



LONG TERM CARE: COVID-19 SERIES

Session 6 Preparing your LTC home for COVID-19 Question & Answers

Disclaimer: All information is provided by healthcare providers working in long-term care facilities across Ontario including those at Baycrest. All identifying information including names of individuals, organizations, or locations have been removed for privacy. **The answers below are amalgamated responses from our Hub team members and Learning Partners.**

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Question 1: I know there has been some discussion now about how delirium could actually be the first presenting sign of COVID-19. Are people generally noticing more delirium in the long-term care population at this time? Or has anyone had any particular individual resident case that presented in a particular way?

Answer: I've noticed an increase in delirium and mostly I put it down to social isolation as a factor and that has been very detrimental to the resident with prolonged isolation with no visits from family members who usually help with stimulation and also who help with fluid intake. There has been a big increase in residents with dehydration. I think last week we had to use hypodermoclysis on an almost daily basis.

I think there are two populations that we really need to pay attention to being: the residents who have delirium and COVID and those with delirium who don't have COVID.

I am noticing an increase use of PRNs related to anxiety and it's difficult to do non-pharmacological things to help with the anxiety due to not having group activities anymore. Residents don't have activities to keep them occupied. Some of the residents that still have good cognition tend to be a bit more anxious about their health concerns. So I noticed our staff doing a lot more physical assessments, providing reassurance and spending more time with them to "talk them off the ledge" so to speak. We've had to increase a few antidepressants for those who were crying all the time. Yes, it is likely situational but how long is this situation going to last? So we've been trialing it and certainly if it does look like delirium we will do the full workup to make sure it's not, to isolate them, and get a nasopharyngeal swab. We have had zero COVID-19 cases at our LTC home and five cases in the community so we've been very lucky.

Question 2: I am concerned about hypoactive delirium. With staff overworked, it's easy to miss a quiet withdrawn resident who might have delirium. How can we better identify these residents during COVID?

Answer: Hyperactive delirium is usually brought to the attention of the physician. The resident would usually present as combative, aggressive or there's something about their behavior which is brought to the attention of the physician. I just worry a lot about the idea of the hypoactive delirium because our staff are just so overworked and overwrought right now. It can be misinterpreted as somebody who's quiet and isn't going to be a bother. And it often presents to us much later. I'm just trying to be very mindful of that when I'm walking around the floor just to see who might have a hypoactive delirium and that variability that we're looking for, the sort of roller coaster in arousal. And then the other comment I see that a couple of people have made about prevention, just how important prevention is. It really does work with delirium and all of the things that work are so much harder to do during COVID times like orientation and hydration and food and attention, love and all those things that really make a difference.

And that extra attention from staff especially when we don't have families coming in. That extra piece has to happen when observing and picking up hypoactive delirium. Usually a family member would be



able to pick up on the quiet behaviour that could be a presentation of hypoactive delirium. So we as staff are trying to increase our “spidey sense” for picking up on those residents and start to notice. My worry is also around functional decline in people as they are being restricted more to their floors and not doing as much as they have been before COVID.

Question 3: So in my role right now I’m not directly caring for residents but I was helping with swabbing residents for COVID-19. I just noticed that on units where staff were actually feeling anxious and worried, I noticed there was an increase of behaviours on that unit. I don’t know if it led to delirium but there was definitely some residents feeding off the fear of the staff. So I just wondering if the fear that is going around could that maybe influence delirium?

Answer: I think it's a really great point, and if you think about the acronym SMILE , I really like that because again, we know with our residents when we do talks on behavioural symptoms of dementia and we know that people who are agitated and who are aggressive, they're often scared and afraid, and if we approach on the unit looking scared and afraid ourselves, then how is that going to impact the residents? So it’s really important for staff to have a place to ask questions, to have support.

COVID-19

COMMUNICATION TIPS FOR CLINICIANS CARING FOR OLDER ADULTS EXPERIENCING DELIRIUM DURING THE COVID-19 PANDEMIC

RGP

April 1, 2020

Isolation protocols and the use of personal protective equipment such as gowns, gloves, and masks can make people feel even more fearful and confused. People with hearing loss may have difficulty understanding what care providers are saying through a mask and may require written communication.

GENERAL COMMUNICATION TIPS

Non-verbal communication is critical to successful interactions. Remember to **SMILE**, they will hear it in your voice even if they can’t see your face and will be reassured.

Stay calm, slow down and be patient.

Maintain eye contact and position yourself so the patient can see you.

Introduce yourself, call the patient by name, and explain your role/what you are going to do.

Listen actively and keep your language and instructions simple.

Engage and empathise.



Question 4: As was mentioned COVID has been going on for a long time. It's a long time for residents to not see their families and for staff too to be working under this stress. So I think it's critical to make sure we have the facts and supports in the workplace. Has anybody come up with an approach to how to support your staff at this time at your LTC home?

Answer: Our administrator has organized every Thursday to have a Town Hall meeting so people can either join in by Zoom or teleconference. I presented on respiratory distress and end stage of COVID-19 and how to handle that palliatively last week. So we had a few participants join every Thursday to ask their questions and usually they ask when this will be lifted and usually the answer is when the Ministry of Health tells us it can be. So it is just reinforcing that we need to follow the rules and keep going because we have done extremely well. Nobody has slipped through the cracks and everyone has been well assessed. We are continuing to maintain our distancing and doing everything we're supposed to be doing and it's working. So we just need to keep the course and that is how our administrator has been trying to keep everyone up to date. And this meeting is for every staff member, not just leadership and management so everyone can join in on these meetings virtually to ask their questions.

We've been also having regular Town Hall meetings but they are not virtual, but they do post the minutes online so those that couldn't attend has access to it.

Ours involves more regular meetings with medical staff, since we are a larger facility we have twelve attending physicians and they are very useful of just walking through the directives, having check ins in how everyone is doing and sharing resources that are available to them as well. So everybody is coming together on this one.

Question 5: In Ontario are we swabbing and testing for COVID for anyone who has symptoms of delirium?

Answer: I think that's a very good question. I think if there's no other obvious reason as the person is simply presenting with confusion, there's no obvious other illness going on then a swab would be a good idea, but you should also do the full workup for other causes as well.

Question 6: Have most LTC homes been swabbing and testing all of your residents and staff for COVID-19 anyway?

Answer: I think early on we were hearing people were only testing for those with fever and respiratory symptoms then it quickly shifted to anything unusual or mild respiratory symptoms and now the list has expanding because particularly for our residents where they present atypically anyway, it makes it much more complicated. So I've had a few residents that we've tested a few times and the test kept coming back negative for COVID-19, and it can be quite challenging because despite it coming up negative each time you don't want to miss it and catch it when we can.

Question 7: How difficult it is to actually do the work-up and investigations if someone you suspect has delirium, can you do the normal series of blood tests, x-rays and so on?



Answer: I would just add to that, that for me, the pain is such a common driver of delirium that the first things I always want to do with somebody who has a delirium is sort of move them and see where it hurts. And I'm finding it much, much harder to do that. During COVID times, there is that hesitation to want to go into the room, the donning and the doffing of all the PPE. I find that particularly from the pain perspective. I often feel like I'm missing something because in my experience, pain is such a common contributor to delirium that it's sort of my go to kind of pain, pain, pain and all the rest, that I find that a real issue for me personally.

And I would add to that the fluid and hydration and nutrition and then that ties into bowels. So if they're not drinking as well, they're maybe not eating as well. And how does that impact the bowels? And I worry about people who have dementia, diabetes, hypertension and congestive heart failure. And then they start not eating as well, maybe not drinking as well. Suddenly, their blood sugars are low or their blood pressures are lower. How are we staying on top of that? And that's even if somebody doesn't have COVID who may or may not be on isolation. So I think this is really challenging times for us. It's a very active management and it's hard to do that right now. And if you start to experience shortages of staff, which is what we're hearing from some homes, then that increases that rate.

Question 8: Any success with any systems people have put in place to try to make sure that our residents are or are getting those assessments that are needed and keeping an eye on how to flag when things are changing differently than you might have done before COVID?

Answer: I think exercising a very high level of suspicion with anything being wrong whether it being COVID and having a low threshold as well and that's concurrent with the directions from our medical officer of health.

One of the things I like about [Sharon Inouye's original sort of formulation](#) was around the idea of delirium having to do with the strength of the insult and the vulnerability of the individual so that for any of us, it might take a serious car accident to push us into delirium, but that for a really frail and vulnerable person, it might take a feather. And I try to sort of remember that in my formulation of folks that there are people where it's amazing how little it takes to tip them over. And just to be thinking about that kind of model as I'm as I'm trying to appreciate a delirium.

So one of the ways we've been keeping a better watch on our residents during COVID is that anyone who presents with unusual or atypical symptoms, we have the nurse on the unit report to a designated team called the Prevention and Control team that consists of four or five clinicians who then review the chart of that person in more detail. So it's a second set of eyes that are going through their chart and offer suggestions to the nurses on the floor. We also have a low threshold for swabbing and testing for COVID, and we also isolate them on the unit in their own room. Then if the swab comes back positive, we have a separate unit. One way we tried to mitigate delirium from changing of location is that we have recreation staff that go to our COVID units and specifically work with those residents. We are fortunate that we are a larger facility so this system has been working so far.



Question 9: How are people managing in 3-4 bed ward rooms and moving people? Is the move itself contributing to delirium? How can we manage having to move people for infection control and minimize risk of delirium?

Answer: It's definitely a question of which came first; the chicken or the egg kind of thing. When a resident presents with atypical symptoms it creates more isolation as we have to move them away from others and wear PPE, and gather swabs. I think we are managing it as best we can because we do see them become more confused as we move them to our isolation rooms, which we have to do. We have a resident right now who is not doing great because of the whole social isolation. I think we are doing the best that we can with our residents, but moving them to isolation can contribute to the disorientation when you move them away from their things and seeing pictures on the walls. Since we do have to exercise infection control and having 3-4 bed ward rooms we did a bunch of reorganizing at the beginning and emptied out offices to make them isolation rooms. Another issue is around not being around regular staff who can connect with residents on a personal level, and we are doing our best to have staff engage and check in on our residents even if it's just at the doorway at least so that they can be seen and also see the traffic going by. We don't have a magic solution that works for everyone, but we are doing the best with the resources we have.

For smaller facilities I think partnerships with acute care hospitals and other nursing homes are very helpful in being able to connect with nurse practitioners, sometimes physicians and IPAC teams at local hospitals for support and supplies, like PPE. I think it's great that acute care hospitals have been reaching out and it's a real opportunity for acute care to understand what's happening in long term care and for those in long term care to understand the pressures in acute care as well. We have a group of internal medicine specialists here who are available to provide some support to LTC homes and it's been an incredible partnership. Other partnerships include palliative care teams and geriatric psychiatry offering their support as well and to help us navigate through these through the next months.

Another thing that wasn't mentioned is virtual care as that is happening in increasing amounts now and the question is whether you can do a cognitive assessment virtually and how best to do that. The Canadian Geriatric Society published "Virtual Approaches to Cognitive Screening During Pandemics" by Dr. Kristen Cark and Dr. Phillip St John. This article reviews the evidence and approach for eight virtual screening tools for cognition and provides advice to clinicians at a time when many are increasingly using virtual means to reach their patients. The full article is available from the [CGS](#).

You can find a news release from the PGLO [here](#).