Ontario Long Term Care Clinicians

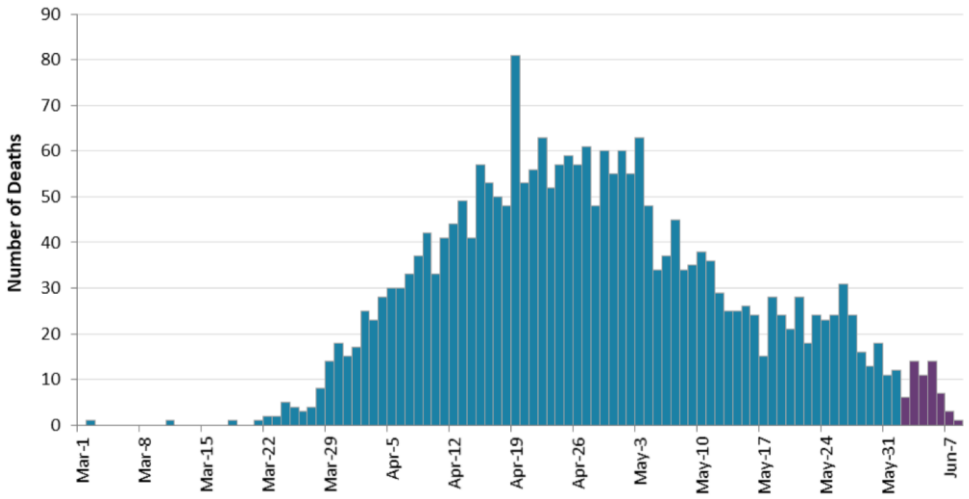
Tuesday, June 9, 2020

COVID-19 REPORT

Ministry of Health and LTC	Ont cases	Deaths	LTC cases	LTC deaths	% LTC deaths
May 11	21,922	1,825	2,953 (PHO)	1,320 (MOH)	72.7%
May 18	23,384	1,919	4,235 (PHO	1,456 (PHO)	75.9%
May 25	26,191	2,123	4,892 (PHO)	1,538 (MOH)	72.4%
June 1	28,709	2,293	5,158 (PHO)	1,652 (MOH)	72.0%
June 8	31,090	2,464	5,274 (PHO)	1,738 (MOH)	70.5%

Over the past few days there is a welcome decrease in provincial deaths from COVID-19.

Figure 4. Confirmed deaths (n=2,462[1]) among COVID-19 cases by date of death: Ontario, March 1, 2020 to June 8, 2020[2]



Epidemiological summary, June 9

Since the Emergency Order of March 17, LTC homes "continue to restrict non-essential visits and actively screen essential visitors, staff, students, volunteers, residents moving into a long-term care home and residents returning to a long-term care home." The pandemic did not develop as anticipated 84 days ago. The surge of patients into emergency departments and acute care did not occur. There was not the anticipated demand on ICU beds for patients with acute respiratory distress syndrome. Ventilators did not need to be rationed. The pandemic became an LTC crisis. Empty hospital beds were used to decant LTC from stricken homes. The transfers were helpful but not ideal. Before COVID-19 inappropriate transfers to emergency and hospital were not in the best interests of the resident. "Transfer often results in long periods in an unfamiliar and stressful environment for the patient. Other hazards include delirium, hospital acquired infections, medication side effects, lack of sleep, and rapid loss of muscle strength while bedridden. Harms often outweigh benefits. Residents assessed and treated at their care home will receive more individualized care, better comfort and end of life care."

https://choosingwiselycanada.org/long-term-care/
COVID-19 ENDOTHELIITIS Increased thrombo-embolism, with strokes and myocardial infarctions, may be a unique feature of COVID-19 infections. The frail elderly and those with conditions like diabetes and atherosclerosis have worse outcomes. Their blood vessels are already more vulnerable. The effect of COVID-19 on blood vessels is reported in small study of lungs from victims of COVID-19 (NEJM). In addition to general inflammation causing an increase int thrombosis, the virus appears to stimulate angiogenesis, which causes further inflammation and clotting. The lungs of people who had died from H1N1 showed nine times fewer blood clots in the lungs. Damage to endothelial cells are found in the lungs, heart, kidneys, liver and intestines of COVID-19 patients. (Lancet). "COVID-19-endotheliitis could explain the systemic impaired microcirculatory function in different vascular beds and their clinical sequelae in patients with COVID-19. This hypothesis provides a rationale for therapies to stabilise the endothelium while tackling viral replication, particularly with anti-inflammatory anti-cytokine drugs, ACE inhibitors, and statins. This strategy could be particularly relevant for vulnerable patients with pre-existing endothelial dysfunction, which is associated with male sex, smoking, hypertension, diabetes, obesity, and established cardiovascular disease, all of which are associated with adverse outcomes in COVID-19."
COVID-19, A disease of blood vessels, The Star, June 4

OLTCC recognizes the role of physicians, Medical Directors and other professional health care providers during the pandemic. Common issues unique to the pandemic, is outbreak management, virtual care, testing, PPE and attending more than one facility. These and other issues were addressed at the recent OLTCC/OMA Town. The link to entire session is available at:
https://vimeo.com/424822667/669fdebdf9

OLTCC will continue to report on the role of our clinicians during the COVID-19 pandemic. Dr. Benoit Robert is the Medical Director of the Perley and Rideau Veterans' Health Centre (PRVHC) and Vice President of OLTCC. When presenting at the OLTCC/OMA Town Hall on May 28, PRVHC just came out of outbreak. The home was fortunate to receive 1,300 swabs a couple of days before the outbreak. It is a 450-bed facility. Preparation for the outbreak included intensive clearing and removing all shared items, including decluttering the halls. Some chairs in the hallways were returned because of increased falls. The outbreak began on April 16 and was declared over on May 26. The source was a health care worker whose spouse worked in an outbreak home. Residents were tested on April 18. Results came 3 days later. Twenty-one residents tested positive and 11 died. Over thirty staff were affected. Because of its size, PRVHC has a full time IPAC person, who was in continual contact with Public Health. Smaller homes are unlikely to have this "band width" of management. Dr. Robert confirmed that PPE works. Two staff tested positive in an area where no residents were affected. After managing all the unpredictability of an outbreak, he discovers "mental exhaustion is very real".