Intermediate Care in Hotels

April 24, 2020

Table of Contents

Overview .......................................................................................................................... 2
Guiding Principles .......................................................................................................... 2
Assumptions .................................................................................................................... 3
Triggers for Intermediate Care Site Activation ................................................................. 4
Roles and Responsibilities ............................................................................................ 5
Requirements for Intermediate Care Sites ...................................................................... 5
Health Care Providers ................................................................................................... 5
Employee Training ......................................................................................................... 5
Intermediate Care Site Referral Process ......................................................................... 6
Intermediate Patient Profile and Flow ............................................................................ 6
Sub-Acute Patient ........................................................................................................... 6
Post-Acute Patient .......................................................................................................... 7
Transport Needs ............................................................................................................. 7
Infrastructure Requirements ........................................................................................ 7
Staff Area ....................................................................................................................... 7
Required Equipment ..................................................................................................... 8
eHealth / Information Technology ................................................................................. 8
Environmental Services ................................................................................................. 8
Food and Nutrition Services ......................................................................................... 9
Pharmacy ....................................................................................................................... 9
Infection Prevention and Control (IPAC) ....................................................................... 9
Emergency Preparedness – Patient Decompensation .................................................... 9
Resources ...................................................................................................................... 9
Appendix A - Simplified Menu for Intermediate Care in Hotel .................................... 11
COVID-19 Intermediate Care in Hotels

Overview
Mitigating the impact of COVID-19 on the health and wellbeing of Saskatchewan citizens is an essential part of Saskatchewan’s preparedness plan. The goal in Saskatchewan is to detect cases as early as possible, and delay and minimize spread as long as possible. By doing so, we help maintain the health of our general population. It also helps to prevent exceeding capacity of the health services including emergency rooms, inpatient units, and intensive care units.

The Saskatchewan Health Authority (SHA) requires a plan to address surge of COVID-19 cases that require intermediate level care in the community. Intermediate care includes a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximize independent living. Intermediate care services are usually delivered for no longer than six weeks and often for as little as one to two weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement. (National Institute for Health and Care Excellence, 2017)

There is the potential for a large number of patients infected with COVID-19 that will require a level of care beyond what can safely be provided with current homecare capacity but do not need to be hospitalised. Cohorting such patients in pre-identified and purpose specified hotels is an option that would enable safe, efficient care for such patients.

The SHA has already implemented a number of initiatives to support care in community to reduce the burden on the acute care system: Testing Sites, Assessment and/or Treatment Centres, Contact Tracing, PHC, family and other physicians delivering care to non-COVID patients, patients not in self-isolation due to travel or a public health directive and who are low risk for having COVID-19, by offering Virtual Care.

Provincial guidance on Field Hospitals and Assessment and Treatment Sites is complete. A similar approach is required for cohorting of COVID-19 patients within the community who require intermediate level care so that acute care admissions can be avoided or delayed.

Guiding Principles
- Connected Care for the people of Saskatchewan remains an anchor as to how the SHA organizes service delivery throughout the pandemic.
• Seamless, high-quality transitions of care will occur.
• The cohorting strategy will:
  o Aim to ensure it enables accessible care, with services as close to home as possible;
  o Provide integrated care, with all necessary services wrapped around the patient;
  o Include needs-based, culturally safe and responsive services;
  o Benefit every patient by offering integrated, consistent care;
  o Benefit every provider through collaborative, cross functional teams; and
  o Shorten hospital lengths of stay and allow for better transitions back home.

Assumptions
Intermediate care includes a range of integrated services that: promote faster recovery from illness; prevent unnecessary acute hospital admissions and premature admissions to long-term care; support timely discharge from hospital; and maximize independent living. Intermediate care services are usually delivered for no longer than six weeks and often for as little as one to two weeks. Four service models of intermediate care are available: bed-based intermediate care, crisis response, home-based intermediate care, and reablement. (National Institute for Health and Care Excellence, 2017)
  • Intermediate care (homecare, connecting to care, seniors house calls) will continue in their current form for Non-COVID clients.
  • All patients who receive intermediate care were living independently prior to contracting COVID-19 and it is anticipated that they will return to independent living following recovery.
  • Designated hotels will be used to expand intermediate care, by cohorting COVID-19 positive patients into a contained area to enable efficient and effective health care services.
  • Designated hotels will also be used, particularly in the urban setting, to enable care for COVID-19 positive vulnerable populations (clients who would typically live in group homes, homeless shelters).
  • In the urban setting, suspected COVID-19 patients will await test results before being moved into a hotel setting (test results can be turned around in 24 hours or less).
  • In rural and north settings, suspected COVID-19 patients who need intermediate care and are presumed cases will be admitted into community hospital settings. However, if demand warrants, intermediate care could be provided in a hotel setting, particularly in regional centres.
  • No planned aerosolized generating medical procedures (AGMP) will be done within the hotel setting.
  • The SHA’s COVID-19 visitation policy will apply.
- A referral process to intermediate care will include an assessment by a physician or nurse practitioner either in an acute care site or at an Assessment and Treatment site prior to the pre-acute patient moving to intermediate care setting.
- Post-acute patients will be referred to an intermediate care setting when being discharged from acute care if still COVID positive.
- Palliative care will ideally not be delivered in the hotel setting.
- Standard Work and Work Standards that match current homecare standards will be in place for how care at intermediate sites (hotels) is delivered.
- Staff entering the hotel setting to deliver care will be screened in accordance with SHA standards.
- Living accommodations for staff working in this setting will be provided; same as for LTC and Acute Care staff, where appropriate.
- Staffing is going to be an ongoing pressure and service delivery models need to be flexible in accordance with available capacity, skillsets and availability at any given time.
- Clients will not be forced to cohort in a hotel, they will be provided with an overview of the risks of not cohorting and commit to adhering to public health orders and would be asked to sign a form acknowledging the same.
- Patients from northern communities once discharged from acute care may require an additional stay in an urban center based on the ability to address the underlying conditions in a northern community.
- Entry to, exit from and escalation of care of patients to acute care from designated hotels will occur in accordance with senior staff decisions and coordinated by the site lead.
- Cohorting of families may be required.

**Triggers for Intermediate Care Site Activation**

The triggers for activation of an Intermediate Care site are based on the phase of the SHA’s operational plan, and takes into consideration the following:

- Integrated Service Areas will determine their own set of triggers based on capacity within community and acute care settings.
- Network and small area geographies should also inform local triggers.
- When the system hits a certain threshold experiencing a lack of ability to deliver PHC in community (number of COVID-19 positive patients requiring PHC).
- Each IHICC needs to develop their own triggers based on their demand, capacity and number of COVID positive patients in their Health Networks.
Roles and Responsibilities
During the COVID-19 pandemic, the Saskatchewan Health Authority (SHA) may have a need for health services which exceed the available resources. Health services refer to those services delivered to the public via acute care facilities, long-term care facilities, and health and community service organizations.

SHA staff and physicians will be responsible to efficiently and effectively maintain homecare services in community, and, if required, begin cohorting COVID-19 positive clients into hotels.

Requirements for Intermediate Care Sites
Intermediate Care sites are a temporary measure to assist with the surge in acute care capacity required to support patients through the COVID-19 pandemic, providing an alternative to remaining at home or being admitted to hospital. These facilities will be utilized to provide a single location for COVID-19 positive patients to receive intermediate care through home care. This can be either early in the course of a mild or moderate illness (pre-acute) or as a step down after more intensive in-hospital care (post-acute). The Intermediate Care Sites have been developed in alignment with a set of guiding principles.

Health Care Providers
Recommendations for staffing at Intermediate Care sites will include:

- SHA OOS Homecare Manager identified to oversee this COVID-19 program to support coordination of care/service delivery/providers.
- Staffing models and mix should be similar to what exists now for homecare, such as CCA, RN, LPN, Community Physio, Therapies, Physician, NPs and Community Paramedicine.
- Two Commissionaires rotating on 12 hour shifts to enforce cohorting and improve security.
- Physician(s)/NPs to provide orders based on virtual or in-person consultation with one physician per up to 50 patients.
- Regular family physicians and nurse practitioners will be consulted during the day with concerns or questions.
- Homecare Assessor Coordinators to do initial assessment.
- RN, LPN and CCA mix will depend on availability of staff and complexity of the patients.
- Therapies staffing and services to support rehabilitation for deconditioned patients in order to ready them to return safely home.

Employee Training
Health Care Worker (HCW) education will include the following:
- Standardization of infection control precautions;
- Review of donning and doffing procedures with initiation buddy system process;
- NP swab Work Standard/process;
- Packing and shipping of specimen samples;
- Environmental cleaning; and
- Safety and site orientation including pre-shift screening and how to report and escalate symptoms in a health care worker (self or co-worker)?

**Intermediate Care Site Referral Process**

Patient will be referred to the Intermediate Care sites through one of three primary channels (See Appendix H):
- Assessment and Treatment Centres
- Emergency Departments
- Inpatient Units (Post-Acute Transfers)

**Intermediate Patient Profile and Flow**

The intent of the patient profile is to describe the types of patients who will be provided care and service at an Intermediate Site. During the COVID-19 pandemic, Intermediate Care Sites will primarily be utilized to provide a single location to provide intermediate care for COVID-19 positive patients who require lower acuity care early in their diagnosis as well as those who require convalescent care following acute care discharge.

**Sub-Acute Patient**

- COVID-19 positive or who require low acuity care and are at low risk of deteriorating.
- COVID-19 positive patients that are medically stable but require observation.
- COVID-19 positive requiring homecare for Non COVID-19 related comorbid conditions.
- COVID-19 positive patients need to have very few medical conditions and persistent hypoxemia.
- COVID-19 positive patients who require but do not have adequate in-home support/caregiver.
- COVID-19 positive patients who are unable to self-isolate and are at risk of infecting others in their household.
**Post-Acute Patient**
- COVID-19 positive patients that require convalescent care or observation following acute care discharge.
- Patients recovering from COVID-19 whose mobility was compromised from their acute care stay.

**Transport Needs**
- Transfer units, wheel chair or stretcher transportation companies with proper PPE and cleaning protocols.
- SHA transfer.
- Family.
- Region based/Band based transport using infection control guidelines (particularly in the far North).
- Transportation protocols being put in place for vulnerable populations could also apply.
- EMS may be used as a last resort.

**Infrastructure Requirements**
- Hotels with full kitchen.
- Wheelchair accessible.
- Hotels with bathrooms where accessibility devices can be used (i.e., raised toilet seats, tub lift/chairs, shower chairs, wall bars, hand held showers, etc.).

**Staff Area**
The following specific areas within the staff area are anticipated:
- Organization of workstations for charting and other equipment, to be flexible, allowing for distribution to best support patient care.
- Separate area for staff breaks/meals that adheres to chairs being places with two meters of separation.
- Donning and Doffing station.
- Change room:
  - Staff are encouraged to change into/out of work clothes upon arrival and when leaving the site.
  - Staff only washrooms.
• Consideration must be made to minimize the provider flow into individual patient rooms. Consider having staff available outside the room to bring any necessary supplies/equipment to the provider.
• Onsite refrigeration for specimen collection.

**Required Equipment**

For Intermediate Care, the following will be required. It is worth noting that a number of items will increase with demand.

• Oxygen available by concentrator or tank.
• Home Health Monitoring System/Tablet (patient could use personal tablet or cell phone).
• Mobile Vitals Cart (“Nursing on Wheels” if possible).
• Nurse over-bed station if possible.
• Otoscopes.
• Wound care supplies.
• Dirty Linen cart – per room.
• Bathroom Accessibility Equipment available, i.e. bars, raised toilet, follow Homecare process to access.
• Glucometer – site specific volume/patient could supply their own.
• Sharps container.
• PPE for non-AGMP procedures (Droplet +).
• AED.

**eHealth / Information Technology**

• Wi-Fi for Home Health Monitoring and Personal Use.
• Charting will occur using regular homecare information systems.

**Environmental Services**

• Hotel staff will need to perform hotel room cleaning.
• SHA Environmental Services will provide training, protocols, adequate cleaning supplies should they be required.
• Field Hospital cleaning guidelines will be applied.
• Cleaning supplies for each room will be provided for clients to do their own light cleaning (wipes).
• Proper PPE will be required for hotel staff to do the cleaning; the SHA would be required to fill in any PPE gaps the hotel has.
• Need a clean drop off area (meds, food, and clothing) separate from a dirty "leaving" area for garbage, etc.

**Food and Nutrition Services**
• Hotel staff will provide food and nutrition services.
• Hotel staff will deliver food. Entrance to the rooms will not be permitted, the protocol will be to place the tray outside the room, knock loudly or perhaps ring a bell to signal the food has been delivered.
• CBOs could support food service delivery.
• SHA Food and Nutrition Services will provide menu guidelines and training if required.

**Pharmacy**
• Arrangements will be made with community pharmacy to deliver over the counter medications and prescription medications. Patients will be encouraged to use their own previously prescription medications.
• The COVID-19 discharge medication process will be utilized to transition Post-Acute Patients.
• The established Homecare procedures will continue for medication reconciliation and referral for IV therapy.
• A limited supply of medications can be supplied to each Intermediate Care facility.

**Infection Prevention and Control (IPAC)**
The IPAC guidelines for homecare services will apply in the Intermediate Care Facility. They are available at [https://www.saskatchewan.ca/covid19](https://www.saskatchewan.ca/covid19).

**Emergency Preparedness – Patient Decompensation**
• Follow existing homecare procedures if patient decompensates.

**Resources**
The SHA shall have information sheets and algorithms to direct referral processes, care instructions, etc. The information should cover:
• Citizen self care;
• Home isolation;
• How to recognize worsening symptoms;
• When to seek medical attention;
• Who to contact and appropriate contact information; and
• Mental health and well being “Check in” process for public presenting to the site should occur daily:
  • Be aware of non-verbal cues such as: no eye contact, hands shaking, crying, expressing worry or hopelessness
  • Consider asking brief questions to open dialogue: How are you coping at home? On a scale of 1-10, 10 being the worst, how are you coping at home? How are your stress levels? How is your mood? How is your anxiety level?

Information sheets are available at Saskatchewan.ca/covid19.
## Appendix A - Simplified Menu for Intermediate Care in Hotel

<table>
<thead>
<tr>
<th>Breakfast</th>
<th>Cold Lunch</th>
<th>Hot Dinner</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Select one from each category:</strong></td>
<td><strong>Select one from each category:</strong></td>
<td><strong>Select one from each category:</strong></td>
</tr>
<tr>
<td>Fruit Juice: 125 ml apple or orange</td>
<td>Soup: 175 ml – vegetable based, can be cream or broth</td>
<td>Sliced Meat: 3 oz. with sauce and garnish as required</td>
</tr>
<tr>
<td>Milk: 125 ml</td>
<td>Crackers: 1 package of 2</td>
<td>Starch: 125 ml potatoes, rice, pasta</td>
</tr>
<tr>
<td>Fruit: 1 medium size piece or 125 ml chopped</td>
<td>Sandwich: 1 whole – 2 slices whole wheat bread, 2 oz. protein in salad form (egg salad, tuna salad, ham salad), shredded lettuce, margarine on bread, mayonnaise added to salad mixture</td>
<td>Cooked Vegetable: 125 ml any vegetable that is cooked to tender</td>
</tr>
<tr>
<td>Protein: 1 hard cooked egg, 125 ml yogurt, 1TBS peanut butter, 1oz cheese</td>
<td>Fresh Vegetables: carrot sticks or celery sticks (4 of each); small tossed salad 125 ml; sliced tomatoes and cucumbers (4 of each)</td>
<td>Dessert: any types dessert, baked good, pudding, ice cream</td>
</tr>
<tr>
<td>Cereal: 175 ml oatmeal, 175 ml cold cereal</td>
<td>Canned Fruit Dessert: 125 ml any type for example applesauce, diced peaches, fruit cocktail</td>
<td>Juice: 125 ml</td>
</tr>
<tr>
<td>Starch: 2 pieces Whole Wheat toast, 1 muffin</td>
<td>Milk: 125 ml</td>
<td>Hot Beverage: tea, coffee</td>
</tr>
<tr>
<td>Hot Beverage: tea, coffee</td>
<td>Hot Beverage: tea, coffee</td>
<td>Condiments: as required for the meal and beverages</td>
</tr>
<tr>
<td>Condiments: as required for items, e.g. cream/sugar for hot beverage, margarine for toast/muffin, brown sugar for cereal, jam for toast</td>
<td>Condiments: as required for the meal and beverages</td>
<td></td>
</tr>
</tbody>
</table>
Work Standard
If you have someone who is on a Texture Modified Diet – for example minced/pureed – contact your local Nutrition and Food Services contact** for further direction.

<table>
<thead>
<tr>
<th>Breakfast - Minced or Pureed</th>
<th>Lunch - Minced or Pureed</th>
<th>Dinner - Minced or Pureed</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Select one from each category:</strong></td>
<td><strong>Select one from each category:</strong></td>
<td><strong>Select one from each category:</strong></td>
</tr>
<tr>
<td>• Instant Oatmeal - not for pureed</td>
<td>• Cream Soup - strained to remove bits</td>
<td>• Cream Soup – strained to remove bits</td>
</tr>
<tr>
<td>OR Instant Cream of Wheat - for pureed</td>
<td>• Tre Puree (frozen)</td>
<td>• Tre Puree (frozen)</td>
</tr>
<tr>
<td>• Yogurt or Applesauce</td>
<td>• Applesauce (canned)</td>
<td>• Pudding (canned)</td>
</tr>
<tr>
<td>• Beverage: juice milk, tea, coffee</td>
<td>• Beverage: juice, milk, tea, coffee</td>
<td>• Beverage: juice, milk, tea, coffee</td>
</tr>
</tbody>
</table>

These guidelines and principles are listed with the assumption that:

1. Food preparation is a current part of your daily operation.
2. At least one person at the site has Food Safe Level 1, if not all food service personnel.
3. A lead cook is on site who can prepare items following standardized recipes and has knowledge of the ingredients in each item in case of allergy notification.
4. The site has a current and valid food service permit and follows Public Health standards in relation to Food Safety practices.
5. Currently has HACCP protocols and tracking in place for temperature control and recording, chemical concentration documentation and personal hygiene in place with attention to hand hygiene and PPE protocols.
6. If necessary, the food lead can contact a local SHA Nutrition and Food Services contact** for information regarding menu planning, texture modifications and diet requests such as allergy alerts.

All these practices must be in place when serving COVID-19+ Patients

1. Room Service delivery and pick up – Touchless delivery of meal tray:
   a. All delivery and pick up can be completed with a trolley, ensuring the trolley stays in the hallways. All food items should be covered when transporting from the kitchen into the public areas. The trolley must be sanitized with appropriate sanitizer prior to putting meal trays on it, and when returned to the kitchen with the dirty trays. Do not combine meal delivery with pick up of trays. Complete this as two separate activities.
   b. Meals may be served on disposables or china, this is your preference – the whole meal must be put on a tray and delivered to the patient’s door. When arriving at the door knock on the door to indicate that the meal is outside the door and then leave.
   c. The meal tray should be left at the door for the patient to pick up and take into their room.
d. Once the patient has finished their meal, the tray can be left outside the door for staff to pick up. The patient should only place on the tray items that are part of their meal. They are not to put any personal items on the tray e.g. tissues, Band-Aids, gauze. If they do this, do not pick up the tray, leave it in the hallway and contact the person to indicate they must remove the non-food service items and place them in their own garbage pail in the room. They can place the tray back into the hallway once this is completed.

e. The dirty tray is returned to the dishwashing area:
   i. If disposables are used, all items go into the garbage and the garbage bag is tied up and taken out after every meal.
   ii. If china is used, the dishes are washed as usual – should only scrap dishes and do not spray (as this may cause the virus to become airborne). If you prefer you, can wear goggles and a mask while doing dishes as a secondary precaution but not required. Dishes will be washed in the dishwasher as normal. If you have a high temperature dishwasher, you need to test at each meal and ensure that your sanitizing temperature is at least 82C and run for at least 10 seconds at this temperature. This can be tested using a T-strip or waterproof thermometer. If you have a low temperature dishwasher then you need to verify that the chemical is at the proper concentration, use a sanitizer test strip and record – this is 50-ppm chlorine or 12.5-ppm iodine or follow the manufacturer’s instructions. Use the appropriate strip for the chemical.

2. Proper Handwashing - follow the proper process ensuring that your hands are washed for a minimum of 20 seconds and all skin surfaces are scrubbed with soap and warm water. You may also have approved sanitizer available to use when you are unable to wash your hands.

3. Sanitizing work surfaces – sanitizing eliminates or substantially reduces the number of harmful bacteria on a cleaned surface. Dishware and food contact surfaces such as counters, tables and cutting boards should be cleaned, rinsed and then sanitized. All work surfaces should be sanitized using the appropriate concentration of approved sanitizer. A Quat sanitizer is preferred and it should be dispensed at 200-400 ppm. This should be tested at the dispensing station by using a sanitizer test strip and recording the ppm.
** SHA Nutrition and Food Services contacts**

<table>
<thead>
<tr>
<th>Name</th>
<th>Area of Coverage</th>
<th>Email Contact</th>
<th>Cell Phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Susan Auty</td>
<td>Regina area</td>
<td><a href="mailto:Susan.auty@saskhealthauthority.ca">Susan.auty@saskhealthauthority.ca</a></td>
<td>306.519.4955</td>
</tr>
<tr>
<td>Hidy Blommaert</td>
<td>Rural - South</td>
<td><a href="mailto:Hidy.blommaert@saskhealthauthority.ca">Hidy.blommaert@saskhealthauthority.ca</a></td>
<td>306.621.4979</td>
</tr>
<tr>
<td>Dena Webb-Listwin</td>
<td>Saskatoon area</td>
<td><a href="mailto:Dena.webb-listwin@saskhealthauthority.ca">Dena.webb-listwin@saskhealthauthority.ca</a></td>
<td>306.221.0736</td>
</tr>
<tr>
<td>Lori Graupe</td>
<td>Rural - North</td>
<td><a href="mailto:Lori.graupe@saskhealthauthority.ca">Lori.graupe@saskhealthauthority.ca</a></td>
<td>306.441.1270</td>
</tr>
</tbody>
</table>