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The Ethics Network of the Catholic Health Alliance of Canada has developed this framework document, one in a series of ethics resources to support each sponsor organization's response to COVID-19. While it reflects a consensus of opinion of relevant principles and moral approaches to address issues arising during the pandemic, the framework is meant to be adapted to each sponsored organization's unique context and circumstances. For more information, please contact Dr. Hazel Markwell, Theology, Policy and Ethics Advisor at hazel.markwell1@gmail.com

Ethical Considerations in the Care and Treatment of Seniors in LTC during COVID-19 Response Planning

Reporting by various media outlets and social media sharing by concerned family members has highlighted the vulnerability of seniors in long term care facilities. Concerns about the care and treatment of seniors in long term care are growing and range from abandonment by staff to elevated mortality rates and disproportionate representation of overall COVID-19 mortality in Canada.

As CHAC sponsors and health organizations respond to COVID-19 and the particular vulnerabilities of long term care populations, due consideration of safeguards is warranted. Many safeguards implemented in the care and treatment of seniors in long term are layered—that is, they include both benefits and resultant harms (e.g. visitation restrictions enhance safety against virus transmission and they also precipitate decline due to social isolation). Implementing and upholding safeguards will require courage, sensitivity and moral imagination.

Emerging Ethical Challenges

The first wave of the COVID-19 pandemic has raised several important ethical challenges for health care organizations. The following list includes issues identified by the CHAC ethicist network from organizations across Canada.

- ***Visitation restrictions*** in LTC facilities create various tensions for and among residents, health care workers, provider organizations and the public. These restrictive measures support the important goal of limiting the spread and harms of COVID-19. They also contribute to significant harms associated with social isolation, reduced quality of life, and limited advocacy in an already vulnerable population. (See CHAC Ethical Reflection on Visitation Restrictions)
- Likewise, the ***transfer of LTC residents to temporary facilities or care environments*** (e.g. 'field hospitals' or home with family) as a protective measure creates significant tensions. Relocating

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COVID-positive residents to temporary facilities aims to guard against further spread of illness. Returning a resident to the care of family in non-institutional care environments may also support this goal and, additionally, reduce harms associated with social isolation. At the same time, these measures bear physical, psychological and emotional burden associated with disruption to routines and placement in less-than-standard-of-care care environments. (In many instances, repatriation of residents to LTC facilities carries its own set of challenges, such as the need for self-isolation on return, potential need to reapply for readmission, etc.)

- Jurisdictions where ***single site practice/employment*** is implemented do so in an effort to limit inadvertent spread of COVID-19 illness between sites through staff with multiple employers or multi-site responsibilities. These measures, however, risk harms associated with inadequate staffing levels—failure to meet care standards, and risks to safe nursing/care practices. (Such decisions also bear potential for the harms associated with health employers competing to maintain adequate staffing.)
- Pandemic-related sanctions require operational, clinical and ethical compromises not otherwise accepted in non-crisis times. Such times are marked by the potential for innovation and inspired solution-making. They are also marked by the potential for increasing and perhaps unavoidable ***tolerance for lesser standards of care***. Even in non-crisis times, health care organizations face resource constraints that shape the range and scope of concerns able to be addressed by care teams and administrators. Challenges in providing quality care and maintaining staff safety may increase during times of crisis where resources are increasingly constrained. [Link to CHAC Duty to Care Document]

Guiding Values and Principles in the Development of Harm Mitigation Approaches

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The Health Ethics Guide captures three calls that arise from the core Gospel value of 'love one another'. These three calls—to respect dignity, to promote justice, to foster trust—reflect foundational and traditional moral elements that undergird Catholic Health Care in Canada. Each of these calls are defined by particular moral values and principles that, together, shape the care experience of residents and patients in Catholic health care facilities across the country. (Health Ethics Guide p. 14-17)

Respect for human dignity
Respect for all human life
The interconnectedness of every human being
Stewardship and creativity
Justice
The common good
Solidarity

Thinking ethically about the challenges in the care and treatment of seniors in long term care during COVID-19 involves consideration of these calls and their guiding values/principles. In the considerations below, several of these ethical commitments are reflected both in the safeguards adopted to ensure the safety of seniors as well as the efforts being made to lessen the impact thereof.

Minimizing Harm

The principle of "minimizing harm" is common to pandemic ethics frameworks and it supports ethical reflection that prioritizes the good of communities and entire populations of people. This, and other principles rooted in public health ethics (e.g. proportionality, minimizing restrictions/ensure restrictions correspond to the level of risk, maximizing good, etc.) justify actions that uphold the 'common good' foreseeing but not intending that, at the same time, some individuals or sub-groups will be negatively impacted by the actions taken.

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The Seniors Long Term Care population is particularly vulnerable to COVID-19 illness—with notably higher mortality rates. Current restrictions and burdensome measures are justified given that such significant harms (e.g. loss of life) may be avoided.

Nonetheless, the impacts of these measures are significant and negatively impact the health and well-being of seniors in long term care facilities. Social isolation, gross disruption of routine and changes in care environments are known contributors to decline in health and well-being in the lives of seniors.

Limiting the impacts of 'minimizing harm'

Transparency and Inclusion

A consequence of prioritizing measures justified by public health ethics is that the voices of the group(s) being 'protected' may become muted, and opportunities for advocacy on behalf of loved ones in care may be reduced.

Administrators and decision-makers are called to ensure that the voices of long term care residents and their families can be heard on issues impacting resident well-being and quality of life.

- In situations where overarching public health orders require local interpretation and implementation of restrictive measures, who will do this interpretation? Who will contribute to, and what will inform the local interpretations?
- What process will be established to ensure individual concerns are heard and fairly dealt with? What appeals process will be used, who will communicate this information, and how will it be communicated?

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  - Can existing structures like the organization's Patient Relations/Concerns process be modified to support an appeals process?
- How will residents and families be included in the process of understanding, interpreting and applying public health orders in their particular context?
  - How might pre-established Patient, Resident and Family Councils or Advisory groups support this process?
- How will front-line managers and administrators balance conflicting values and how will they be supported in implementing controversial measures?
  - Is access to the organization's ethical decision-making support services clear? Can OHS be integrated into the support structure for decision-makers?
- How will advocates for residents of LTC facilities be supported in their role?

Innovation and Creativity

Health care workers and administrators are being required to adjust expectations for how care is delivered and the quality of care experience that they can provide under evolving restrictive measures. Given the very real impacts of these measures, individuals, teams and organizations face the opportunity and need to respond with creativity and innovation.

- When responding to challenges such as visitation restrictions, mitigating (formal/informal) care-giver burnout, changes in expectations for care delivery, how will opportunities to "think outside the box" be identified?
  - Can 'outdoor visits' or other creative ideas be implemented or at least trialed to reduce burdens of restrictive safeguards?
- What processes will be implemented and how will creative solutions be given voice?

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  - Can human resources be dedicated to identifying alternative solutions—e.g. a solutions-focused innovation 'think tank'
- What level of 'risk' in innovation and trying something new is acceptable?
- How will the well-being costs to residents be balanced with creative solutions that carry financial costs?
  - How can access to communication technology for residents and families be enhanced by the facility? E.g. provision of ipads? Opening Wifi access?
- How will emerging gaps, the need for change and opportunities for the health system/organization be captured for further refection in the recovery phase of the pandemic?

Moral Distress

Residents of long term care facilities, their family members, and health care staff and administrators may experience moral distress and stress related to the implementation of measures aimed at protecting the seniors population. 'Moral distress' requires due consideration and strategies to prevent or lessen it, given the implications for trust of those receiving care, and workforce health and sustainability. The following questions may support the development of strategies in addressing moral distress:

Moral Distress mitigation in visitation restrictions

- Who ought to inform and who ought to determine making exceptions to visitation restriction?
  - Can front line staff and managers be protected from the burden of adjudicating requests for visitation exceptions?

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- What criteria are used for exception-making? What level of transparency is required in communicating criteria for exceptions?
- What is the process for appealing decisions re: visitation restrictions? How will fair and consistent application of exception-making be demonstrated?

Mitigation in single site practice/employment

- Given the economic vulnerability of much of the LTC workforce (i.e. Care Aids, Health Care Aids, etc.) how will the interests of staff be involved/reflected in the implementation of this protective measure?
- In cases of multi-site staff with single-employers, what education, direction and risk minimization strategies are necessary to support staff, protect residents and preserve trust with families?

Resisting increased tolerance for reduced standards of care

- How will staff be supported in cases where expectations and care standards cannot be met in usual ways, or at all?
- How will accountability for changes and compromises in quality be addressed and how will this be communicated?
- How will modified expectations be communicated to staff and providers, residents and families and what 'warning mechanisms' ought to be developed to resist normalizing reduced expectations for care?

Exercise our moral imagination.

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Moral imagination calls us to think individually, and as a team 'outside the box'. It calls us to envision ways to be both ethical and successful in our actions. To mitigate risks by listening to those most affected so that we can respond creatively and compassionately to their needs.