Long-term Care
Communication Bulletin

TO: Long-term Care Physicians and Nurse Practitioners **DATE:** March 23, 2020

FROM: Dr. Margaret Manville, Medical Director Long-term Care

RE: LTC update

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1. **Please see the new order from Dr. Stanwick re: transfers from LTC to acute care:**

   Refrain from transferring a resident to any other healthcare facility, including without limitation another LTCF or a hospital as defined in the Hospital Act, RSBC 1996, c. 200, without prior notice to and authorization of the MHO or delegate. In an emergent situation, where a patients goals of care are compatible with transfer to an acute care hospital (i.e. having a stroke and full code), LTCF staff should call 911 prior to providing notice to the MHO or delegate. Notice to the MHO or delegate must be provided as quickly as possible.

2. **NON-COVID-related acute care transfers:** The above order demands that ANY transfer to acute care must be deemed critical to the comfort or medical care of the individual patient. It requires a fully-informed patient or family member as to the risks involved, and must be agreed to by the physician, ERP and MHO UNLESS to do so would result in an unacceptable delay in needed medical care. The transfer must be aligned with the patient's MOST order and goals of care.

3. **Please only visit a LTC facility in-person if there is no other way to provide an accurate and safe medical assessment or medical treatments**. We are restricting to essential visitors only. Most sites can assist you by phone and give you good information about the needs of your patient. Physicians and nurse practitioners are to use their good clinical judgment to decide what is essential for each situation and context. You must check in with the greeter if you visit.

4. **PREVENTING TRANSFERS to ER for suturing** please try to suture on site. Here is a list of suture materials and costs that can be shared in your locations. Some patients may require mild sedation prior to suturing to ensure your/their and staff safety.

ResServices
Laceration & Biopsy K

5. **Nebulized medication and MDIs**: Since our last recommendation, we have learned that there is a critical shortage of MDIs (especially Ventolin). Because of the shortage, we CANNOT recommend widespread conversion of everyone from nebulisers to MDIs, and must reserve them for those who need it most. Here are the recommendations from Island Health Pharmacy and from our LTC- MAC:

    a. Assess whether your resident still needs nebuliser therapy
    b. Ask if this resident can be stepped down to PRN therapy safely
    c. **Use alternate bronchodilator puffers for maintenance therapy when clinically appropriate. Options include salbutamol + ipratropium (Combivent Respimat), terbualine (Bricanyl Turbuhaler), salmeterol (Serevent Diskus), formoterol (Oxeze Turbuhaler), salmeterol + steroid (Advair MDI, Advair Diskus), formoterol + steroid (Zenhale MDI, Symbicort Turbuhaler). There are newer LAMA/LABA puffers (Inspiolto Respimat, Anoro Ellipa, Ultibro Breezhaler, Duaklir Genuair) that may be suitable**.
    d. Phamacists would be a good resource re: availability and suitability when choosing an alternate bronchodilator. Use alternate bronchodilators for maintenance therapy when clinically appropriate. Options include salmeterol, formoterol and ipratropium (+/- corticosteroid**).**
    e. **Reserve salbutamol MDIs for non-intubated patients with a confirmed or probable coronavirus infection. If nebulized therapy must be used, observe appropriate infection control precautions.**
    f. **Use nebulized salbutamol (+/- ipratropium) in patients with no precautions or those on closed system ventilator support and if your patient does not tolerate any substitutions**
    g. Island Health Pharmacy will attempt to bring in terbutaline (BRICANYL TURBUHALER) or COMBIVENT RESPIMAT. If supply comes in, these non-formulary products will be made available.

6. **CPAP in COVID-suspected or COVID-infected patients.** CPAP should be held until NP swab result is known. If the patient has no infection, CPAP can continue as ordered. **If CPAP is absolutely necessary in COVID-positive patient, proper infection control for AGMAP must be followed.**

7. Treatment: from the Lynn Valley experience, LTC patients infected with COVID only survive 1-3 days after diagnosis with a 25% mortality rate so far. Dr. Manville is on a provincial task force to create a care pathway for COVID positive patients for physicians. This will be distributed as soon as is ready. VIHA has a treatment guideline document attached below and another with recommendations re: ACE/ARBs in COVID patients.


SBAR COVID-19 Therapies_IMAC_Marc


CCSCHFSstatementregardingCOVID.pdf

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8. **GOALS OF CARE AND MOST please review your M3-C2 patients**. In order to help physicians and NPs with these difficult conversations, we are asking for a statement from public health officers that COVID-infected patients can be safely looked after in LTC. Here are some excellent communication tools from our palliative care colleagues to help with these conversations, specific to COVID-19**. The majority of LTC patients are M1-M2 due to their frailty and burden of medical co-morbidities.**


SIC with SDM in LTC - preparing for COVID-


COVID ready communication.pdf

9. Dr. Stacey McDonald has also prepared a document to help guide what to do after a LTC patient dies of suspected or confirmed COVID.


Death of Patient LTC final draft.docx

Thank you for the excellent care you provide to our most vulnerable patients, and for your ability to provide this care under trying circumstances.

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