Guidance for Pharmacies Providing Services to Long-Term Care Facilities

PREAMBLE

Long-Term Care facilities (LTC) in New Brunswick include nursing homes and special care homes. Nursing homes are subject to the New Brunswick Nursing Homes Act, Regulations and Standards. Special care homes are considered private homes and are subject to the New Brunswick Family Services Act and Regulations. The size and services offered at each of these facilities is wide ranging and pharmacy services have by necessity, adapted to each of their needs while adhering to legislative requirements. This document contains guidance applicable to both these types of living arrangements for seniors and other citizens who require ongoing daily care.

COVID-19 will cause proportionally greater rates of morbidity and mortality in LTC residents than the general population due to residents' characteristics (frail, older, immune system dysfunction and multiple co-morbidities), environmental (shared living quarters, frequent and close contact with care providers) and staff resourcing (high ratio of residents to staff, significant rates of staff absenteeism including those responsible for drug management secondary to COVID-19 infections and staff working in multiple facilities[1]). It is estimated greater than 80% of all Canadian deaths due to COVID-19 have occurred in LTC. (Holroyd-Leduc J)

The New Brunswick College of Pharmacists (the College) recognizes the importance of continuity in clinical pharmacy services and drug distribution services to LTC during a pandemic. There are limited numbers of pharmacies in the province that are equipped to provide medication in compliance with established requirements (Nursing Homes Act) and Standards of Practice for pharmacists and pharmacy technicians in the context of LTC. Therefore, the College has developed:

1. this guidance that focuses on the outward provision of LTC patient[2] services, and
2. separate guidance on aspects of business continuity planning to pharmacies that focuses on internal pharmacy processes

This guidance may have application to the provision of pharmacy services to incarceration facilities and should be adapted as necessary.

ACKNOWLEDGEMENTS

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[1] At time of publication, government and facilities were working to prohibit LTC staff from working at multiple sites.
[2] The terms 'patient' and 'resident' are used interchangeably throughout this guidance. 'Patient' denotes the vulnerability of these individuals in the context of healthcare.

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CORRESPONDENCE

Correspondence related to this guidance should be sent to the College at info@nbpharmacists.ca with the subject line "LTC guidance" and will be directed to the Deputy Registrar.

GOAL

To provide pharmacy staff and pharmacy managers with direction for ensuring the population living and dying in LTC during the COVID-19 pandemic receive ethical, reliable, timely, safe and effective access to medication and pharmaceutical care.

AUDIENCE

- Primary: Pharmacy managers, pharmacists and pharmacy technicians working with LTC residents and facilities.
- Secondary: LTC administrators, physicians and nurses responsible for medication-related services to LTC residents
- Potential: Health care professionals and administrators of incarceration facilities may wish to adapt this document to fit their unique needs.

INTRODUCTION

Long-term care pharmacy services will shift to include routine provision of chronic disease management as well as providing care and medications needed for the relief of minor to severe symptoms associated with COVID-19 infections. LTC patients experience proportionally higher rates of life-threatening COVID-19 infections than the general population. Most will not be transferred to acute care facilities for ventilation and critical care. Residents also may be at heightened risk of experiencing medication errors (Ordre des Pharmaciens du Quebec) These individuals have a right to high-quality treatment and/or palliative care. The following guidance sets out activities that pharmacy managers and staff, in conjunction with LTC administrators, prescribers and professionals involved in administering medication should undertake while providing care. It is presented as a checklist table to maximize utility. Explanations and detail for each line of the table are provided within accompanying index to the table. The guidance here should be considered in the overall context of COVID-19 preparations and response within respective LTC facilities (CDC).

GUIDANCE

The following checklist and index identify key considerations for pharmacies that serve LTC facilities. Pharmacy managers and staff can use this guidance to assess their preparation and activities in the context of COVID-19. It does not describe mandatory standards but rather highlights areas that must be addressed for optimal health outcomes of people living in LTC environments.

A separate checklist will be required for each individual LTC facility that a pharmacy serves.

The following document has been designed for double-sided printing with the checklist on one side and index on the reverse.

CHECKLIST

Action	Notes	Person Responsible	Complete or Not Applicable
1. Communication			
A. Establish technology and timing for regular ongoing planning discussions with LTC administration and key stakeholders			
B. Establish technology and timing for ongoing clinical team communications throughout pandemic response			
C. Establish on-call schedule and disseminate guidance for how team members should use this resource			
D. Set up system for early warning to pharmacy of upcoming patient admissions			
E. Discussions to set out 'worst case' contingency planning for • role of pharmacy professionals in LTC • loss of pharmacy services			
2. Infection Control			
A. Transportation container and medication packaging as vectors			
B. Delivery protocol			
C. Receipt of returns protocol			
D. Virtual clinical pharmacy services			
E. Staff limited to single site			
F. Deferral of non- 'essential' services			

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1. Communication:

A. The pharmacy manager or designate must establish regular ongoing remote communication with LTC administrators and key stakeholders to plan for increasing demands for pharmacy expertise, medication volume and medication reconciliation (patient transfers from acute to LTC). This facilitates resourcing to ensure quality care. Discussions must result in tangible actions and assigned responsibility for components of care described in this document.

B. The pharmacy team must establish reliable, safe and regular communication with other clinicians responsible for providing resident care. Prescribers as well as nurses administering medication must understand any regimen change results in a cascade to pharmacy whereby medicines are returned to pharmacy and new ones will need to be issued. This is not an efficient use of limited resources (See *3. Reliable supply of medications for chronic disease states* below)

C. On-call pharmacy service (pharmacist or pharmacy technician to triage) may be required due to admissions and emerging patient issues. Develop written communication for LTC staff to encourage appropriate use of on-call service.

D. Pharmacy must be informed in advance of upcoming transfers from hospital or community so that new patient medications are available upon arrival. Daily meetings will facilitate this transfer of knowledge.

E. Contingency planning should occur immediately to establish

- The role of pharmacy professionals in a worst-case scenario (i.e., LTC professional staffing levels preclude drug provision). Discussion with administration and care team should establish contributions a pharmacist or a pharmacy technician can make as a front-line healthcare provider[3] in terms of medication provision and requisite training to be competent in the role.
- Pharmacists should consider prescribing activities as set out in Section 21 of the Regulations of the NB College of Pharmacists and the Office of Controlled Substances (OCS) recent Section 56 (1) Class exemption for Pharmacists prescribing. Changes to the current pharmacist prescribing role must be established with the LTC facility.
- Back-up pharmacy or substitute pharmacy team to replace existing in the event usual pharmacy staff are absent.

2. Infection Control: LTC facilities have established processes for people and goods moving in and out of their premises. Pharmacies must adhere to the LTC facility procedures in addressing:

A. Transportation containers and medication packaging as infection vectors:

- Option to use disposable cardboard box containers. Virus has shorter lifespan than on plastics (Van Doremalen N)
- Dedicating reusable containers to a specific LTC facility to reduce cross-contamination between facilities
- Cleaning protocols for pharmacy and LTC staff of reusable transportation containers and medication packaging
- Quarantine for 72 hours (minimum) of medication packaged in plastic mitigates risk of virus transmission (Van Doremalen N). Period of quarantine results in facility ordering days in advance to avoid disinfecting protocols
- Pharmacy must employ infection control measures in medication preparation. Infection measures include daily screening of pharmacy staff for COVID-19, frequent and proper hand hygiene, masks and gowns.

B. Delivery Protocol: Delivering medications and accompanying documentation

- Parties involved
- Time and place for non-contact handover
- Non-contact documentation of receipt

C. Receipt of Returns Protocol: Receiving medication back at pharmacy and accompanying documentation protocol

- Preferred: Postponing returns of medication from LTC until pandemic is over
- Alternatively: Quarantine of returns according to virus stability times (Van Doremalen N). LTC staff place in bag and seal with documentation of date. Package sent back to pharmacy but not opened within 3 days of return
- Non-contact documentation of returns

D. Virtual Clinical Pharmacy Services: Clinical components of care may be accomplished virtually by pharmacists to minimize risk of virus transmission between professionals and residents.

E. Pharmacy staff working on-facility site should not work at multiple sites due to associated COVID-19 spread (Temet M)

F. Non-essential (during pandemic) pharmacy activities should be identified and deferred.

[3] Section 22 of the Regulations to the NB Pharmacy Act, 2014 describes the expectations of pharmacists involved in administration of drugs. The Administration of Injections Policy sets out requirements for pharmacists to administer drugs, biologicals or blood products via IM and SC route.

Action	Notes	Person Responsible	Complete or Not Applicable
3. Reliable Medication Supply for Chronic Disease States			
A. Non-essential medication changes/reviews delay (start & projected end)			
B. Increase number of weeks supply provided			
C. Storage of increased medication volume			
D. Rationalizing medication administration			
4. Shifting Therapeutic Needs			
A. Establish standardized medication protocols for care of residents with COVID-19			
B. Medication for symptoms of COVID-19 available in · Pharmacy stock · LTC stock			
C. Medication needed for palliation of acute respiratory failure due to pneumonia available in · Pharmacy stock · LTC stock			
D. Medication needed to contribute to active treatment of COVID-19 available in · Pharmacy stock · LTC stock			
E. Medication needed to treat other acute indications (non-COVID-19) to avoid transfer to hospitals			
F. Monitoring of viable route, pharmacodynamics and kinetics due to changes in patient condition/level of consciousness			
5. Changing Routes of Administration			
A. Contact with Extramural Program: Local or provincial resource person			
B. Sterile preparation compounding pharmacy engaged and contracted			
C. Supplies for initiating and maintaining injection site access			

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3. Reliable Medication Supply for Chronic Disease States

A. Collaborate with prescribers immediately to establish a point in time that all non-essential medication changes and reviews[4] are delayed. The resulting stability in patient medication regimens permits the provision of multiple weeks worth of current and correct medication.

B. Four to six weeks may be reasonable. Predicated on resident numbers and stability of patient population.

C. Consider whether secure and stable (eg. cold chain) storage exists to maintain extra supply . Multiple storage locations may be necessary.

D. Reducing medication and administration times contributes to decreased nursing requirements while minimizing patient impact[4]. Pharmacists, with the team, can rationalize medication administration. Please visit [LINK] for an excellent resource for rationalizing medication in the context of a pandemic.

4. Shifting Therapeutic Needs: Resident health status may rapidly change, and care plans will follow suit.

A. Using evidence to produce standard medication protocols results in better patient care and facilitates pharmacy amassing inventory (drug entities and volumes) to meet needs of these patients. Order sets expedite clear prescriber ordering of medications as per the protocols. Pharmacy must collaborate with prescribers and administrators to establish these documents.

B. Providing medications needed to manage symptoms (Arya A) (Roland K) (Center to Advance Palliative Care) associated with COVID-19 infection. Symptoms include:

- Fever
- Dyspnoea
- Respiratory Congestion[5]
- Pain
- Nausea
- Delirium

C. Palliation includes provision of medication to manage (Arya A) (Roland K) (Center to Advance Palliative Care):

- Symptoms of acute respiratory failure due to pneumonia
- Pain
- Anxiety

D. Some patients will require active treatment of COVID-19 using oral or IV anti-infectives and fluids. Extra-Mural Program (EMP) is the primary source for provision of IV medication (depending on geographic area, urgency and injections competency of staffing) however, EMP may be challenged to meet demand. Ready-to-administer IV medications may alleviate demands on EMP. See 5B below.

E. To minimize the transfer of LTC residents, conditions normally treated in hospital may be provided at the LTC facility. Examples: IV antibiotics for urinary tract infection (UTI) or IV furosemide for symptomatic management of CHF.

F. Anticipate fluctuating levels of consciousness (dosing, route) and pharmacodynamics/kinetics.

5. Changing Routes of Administration: There may be need to administer medication via injection as their clinical condition deteriorates (Roland K).

A. Determine responsibility (who and how) for consulting with external agencies (i.e. EMP) to establish IV access and medication administration

B. Explore partnerships with sterile preparation pharmacies for supply of ready-to-administer injectable medications.

C. EMP is generally responsible for provision of supplies (infusion systems and cannulae) necessary for injection administration at LTC. Pharmacy should confirm with the LTC facility whether there will be potential need for the pharmacy to be involved in supplies provision and ensure supplies are available.

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[4] Quarterly medication reviews are mandated by the Government of New Brunswick's Standards Manual for Nursing Home Services. Rationalizing of medications constitutes a medication review and would be expected to meet this standard.

[5] Metered dose inhalers should be used in lieu of nebulised aerosols due to aerosols existing for 1-2 hours post-administration which could contribute to transmission of virus. (Ouslander)

Action	Notes	Person Responsible	Complete or Not Applicable
6. Readily Available and Securely Stored Medication for COVID-19 Symptom Management			
A. Stat boxes / Symptom management kits packaged and stocked (nursing homes) in an easily accessible but locked location			
B. Medication included in stat boxes / symptom management kits is standardized.			
C. Patient-specific prescription standing orders available in anticipation of patient need (special care homes)			
D. Over the counter 'prn' medications can be stocked rather than provided on individual patient basis (special care homes)			
E. Enough pharmacy stock and sufficient on-hand LTC facility stock of medications used in COVID-19 infections.			
F. Support clinicians in the regulatory requirements associated with stat boxes / symptom management kit inventory and storage			
7. Patient Transfers			
A. Establish method for regularly (at least daily) monitoring for transfers to LTC			
B. Pharmacists conduct medication reconciliation to ensure seamless care			
8. Other			

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6. Readily available and securely stored medications for COVID-19 symptom management:

A. Nursing homes may be best served through the packaging and stocking of stat boxes/symptom management kits. Implementation of these standardized kits facilitates medication (as well as infusion systems and subcutaneous cannulae for administration) transport and availability at bedside. These kits must be securely stored in an easily accessible area until needed/prescribed.

B. Stat box/symptom management kit contents may vary from facility to facility however recent publications (Arya A) (Roland K) set out suggested contents. Contents include narcotic and controlled medications and should be consistent within the facility. References at the end of this document provide suggested medications used in LTC palliation.

C. Special care homes require patient-specific orders. Special care homes may not have standardized protocols. This presents challenges to the expedient provision of medication. Prescribers can be encouraged to prescribe 'advance standing orders' for residents with anticipated needs. (Roland K)

D. Over the counter medications are not required to be provided on an individual patient basis in special care homes. Pharmacies must anticipate the level of stock OTCs needed to maintain residents' comfort in special care homes and ensure availability.

E. Enough medication volume must be stocked at the pharmacy to facilitate ongoing supply to the LTC facility. Amounts stocked at the LTC site must allow prompt administration. The amount of stock should balance the risk of diversion of large amounts of controlled medications. Sufficient stock also minimizes after-hours calls. Estimated rates of infection vary however, in one LTC facility in Washington, 62% of residents were infected over a two-week period. This figure along with daily/hourly trend analysis and advance planning with LTC administration may allow for projection of volume of medication required at the peak of a COVID-19 crisis in LTC. On-call pharmacy services allows for rapid replenishing of medication stock.

F. Morphine or hydromorphone (or alternate opioid) and benzodiazepines are included in Stat boxes/symptom management kits for palliation of residents experiencing dyspnoea. These medications are subject to documentation of possession according to Health Canada's Office of Controlled Substances legislation. Pharmacists must liaise with physicians and nurses to ensure legal requirements are adhered to with respect to inventory records, storage, administration and documentation[6].

7. Patient Transfers: Ensuring seamless care between acute care (hospital) to LTC facilities is of vital importance to the safety of residents. Pharmacists should engage in preparation for transfer as early as possible to minimize delay in transfer. Acute care will be faced with bed shortages and will be forced to move patients who may, in more typical times, be retained in hospital.

A. See Communication section 1C and 1D above regarding on-call pharmacy service and advance notification of transfers. Pharmacy team should establish a regular (perhaps multiple times a day) monitoring routine for transfers to LTC.

B. Pharmacists must (in conjunction with LTC professional staff and families) conduct medication reconciliation of regimens for those patients being transferred. Collaboration with external agencies and (where appropriate) sterile preparation pharmacies will be necessary in some cases to provide medications and seamless care. Hospital resources are focused on acute patients and hospital is not expected to provide transfer bridging medications.

8. Other: Individual pharmacies may identify other conditions requisite for maintaining and adjusting services during pandemic. This section facilitates individualization of the checklist.

[6] Practitioners can order office stock from a pharmacist pursuant to Regulation 31(2)(b) under the Controlled Drugs and Substances Act (CDSA). If they are stored at a location (i.e., LTC facility), they remain the practitioners' responsibility. Practitioners providing substances from that stock must keep appropriate records (Section 55 of Regulations)

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