

# Coronavirus disease (COVID-19) and people living with dementia:

A guide for those looking after residents in  
Long-Term Care, Designated and Supportive Living



May 2020

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**Note:** This guidance document complements ECC-approved [Guidelines for COVID-19 in Congregate Living Sites](#) and the [AHS Continuing Care and COVID-19 FAQ](#)

May 8, 2020

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## COVID-19 infection in older adults

Older adults have a greater risk of infection and death from COVID-19. Residents living in congregate living settings are at particular risk of infection since they live in close proximity to others, facilitating viral spread. Advanced age and the likeliness of mental, cognitive, physical and social challenges increase vulnerability of older residents including persons living with dementia, resulting in poorer outcomes if they become infected.

### Atypical presentation

While there are few research data, frontline experience suggests that many older people do NOT present with typical symptoms. Residents with dementia often have difficulty communicating what they are experiencing so staff need to be extra vigilant in their observations, noting anything new or unusual. Furthermore, it takes 2–14 days from the time of exposure to develop symptoms therefore infected residents may be asymptomatic and still be able to spread the virus.<sup>1</sup>

Typical symptoms include fever, cough, shortness of breath, difficulty breathing, sore throat and runny nose. These may be absent in the elderly despite respiratory disease. And, only 20–30% of geriatric patients with infection present with fever.<sup>2</sup> It is important that staff are aware of atypical symptoms as per table below, and remain vigilant to the risk of infection to ensure early identification of COVID-19 infection so that testing and contact and droplet precautions can be immediately implemented.

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<sup>1</sup> Webinar. 2020. *Preparing Nursing Homes And Assisted Living Facilities For COVID-19*. Available at: <https://www.youtube.com/watch?v=p1FiVFx5O78>

<sup>2</sup>Rgptoronto.ca. 2020. *COVID-19 In Older Adults*. [online] Available at: <https://www.rgptoronto.ca/wp-content/uploads/2020/04/COVID-19-Presentations-in-Frail-Older-Adults-U-of-C-and-U-fo-T.pdf>

**Table: Typical and Atypical Symptoms of COVID infection in Older Adults<sup>2</sup>**

Typical Symptoms	Atypical Symptoms in Older Adults Indicating Possible COVID Infection	Other possible presenting symptoms indicating COVID Infection
<ul style="list-style-type: none"> <li>• fever</li> <li>• cough</li> <li>• shortness of breath</li> <li>• difficulty breathing</li> <li>• sore throat</li> <li>• runny nose</li> </ul>	<ul style="list-style-type: none"> <li>• delirium</li> <li>• falls</li> <li>• generalized weakness</li> <li>• malaise</li> <li>• myalgia (muscle aches) and arthralgias (joint aches)</li> <li>• functional decline</li> <li>• increased sputum production</li> <li>• hemoptysis (blood in coughed up phlegm)</li> <li>• abdominal pain</li> <li>• nasal congestion</li> <li>• anosmia (loss of smell and taste)</li> </ul>	<ul style="list-style-type: none"> <li>• tachypnea (rapid breathing)</li> <li>• unexplained tachycardia (pulse rate &gt;100 beats per minute)</li> <li>• hypotension (decrease in blood pressure)</li> <li>• hypoxia (Oxygen saturation &lt;90%)</li> <li>• conjunctivitis</li> <li>• anorexia</li> <li>• dizziness</li> <li>• headache</li> <li>• chest pain</li> <li>• nausea/vomiting</li> <li>• diarrhea</li> </ul>

Some questions to ask to identify atypical symptoms if typical symptoms are absent include:<sup>3</sup>

- Has the resident's behaviour changed from usual, from previous day or previous shift?
- Does the resident need more help than usual?
- Is the resident more unsettled than usual?
- Are there any new onset hallucinations or delusions?
- Is there more wandering than usual?
- Is the resident eating or drinking less?
- Is the resident lethargic or having difficulty staying awake?

<sup>3</sup>COVID-19 Recognizing Early Symptoms in Seniors. Seniors Health: Community Seniors and Continuing Care. Alberta Health Services. <https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-recognizing-early-symptoms-in-seniors.pdf>.

Older age, frailty, and increasing number of comorbidities increase the probability of an atypical presentation. Atypical presentation may be due to several factors, including physiological changes with age, comorbidities, and an inability to provide an accurate history. Therefore, older adults may present with mild symptoms that are not indicative of the severity of their illness. For example, the threshold for diagnosing fever should be 37.5°C or an increase of >1.5°C from usual temperature. It is critical to recognize illness in residents as soon as possible.

**DO:**

- Complete the [Resident Daily Screening Questionnaire](#) and document resident observations in accordance with established process.
- Immediately report concerns to a regulated health care provider (supervisor) or medical professional.
- [Contact and Droplet Precautions](#) should be implemented immediately when the resident has suspect (whether tested or not), probable or confirmed symptoms of influenza-like or COVID-19 symptoms.<sup>4</sup>

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<sup>4</sup> *Guidelines For COVID-19: Outbreak Prevention, Control And Management In Congregate Living Sites*. Albertahealthservices.ca. 2020. <https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-outbreak-management-congregate-guidelines.pdf>

## Managing suspected and confirmed COVID-19 in residents with dementia

Since dementia causes difficulty in processing messages, residents who feel unwell may have less attention and focus. People living with dementia with COVID-19 might have difficulty remembering safeguard procedures such as wearing masks, or understanding public health information. As a result, residents might feel frustrated which could lead to feelings of loneliness and abandonment and they may become withdrawn.

Residents, including those with dementia, and their families must be educated on the virus, the disease and the precautions which must be taken to protect themselves and their loved ones from infection.<sup>5,6</sup> Ignoring the warnings and insufficient isolation measures could expose others to risk of infection.

### Communicating with residents with dementia

Clear education and communication with residents can mitigate effects such as anger, agitation, stress and withdrawal during isolation. Residents with dementia need repeated, simple explanations about the requirement for precautions during the COVID-19 pandemic.<sup>7</sup> Persons with dementia, regardless of severity of their cognitive impairment, need to be informed of what is going on and what is needed to reduce risk of getting sick. Visual communication methods such as images and posters may also be used as an educating technique. Persons with dementia may also need reminders and cueing due to inability to recall previous teaching. Normalize isolation precautions explaining that there is an illness. Ask them if they have been sick before, and what it felt like for them.<sup>8</sup>

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<sup>5</sup> Infection Prevention and Control guidance for Long-Term Care Facilities in the context of COVID-19 *Apps.Who.Int*, 2020, [https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC\\_long\\_term\\_care-2020.1-eng.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf?sequence=1&isAllowed=y).

<sup>6</sup> *Novel Coronavirus (COVID-19) Information For Albertans*. AlbertaHealthServices.ca, 2020. <https://www.albertahealthservices.ca/topics/Page16997.aspx>

<sup>7</sup> Coronavirus: Managing Delirium In Confirmed And Suspected Cases | British Geriatrics Society. *Bgs.Org.Uk*, 2020, <https://www.bgs.org.uk/resources/coronavirus-managing-delirium-in-confirmed-and-suspected-cases>.

<sup>8</sup> Youtube. 2020. *Teepa Snow: Teepa Snow And PAC Team - Offering Comfort When Quarantined Using The Positive Physical Approach*. [online] Available at: [https://www.youtube.com/watch?v=He\\_PFsvaXDE&feature=youtu.be](https://www.youtube.com/watch?v=He_PFsvaXDE&feature=youtu.be)

Non-verbal communication is an important part of conveying information. Consider eye contact, volume, tone of voice and approach. Ensure glasses if worn, are clean and hearing aids are working. Masks and personal protective equipment (PPE) hide facial features and expressions, so focus on eye contact, tone of voice and body language.<sup>9</sup>

To help a resident follow infection prevention measures, care staff should first demonstrate what the resident should do such as putting on a mask, cleaning hands with sanitizer or coughing in the elbow.<sup>10,11</sup> To help residents wash their hands longer, distraction after starting the task could be tried such as with a story or by singing a familiar song.<sup>12</sup>

When the resident is unwell, allow more time to understand the message. Give only one instruction or direction at a time. Use 5 or fewer words. Listen to the resident and watch their body language. If tension is sensed, stop and try to reconnect before repeating or giving a new message.

It is important for care staff to be self-aware of their own emotions when talking to residents with dementia due to the emotional contagion between caregivers and persons with dementia. A staff member's stress about COVID-19 and increased workloads may cause fear and stress in residents.

Families can help reinforce messages about requirements during isolation and the need for extra precautions therefore it is beneficial to connect the resident and family virtually on a regular basis.

## Communicating with family and caregivers

Families and caregivers supporting residents living with dementia can feel cut-off, overwhelmed and anxious. Facilities need to maintain frequent and open communication to provide reassurance about infection control measures and provide updates on their loved ones. Consider forming a proactive communication team in order to do this. Staff can try to be understanding, listen to family concerns, and respond in a timely manner recognizing that this is a stressful time for everyone.

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<sup>9</sup> Communication-tips-for-clinicians-caring-for-older-adults-experiencing-delirium.pdf Rgptoronto.ca. 2020. Available at: <https://www.rgptoronto.ca/wp-content/uploads/2020/04/COVID-19>.

<sup>10</sup> Youtube. 2020. *Teepa Snow And PAC Team - Using Positive Physical Approach When A Face Mask Is Necessary*. Available at: <https://www.youtube.com/watch?v=EyQgUvsOa80&feature=youtu.be>

<sup>11</sup> Alzheimer's Disease and Dementia. 2020. *Coronavirus (COVID-19): Tips For Dementia Caregivers*. Available at: [https://alz.org/help-support/caregiving/coronavirus-\(covid-19\)-tips-for-dementia-care](https://alz.org/help-support/caregiving/coronavirus-(covid-19)-tips-for-dementia-care)

<sup>12</sup> Youtube. 2020. *Teepa Snow Wash Your Hands: Tips For Dementia Care Partners*. Available at: <https://www.youtube.com/watch?v=e7sHsQkkch0>



To preserve important resident care time, ask families to designate one member to communicate with the facility and pass information on to other loved ones. Care teams could determine which staff are best able to support residents with the use of technology (i.e., scheduling and making calls) based on staff mix and availability.

Family presence, even virtually, can decrease resident anxiety, improve outcomes, and provide essential history and context to inform care. Goals of Care and Advanced Care Planning should be discussed at the earliest opportunity (see appropriate section in this guide). Arrange electronic means of communication between residents and families where possible. A [communication guide for families](#) can be shared with families for information on how to communicate with their loved ones using apps such as Skype and Facetime, as well as text or email. Consider making electronic resources available to residents who can use them to make this easier.

Families and caregivers can be directed to trusted websites such as the [Government of Alberta](#) and [Alberta Health Services](#) for COVID-19 information and for guidelines on visitation with residents.

## Supporting staff

Due to the constant fear of infection and worries about the residents' condition, the level of anxiety among staff in LTC facilities and supportive living environments is high. They are at risk of exhaustion and burnout due to weeks under lockdown, as well as becoming infected themselves. Regularly monitoring staff for wellbeing and ensuring timely, transparent communication of COVID-19 updates and latest infection prevention measures will ensure that members of the care team stay safe and continue to fulfill their roles in a meaningful way. [Infection Prevention and Control guidelines](#) for long-term care and supportive living can be found on the [Alberta Health Services](#) or [Health Canada](#) websites.

Should a staff care team member show signs of possible infection through symptoms or exposure to a COVID-19 infected individual inside or outside the facility, they must self-isolate immediately. Congregate Living Setting Operators must contact the Coordinated Response Line at 1-844-343-0971 to report staff illness with influenza-like or COVID-19 symptoms.

Regular formal and informal communication throughout shifts can also assist with recognizing early infection symptoms in residents and any changes in residents' conditions.<sup>13</sup> Encouraging interdisciplinary discussion to share triggers and successful interventions during rounds, team huddles, or shift report can also assist with mitigating or addressing responsive behaviors.

As much as possible, protect and support staff from stress, both physically and psychologically. Before each shift ends, take a moment to reflect with the team. Acknowledge one thing that was difficult and allow staff to let it go, acknowledge one thing that went well, and express pride in the care given that day. When work is done, ask staff to switch attention to resting and recharging for the days ahead.

Wellness resources can be accessed through workplace [employee and family assistance programs](#). Other available resources include [AHS Supporting Your Mental Health, the Canadian Association from Mental Health –Resources for health care workers, Self-Care and Resilience Guide](#). A complete guide of frequently asked questions can also be found at: [www.ahs.ca/assets/info/ppih/if-ppih-ncov-2019-staff-faq.pdf](http://www.ahs.ca/assets/info/ppih/if-ppih-ncov-2019-staff-faq.pdf).

## General tips for physical distancing and isolation<sup>14</sup>

- Isolate infected residents to single room with own bathroom if possible
- Do not cohort infected resident with suspected only individuals
- Avoid moving infected resident near immunocompromised individuals
- Minimize movement / transport of confirmed COVID-19 resident
- Stagger mealtimes or provide meals in rooms
- Distance during group activities such as doorway games or cancel group activities
- Place clear signage/posters at entrance of suspected or confirmed COVID-19 resident's room of requirement for [contact/droplet isolation](#) and [proper PPE use](#), or posters on [donning](#) and [doffing](#).

Other infection prevention considerations when caring for residents during the COVID-19 pandemic can be found at: <https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-sl-dsl-hl-recommendations.pdf>.

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<sup>13</sup> COVID-19 Recognizing Early Symptoms in Seniors. Seniors Health: Community Seniors and Continuing Care. Alberta Health Services. <https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-recognizing-early-symptoms-in-seniors.pdf>

<sup>14</sup> *Apps. Who. Int*, 2020, [https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC\\_long\\_term\\_care-2020.1-eng.pdf?sequence=1&isAllowed=y](https://apps.who.int/iris/bitstream/handle/10665/331508/WHO-2019-nCoV-IPC_long_term_care-2020.1-eng.pdf?sequence=1&isAllowed=y).

## Addressing loneliness, social routines, mood and emotional decline for residents with dementia and COVID-19

Physical distancing measures, changes in the environment, cohorting, as well as changes in staff appearance and behavior, may cause disorientation and confusion for a resident with dementia leading to social isolation and loneliness. This may result in the development or escalation of responsive behaviors on one hand and withdrawal on the other. (See Management of responsive behaviors section.)

Residents who wander should be prioritized for behavioural and one-to-one support to ensure safety and reduce the risk of spread to other residents, recognizing that this may not be possible in times of staff shortage.<sup>15</sup> Ability to move and walk may be facilitated through room de-cluttering to allow space to move, personalized interventions and scheduled walks with full [contact and droplet precautions](#) including use of Personal Protective Equipment.

Attention must be given to unmet care needs as well as the need for meaningful engagement to mitigate social isolation and loneliness. Residents with mild or moderate cognitive impairment are at additional risk as they may self-isolate if embarrassed about their abilities and feel unable to navigate the changes they notice or act upon them.<sup>16</sup> Cognitive, sensory, and communication impairment also present challenges. Persistent feelings of loneliness may lead to depression, increase in the inflammatory response and lowered immune system to fight COVID-19.<sup>16</sup>

Residents living with cognitive impairment may express anxiety and depression as agitation and aggression. However, loss of interest in activities one enjoyed or anhedonia is one of the best indicators that a significant change is occurring in mood, such as loneliness, grief or depression. Severe symptoms, resulting in risk taking behaviors or vocalizations about suicide require immediate assessment and intervention.<sup>16</sup>

It is vital for care staff to ensure meaningful engagement with residents during the pandemic. Frequent, brief social interactions can be used during regular care tasks, and reduce social isolation and loneliness, when they provide a sense of connection or engagement. Some examples of meaningful engagement may include conversations about resident's personal stories, family members or pictures in the room.

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<sup>15</sup> Guidance for Supporting residents who wander and require physical isolation <https://www.rgptoronto.ca/wp-content/uploads/2020/04/FINAL-COVID-19-BSO-RGP-Wandering-Guidelines-2020-04-14-1.pdf>

<sup>16</sup> Webinar. *Combating Resident Social Isolation In The Era Of COVID-19 Sponsored By Sodexo.Mp4*. Available at: <https://drive.google.com/file/d/1vh6fzBExz4styrOKadPnPaXdV2DKGKx/view?usp=sharing>

Consult with allied health (recreation therapy, occupational therapy) and behavioural team members to set up personalized, stimulating and dementia-friendly activities to support the resident to maintain room-based meaningful occupation, routine, variety, external social contact via virtual platforms and physical movement<sup>17</sup>.

## Delirium

Delirium is important in the context of COVID-19, because:

- a) delirium may be a symptom at presentation and/or during management, and
- b) the behavioural changes commonly seen in delirium, particularly agitation, may make management including delivery of care and reducing the risk of cross-infection more challenging.

Delirium, especially its hyperactive (agitation, restlessness, heightened levels of purposeless activity) form, will present significant additional challenges in the context of the COVID-19 pandemic. Standard non-pharmacological measures to treat or prevent delirium may not be possible in isolation environments, and these environments may themselves worsen delirium.

While hyperactive delirium may more readily reveal COVID-19 infection, staff must also be watchful for hypoactive delirium where residents may be more sleepy, quiet or withdrawn as a result of COVID-19 infection.

### Recommendations for management and prevention of delirium

Every effort should be made to avoid hospital transfer and provide care in place, as long as the Goals of Care Designation (GCD) supports this and the resources of the site and/or available to the site support care and treat in place, during COVID-19 pandemic. Site management of delirium will be necessary.

As a foundational requirement, good general care including prevention, early detection, and non-pharmacological management should be provided. Supports for this include:

1. Enhanced implementation of assessment for delirium, considering staff and time limitations using the Confusion Assessment Method (CAM).

[\[https://www.ahs.ca/assets/about/scn/ahs-scn-bjh-hf-delirium-screening-tool.pdf\]](https://www.ahs.ca/assets/about/scn/ahs-scn-bjh-hf-delirium-screening-tool.pdf)

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<sup>17</sup> Individualized meaningful engagement through COVID-19 and beyond, Dementiability & Behavioural Supports Ontario <https://www.dementiability.com/resources/1-DementiAbility-BSO%20Engagement-Mar-3.pdf>

2. Reduce the risk of delirium by avoiding or reducing known precipitants. Actions include regular (re)orientation, hydration, avoiding constipation, treating pain, early identification and treatment of super-added infections, medication review, maintaining oxygenation, avoiding urinary retention. See the AHS delirium guidance [<https://www.albertahealthservices.ca/scns/Page13393.aspx>]
3. Ongoing emphasis on consistent Comfort Rounds and NICE & EASY care approach and the importance of the 5 P's.  
<https://extranet.ahsnet.ca/teams/policydocuments/1/klink/et-klink-ckv-dementia-seniors-inpatient.pdf>
4. With behavioural disturbance, look for and treat direct causes including pain, urinary retention, dehydration, constipation, etc. Where these interventions are ineffective or more rapid control is required to reduce the risk of harm to the patient and others, it may be necessary to move to pharmacological management. In these circumstances we would recommend the guidance below, or using the order set found at [<https://www.albertahealthservices.ca/frm-21014bond.pdf>]
5. If patients are treated using medications, monitor for side effects, vital signs, hydration level and consciousness aiming for at least every hour until there are no further concerns about the person's physical health. Be mindful of use of benzodiazepines with respiratory depression. In older adults the maximum dosage for haloperidol is 5 mg in 24 hrs, but a more conservative approach with maximum 2 mg in 24 hours in the first instance is warranted. Where higher dosages are required seek specialist advice.
  - a. Note the usual guidance of caution with use of medication in older people, and especially certain medications in people with Parkinson's disease or dementia with Lewy bodies (e.g., antipsychotic medication)
6. Delirium may cause considerable distress amongst both staff and families in addition to the patient. Provision of information around delirium is important using locally available resources. See <https://myhealth.alberta.ca/Alberta/Pages/what-is-delirium.aspx>

## Medication considerations in delirium

The evidence for use of medications is limited and may actually cause/worsen delirium. Before considering prescription, review current medication list for medications that cause confusion (i.e., psychoactive medications; anticholinergic burden). If significant aggression develops that puts the resident or others at risk of harm, consider reduced doses of antipsychotics as below.

Risperidone 0.125 – 0.5 mg PO Q8H PRN

Olanzapine 2.5 – 5 mg PO or IM, bid with maximum dose of 10 mg

Quetiapine 6.25 – 12.5 mg PO tid, maximum dose of 100 mg

Haloperidol 0.25 – 0.5 mg Q 1 – 8 hours, up to 4 doses/ 24 hours

Loxapine\* 2.5 – 5 mg Q 4 hours maximum of 20 mg/ 24 hours

\*Note: least preferred medication

## Responsive behaviours

If a resident is displaying changed behaviours and is suspected of having an active COVID-19 infection, normal infection control procedures should continue to be followed. In this situation, certain types of behaviours, such as aggression and ‘wandering,’ may pose greater risks for the resident, other residents, staff and visitors.

Memory strategies, reminders, cues and environmental modifications may be used to ensure [nonpharmacological isolation measures to support individuals with dementia](#), including the following of safeguards such as hand hygiene and wearing masks. Utilize meaningful distractions, cognitive and social stimulation, calming and relaxation strategies to reduce responsive behaviours (e.g., pacing, wandering and agitation). Clear signs guiding residents to the bathroom can help direct residents and reduce wandering. Doors to bathrooms may also be left open so that they the toilet is visible.

A [delirium screen](#) should always be performed (see delirium, above). The screen should comprise a check of vital signs (pulse, blood pressure and temperature), a physical examination by a doctor or Nurse Practitioner, preferably one who provides their usual care, who may order blood tests, appropriate cultures, and other investigations the doctor may feel to be relevant.

Avoid restraint use and, instead, aim for redirection and effective communication techniques such as using the NICE & EASY Behavioural Approach.

## NICE & EASY Behavioural Approach

- Contact – offer your hand to shake paying attention to their non-verbal communication (taking in to account current recommendations for infection prevention and COVID-19 context)
- Eye contact – ensure they can hear and see you
- Explain what you are going to do before doing it
- Consider unmet care needs (e.g. pain, thirst)
- Avoid arguments – consider coming back later to complete care if non-urgent
- Smile – consider your non-verbal communication
- You are the Key – stay calm, don't rush and reassure them you are there to help; You can change your approach to behavior management – they can not

## Restraints

Care providers may face the complex issue of how to assist a person with dementia to self-isolate in the event of an infection.

The first question that should be asked is:

*'Does this particular behaviour place anyone at increased risk of infection?'*

If the answer is 'no,' then there is no reason, in terms of managing infection risk, to restrain a person in any way.

The use of restraints is not without significant morbidity and mortality risk. Certain types of behaviours, such as aggression and wandering, may pose greater risks for the resident, other residents, staff and visitors.

Restraints used to enforce restricted mobility or immobility to a person with a potential serious respiratory infection will have increased risk for symptom exacerbation, delirium, injury and distress. To minimize these risks, care teams should implement risk management measures relating to supportive interventions first as listed on the [AUA Toolkit](#). Strategies such as modifying the environment and addressing unmet needs such as with comfort measures like promoting sleep and toileting or identifying and addressing pain and boredom, are some examples<sup>18</sup>. A monitoring and communication

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<sup>18</sup> Guidance for Supporting Residents who Wander and Require Physical Isolation. Regional Geriatric Program of Toronto. <https://www.rgptoronto.ca/wp-content/uploads/2020/04/FINAL-COVID-19-BSO-RGP-Wandering-Guidelines-2020-04-14-1.pdf>  
April 14,2020



plan as well as a least restraint approach should be implemented. Refer to the [AHS Restraint as a Last Resort Toolkit](#) policy.

There are a range of options to consider when trying to prevent virus spread among residents who are positive for COVID-19. In general, the options need to be considered sequentially, with those with the least risk applied before others which carry more potential risk.

### 1.1 support

1:1 is usually an important first strategy to support residents. However, during the COVID-19 pandemic and particularly during an outbreak, staff shortages may make 1:1 support impossible. Utilizing the allied health team to full scope in an organized manner while prioritizing residents who need care most, and cohorting according to IPC protocols can facilitate 1:1 integration into care. Consider 1:1 care providers where, in rare situations, the resident's care needs cannot be met without the visitor's assistance.<sup>19</sup>

Should the resident not be able to be persuaded to comply with required infection control measures such as donning PPE and/or residents have escalated responsive behaviours that prevents isolation, trying to modify the environment may be considered.

### Modify the environment

Allow mobility within a limited area, perhaps a sub-space within a larger unit which allows 2 meter distancing from other residents. This can be created by closing doors to other wings or areas or using portable room dividers. A limited area forms a lesser restraint as it seeks to physically distance people from restricted areas or each other but does not confine an individual to a specific area or location.

### Use of restraints when supportive interventions are unsuccessful

When environment modification or 1:1 is unsuccessful to facilitate isolation. Consider a least restraint approach to the use of restraints. All restraints need to follow [AHS Restraint monitoring procedure](#) to ensure that any new or existing restraints are safe and will not cause harm.

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<sup>19</sup> Open.alberta.ca. 2020. *CMOH Order 09-2020 : 2020 COVID-19 Response - Open Government*. [online] Available at: <https://open.alberta.ca/publications/cmoh-order-09-2020-2020-covid-19-response>.



### Least use of environmental restraints

Before resorting to locked rooms and/or mechanical restraints, consider:

- Partial doors or partial gates: resident can still see outside of room and communicate
- Stop signs, full length mirror, distracting/personal objects on the wall in front of doorways that act as a visual barrier and distraction

### Least use of mechanical restraints

Before resorting to full rails, geriatric chairs, wrist, chest, lap straps, seat belts

- Wheelchair dependent residents: Seat belts and wrist restraints can lead to unintended consequences. Consult with OT/PT for lesser restraints such as a push lap tray or a Velcro waist belt.
- Ambulatory residents: If there is a concern that a resident who is unable to voluntarily isolate themselves and may be infected with COVID-19, confirm through a continuous point of care assessment that a 1:1 assessment is an essential service where the benefit of a 1:1 intervention outweighs the risks. If the intervention is necessary, then the use of a 1:1 intervention with the use of appropriate PPE is advised. It is important to recognize that use of PPE may be scary for the resident, thus calm reassurance and eye contact remain critical.

### When to consider pharmacological agents

Pharmacological agents could be considered when there is imminent harm to self or others due to physical aggression and potential for bodily harm or unnecessary suffering. Imminent Harm to self or others may also include inability to contain patient in isolation despite environmental modifications, 1:1 support and environmental or mechanical restraints.

Ensure documenting the following regarding the use of pharmacological restraints:

- the nature of the need for the pharmacological agent such as aggression/safety issues to self or others, or due to inability to isolate;
- when the pharmacological agent is to be used noting expected benefit, e.g., limited mobilization;
- if it is likely that the behaviour will last more than 24-hours;
- monitoring schedule; and

discontinuation plan such as when the resident is no longer positive for COVID-19 or the circumstance changes such that the resident is no longer a risk to others.

## Rehabilitation and recovery

Levels of functional dependency in Activities of Daily Living (ADL) and ability at the onset of illness influences functional decline as illness progresses. Understanding abilities, disability, multi-morbidity and frailty are crucial for providing personalised recommendations on treatment, risk of decompensation and recovery.

### Rehabilitation

Rehabilitation intervention for those who have contracted COVID-19 is important to prevent significant functional deterioration, to improve mobility and safety and to support transition back into daily routines.

Physical activities and mobilization are indicated **with caution** in stable residents with COVID-19. Oxygen saturation levels and/or reports or signs and symptoms of shortness of breath or fatigue should be closely monitored, as some patients with COVID-19 experience a sudden and significant drop in oxygen saturation levels, particularly at approximately 8–12 days after exposure. Care providers should listen to and respect resident reports of shortness of breath and fatigue, discontinue the current activity and encourage rest and recovery and adjust future programming accordingly.<sup>20</sup> Therefore, it is important to be cautious with mobilization with any person in a congregate care facility with suspected or confirmed COVID-19 infection.

Once stabilized, there is no reason to believe that persons with dementia should be any less eligible for active rehabilitation within limitations than any other patient or resident. Strong evidence suggests that the loss of mobility, in particular, has a huge toll on the quality of life and existence, and a decrease in the quality of working life for those looking after them.

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<sup>20</sup> American Physical Therapy Association (2020, March 28) COVID-19: Clinical Best Practices in PT Management [Webinar]. Retrieved from [https://cdn.ymaws.com/www.acutept.org/resource/resmgr/uploads\\_for\\_links/3-2820\\_HPA\\_Webinar\\_Recordin.pdf](https://cdn.ymaws.com/www.acutept.org/resource/resmgr/uploads_for_links/3-2820_HPA_Webinar_Recordin.pdf)

While deconditioning from reduced mobility, is significant and often the focus for rehabilitation, other areas impacted requiring rehabilitation may include:

- Respiratory therapy
- Dysphagia and impact on vocal chords
- Nutrition
- Cognitive deficits secondary to neurologic issues such as stroke
- Complications related to sepsis, cytochrome storm, hemorrhagic encephalopathy

## Emotional recovery

While we know little, if anything, about the psychological impact of isolation, treatment and recovery in dementia residents with COVID-19 infection, there are some data about these effects in general. Separation from loved ones, the loss of freedom, uncertainty over disease status, and boredom can, on occasion, create dramatic effects.

Suicide has been reported and substantial anger generated. Literature suggests that a psychiatric history is associated with psychological distress after experiencing any disaster-related trauma and it is likely that people with pre-existing poor mental health may need extra support. In addition to worsening of existing mental health conditions, new onset anxiety or depression may occur after infection or in the post-acute care period. Therefore, it is important for care teams to actively look for and recognize changes to support the physical and emotional well-being of residents<sup>21</sup>.

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<sup>21</sup> Frontiers. 2020. *Cognitive, Psychological, And Psychiatric Consequences Of The Coronavirus (COVID-19) Pandemic In The Population Of Older Persons With Cognitive Impairment, Dementia, And/Or Neuropsychiatric Disorders*. [online] Available at: <https://www.frontiersin.org/research-topics/13776/cognitive-psychological-and-psychiatric-consequences-of-the-coronavirus-covid-19-pandemic-in-the-pop>

# Advance Care Planning (ACP), deciding to hospitalize & End of Life (EOL) care

## Advance Care Planning

ACP with residents and/or substitute decision makers is a foundation of any care plan. Knowing the wishes of residents as they experience changes in medical condition and at the end of life should be an informed process.

With the pandemic there is an urgent need to understand the wishes of residents and decision makers to inform ACP decisions. Care plans need to be updated to reflect those conversations with specific reference to goals of care. For example, resuscitative care may not be medically appropriate or desired if a resident's health situation worsens. Frail older adults, including those with COVID-19 infection, have poor survival after intubation. A proactive approach is strongly encouraged to ensure that wishes are known early and to avoid rushed decision-making not in alignment with the resident and family goals of care<sup>22</sup>.

There are a number of resources available to help with this process of Advance Care Planning and Goals of Care during the COVID-19 pandemic.

Advance Care Planning / Goals of Care:

<https://www.albertahealthservices.ca/info/Page9099.aspx>

Streamlined goals of care decision making for COVID-19:

<https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-19-gcd-algorithm.pdf>

Planning Ahead with Vulnerable Patients During COVID-19: A Conversation Tool for Clinicians

<https://www.ahs.ca/assets/info/ppih/if-ppih-covid-planning-with-vulnerable-patients.pdf>

How to talk to your loved ones & healthcare team about your wishes & goals if you become sick with COVID-19

[http://amytanmd.ucalgaryblogs.ca/files/2020/04/Guide-for-Talking-about-Wishes-Goals-with-COVID-19-Handout-by-Dr.-Amy-Tan-April-3\\_20-v2.pdf](http://amytanmd.ucalgaryblogs.ca/files/2020/04/Guide-for-Talking-about-Wishes-Goals-with-COVID-19-Handout-by-Dr.-Amy-Tan-April-3_20-v2.pdf)

Coronavirus Disease 2019 (COVID-19) Shared Decision-Making Tool

<https://www.nhpco.org/wp-content/uploads/COVID-19-Shared-Decision-Making-Tool.pdf>

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<sup>22</sup> "Choosing Wisely COVID-19 Recommendations". *Choosing Wisely Canada*, 2020, <https://choosingwiselycanada.org/covid-19/>.

## Deciding to hospitalize

Transfer to the hospital for non-COVID-19 related illness exposes older adults with chronic medical conditions to increased risk of infection, long waits in the emergency department, increased confusion and poor sleep as well as loss of muscle mass from being immobile and medication side effects. Transfer to hospital should only occur as per the resident and family/caregiver wishes and if urgent medical and comfort needs cannot be met on site.

Transfer to emergency departments and hospital admissions should be discussed with hospital physicians to ensure that the best care can be provided in a timely manner. Community paramedics and other resources are also being utilized to increase access to care that would otherwise have been provided in hospital. Medical care should be provided at the long-term care or supportive living home for those who develop symptoms of COVID-19 infection.

## End-of-Life Care

Specific treatment of COVID-19 remains supportive where care is non-curative care and comfort measures are not directed towards treating a condition. This could include simple analgesia, high flow oxygen to mechanical ventilation.<sup>23</sup> Depending on the resident's wishes and availability of resources, a transfer to hospital may be appropriate for some. Those in respiratory failure may require increased supportive care. However, as in other seasonal infections such as influenza, this is very often the very last event in the life of a frail resident and can often cause death.

If natural death is expected or in alignment with the resident's goals of care, then an EOL care plan is key.<sup>24</sup> [Symptom management guidelines](#) and [Management of dyspnea at the end of life](#) resources may be referred to.

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<sup>23</sup> Interior Health. Clinical Decision Pathway COVID-19 in LTC Residents.  
[https://www.divisionsbc.ca/sites/default/files/64258/IH-PH-COV-360%20Clinical%20Decision%20Pathway%20COVID-19%20-%20LTC\\_06Apr2020.pdf](https://www.divisionsbc.ca/sites/default/files/64258/IH-PH-COV-360%20Clinical%20Decision%20Pathway%20COVID-19%20-%20LTC_06Apr2020.pdf)

<sup>24</sup> Pandemic palliative care: beyond ventilators and saving lives [<https://www.cmaj.ca/content/192/15/E400>]

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