



LONG TERM CARE: COVID-19 SERIES

Session 2: 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: What are your greatest challenges in safely, compassionately and effectively isolating residents within long-term care?

What are your greatest challenges in safely, compassionately, and effectively isolating residents within LTC?



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Answer: Based on the poll results, I see people have answered space, dementia, wandering residents, loneliness, wearing PPE, ineffective communication and many more. These are all challenges here and obviously there is the issue around those with dementia and being able to understand their needs. I think there are a few ideas really worth talking about here as well...the idea of family not agreeing with the isolation methods and to what extent do the decision makers have to agree that their family member needs to be isolated?

I also see some of you answered capacity and do people have a choice in this regard. What determines whether someone is capable of being involved in this decision making as well. Finally I see space as a popular answer as a challenge in how to use the physical environment. I'd be interested in hearing how much planning is going into different homes that don't have outbreaks. I think a valuable thing about this Dementia Isolation Tool is that you don't have to wait for an outbreak to start planning. For example on our unit there were people on our unit we did not want to get COVID and imagine if they did and we had to isolate them. So in some ways you start off with the ones you're most worried about and develop a plan for them before you're at a point of needing a plan. That was a valuable exercise for us because in the end it was the individuals who we least wanted to need to be isolated, who needed to be isolated. So we were kind of equipped.



Question 2: What strategies are helping people that smoke?

Answers:

1. We've been lucky that so far we had a practice outbreak, but it turned out it was likely falsely positive. Quite a few of our residents smoke and some of them are very avid smokers and have other mental health issues to go along with that so their need to smoke is high. We have limited resources for this. We have smoking rooms where you can only have two people in there at a time and they need to be escorted there. There are a lot of logistical issues. So everybody is now on NRT (nicotine replacement therapy) to try to cut down on the amount people smoke.

2. There is a geriatric addictions specialist with Toronto Central LHIN BSO who is an excellent resource when it comes to smoking and long term care. She has provided virtual consults for homes outside of the TC-LHIN as well. There have been homes that have been supplied with nicotine spray that is sprayed in the mouth. Homes that have been using it for the most part, have been reporting success with use of the spray. I know she is very open to any kind of consultation, as she works with the BSO (Behavioural Support Ontario).

3. I have a low income population and people haven't been able to pay for NRT. We have a number of residents who, for various reasons can't afford the patches, but are clearly going through withdrawal. We had to have the discussion on whether we use medications that are covered such as lorazepam, benzodiazepines and antipsychotics to reduce some of that withdrawal, but we decided that in their case and since our home hasn't had an outbreak, the best way to deal with their withdrawal is to reintroduce a few cigarettes per day at specific times with the staff member escorting them to the smoking area. This slow tapering down of smoking at specific times of the day has been successful and some are completely off cigarettes through this process.

4. We've had to problem solve the issue with smoking at a few homes around this issue. The challenge is balancing the directives with what is feasible. There are some homes that are saying we need to restrain these people who want to go out and smoke and is that based on the degree of risk associated with that behaviour? Is that kind of more restrictive intervention warranted? In most cases it's not that, and some need to discuss and negotiate with the person who wants to smoke about that behaviour. Obviously, a lot of homes are nervous about the risk this behaviour presents with going in and out of the facility. So part of the decision is working through what are the risks and what are the best ways of mitigating the risk and coming to a reasonable decision on how to address the behaviour.

I know some homes want to be able to follow the directives as strictly as possible, but it doesn't always make sense for the rights of the individual resident to be in the position of restraining them if they are insisting on smoking. That is an example of the kind of difficult decisions that we are making at this time.

5. The OTN Geriatric Addiction Rounds presentation on May 12 was on [Supporting smoking cessation in long term care, mental health, legal and ethical considerations](#).



Question 3: Engaging people can be difficult with staff shortages and the tool you mentioned seems like an amazing approach when resources are infinite, but of course they're not. We can spend extended amounts of time sitting and chatting with our residents, but it does put a burden on staff and often there aren't enough staff to go around. Also everyone has their anxieties, stresses and pressures going through this thing and everyone wants to be treated fairly and safely.-So when you were designing your tool, was there also consideration of the impact it has on staff and what is ethical and fair for staff as well?

Answer: The tool designed in plain language because we actually hope that it will help frontline staff who are making difficult decisions to think about issues, such as isolating residents. It's one thing for us to say "you must isolate this person" and then you are confronted with having to do that and what it means to actually isolate someone. What risks are they putting themselves in? We certainly had that challenge on our unit if you try to compel someone to stay in their room and they don't want to, then there is always the risk the resident may view you as their jailer. That may lead them to get angry and lash out, and that is putting staff at risk. And I think all of that should factor into that plan, and to think "has this person lashed out when these things have been done?", and that should help people know what the next steps should be. Staff safety when engaging in these different practices should be part of the equation and are a big part of that equation because you certainly can't ask someone to do something that's unsafe. So it's all part of that equation.

Question 4: Are you finding ways to keep residents engaged without staff?

Answer:

1. We just [published a case report](#) in the American Journal about an individual we had to isolate and quarantine on our unit. They didn't actually have COVID but they had exposure to COVID. It's one of those instances where it's a combination. There were times when this individual did need more restrictive measures, but then there were long stretches of the day when this person was able to be engaged in their room with different activities that were specific to them and activities that they enjoyed doing, like math worksheets, colouring, and watching TV on an iPad. In the end the amount of waking hours that this individual was restrained was 10% of waking hours so there were moments when this person needed to be restrained, but it wasn't the only thing that worked. So it's the ideal of individualizing isolation that we found helpful and frequent checks. The frequent checks can be difficult with staffing issues so is it realistic to have someone in the room every 15 or 30 minutes to engage someone socially? But in this resident's case, it did seem to help for her to know that someone would be back soon and it meant she would stay in her room for longer periods of time. So these staff checks may not always be feasible, but in the context of COVID, co-horting strategies can remove the need to keep someone in their room, but in a very small outbreak that's not always possible.

2. At our LTC home, we have a resident who is an intentional wanderer with an agenda. Lately his agenda has been to get beer from his truck and it always happens in the evening when he insists to get his beer. We negotiated with the family to supply him with some near beer and so the strategy has been



that when he insists on wandering around to look for beer, we gently tell him that his wife dropped some off that morning for him. This has been working well so far and I think it highlights the need to know the individual and to what the need is rather than getting restrictive and saying “You can’t go outside! You have to stay inside!” I think an approach to try to prevent the behaviour than to have to deal with the behaviour when it arises is best and it works well. And the resident is happy with it too.

3. We actually opened a temporary transitional care unit. It was open for a few weeks, but we had a patient who was wandering into another patient’s room who was MRSA positive, and it’s something where we don’t have much time to get to know the person because she’s only been on the unit for three weeks. What we did discover through looking at her baseline assessments is that she had been experiencing discomfort and some pain because she hadn’t had a proper bowel movement in over a week. Just by giving her suppositories and having a proper bowel movement, it helped with her restlessness. Doing a proper PIECES assessment, what are the physical, intellectual, emotional causes and so on. A lot of great resources are on how to approach people with responsive behaviours, behavioural and psychological symptoms of dementia, in order to generate some hypotheses that will then help us then to try out different things to help keep residents engaged in a meaningful way.

Question 5: What are some helpful strategies to help residents remain in their rooms without the need of additional staff?

Answer: One strategy that has had some success with reminding people to stay in their rooms is a poster with a picture of a comfy chair and below it says something to the effect of “there is a virus going around- please stay in your room to stay safe”. It was something we learned from one of the behavioral support leads that mentioned they had some success with this poster that they created and they put it in a conspicuous place as a way of an environmental reminder to encourage people to stay in their room. Especially for those with dementia, reading is often preserved until later stages than people give credit for.

The verbiage of the visual cue can also make a difference, such as saying “Stay in your room to protect yourself” rather than “Stay in your room so you don’t infect others”.

At our LTC home we used some non-verbal type signs as well, pictures that sort of indicate that someone shouldn’t leave their room. We had mixed success with that and I guess its figuring out the right sort of visual cue that will be valuable. If we find one that works we will share with you all, but I think it’s the whole idea of creating reminders. What if residents are just forgetting that they need to stay in their rooms and what reminders and cues can we put into place to help them stay in their room. I know some people have been using those Wander Strips, those Velcro strips that go across the front of doors and for some people that’s enough to remind them not to leave the room. This is a step up in terms of restrictiveness because you’re putting a barrier in place. You can get door alarms, but they’re the same as basically a chair and bed alarms. They ring loudly if someone passes the threshold of their room. That can be unpleasant to have an alarm go off every time you leave your room but for some people it’s enough of a reminder to prevent them from leaving the room. The advantage of the alarms is



that it is also a way of alerting staff that someone has left their room and so it's an opportunity to look into these types of equipment and tools and have them on hand.

Question 6: What is reverse isolation?

Answer: So unfortunately we got hit hard on our LTC unit and our residents are severely affected by dementia. A lot of cognitive issues and many of them don't understand the virus in isolation. So 20 out of 24 residents tested positive for COVID-19 and many of the ones that tested positive were ones that wander and need to walk around. So we realized it was easier to keep the four that were COVID-negative in their rooms and reverse isolate for their protection.

We also initially had an issue with staffing, but once we had more staff we were also able to increase cleaning measures, such as, wiping down railings and frequently used surfaces.

Question 7: At our LTC home we have been pretty diligent in preventing a COVID outbreak. When you talked about planning, our home has the opportunity to plan, but there are challenges in isolating residents when we have a 4 bed ward. Has anyone heard anything about flexibility around occupancies being held at a lower level without losing funding and to turn a four bedroom into a three or two?

Answer:

1. I think it is a great question to pose to the Ministry of Health and Long Term Care. As we are at the end of the beginning of this pandemic, and shifting into the maintenance stage before the second wave comes, it may be a good opportunity to advocate for those kind of things for plans to be put forth in future.

It does sound like you're doing the right things, through monitoring and surveillance and planning to the best of your abilities around the space and resources available. Another thing that came up in a few facilities that started doing cohorting were issues around cleaning. I'm not an expert on this but wanted to raise that issue. Something to think about is having a good cleaning plan especially when you are moving a COVID-negative resident into a room that once had a COVID positive resident before. So that is another aspect to consider when making a plan on how to effectively isolate residents in your facility.

2. We are taking advantage of our lower occupancy and no admissions to reduce our ward rooms to no more than 3 people.

3. We were in 2 bedrooms and we got funding for a retro fit and will have mostly 1 to a bedroom and share a bathroom with 1 other instead of 3 others. We were supposed to break ground in the Spring. Adding one section and moving wings one at a time until it is finished

4. We had almost an entire unit test COVID+ and many of them we were unable to isolate. So we were lucky and able to get a unit aid that was there to wipe down common spaces continuously as well as redirect wanderers away from others. We tried to "reverse isolate" those that were negative, because they had fewer responsive behaviors.



Question 8: What about the ethical guidance of capacity to consent, substitute decision making, families that are in agreement versus no agreement?

Answer: We're in the process of our second tool, which is going to be a legal and regulatory framework that will set out some of these issues around consent and the law around this regard. So certainly you want to involve them in the decision making and in any decisions around helping them understand what is happening and the care that their family member is getting. For many they are scared to hear that their family member is COVID-positive or in a unit with someone that is positive so that can sometimes get in the way of communication. So the idea is really about optimizing that communication as best as possible so that you don't get into situations where you're in conflict around the best interests of the resident and what the family is willing to consent to in the best interest of other residents on the floor.

But, fundamentally when it comes down to it, the family members do not need to consent to isolation. Isolation is part of the infection control directives which are made by the province. Someone who is COVID-positive is to be put under droplet and contact precautions. So it can be a challenge to implement these isolation protocols, but family members can't say to you "you're not allowed to isolate my loved one".

The other question that comes up is around deciding what measures to use to keep someone in isolation and whether you need consent from family members to use that. So for example, a resident getting aggressive or agitated about the need to stay in their room and this resident is the only COVID-positive resident among many negative residents and they are putting the whole unit at risk from their behaviour. There is clear argument for using the common law in these circumstances where it would be considered an emergency measure to use medications and hopefully the family would understand that it was necessary and to lay out for them the ways you were mitigating the risks associated with using a medication or other measure in these circumstances and that the family would understand and accept it.

So hopefully when our next ethical guidance comes out it will lay some of this out. It's not always necessary to get consent in an emergency situation where people are imminently at risk of harm. But, also since staff need to have ongoing relationships with the families and residents, you want to do whatever possible, whenever possible to get their understanding and their agreement. So this is what the next framework will focus on.

I had a resident in our LTC unit who needed to be isolated because they were COVID-positive with wandering behaviour and we tried many non-pharmacological strategies to keep them isolated that was not effective. This resident was paranoid, probably delirious and believed that their room was cursed. So we had recommended using medications and the family initially didn't agree, but after we spent time educating and working with the family members, we made it clear that this was an emergency measure. In the end, the resident tested negative for COVID-19 and we no longer needed to use the medications to prevent them from wandering. That was the process we went through.



Question 9: Have you ever determined that you needed to use some form of physical restraint on residents that are difficult to keep isolated?

Answer: We never want to use physical restraints to manage these behaviours, but there are situations where we may need to make that decision. It's about weighing everyone's safety and taking that into account. I think the key thing here is that this is a short term measure and it's never the only measure. You may be putting someone in physical restraints, but you're still making sure that they're safe and you're still engaging them in their room and still communicating with them and reminding them they need to stay in their room. It's important that you're following the best practices around use of restraints.

This is hopefully our third tool in that we know that a lot of LTC homes may not have much experience on how to safely restrain someone and the kinds of best practices because there hasn't been a need to and therefore not in many people's skillset. Not that we necessarily want everyone to be using restraints, but there may be instances that is an appropriate intervention. So in the [case study](#) that I mentioned earlier, we did use physical restraints in that case as well. We really tried to minimize the use of restraints and we were pretty successful with that, but there is a skill in restraining someone in way that is safe. So I think it's important to make use of resources that are available to you, such as your geriatric psychiatrist, your outreach teams, so that if you don't know how to safely restrain someone, you can turn to those that do.

In our unit, we required three staff members to safely use restraints and this may be challenging in homes that are understaffed. And with limited PPE that may also pose a challenge. So that is part of the rationale of this decision tool is to think through these potential scenarios and weigh in the benefits and risks and how to mitigate and adjust to a solution that works.

Question 10: What are some useful resources for residents with dementia who many not remember what they have been told about COVID-19 and not understand what is going on?

Answer: There is a company called Dementiability who has created large print COVID-19 books for people living with dementia. The goal is to help them to understand what is going on and why. This book provides the facts - and the reminders - about the new rules that must be followed by all. There are a number of versions of this book, each one focusing on understanding COVID-19. Each one has a bit of a different focus.

1. Understanding COVID-19 in LTC in Canada (Sample message provided below)
2. Understanding COVID-19 when living in the community - in Canada
3. A generic version - for anyone - in any country - or living situation (LTC and community)
4. Understanding COVID-19 in LTC in Australia
5. Understanding COVID-19 in the community in Australia
6. Understanding COVID-19 in the UK



The [Aphasia Institute](#) has some nice resources for persons living with aphasia.