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

## Restrictions for Visitors

### Situation

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

**What ethical considerations ought to inform our visitation guidelines for family member(s) of residents who are confirmed (or probable) COVID-19 positive and become critically ill and who are likely to die?**

### 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[1]

**It is reasonable to restrict visits to a person with confirmed COVID-19 where the risk of transmissibility cannot be mitigated by standard infection control procedures.**

***Key facts or assumed facts (on the basis of information that is currently available[2]):***

- COVID-19 is currently understood to be a highly infectious and easily transmittable virus.
- Infection control measures of droplet and contact precautions should be strictly maintained when interacting with and caring for all patients who are known or suspected to be COVID-19 positive to reduce the risk of transmission.
- Isolation is currently a strategy recommended for COVID-19 containment; persons who are found to be COVID-19 positive are required to isolate.

[1] The ethical analysis for this question has been considered and adapted from Ebola planning work untaken by the Fraser Health Authority Ethics Service

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

- The risk of harm to others from COVID-19 transmission is great. Some populations, including frail older adults and those with comorbidities, experience high morbidity and mortality following COVID infection[3]. The probability of COVID-19 spread is also very high if not appropriately mitigated by strict isolation and use of PPE.
- **At the time of this writing, there is a worldwide shortage of personal protective equipment (PPE). Thus, PPE ought to be restricted for use only by healthcare professionals (HCPs) who are providing clinical care. Without PPE, there is no strategy to mitigate the risk of COVID-19 transmission to visitors[4].**
- The risk of COVID-19 transmission from an infected patient to family members, 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 visitation to patients or residents is especially restraining, it is proportionate and commensurate with the current level of threat and risk associated with COVID-19
- Fairness
  - PPE resources must be deployed to achieve the maximum benefit for the greatest number
  - Protecting health care providers from harm (in this case COVID-19 infection) ensures sustainable health care delivery to the entire population
  - At present PPE is assessed to be critically scarce. Thus, restricting PPE to be used by HCPs only ensures ongoing care provision for current patients affected by COVID-19, and to future patients
- Procedural justice
  - Reflects the best available evidence, and ensures assumptions made are well grounded and defensible
  - Requires consistent and transparent communication to affected patients and families

[3] 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

[4] For further ethical discussion on ethical PPE allocation considerations and recommendations, refer to the PPE allocation SBARs (documents being prepared for delivery on 20 Mar 2020)

***Values in tension with this decision***

- Respect
    - When possible, individual liberties and cultural preferences should be respected
    - However, in pandemic settings individual rights, including those of visitation, do not supersede public health safety concerns
- Least coercive and restrictive means
    - All efforts should be made to implement measures that are the least restrictive and coercive as possible
    - In this setting, scarcity of necessary PPE and elevated public health risk justify intrusive measures aimed at protecting the public

**Discussion**

Restriction around visitation has been mandated for public health reasons, and it is important to clearly explain to patients, residents, and families the rationale. HCPs should communicate restrictions in an honest and transparent fashion, while being firm about the need for such restrictions. Facilitated communication with appropriate team members including directors, social workers, spiritual care practitioners, nurse practitioners and physicians (with language interpretation services, if needed) may be required.

Restricting family from visiting a loved one who is critically ill and/or dying is recognized as a maximally restrictive measure. It can be anticipated that patients and families will experience powerful emotions in reaction to the restriction, including disbelief, anger, fear, grief and sadness. HCPs may experience moral distress in communicating restrictions, particularly when family members/visitors articulate distress.

Care providers should anticipate scenarios where family members bring in their own outside supply of PPE and ask to visit their loved one. While this approach ostensibly offers infection control while protecting HCPs supply of PPE, it should be actively discouraged. Most HCPs lack the training and knowledge to authorize the use of outside PPE of unknown quality, provenance, and effectiveness. Further, if outside PPE are allowed, private individuals may be encouraged to acquire and hoard PPE, diverting this essential resource away from HCPs.

As an alternative to in person visits, loved ones can be encouraged to make contact with their ill relative via digital electronic media. It may also be reasonable to permit persons to be near their loved one (e.g., at a sufficient distance to reduce the risk disease transmission, based on currently available infection control guidelines) but without actually allowing contact.

If family members persist in demanding to see their loved one, despite all efforts of the health care team, they should be referred to the director of the facility, and possibly the Office of the Provincial Health Officer.

**Recommendation**
**COVID-19 is a highly transmissible and virulent infection, and constitutes a serious public health threat. In situations where the spread of infection cannot be reduced by accepted means (i.e., lack of PPE), HCPs are justified in restricting visitation by family members to critically ill/dying patients.**

**Should strategies to mitigate risks of COVID-19 transmission become available (e.g. if there is an adequate quantity of PPE to provide protection for both HCPs and family/visitors), this decision should be reconsidered.**

1. Seek regional and/or provincial endorsement to uphold the value of *consistency*. Consistency ensures that all families and visitors receive the same care, regardless of where their loved one resides. In the setting of PPE shortage, policies and guidance from local authorities will be essential to maintain limits on visitation.

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 visitors or family members who may be impacted by this restriction. Recognize the emotional harms that may arise to individuals impacted and offer all available supportive options. Consider all other non-physical options for family/visitors to connect with the resident, and where possible assist visitors to identify and use digital means of communication with loved ones.

4. If visitors persist in demanding to see their loved one, despite all efforts of the health care team, they should be referred to the director of the facility, and possibly the Office of the Provincial Health Officer.