Ontario Renal Network – Regional Renal Program COVID-19 Information Calls (week of March 16 – 20)

For completeness of notes, key discussion points from previous weeks have been included, but have been italicized/greyed out

Date:
20 March 2020

Attendees: Dr. Peter Blake, Rebecca Cooper, Phil Holm, Kieran Bergmann, Angie Yeung, Regional Renal Program Directors and Nephrology Division Heads, Regional Medical Leads, Provincial Medical Leads

Topic	Key Discussion Points
Purpose	The Ontario Renal Network (ORN) is setting up regular, optional calls with the administrative and medical leads from each of the 27 Regional Renal Programs (RRPs). The purpose of the calls is to facilitate information exchange amongst RRPs on approaches for patients with CKD, in particular the dialysis population. ORN's role is not to interfere with hospital protocols nor to provide infection control direction. We want to provide support to the network through information sharing, gathering, and dissemination.
Prevention	Screening

Topic	Key Discussion Points
	• *Many RRPs are continuing to screen patients on arrival. Screening includes questions about travel, respiratory symptoms, or if they have been in contact with someone who has recently travelled and has symptoms. If patient is symptomatic and/or positive for travel history they are put into a designated room for isolation and tested for COVID-19* • *Some RRPs are calling patients in advance and asking screening questions over the phone. If positive they go straight to isolation room on arrival for dialysis and testing, and are connected with Public Health* • *Some RRPs have set up additional handwashing stations, some are considering having patients use hand sanitizers at the registration desk, and some are wiping down chairs in waiting rooms in between each shift* • Many hospitals have moved to centralized screening of all patients, visitors and staff at main entrance, but some RRPs are continuing to screen at the entrance to the dialysis unit • It is important that screening be done by nursing/clinical staff (as opposed to administrative staff) to be able to ask the right questions, in particular with dialysis patients with baseline symptoms • Sunnybrook – treating all patients with droplet precaution with face mask and face shield preservation (mask and face shield changed between patients only if wet; gowns and gloves changed between patients) • Some RRPs/hospitals have expanded criteria for swabbing (no travel history required) • Sunnybrook – have swabbed all patients with baseline symptoms, and will not be swabbed again unless symptoms change • Some RRPs identified lack of availability of swabs, but this has improved over the week • Challenges identified with shortage of reagents for testing and delay in results Information Dissemination • *A few RRPs / hospitals have set up committees that meet daily to discuss new developments and changes to practices* ○ *Sunnybrook – nephrology specific committee meets daily to intake all information related to COVID-19 and determine what and when to spread to staff and patients. Goal is to reduce volume of communications, reduce confusion from multiple sources of information, and provide points of contact* ○ *Humber has a daily committee that is led by hospital IPAC; not specific to nephrology but includes representatives from each clinical program* • *Some RRPs have sent letters to patients outlining policies related to COVID-19* • *Many RRPs have posters and other educational materials regarding protocols, handwashing, etc.* • GN patient handout shared by Sunnybrook – other RRPs can use/share with patients as needed • Patient FAQ website shared by Kingston Social Distancing

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	• *Many RRPs identified that social distancing amongst patients receiving dialysis is incredibly difficult given their current capacity challenges* • *Several RRPs have cancelled group events including education sessions, gatherings of more than 15 – 20 people (e.g., rounds), World Kidney Day events, etc.* • *Some RRPs are restricting visitors in the HD unit unless they are required to get the patient to and from dialysis* • *It was suggested that RRPs may want to consider providing direction on handshaking, hugs, etc.* • Some RRPs are still doing regular rounding within in-centre dialysis units, but maintaining distance and using appropriate PPE • It was suggested that rounding could be done only for patients where need has been identified • RVH – have asked IT team to set up OTN for satellite units • Kingston – at satellite sites, nursing doing telephone screening 24 hours before, and also screening at entrance; if screening is positive, physician is called to do assessment to determine if dialysis at satellite unit is appropriate • Some RRPs have restricted visitors or limited visitors to essential caregivers Clinics • *Many RRPs are reviewing clinics over the next several weeks to determine which can be cancelled, postponed, or moved to OTN/virtual* • *St. Michael's – reviewed next 8 weeks of home dialysis clinics and reduced some patients to every 3 months vs 2 months where appropriate; have reviewed which patients could do OTN vs. come in person; nurses are calling patients day before appointment to do pre-screen. They will be doing this for MCKC as well* • *St. Joseph's Hamilton – For MCKC and general nephrology, as of March 23rd only urgent cases will be in-person, all others virtually. For older patients who are not tech savvy they will likely have to be phone calls* • *Humber - calling patients for any URI symptoms, if they have visits will be virtual. If they can't do virtual appointments they will reschedule in 2 months (looking at bloodwork to ensure this is appropriate)* • *RVH – calling patients the day before clinics. Clerk helps them wash hands when they arrive* • *London - looking at scaling back transplant clinics. There is a secure app available for OTN that can be used over smart phones, which doesn't require hospital to hospital communication* Access Procedures • Many RRPs are continuing to insert PD catheters • Some RRPs have stopped PD catheter insertions, but are revisiting

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Suspected or Confirmed COVID-19 Cases	*Some RRPs plan to admit COVID-19 positive patients, others are looking into options for transporting patients back and forth from their homes three times per week for dialysis* • *Sunnybrook – currently plans to admit even COVID-19 positive patients with mild cases due to issues regarding transporting patients back and forth from home three times per week for dialysis* • *Most programs said they are unable to admit COVID-19 positive patients who don't meet regular criteria for acute hospital admission due to limited inpatient capacity. Only COVID-19 positive patients who are unwell and require inpatient services would be admitted* • *Suggestion to treat on a case by case - in certain circumstances may need to admit whether patient is well or unwell* • *Some satellites/IHFs are transferring suspected cases to the hub / closest hospital / their home Regional Renal Program. Receiving hospital is called in advance so they can take necessary precautions (e.g., Brockville IHF, Sheppard/Sussex Centres).* Droplet/Contact vs. Airborne Precautions • *RRPs are still awaiting guidance on whether they should be using droplet precautions only or airborne precautions as well. Some sites do not have airborne isolation rooms or have a limited number of airborne isolation rooms and would therefore have to transfer positive patients if airborne precautions are in place. If contact/droplet precautions are put in place, practices may change.* • RRPs are now taking droplet/contact precautions for suspected cases, based on updated guidelines; however, some are experiencing push back from ONA wanting nurses to take airborne precautions • OH is aware of the union issues provincially, but no recommendations have been provided yet Transportation of positive patients • *Most RRPs will be unable to admit COVID-19 positive patients that are mild cases. Ideally, family members could drive them to their treatments while protecting themselves (mask and gloves)* • *Many IPAC teams are suggesting that people should not take public transit* • *Suggestion to send positive patients home with gloves and masks that can be used during transportation back and forth to hospital* • *Several RRPs (e.g., Unity, Humber, Ottawa) are planning to leverage existing contracts with taxi companies to transport patients for dialysis. Obligation to inform taxi agency that they need transportation of COVID-19 positive patient and plan to use that company for all treatments. Driver has the right to turn down the fair (Ottawa has encountered this)*

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	• *ORN is seeking input from the provincial OH lead for COVID-19 regarding transporting a confirmed COVID-19 in-centre hemodialysis patient to and from the dialysis unit using medical transportation companies.* • Some RRPs are continuing to use taxi to transport positive or suspected COVID patients; some still plan to admit positive COVID patients because of transport issues • It was noted that because of privacy, hospitals are not required to identify if a patient is COVID positive to the taxi company/driver; there has not been push back from taxi companies • Humber – Patients who are transported by taxi continue to be provided with mask and gloves, but clarified with IPAC that taxi drivers do not need to be provided with mask (they can choose to wear one themselves). Approach is consistent with what is occurring at assessment centres. • The issue of volunteer drivers who are self-isolating or refusing/shutting down was identified. No solution has been identified so far, but it is anticipated that this will become a more widespread issue. • TTC has confirmed that starting on Monday, there will be 16 designated operators (trained on PPE) and vehicles to transport suspected COVID patients • ORN is putting forward proposal for additional provincial funding to support RRPs with transportation costs
Multiple Confirmed Cases	Cohorting of COVID-19 patients • *Lakeridge is looking to proactively set up two COVID-19 units to cluster any positive, admitted patients. They are trying to forecast how many might be dialysis patients* • *London is considering a nocturnal shift to provide cluster care for COVID-19 positive patients if there are multiple cases; St. Joe's Hamilton is considering a nocturnal shift for non-COVID patients* • For patients requiring isolation, dialysis schedules may need to be changed in order to stagger patients • Some hospitals have created COVID units – positive dialysis patients would be admitted there "Rationing" Dialysis • *Potential to reduce some patients to two treatments per week in the event there is an increased demand for dialysis in the event of multiple critical cases with multi-system organ failure* • *London has developed an algorithm to proactively "ration" dialysis so that they are not scrambling in event of emergency (i.e., determining who could do 2 times per week). Contact Dr. Andrew House if you would like to see this* • Algorithm shared by Dr. Andrew House (London) – it was suggested that this exercise be done and kept up-to-date for all dialysis patients, in the case that dialysis treatments need to be reduced

Topic	Key Discussion Points
	Staffing • *Many RRPs raised the concern around staffing in the event that multiple staff are sick/ under self-isolation* • *If staff are sick but well enough to work, need to incorporate ethical principles* • *Humber is looking to build enough capacity in NRT to manage patients from physical perspective and have dialysis nurses focus on skilled care such as managing cannulation and machine management* • *In the GTA, nurses are shared across multiple hospitals and are therefore very vulnerable to getting sick. During SARS, staff were required to choose one site to work at rather than moving from site to site* ○ *This approach could put some programs at risk as some programs are only able to offer part time hours so staff are more likely to choose to work at programs that can offer full time hours* • While staffing continues to be a big concern, RRPs are considering different options but have not yet changed any staffing models Management of AKI of COVID-19 Patients in ICU Setting • *Need to consider acute dialysis capacity in the event that multiple patients have multi-organ system failure* • *In Italian context, there has been difficulty providing dialysis support to all of the patients who have become critical and experience multi-organ failure* • *Non-COVID related issues requiring acute dialysis are still occurring so even a modest influx would be a big strain on the system* • For planning purposes, ORN has updated an inventory of HD machines, and has obtained an inventory of Baxter PrismaFlex machines • In Toronto Central region, there is a shortage of CRRT machines, and it is not uncommon to swap/borrow machines within the region • RRPs are also anticipating a shortage of solutions and filters for acute dialysis • It was noted that regular dialysis machines can be used for acute patients • The concern about the availability of ICU beds in general was identified, and that hospitals are starting to plan for the use of unconventional spaces for ICU patients
Assisted PD	*Need to consider PD patients on assistance and what to do in the event healthcare workers are positive and/or don't have capacity because the healthcare system is already strained* • *RRPs should contact CCAC/Home and Community Care to discuss plans* • *Ottawa is currently looking into this as Ottawa staff provides assistance themselves*

Topic	Key Discussion Points
	• *RRPs should be prepared to bring some of these patients in-centre in some hospitals* • *Consider reducing PD in some cases, e.g., to every other day PD*
Transplant	*Pre-Transplant Considerations* • *Living donors willingness to travel given current travel restrictions* • *Screening re travel history of living donors* • *Transplant Ambassador Program - has not yet been closed but have told patients to follow volunteer practices of hospital. If anyone feels uncomfortable they may speak to staff over the phone* *Surgery* • *Transplant surgery is considered elective so if any hospitals decide to cancel elective surgery both deceased and living donor surgeries will be impacted* • *RVH had a patient turn down a kidney based on COVID-19* *Post-Transplant Patients* • *For patients that are well, it's possible that visits could be done remotely* • *Evidence may suggest that immunocompromised patients may require less exposure for transmission* *Amit will check in if TGLN has guidance* Trillium Gift of Life Network Medical Director provided an update: • Living kidney donor activity has been put on pause provincially and nationally until end of month • Looking into whether evaluation of donor candidates can be done by conference call • Practices for screening donors has been updated; tool has been developed • Deceased kidney donor activity has been put on hold for 2 weeks • Transplant Ambassador Program (TAP) is on hold in terms of in-person visits • Letters are being developed to be provided from transplant centres for patients about immunosuppression and to allow individuals to remain at home

APPENDIX

Questions for Regional Renal Programs concerning COVID-19 virus in Ontario

FOR DISCUSSION PURPOSES. Questions are intended as guidance only and should not be seen as directive from the Ontario Renal Network.

A. Prevention

1. Do you have a policy informing in centre HD patients what to do if they have fever and cough +/- history of relevant travel or of exposure to other people with relevant travel?
2. Should they come to the unit or be reviewed by phone or go elsewhere if there is reason for concern?
3. Do you have a policy informing in centre HD staff what to do if they have fever and cough +/- history of relevant travel or of exposure to other people with relevant travel?
4. Should in centre HD staff come to work at or be reviewed by phone or go elsewhere if there is reason for concern?
5. Have you considered policies to introduce more 'social distance' where feasible between HD patients, other HD patients and HD staff?
6. There are multiple documents circulating to staff and even patients about COVID-19 and these may cause confusion. Have you a strategy to deal with this?
7. Do you have a good line of communication to your hospital infection prevention and control team and do you think they recognize specific issues related to in centre HD?
8. Is your hospital and/or in-centre HD unit screening patients? Who is doing the screening (i.e. clinical vs. non-clinical staff)? Are they wearing appropriate PPE?
9. What is your criteria for quarantining exposed/unwell staff?
10. How are you communicating to patients about changing policies and protocols?

B. Scenario where one HD patient has confirmed or strongly suspected COVID-19 virus

1. Where and when would you dialyze that patient to minimize risk to other patients and staff?
2. Where would the patient be 'hospitalized' between HD treatments?
3. In this scenario would all staff and patients mask while in the same HD unit as the affected patient?
4. In this scenario, would you have a dedicated HD machine?
5. Are the HD staff comfortable and up to date with PPE (N95s etc)?
6. Are your staff aware of your plan?
7. What is your criteria for swabbing patients and/or staff?
8. How will you transport suspected or positive cases to and from HD treatments? Will you admit all positive patients?

C. Scenario where multiple HD patients have confirmed or suspected COVID-19:

1. Would you consolidate infected patients in one area or one of your HD units in such an event and, if so, do you know where?
2. Is your hospital infection prevention/control team aware of these potential HD issues and especially of the point that infected HD patients will require admission even if relatively well?
3. Have you considered reducing the frequency of dialysis for patients where it is appropriate?
4. How will you manage/maintain staffing in these scenarios (e.g. bring in staff from other areas, retired staff, etc.)?

D. Home Dialysis Issues:

1. What would you do if assisted PD program in one or more of your regions was compromised by lack of home care staff to deliver it?
2. Are you continuing to insert PD catheters? What is your plan if your hospital decides stops inserting PD catheters?
3. Will you continue to train new home dialysis patients?

E. AKI in COVID ICU Patients:

1. Would you use CRRT, SLED, conventional HD (or all 3)?
2. How can the program cope with double or triple the volume of patients requiring acute dialysis?
3. Will there be enough machines, supplies/solutions, and staff?
4. What would be the role of the nephrologists vs. intensivists? What would be the role of renal nurses vs. ICU nurses?

F. Other Outpatient Groups:

1. Are you cancelling in-person clinic visits and/or converting to virtual/phone visits where possible?
2. What instructions are you providing to immunosuppressed or vulnerable patients?

Date of Questions: Last Updated March 20, 2020

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