Ethical analysis and recommendations for issues in Long Term Care (LTC) and Assisted Living (AL) arising from the COVID-19 pandemic

Responding to Suspected COVID-19 for Residents in Shared Rooms

Situation

The COVID-19 pandemic presents a number of significant ethical issues in Long Term Care (LTC) and Assisted Living (AL) settings. This SBAR discusses the following ethical question and provides recommendations for consideration:

- **What ethical considerations ought to be considered for residents in shared rooms who exhibit signs/symptoms of COVID-19 and for whom test results are pending or are confirmed to have acquired COVID-19, when private rooms are not available and/or when a COVID-19 designated room is unavailable?**

Background

The ethical analysis and recommendations in this report follows the *BC COVID-19 Ethical Decision-Making Framework (EDMF): Interim Guidance* (in draft, effective March 2020).

This EDMF reflects the core ethical principles of public health ethics: respect; the harm principle; fairness; consistency; least coercive and restrictive means; working together; reciprocity; proportionality; flexibility; and procedural justice.

Assessment

In circumstances where private rooms are unavailable, and in circumstances where a designated shared COVID-19+ cohort space is unavailable, it may be ethical to apply isolation and restrictions to all the residents in an entire shared room.

Impacted individuals should be tested and all reasonable efforts to protect in-room transmission should be maximized.

Key facts or assumed facts (on the basis of information that is currently available[1])

- **Should a person residing in a shared room be suspected or confirmed to be COVID-19+, the authors have assumed residents also residing in that shared room face a high likelihood of having acquiring COVID-19. Should**

[1] Including BC Center for Disease Control: COVID-19 Care. Accessed 17 March 2020 at http://www.bccdc.ca/health-professionals/clinical-resources/covid-19-care

information become available that indicates this assumption is mistaken, this decision should be reassessed immediately.

- COVID-19 is currently understood to be a highly infectious and easily transmittable virus.
- **At present, it is believed that COVID-19+ individuals may not demonstrate symptoms for several days and may be highly infective and thus pose a risk to others.**
- The risk of spread of COVID-19 is currently thought to be high in both community and health care settings.
- Infection control measures of droplet and contact precautions should be strictly maintained when interacting with and caring for all residents who are known or suspected to be COVID-19 positive to reduce the risk of transmission. Should an individual resident in a shared room acquire symptoms of COVID-19 and/or be confirmed as COVID-19, identify and explore ***all*** possible options to prevent transmission within the room in collaboration with infection control team input.
- The magnitude of the harm from COVID-19 to LTC/AL populations, where individuals are commonly frail older adults with comorbidities, is high and includes death[2]. Combined, the risks of transmission and harm to others indicate that maximally restrictive options may be justified.
- The risk of infection from an infected resident to care providers and the wider public is currently thought to be high. Thus, the risk of harm to society is high and needs to be factored into any ethical response.

Values grounding this decision

- The Harm Principle
  - Society has a right to protect itself from harm
  - Maintaining public safety means minimizing the risk of COVID-19 exposure and spread to the larger population
- Proportionality
  - Highly restrictive measures may be justified to reduce the risk of highly detrimental threats
  - While restricting residents to a room where another person is COVID+ (or suspected) is especially restraining and maximally restrictive, it is proportionate and commensurate with the current level of threat and risk associated with COVID-19

Values in tension with this decision

- Least coercive and restrictive means

[2] See: Huang, C, Wang Y, Xingwang L et al. Clinical features of patients infected with 2019 novel coronavirus in Wuhan, China. The Lancet. 2020; 395(10223): 497 – 506. DOI: https://doi.org/10.1016/S0140-6736(20)30183-5

  - Restricting suspected residents to a space where suspected and/or confirmed COVID-19 is present, is recognized as a maximally restrictive means.
  - In light of what is recognized currently as a high degree of transmission, there is an increased probability that other residents within a shared room may have acquired COVID-19. As many frail older adults reside in LTC/AL, acquiring COVID-19 from this decision may result in death.
- Respect
  - When possible, individual liberties and cultural preferences should be respected.
  - However, in pandemic settings individual rights, including those of changing rooms, do not supersede public health safety concerns.

Discussion

This decision distributes harms of COVID-19 equally across all other residents in a shared room—while affected individuals may suffer harm, they do not suffer an injustice from this decision. In light of the considerable risks of COVID-19 to other residents in LTC/AL, and the fact that those in the same room may already have been exposed and thus spread the infection, this is an ethically justifiable decision.

Health care providers must also be prepared to restrict visitors from rooms that house COVID-19 positive patients, given the significant risk of transmission. This may mean that COVID-19 negative/asymptomatic patients are not able to receive visitors because the entire room is in isolation.

It is understandable that COVID-19 negative/asymptomatic residents and their families/visitors may be distressed by the room restrictions, and HCPs must be prepared to share the rationale for the restriction in a transparent and compassionate way.

All efforts to decrease in-room transmission should be undertaken[3] (e.g. strict PPE use for all patients, with entire PPE change-over when a caregiver switches to care for the next patient; removal of non-essential items and clutter, especially those that cannot be wiped down with cleaning products; use of curtains or screens to decrease the spread of droplets, if available; positioning resident's beds as far apart as possible).

Recommendations

A key assumed fact in this decision is that persons residing in shared rooms where an individual is suspected or confirmed to be COVID+, faces a high probability of also acquiring a COVID-19 infection.

[3] Center for Disease Control. Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings (2007). Accessed on March 19, 2020 at: https://www.cdc.gov/infectioncontrol/guidelines/isolation/precautions.html

Should this assumed fact be incorrect, or should new information become available, this decision should be reassessed immediately.

1. Seek regional and/or provincial endorsement to uphold the value of *consistency*. Consistency ensures that all residents receive the same care (including a just distribution of both benefits and possible harms), regardless of where they live or the bedroom assigned.

2. Communicate this decision openly and transparently. Where possible, clearly articulate the rationale for this decision. Efforts can be made to create signage, pamphlets, or videos (in different languages) that families can refer to for additional information.

3. Seek to maximally support patients and family/visitors who may be impacted by this restriction. Recognize the emotional harms that may arise to individuals impacted and offer all available supportive options. In the setting of isolation shortage (e.g. unavailable private rooms and/or unavailable COVID-19 cohort rooms), some residents who may have been COVID-19 negative may become infected as a result of system-level critical shortage of isolation (and/or COVID-19 cohort options). Consider all options to support residents and family/visitors who suffer from this decision.

4. If residents/family members insist on relocating a resident who is confirmed COVID+ and/or who is suspected to be COVID-19+ despite all efforts of the health care team, refer to the director of the facility, and possibly the Office of the Provincial Health Officer.