Ontario Long Term Care Clinicians

Tuesday, July 14, 2020

COVID-19 REPORT

The number of long-term care homes experiencing a COVID-19 outbreak is down to 27.

Ministry of Health and LTC	Outbreaks	Ont cases	Deaths	LTC deaths	% LTC deaths
July 06	30	36,060	2,691	1,821	67.7%
July 13	27	36,090	2,723	1,836	67.4%

An Emergency Order issued on March 28 included direction that *care conferences are on hold except to meet the "clinical needs of the resident". The annual physical examination is not required but a physical examination should occur "within a reasonable period of time after the resident's last examination"*. (OLTCC COVID-19 Report, March 29). OLTCC members ask about resuming annual examination and care conferences. These orders were necessary to protect residents from COVID and to ensure that staffing and resources are available during the COVID-19 crisis. The crisis was not expected to last this long. Although the emergency orders remain in effect, physicians are should do examinations, with precautions and PPE. Family conferences should occur, likely by some means of teleconferencing or videoconferencing.

Managing Resident Deaths Reports (MRDR), which began on April 13, was stopped earlier this month. Members and homes are dealing with the completion of death certificates. Issues that have arisen include COVID precautions at the time of death, removals by funeral services and expectations that MDs come into the home through current screening protocols. The attached memo was sent from the Office of the Registrar General to funeral directors on May 20. A fillable PDF of a Medical Certificate of Death (MCOD) is available. The attached 44-second video shows how CPSO members can access Form 16 from the CPSO website. OLTCC would like to know your experience with using this link.
http://www.forms.ssb.gov.on.ca/mbs/ssb/forms/ssbforms.nsf/FormDetail?OpenForm&ACT=RDR&TAB=PROFILE&SRCH=&ENV=WWE&TIT=11291&NO=007-11291E

Clinicians should be able to complete the MCOD on-line, like the coroners did during MRDR. The attending MD or NP knows the decedent and, most importantly, the trajectory of illness causing death. A clinician may be delayed in getting to the home, contributing to the grief the waiting family. Expedient completion of MCOD allows the LTC home to release the body. It respects cultural sensitivity by ensuring no delay to certain religious or culture rituals. During pandemic times, it lessens the movement of health care providers between health care settings. The link below is a petition to the Ministry of the Solicitor General. Sign and share:
http://chng.it/6YLzRmGm

Save the date: **IN THE WAKE OF THE FIRST WAVE, Friday, July 24, 12:00 – 1:00**. OLTCC will host a webinar with Dr. Allison McGeer, Infectious Disease Specialist at Mt Sinai hospital. Participants will be informed about the Control Covid study, which examines the role of chemo-prophylaxis for LTC outbreaks. Join the meeting at
https://zoom.us/j/95356260497?pwd=Y3MwRDdxbHV5T1ZRaHhrTnNiWS9rQT09

SOLVING THE COVID-19 CRISIS IN LTC

An article published today in the Journal of the American Medical Director's Association (JAMDA) is attached. AMDA—the Society for Post-Acute and LTC Medicine—is dedicated to quality in LTC process and outcomes. Canada and USA witness similar misfortunes of COVID-19 in LTC facilities. LTC learned "more about how to respond to outbreaks, and the dire consequences when our responses have been ineffective, or worse, ignored, or blocked by health and/or government authorities." This special article presents five keys to solving the COVID-19 crisis in LTC. These keys are applicable to our situation in Ontario:

1. ***LTC expertise must be included in policy decisions that affect LTC***. In Ontario, some of the severe outbreaks required belated rescue by outside agencies like hospitals and, incredibly, the army. The majority of homes that have kept their residents safe are not recognized. Outsiders, both in and out of the health care system, have made observations and recommendations without understanding the culture of LTC.
2. ***Collaboration across health care sectors must be the norm***. Greater communication with hospitals and Public Health provide greater "leverage in time of crisis; they bring speed, and an understanding that all stakeholders must work together to find solutions." The negative press and opinions of others have caused "hostility" towards LTC. A "cultural fear and societal revulsion around aging" may ignore the essential needs of residents and health care workers in LTC.
3. ***Do not look for a one size fit all solution***. COVID-19 outbreaks show regional variability. Resources like testing and PPE should be assigned accordingly; for example, the recommendation to regularly test all residents and staff. This also applies to the criteria for transferring residents to and from hospital. These decisions are based on local testing, outbreak status and hospital capacity. The best solutions are often found at the local level.
4. ***Policy leadership must be proactive, not reactive; and supportive and not punitive***. The COVID-19 crisis in LTC was missed because the emphasis was on preventing a surge into acute care and intensive care units. It is evident that "nursing homes were not prioritized for access to PPE, testing, staff capacity, or other infrastructure support such as alternative bed capacity for cohorting…" With respect of the role of the Medical Director, the current Ontario Long Term Care Homes Act (2007), remains unchanged from the prior Nursing Homes Act, circa 1962. Medical services and directorship need to be defined and updated in keeping with OLTCC Medical Director Curriculum.
5. ***LTC needs massive restructuring***. The Royal Society of Canada report, Restoring Trust: COVID-19 and the Future of LTC (June 2020) states that "Canada's LTC sector has its roots in the Elizabethan Poor Law of 1601, not in the healthcare system. Provincial and territorial plans are disparate and piece-meal." The pandemic exposes the increased acuity, vulnerability and limited life expectancy of most current residents in LTC. While care demands increased, staffing levels remain fixed. Many of the worse outbreaks were in older C-bed homes, long overdue for redevelopment. More education and preparation are needed for infection prevention and control.

LTC reform requires “a new lens toward policy, collaboration, individualization, leadership and reorganization”.