service: Fax requisition to: 204-831-0828

- Please do **not** do routine/non-urgent x-rays at this time;
- X-ray service can do all X-rays except skull, spine, and abdomen;
- X-ray service is taking all precautions to ensure equipment and staff cleaning prior to entering and leaving a PCH, and between each patient visit.