Long Term Care: COVID-19 Series

Session 1: Symptom Management & End of Life Care in COVID-19 Positive Resident Post-Didactic Q&A

Question 1: With regard to fever, the new guidelines state to swab anybody in LTC with a temperature of 37.8C. However, many resident's baseline temperatures are anywhere between 35.8-36.5C. If a resident has a temperature 1 to 1.5 degrees greater than their baseline, would we still consider this a fever and grounds to test for COVID-19?

Answer: This is a concern that we've had at Baycrest (Apotex) LTC home and we have adopted 37.2 C as being a threshold to inform the attending physician and our IPAC team then a decision is made at that point whether a swab should be done earlier or whether to evaluate when temperature reaches 37.8C. That is how we've adopted it and we are not necessarily swabbing people at 37.2, but we are bringing it to the attention of the physician and IPAC team. **– Dr. Sid Feldman**

Question 2: I find the new guidelines challenging, especially with atypical symptoms. Not everything is COVID-19 related; residents still require management of other co-morbidities (i.e. urinary tract infection, end stage congestive heart failure etc.). Say a resident prior to this pandemic always vomits, and now is placed in 14-day isolation due to vomiting. Now we are using PPE and other resources on a resident that may be negative for COVID-19. How can we deal with this dilemma in managing chronic conditions and adhering to the new COVID-19 assessments?

Answer: It's really tricky as residents who present with vague symptoms in the past will continue to have vague symptoms in the future and we are struggling with a disease that also presents with vague symptoms in older adults. Our experience here at Baycrest and from the literature is unfortunately, our patients with COVID-19 do present atypically. We do need to have a high level of suspicion as a result. – **Dr. Sid Feldman**

Question 3: Should you still test for COVID-19 in residents that are end of life, especially since fevers are common at the end of life?

Answer: So I work on a palliative care unit with people who are mostly actively dying and everyone has a temperature related to their disease. So adopting a low threshold of suspicion (notifying attending physician with temperature of 37.2C) and especially in the context of if they had an essential visitor and they're having a fever, we are respectful and do test for COVID-19 and unfortunately isolate them until results come back. At Baycrest, we are mindful of what IPAC is recommending and there is always communication and some kind of negotiating with IPAC. If there is any part of the history, such as symptoms and recent essential visitor, you raise your index of suspicion and we do swab even if somebody's on their last breaths. These precautions are also for the safety and protection of our staff

managing residents at the end of life to ensure they are wearing the appropriate PPE. It is very challenging and complicated so I am acknowledging the challenges involved. –**Dr. Giulia Perri**

Question 4: What are the indications for use of indwelling catheters in managing residents at the end of life with COVID-19?

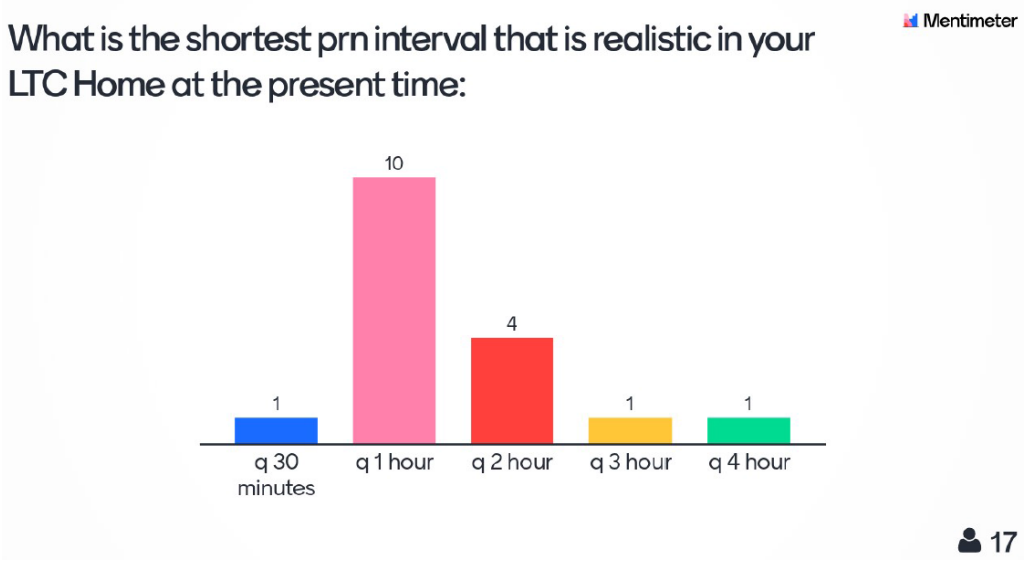
Answer: So the context is a resident who is frail, has multiple co-morbidities who is having symptoms and is headed towards end of life. So the rationale is because symptom severity will vary, not all COVID-19 positive residents will progress in terms of symptom severity. My caveat is the resident who is heading towards end of life, who has respiratory distress most definitely is on scheduled opioids and possibly an anticholinergic for respiratory secretions. These are medications that can lead to urinary retention so for the comfort of our resident, and for staff as well, an indwelling catheter PRN order is part of any standard order set. Of course use your clinical judgement, not everyone will need a catheter right away and the MRP will decide if catheter PRN is necessary based on the history and presentation. The benefit to catheter PRN is the nurses can use their judgement if they feel the resident is retaining and the order is already there. –**Dr. Giulia Perri**

Question 5: Typically our LTC home has not offered parenteral hydration. In this setting I see parenteral hydration being helpful in the non-palliative resident. We are trying to establish ways to support staff if we do needs this. We have a hypodermoclysis policy, though it is rarely used and intravenous hydration is not offered as staff doesn't have much experience with initiating IV hydration. Do others have experience in this? How best to support staff and residents who are looking for hydration?

Answer: So my mind automatically goes to the two prong approach depending on the goals of care and symptom severity prognosis. So if the goals of care is for life prolongation, maybe in the context of symptom severity or symptom burden is not high and you feel they are doing okay (not end of life) then I frame it to my residents as intravenous hydration is for resuscitation. If we want to support somebody's life to get through COVID-19 infection or an illness exacerbation, CSCI can do just about the same thing. CSCI is not used for resuscitation – you can't give boluses of fluids, but running a CSCI at 50 CCs an hour and monitoring for absorption is reasonable.

However, if I feel somebody is in respiratory distress and they are oxygen hungry, you are heading into trouble when you're going from 2L to 3L up to 6L of oxygen and for those individuals, my advice in my experience is that CSCIs are not going to prevent death from happening and there is no medical indication for hydration at end of life. However, do I do it? Absolutely, because for some residents or their families see CSCI as standards of care. So there is a real communication with the family as to why the resident would need CSCI. Some medical indications for CSCI may be if there is myoclonus involved or if the resident had a history of hypercalcemia in the past and heading towards end of life. They are COVID positive and now they are in respiratory distress and you just have to use your judgment call. However, folks with respiratory distress have issues with any fluid overload and an exacerbation of symptom control so for that reason most of the time I don't offer hydration at the end of life. I hope I answered the question; just my experience.—**Dr. Giulia Perri**

Poll Question 1: What is the shortest PRN interval that is realistic in your LTC home at the present time?

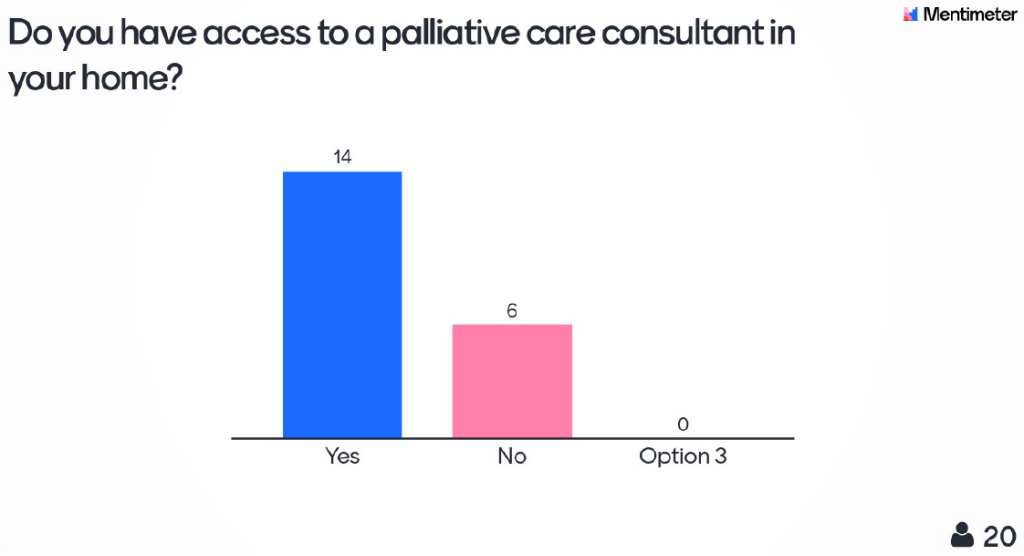


Question 6: So it looks like around q1hour is where most people think they would be able to handle so also worth thinking then, does that change the strategy LTC staff should use at all?

Answer: My framework would be the shortest time frame that we can safely do is q30 minutes PRN. Often times I'm in situations where the nurse will call back an interval shorter than an hour saying "I need something". Having said that, I think it's a balance. So if any particular LTC home wants to do q1h or q4h PRN, there is nothing wrong with that. It is a team effort and communication that will go back and forth with the staff caring for the resident and the MRP (attending physician). For say opioids, we know that the shortest safest dosing interval is q30minutes PRN or even q20 minutes then as the MRP or the nurse following the resident's care will know and have the confidence to go less than 1 hour. **– Dr. Giulia Perri**

In my mind it becomes a question around the resources on that particular day and I think given COVID time it takes into account staff who may be off, being short-staffed and the critical question is tonight, given what is going on, how often do you think you can give PRNs. Is there someone else that can help out, is the resident looking unstable, and looking at trying to give every 30 minutes until we get the resident comfortable. Are there other resources that you can pull in to do some of your other work so that we can really focus on this and if not then I might be inclined to give doses that are a little bit higher, more regularly, or even if its q1 or q2 so we can try to do the best we can under the circumstances. **–Dr. Sid Feldman**

Poll Question 2: Do you have access to a palliative care consultant in your home?



So it looks like some do have access to palliative care consultant in their LTC home and some do not. https://www.ontariopalliativecarenetwork.ca is a website containing provincial efforts that address the need for good palliative care for our LTC residents who have COVID. **–Dr. Sid Feldman**

Question 7: In addition to medication-based management of COVID-19, what are some of the non-pharmacological things we can do for our residents at the end of life?

Answer: So in general I think it's so challenging when residents are seeing caregivers and us coming in with full PPE and just their own fear; just acknowledging their own fear and the suffering that they might be going through as they are heading towards end of life. I think communication actually is the best non-pharmacological strategy and the reassurances that some of us are used to giving and really good at giving needs to continue and that compassionate care towards the resident and their families. We are trying to reassure everyone that we are in this together and we're trying to do our best to anticipate problems, prepare for problems and deal with problems right now, but you asked if I have the number one non-pharm strategy is communication and having this conversation in advance because it really provides peace of mind and it kind of proves how caring we really are when we reach out to talk in advance. –**Dr. Giulia Perri**