nova scotia health authority
Cancer Care Program

COVID-19 Protocols for Oncology

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INTRODUCTION

This document provides direction to all NSHA Cancer Care Program (CCP) staff and physicians regarding oncology service adjustments in response to the COVID-19 pandemic. This has been informed by NSHA Cancer Care Program clinical leadership as well as by other cancer agency pandemic plans and approved by NSHA CCP Leaders.

It is recognized that there is a need to treat cancer patients during a pandemic.[3] Resources may affect the capacity for centres to treat nearly as many patients as usual. Determining which patients will be treated may be necessary. It is also recognized that patients with cancer can be immunocompromised and therefore at a greater risk of infection with poorer outcomes.[1]

This is supplemental to general NSHA guidance and is specific to **adult** medical and radiation oncology and malignant hematology patients across the NSHA. This document does not address the needs of surgical oncology patients.

Please refer to all NSHA Covid-19 guidance.

Guidance for pediatric oncology and hematology patients will come from the IWK.

THIS GUIDANCE DOCUMENT WILL CONTINUE TO CHANGE AS NEW EVIDENCE BECOMES AVAILABLE.

GENERAL PRINCIPLES

1. The NSHA Cancer Care Program will continue to provide care and treatment to oncology patients as well as provide support for our front-line teams:
   - Cancer Site Team case conferences will continue. Case conferencing will be by Skype. No in person case conferencing will occur.
   - Processes to support discussion/decision making regarding exceptional status drug requests, and other drug-related issues will continue but may be modified.

2. Patients will be screened for COVID-19 according to NSHA guidance and NSHA Quick Reference Guide for Ambulatory Clinics,

3. For patients on active treatment who exhibit pandemic related symptoms or require self-isolation because of travel or contact with a confirmed patient, continuing treatment will be at the clinical judgment of the attending physician. Arrangements must be made prior to such visits to minimize exposure to other patients and staff.

4. To protect staff and other patients, follow NSHA Infection Prevention & Control (IPAC) Point of Care Risk Assessment and aerosol generating medical procedures guidance for those patients attending a clinic who have pandemic-related symptoms thought to be cancer-related or a treatment side effect, in case the patient does have an infection.[3,4]

5. Wherever possible, care that can be provided remotely (e.g. telephone, telehealth) should be provided remotely.[1]
   - Laptops with Real Presence software installed will be provided to physicians who are in self-isolation to support virtual care clinics.
   - Tele-oncology visits are preferred where possible.
   - Whenever possible and appropriate, toxicity assessments will be done by telephone.

6. All group teaching/education sessions are suspended until further notice.
   - Patients newly starting systemic therapy can be directed to online learning modules and/or provided with one-on-one teaching with an oncology nurse.

7. All volunteer programs will be suspended until further notice.
   - Support rooms are closed.

8. Patients will be contacted the day before their scheduled appointment and screened for 'pandemic-related symptoms' using the Pre-Screen Assessment Tool.[1,3]

9. A system to determine a priority for consultation and treatment of patients with cancer is necessary to have a consistent approach for all facilities across the province.

FOR ALL ONCOLOGY CLINICS AND PATIENTS

This section applies regardless of need for pandemic prioritization.

1. Teams will put processes in place to review patient lists and determine which patients can be managed by telephone, video, etc.[1]

2. All patients will be called prior to appointment to screen for possible COVID-19 infection/other infections using the Pre-Screen Assessment Tool.[1,3]
   2.1 The script for pre-screening assessment will be updated as required to reflect best evidence and recommendations.

3. Urgent referral to COVID-19 Assessment Centre will be arranged for any patients that meet the criteria for testing either during an in person or telephone assessment, including pre-screening assessment.

   3.1 For patients identified as requiring COVID-19 testing during a telephone assessment, fax referral form to the nearest COVID-19 Assessment Centre and request for Centre to contact patient with an appointment for screening.

   3.2 For patients identified as requiring COVID-19 testing while in the clinic:

      3.2.1. Provide patient with a surgical mask, instruct to clean their hands and place in a room with the door shut.
      3.2.2. Call the nearest COVID-19 Assessment Centre to arrange an appointment and fax referral form.
      3.2.3. Once the patient leaves the clinic, contact housekeeping to complete a terminal clean of the room.

   3.3 Treating oncologist to be informed that patient has been referred for urgent COVID-19 testing.

   3.4 Patients will be instructed to self-isolate until test results are known. When test results are known (positive or negative), patient to contact cancer team to assist in planning their care.

IN THE EVENT PANDEMIC PRIORITIZATION IS REQUIRED, THE FOLLOWING PATIENT PRIORITIZATION GUIDELINES WILL BE IMPLEMENTED.

PATIENT PRIORITY STRATIFICATION

Priority 1[2,3]

- Curative intent treatment will be the highest priority to be maintained during the pandemic.
- Treatment that is ongoing, should proceed uninterrupted, wherever possible, particularly those treatments associated with survival improvement or where symptom control is the goal.
- Patients requiring imminent intervention in order to prevent life or limb threatening clinical deterioration and suffering.
- Patients who may have a suspected diagnosis that has the potential to be life threatening, are clinically unstable or have intolerable suffering, including:
    - Rapidly progressing tumours such as brain, acute leukemia, aggressive lymphomas, cervical cancers, anal cancers and most head and neck cancers require assessment. Such patients may have priority for ambulatory radiation or chemotherapy if their cancer is potentially curable.
    - Spinal cord compression requiring emergency MRI and radiation oncology consultation and ongoing symptom management.
    - SVC syndrome, requiring radiation oncology consultation.
    - Septic shock.
    - Acute and massive GI bleed or hemoptysis – requiring aggressive analgesic and anxiolytic admission, possible investigation to identify source of bleeding, possible radiation oncology consultation depending on site and etiology of the bleed.
    - Acute pain crisis – requiring assessment to determine etiology of acute pain and initiate appropriate pain control measures.
    - New onset, acute delirium – probably requiring assessment of patient to determine etiology and appropriate treatment of delirium.
    - Acute, new onset or progressive dyspnea – requiring assessment; depending on etiology and performance status, the patient may need radiation, thoracentesis, chest tube drainage, possibly pleurodesis, and possibly palliative chemotherapy, or, if intervention is not appropriate or possible, then symptomatic management of dyspnea will be needed.
    - Malignant bowel obstruction or bowel perforation – requiring assessment and alleviation of acute symptoms, may need radiology services, and may need NGT decompression of G-tube or surgical procedure.
    - Metabolic crisis assessment and care for hypo- and hypercalcemia.
    - Pathologic fractures of an anatomical location requiring orthopedic assessment regarding fracture stabilization, radiation oncology consultation, and ongoing pain management.

Priority 2[2,3]

- Patients who require services/treatment (including supportive care, psychosocial and toxicity management) but whose situation is deemed non-critical (no unbearable suffering, patient is stable and condition is not immediately life threatening).
- Treatment could be discontinued or transferred to community for 6-8 weeks.
- **Whenever possible, consultations occur by telephone or via telemedicine to avoid patients having to come into the cancer centre.**

Priority 3[2,3]

- Patients who are generally healthy whose condition is deemed as non-life threatening where the service can be delayed without anticipated change in outcome.

NEW PATIENTS[2,3]

- New patient intake and triage should continue for cancer patients in the ambulatory care setting, *subject to increased disease transmission protection protocols,* including:
    - A revised new patient triage process for new patient referrals in the event pandemic prioritization be required. A process to review referrals to determine priority 1, 2 or 3 should be established.
    - Priority 1 patients should be contacted with an appointment.
    - Priority 2 patients should have a phone consultation to explain the process for appointments. Patients should be put on a list and informed that they will be contacted again for an appointment when it becomes safe to do so. Provide the patient with a number to call if the clinical condition changes.
    - Priority 3 patients will not be accepted at this time.
    - COVID-19 screening criteria should be completed prior to first patient visit.

- Clinics need a process to regularly reassess patients who have been waiting for initial consult, to determine whether it is appropriate to continue to wait for consultation and make informed triage decisions.

FOR SYMPTOMATIC PATIENTS

1. Patient presents with fever and/or cough but not recent travel or exposure history
   1.1. Decision to proceed with treatment up to the discretion of treating oncologist.
   1.2. To protect staff and other patients, these patients should be put on droplet and contact precautions. Follow NSHA IPAC Point of Care Risk Assessment and aerosol generating medical procedures guidance for those patients

2. **For patients who meet testing criteria for COVID-19, all treatment will be on hold pending test results unless it is deemed to be a life-threatening situation**.[3]

   2.1. **If negative**: proceed as per standard oncology principles.

   2.2. **If positive:**

      2.2.1. Curative/significant prolongation of survival intent treatment or significant expectation of improved quality of life: careful risk-benefit analysis of urgency of treatment initiation versus treatment delay with close monitoring of condition and consideration of treatment when asymptomatic. Consider age and risk of severe COVID-19- related complications.

         2.2.1.1. To protect staff and other patients, follow NSHA IPAC Point of Care Risk Assessment and aerosol generating medical procedures guidance for those patients attending a clinic who have pandemic-related symptoms in case the patient does have an infection.

      2.2.2. Palliative intent treatment: reassess after 14 days self-isolation.

FOR ASYMPTOMATIC PATIENTS

1. **Asymptomatic patients who have traveled outside Nova Scotia within the past 14 days or who have been exposed to someone who has tested positive for COVID-19**:

   1.1. Curative/significant prolongation of survival intent treatment or significant expectation of improved quality of life: proceed as per standard oncology principles.

      1.1.1 Place patient on droplet precautions and ask to wear a mask as per IPAC recommendation.

   1.2. Palliative-intent treatment: delay treatment until 14 days of self-isolation is complete. Patient should contact their clinical team if they develop pandemic-related symptoms.

2. **Asymptomatic with family members/co-workers who have traveled outside of Nova Scotia:** proceed as per standard oncology principles for all patients regardless of treatment intent.
    2.1. Advise patient to maintain distance from any individual with a recent travel history.
    2.2. Advise patient to self-monitor for symptoms, including taking temperature twice daily (morning and night) to ensure it's not >38°C and assess for development of cough, shortness of breath, or other symptoms including fatigue, muscle aches, headache and sore throat.[5]

TREATMENT-SPECIFIC ADJUSTMENTS

Systemic Therapy Adjustments

1. Bisphosphonate:
    - All bisphosphonate treatment for adjuvant breast cancer is delayed until further notice.
    - Bisphosphonate treatment for multiple myeloma will move to once every 3 month schedule unless the patient is coming for systemic therapy more frequently.
    - All bisphosphonate treatment for bone metastases being delivered on a monthly schedule will be changed to once every 3 month schedule or delayed until further notice.
    - Bisphosphonate treatment for hypercalcemia will not be delayed.

2. Telephone toxicity assessments can be done for more than one cycle of systemic therapy. The oncologist-primary nurse team will determine how many sequential telephone toxicity assessments can be performed for each patient. Policy Statement 4 CL-ON-001 Toxicity Assessment by Telephone for Patients Receiving Chemotherapy for Cancer is suspended until further notice.
    - These will be recorded in OPIS as PHONE visits (not TELTOX).

3. All non-urgent appointments including non-treatment decision appointments (e.g. scan review, endocrine therapy review for breast/prostate cancer, long-term follow-up, etc.) will be changed to telephone appointments or delayed until further notice.

4. For patients followed by Gynecologic Oncology, only new patients and those on active treatment will be seen.

5. All patients on systemic therapy who have been given a yellow or orange alert card will also be given a COVID-19 Pandemic Instructions for Cancer Patients on Active Treatment card (see Appendix) at their first face to face appointment.

Radiation Oncology

1. Regular review clinics are suspended. Only patients with concerns, symptoms or side effects will be seen.[1]

2. It should be possible to determine, at the time of consultation, whether the risks of the pandemic infection outweigh the risks of delaying treatment for that individual patient. It should be noted that a delay in instituting radiation treatment should be as short as possible. Evidence suggests that there is no safe delay period, so the decision rests on an assessment of relative risks for an individual patient.[3]

PATIENTS WITH FEVER OR OTHER SYMPTOMS OF INFECTION

1. Patients with a fever (suspected febrile neutropenia) who have received a Yellow or Orange Alert Card should still present to the nearest Emergency Department for assessment.

2. Patients with a fever without a Yellow or Orange Alert Card should call the cancer clinic during regular clinic hours for a telephone assessment with the clinic team to direct the patient to an Emergency Department or a COVID-19 Assessment Centre.

COMMON AREAS (e.g. waiting rooms)

1. To minimize number of people in waiting rooms, patients will be instructed during the pre-screening call not to report to cancer centre until their appointment time.
    1.1. Instruct Full Bladder/Empty Rectum patients to do their voiding/drinking prior to arriving for their appointment.

2. Recognizing the fine balance between the real needs for emotional support and the implications of spreading COVID-19 in our treatment areas to vulnerable patients, the following visitor/companion policy will be implemented at 0800 Tuesday March 24.

    Except under exceptional circumstances (e.g. mobility concerns, substitute decision maker in place, etc.) patients must attend appointments alone as per NSHA guidelines.[4]

    2.1. Inpatients
    We are encouraging the family members of cancer patients to adhere to the no-visitor restriction. If a patient has unique physical, emotional or cognitive complexity we will make an exception and allow 1 visitor to be present.

    2.2. Treatment
    We are not permitting companions in the treatment venues, as the physical layout makes social distancing difficult and the vast majority of patients are immunocompromised.

    2.3. Ambulatory clinics

In keeping with cancer centers across Canada, the NSHA cancer care program will permit patients who are having their first appointment to bring 1 companion with them.

We will also be giving the option to join in via phone/facetime should companions not wish to enter the facility. For subsequent clinic visits, we are asking patients respect the no visitor restriction but will make exceptions if the patient has unique physical, emotional or cognitive complexity impacting their ability to attend alone."

3. Seat patients at least 2 metres (6 feet) apart from other people in waiting rooms and treatment areas.

4. Wipe down chairs between patients.

5. Remove loose, shared items including patient brochures and tablets and any food and drink from waiting rooms.

6. Clean and disinfect work areas, including keyboards, frequently as per NSHA guidance.

SUPPORTIVE/PSYCHOSOCIAL CARE:

Canadian Cancer Society Services (CCS)

1. Suspended Services:
    - All in person CCS programs are suspended until further notice, including hosting of support groups.
    - The CCS Wig Bank and Breast Prosthesis Services are suspended until further notice.

2. Online self-care support programs will continue to run, visit: https://wellspring.ca/nova-scotia/

Lodging

1. The Lodge that Gives (Halifax):
    - Has implemented new screening protocols which will be used as part of admission process including an admission form, intake phone call and at check in.
        - Patients that respond "yes" to any of the screening questions will be denied accommodation unless a doctor's note clearing them is supplied.
    - NSHA staff/physicians should alert the CCS of any changes to the health of those patients who are staying at the Lodge that Gives

2. Point Pleasant Lodge (Halifax)/Atlantica Hotel:
   Point Pleasant Lodge (PPL) is closed from Friday March 20th until March 31st at the earliest. Alternate arrangements for patients who would have met the criteria for PPL have been made with The Atlantica Hotel for patients to stay at no cost for their accommodation.
   - All requests for NSHA covered accommodations at the Atlantica Hotel are to be sent to Belinda Riles Belinda.riles@nshealth.ca with the following information.
     - Name
     - Companion name if applicable
     - Address
     - Phone number
     - Check in date
     - Check out date
     - Any special accommodations req'd
     - Service/Care Area contact

   - Parking is free at the hotel and the Casino Taxi service is also available for free for back and forth to the hospital.

   - Meal vouchers (where applicable) will be provided to be used at the QEII cafeterias. These cannot be used at the Atlantica.

3. Holy Redeemer (Sydney):
   - Holy Redeemer is closed from Friday March 20th. Patients will be transferred to the Holiday Inn, Sydney. Shuttles are no longer running. Meals are being arranged for patients.

References

1. American Society of Clinical Oncology. COVID-19 clinical oncology frequently asked questions. March 12, 2020.
2. Cancer Control Alberta. Pandemic Planning Clinical Guidelines for Patients with Cancer. March 17, 2020
3. Ontario Health Cancer Care Ontario. Pandemic planning clinical guideline for patients with cancer. March 10, 2020.
4. Nova Scotia Health Authority. Coronavirus Disease (COVID-19) Updates. Retrieved from: https://intra.nshealth.ca/SitePages/coronavirus-update.aspx
5. Public Health Agency of Canada. Know the Difference: Self-monitoring, self-isolation and isolation for COVID-19. Retrieved from: https://www.canada.ca/content/dam/phac-aspc/documents/services/publications/diseases-conditions/know-difference-self-monitoring-isolation-covid-19/know-difference-self-monitoring-isolation-covid-19-eng.pdf

6. BC Cancer Agency. COVID-19 and cancer treatments- information for patients. March 22, 2020. Retrieved from: http://www.bccancer.bc.ca/about/news-stories/news/2020/covid-19-and-cancer-treatments