Ontario Long Term Care Clinicians

Friday, May 22, 2020

COVID-19 REPORT

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As of May 21, Public Health Ontario (PHO) reports 221 LTC outbreaks, up by only one from May 18. The Ministry of Long Term Care Daily Report is 171, down from 190. Although there have been 30 more deaths, the trends may be levelling.

Ministry of Health and LTC	Ont cases	Deaths	LTC cases	LTC deaths	% LTC deaths
May 11	20,546	1,669	2,725	1,235	74.0%
May 14	21,922	1,825	2,953 (PHO)	1,320 (MOH)	72.7%
May 18	23,384	1,919	4,235 (PHO	1,456 (PHO)	75.9%
May 18			2,538 (MOH)	1,409 (MOH)	
May 21	24,628	2,021	4,741 (PHO)	1,486 (MOH)	73.5%

Ontario COVID-19, May 19

The above figures indicate an overall provincial death rate of just under 8%. The disproportionate death rate in LTC will be the grim legacy of this pandemic. The Case Fatality Rate (CFR) from COVID-19 will likely be less over time. CFR is the rate of death from a diagnosed infection. It is the proportion of people who die from a disease among all those diagnosed with the disease over a certain period. The possibility of asymptomatic infection and underdiagnosis owing to mild illness gives an underestimation of current cases. This quantification can improve CFR estimates. "The adjusted CFR of COVID-19 in Canada is likely to be less than 2%. The CFR estimates for the US were higher than those for Canada, but the adjusted CFR still remained below 2%."

Temporal estimates of COVID-19 CFR, CMAJ, May 22

LTC witnesses an unexpected mortality from COVID-19 while the anticipated surge into acute care did not happen. Advance care planning (ACP) in LTC prevents avoidable transfers to the emergency department (ED). More than age, vulnerability factors for COVID-19 are frailty, functional trajectory, and multi-morbidity—all characteristic of many LTC residents. ACP proactively identifies patients who do not wish to receive aggressive, invasive interventions. The clinical frailty score (CFS) can be useful to provide goals of care (GOC). Recognizing that baseline functional status is an important predictor of survival for critical illness. The CFS is a 9-item pictorial scale identifies patients who are severely frail. *Managing Older Adults with Presumed COVID-19 in the Emergency Department: A Rational Approach* emphasizes that GOC decisions should be done prior to transfer to the emergency. GOC discussions reduces unnecessary transfers and reduces the risk to transmission of COVID-19. "Providers working in EDs are trained in disaster medicine, triage, and resource prioritization and are comfortable rapidly caring for multiple critically ill patients simultaneously. This process is made even more challenging during the pandemic because many EDs have implemented limitations on visitor policies to minimize spread of infection."

Managing Older Adults with COVID-19 in the ED, May 21 h

Public Health Ontario COVID-19 webinars this week reviewed PPE and cohorting residents in LTC and the nursing home. Visits by Public Health to facilities across the province find inconsistent, excessive or inappropriate use of PPE. Supply shortage, or the fear of short supply, contributes to this uneven use. Transmission of COVID is through direct contact with respiratory droplets. Most transmission is person-to-person. The role of asymptomatic and presymptomatic persons in transmission remains uncertain. Droplets contaminate surfaces and so both droplet and contact precautions are required. Airborne precautions are necessary with aerosol generating medical procedures (AGMP), such as CPAP and airway suctioning. Masks are classified as medical devices and are regulated accordingly. Guidance for use of non-medical masks should be provided by the facility. Masks must be worn by all staff and visitors in LTC. The mask can be removed at break and mealtimes. The mask should be removed and not lowered below the chin Further recommendations and instructive videos include eye protection and glove use.
Putting on personal protective equipment, PHO

Cohorting is grouping residents or staff based on a particular factor. Cohorting is confining two or more residents who are infected by the same infection. Cohorting staff means assigning health care workers to affected residents, or non-exposed residents, but never both. When this is not possible, HCW's should plan to first see unaffected residents, then see those in isolation with full PPE. Cohorting staff should also be in separate areas, for breaks and meals, when not providing care. The wandering resident is a challenge for cohorting residents in LTC. Extra measure includes optimizing hand hygiene, enhanced environmental cleaning and decluttering. Wanders in common areas should be encouraged to wear masks. One-on-one supervision may be necessary. With the exception of gloves, resident cohorting permits preservation of PPE by the care staff.

A COVID-19 positive resident is cleared of infection fourteen days after onset of symptoms. If the resident has not been to hospital, a negative swab is not required. There is currently no evidence for re-infection, but it is unclear whether someone who is cleared has immunity or is susceptible if re-exposed to the virus. There is no requirement for a positive test for clearance. "Detecting of virus after clearance most often represents ongoing shedding of dead virus that is not infectious to others." The public health unit can be contacted if there is any uncertainty.

OLTCC and the OMA Section of Long Term Care and Care of the Elderly will host another Zoom Town Hall on Thursday, May 28, at 7:00. Details will come early next week. Panelists will answer your questions on caring during COVID-19. Topics will include advance care planning, virtual care, outbreak management and physician health and wellbeing.