This Consolidated Technical Report aims to provide information to the Committee of Defense of the Rights of the Elderly of the Federal Chamber of Deputies in the emergency coping of the Covid-19 pandemic, with a focus on long-term care facilities for the elderly.

NATIONAL FRONT TO STRENGTHEN THE LONG-TERM CARE INSTITUTIONS FOR THE ELDERLY

FN-ILPI, an urgent action!

Brasília, April 2020

WORK GROUPS / COORDINATION	PARTICIPANTS	SUMMARY
General Coordination	Karla Cristina Giacomin (Minas Gerais)	
GROUP 1: CONTAGION PREVENTION AND EARLY DETECTION Silvana Poltronieri Lamers (Rio Grande do Sul)	Alda do Socorro Morais Lima (Pará) Cristina de Lima (Rio de Janeiro) Cristiane dos Santos Rosa (Rio de Janeiro) Elizabeth Moura Soares de Souza (Alagoas) Felipe Willer de Araújo Abreu Junior (MG) Glécio Sandro Silva (Maranhão) João Toniolo Neto (São Paulo) Lis Alecrim (Distrito Federal) Márcia Caldas Reis (Rio de Janeiro) Maria Onete Feliz Fonseca da Silva (Pará) Natalia de Cássia Horta (Minas Gerais) Romulo Delvalle (Rio de Janeiro) Silvana Melro Devillart (Rio de Janeiro) Tânia Patrícia Costa (Minas Gerais)	Provide guidelines on contagion prevention in institutions for residents, professionals, and visitors. Identify signs and symptoms related to flu-like syndrome; Suggest instruments to detect and monitor the severity of the cases; Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).
Group 2 COMMUNICATION WITH FAMILY MEMBERS Marisa Acioly (São Paulo)	Crismédio Vieira Costa Neto (Alagoas) Cristina Lima (Rio de Janeiro) Daniella Nunes (São Paulo) Michele Falcão (Amazonas) Mônica Barbosa Pacheco (Minas Gerais) Nadir Menezes Silva (São Paulo) Silvana Melro Devillart (Rio de Janeiro) Vania Beatriz Merlotti Herédia (Rio Grande do Sul) Vicente de Paula Faleiros (Distrito Federal)	Provide guidelines as to the need and ways of maintaining contact with residents and teams at the LTCF during the pandemic. Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).
GROUP 3: DEALING WITH SUSPECTED CASES WITHIN THE LTCF Cristina Hoffmann (Distrito Federal)	Albamaria P de C Abigalil (Distrito Federal) Aletea Ferreira Prado de Figueiredo (Minas Gerais) Ana Paula Moura de Melo Silva (Alagoas) Celene Mirtes Alves Mendes (Pará) Cristiane dos Santos Rosa (Rio de Janeiro) João Bastos Freire Neto (Ceará) Maria Cristina Corrêa Lopes Hoffmann (Distrito Federal) Dilma Miranda Lobato (Pará) Lucimar de Souza Campos (Rio de Janeiro) Roberta Viegas Magalhães (Minas Gerais) Romulo Delvalle (Rio de Janeiro)	Provide guidelines for notification of suspected cases - residents, professionals, or visitors; Suggest instruments to detect and monitor the severity of the cases; Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).
GROUP 4: DEFINITION OF THERAPEUTIC FUNCTIONALITY AND PROPORTIONALITY Walquiria Cristina Batista Alves (Pará)	Aline Fatima Alves Teixeira Pacheco (Minas Gerais) Bárbara Gazolla de Macedo (Minas Gerais) Gisela Gonçalves de Figueiredo(RJ) Karina Silveira de Almeida Hammerschmidt (Paraná) Marco Aurélio Ferreira Lopes (São Paulo) Michele Bertoglio Clos (Rio Grande do Sul) Mônica Barbosa Pacheco (Minas Gerais) Raphaella Santos Loureiro (Pará) Rodrigo Caetano Arantes (Minas Gerais) Rosimere Ferreira Santana (Rio de Janeiro) Walquiria Cristina Batista Alves (Pará)	Provide guidance to the teams as to the functionality of the residents and suggest instruments and criteria to help with therapeutic proportionality Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).

WORK GROUPS / COORDINATION	PARTICIPANTS	SUMMARY
GROUP 5: PALLIATIVE CARE Juliana Elias Duarte (Minas Gerais)	Daiane de Souza Fernandes (Pará) Fabia Maria de Lima (Pernambuco) Juliana Elias Duarte (Minas Gerais) Lígia Py (Rio de Janeiro) Maria Betânia de Jatobá de Almeida (Alagoas) Mariana Brandão de Azevedo (Minas Gerais) Mônica Barbosa Pacheco (Minas Gerais) Rosalina A Partezani Rodrigues (São Paulo)	Provide guidance to the teams related to: the concept, criteria for indication and how to deal with terminal illnesses in LTCF. Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).
GROUP 6: CRITERIA FOR REMOVAL AND RETURN TO THE INSTITUTION Virgílio Garcia Moreira (Rio de Janeiro)	Cláudio Stucchi (São Paulo) Guilherme Coen (Rio de Janeiro) Helena Akemi Wada Watanabe (São Paulo) Maria José D'Elboux (São Paulo) Raphaella Santos Loureiro (Pará) Sérgio Márcio Pacheco Paschoal (São Paulo) Virgílio Garcia Moreira (Rio de Janeiro) Yeda Aparecida de Oliveira Duarte (São Paulo)	Provide guidance to the teams regarding: criteria for removal of residents (when, why, how, where to) and on the safe return to the LTCF. Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).
GROUP 7:ACTIONS IN CASE OF SUSPECTED COVID DEATHS IN THE LTCF Marília Anselmo Viana da Silva Berzins (São Paulo)	Douglas Alexandre da Silva (Minas Gerais) Elisabeth Toledo de Lima (Alagoas) Marília Anselmo Viana da Silva Berzins (São Paulo) Rodrigo Caetano Arantes (Minas Gerais) Walquiria Cristina Batista Alves (Pará)	Provide guidance to the teams as to the actions before the Health System, Social Services. Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).
GROUP 08: PROFESSIONAL BEST PRACTICES Rosalina A Partezani Rodrigues (São Paulo)	Albamaria Abigail (Distrito Federal) Andréa Maria Duarte Vargas (Minas Gerais) Fernanda E. Gimenes (São Paulo) Jack Roberto S. Fhon (São Paulo) Katia Stancato (São Paulo) Jurilza Maria Barros de Mendonça (Distrito Federal) Luciana Amorim de Santana Mota (Goiás) Luciana Kusumota (São Paulo) Maria Cavalcante Vicente (Distrito Federal) Maria Lucia Secoti Filizola (São Paulo) Ráisa Camilo Ferreira (São Paulo) Renata Cristina Reis (São Paulo) Rosalina A.P. Rodrigues (São Paulo) Sandra Rabello de Frias (Rio de Janeiro)	Provide guidance to the teams regarding the safety of the residents, family members, professionals, and visitors; Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).

GROUP 09: LEGAL ISSUES RELATED TO LTCF **Cláudio Stucchi (São Paulo)**	Alexandre de Oliveira Alcântara (Ceará) Ana Lúcia da Silva (Distrito Federal) Anna Carolina Mondillo (São Paulo) Cláudio Stucchi (São Paulo) Cristiane Branquinho Lucas (Rio de Janeiro) Elaine Carvalho Castelo Branco (Pará) José Araújo da Silva (Paraná) José Augusto Cutrim Gomes (Maranhão) Leandro Reis Nunes (Rio de Janeiro) Marcela Giovanna Nascimento de Souza (Minas Gerais) Márcio José da Silva (Paraná) Paulo Roberto Hilel da Costa Tourinho (Minas Gerais)	Provide guidance to the teams regarding legal issues that may occur during the pandemic, especially: advanced directives; access to financial resources; need for hospitalization, and death; Suggest action protocols to be followed at long-term care facilities (hereinafter referred to simply as LTCF).

Summary

DEDICATION

This National Front to Strengthen Long-Term Care Institutions for the Elderly - "FN-ILPI - dedicates this Report to the people that spend or have spent their lives fighting to ensure the integrity and integral care of the elderly.

Tomiko Born, whose name means beauty and simple purity, is the source of knowledge and restlessness that impels us to take a generous look at the LTCFs and teaches us go within ourselves and let creative study, keen criticism, and fearless action flow from within each one of us to deal with what is ponderable and the imponderable in old age that inhabits houses other than our homes.

Maria da Penha Silva Franco ***(in memoria)***, who crafted the National Policy for the Elderly, is the comet whose infinite trail we longingly admire for her brilliance, vigor of obstinate management, her hearty laughter, and her suffering indignation at the neglect of the elderly.

Renato Maia Guimarães ***(in memoria)***, of overflowing talents such as intelligence, creativity, leadership, elegance, good humor, crowned by the surprising courage expressed in the determination to never succumb to physical limitations, who leaves us an eternal legacy of the quest for the purpose of life.

To you, our eternal gratitude.

INTRODUCTION

Considering the Inter-American Convention on the Protection of the Human Rights of the Elderly, as well as the United Nations Principles for the Elderly (1991), the Proclamation on Aging (1992), the Political Declaration and the Madrid International Plan of Action on Aging (2002), as well as regional instruments, such as the Regional Implementation Strategy for Latin America and the Caribbean of the Plan of Action -3 - Madrid International on Aging (2003), the Brasilia Declaration (2007), the Pan American Health Organization's Action Plan on the Health of the Elderly, Including Active and Healthy Aging (2009), the Declaration of Commitment of Port of Spain (2009) and the San José Charter on the Rights of the Elderly in Latin America and the Caribbean (2012); World Report on Aging and Health (2015) and all the Brazilian legislation that ensures the Network of Prevention, Assistance and Health Promotion Services for the Elderly and that, in an emergency, needs to be articulated, to adopt training and capacity building measures for the Network Services aimed at the Elderly, to prevent and face the consequences caused by the pandemic of the new corona virus;

Considering the transmission and lethality rates of Covid-19 in the elderly population in Brazil and in the world;

Whereas the Covid-19 pandemic may lead to the neglect and abandonment of those most vulnerable;

Whereas the institutionalized elderly population is even more vulnerable to biological agents such as the virus that causes Covid-19 due to the level of fragility and comorbidities due to chronic illness;

Whereas there is a need to offer integral care to this population, including palliative care;

Whereas the elderly population residing in Long-Term Care Facilities for the Elderly (LTCF), accredited before SUS (the Brazilian Unified Health System) is of around 78,000 people, and the total number of institutionalized people, if the index of 1% of the overall elderly population is maintained, should reach around 300,000 Brazilians;

Given the connection of the LTCFs to the National Policy of Social Assistance;

Whereas it is not mandatory for there to be health professionals working at the LTCFs;

Considering the scarcity of financial resources in philanthropic LTCFs, and even among some private institutions that cater to underprivileged populations;

Considering the standards issued by Social Assistance and Healthcare agencies, and Scientific Societies;

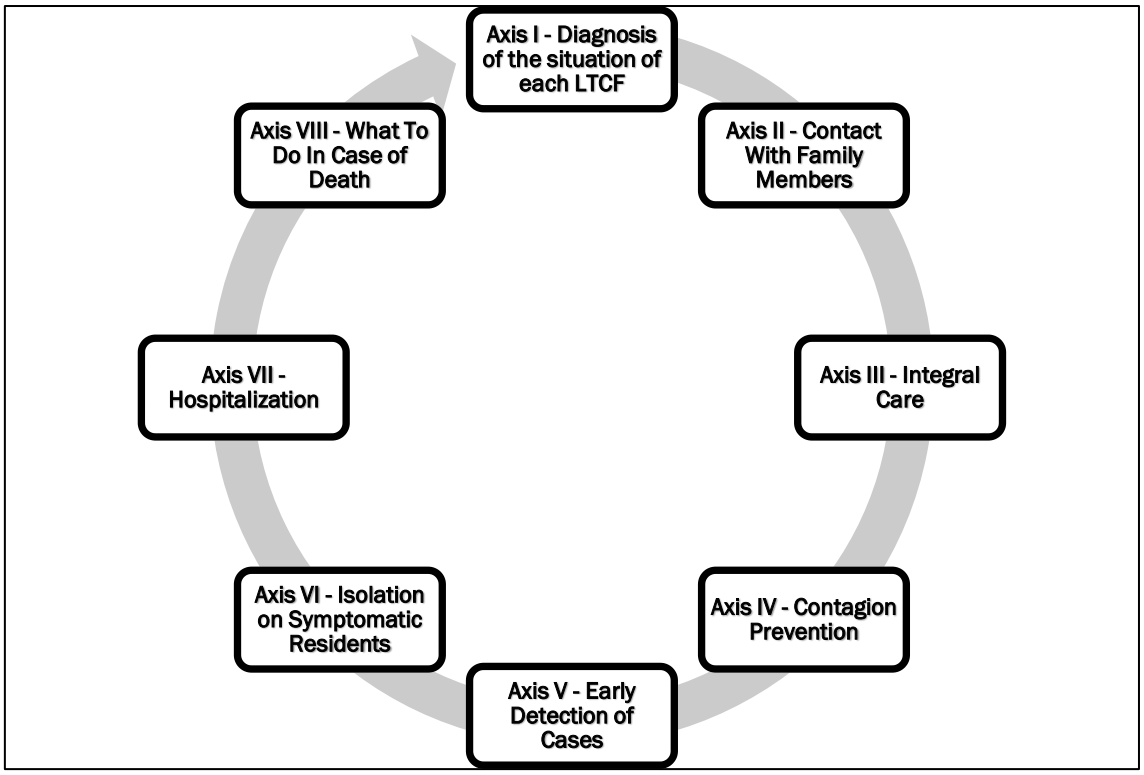
Whereas on April 7, 2020, the Committee of Defense of the Rights of the Elderly of the Chamber of Deputies held a Public Hearing on April 7, 2020;

Whereas to respect the fundamental right to life, there is absolute need to minimize the contagion and dissemination of Covid-19 among residents, professionals, and caregivers at LTCFs, some participants in the conference call held by the Chamber of Deputies on April 7, 2020 organized themselves into working groups to propose emergency guidelines and their respective financing for public managers, society, the councils for the defense of the rights of the elderly, public policy councils, professional class bodies, maintainers, owners, professionals, family members and residents of LTCFs.

This document, thus, aims to provide information to the Committee of Defense of the Rights of the Elderly of the Federal Chamber of Deputies in the emergency coping of the Covid-19 pandemic, with a focus on long-term care facilities for the elderly.

It is divided into sections that include the different lines of action of the long-term care facilities in coping with Covid-19 (Figure 1), followed by other sections: Summary of Best Practices in LTCF, Legal Issues of Interest, and Funding.

Figure 1 - Lines of Action of Long-Term Care Facilities in coping with Covid-19



We hope that it is considered when making decisions at this moment that asks for all to be solidary and responsible towards the population that is the most vulnerable to COVID-19: institutionalized elderly people.

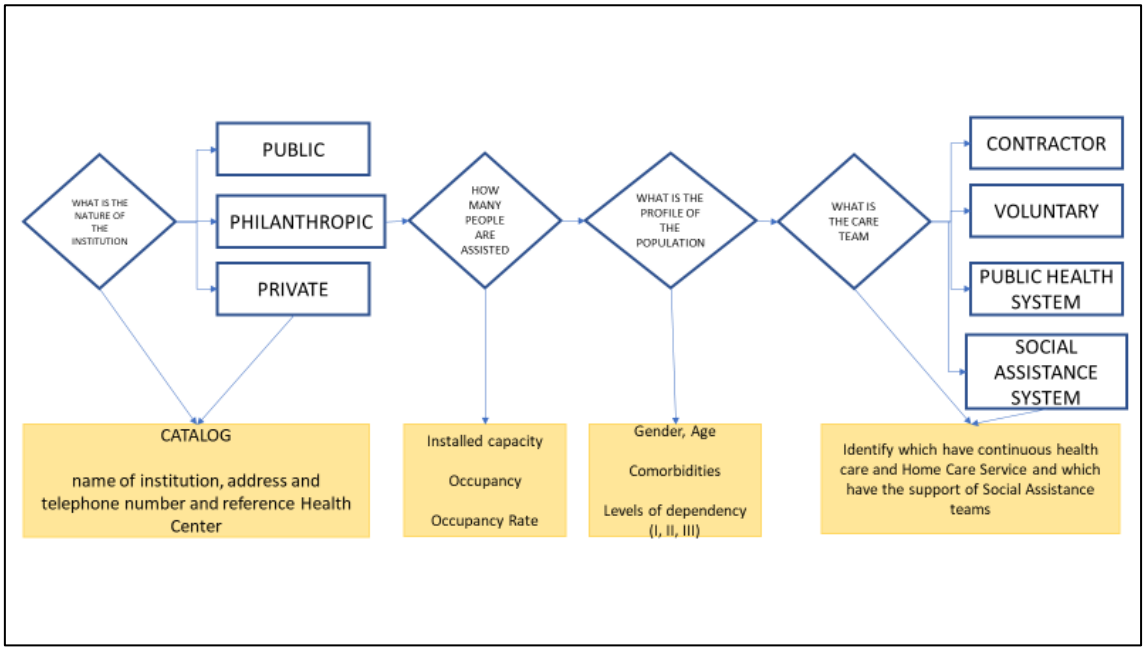
NATIONAL FRONT TO STRENGTHEN THE LONG-TERM CARE INSTITUTIONS FOR THE ELDERLY

AXIS I - DIAGNOSIS OF THE SITUATION

It is recommended that the City Committee for the Rights of the Elderly, where such committees exist, or the City Councils for Social Assistance and Municipal Health Inspection, throughout all of Brazil, carry out an active survey with LTCFs regarding their needs and resources through the application of a questionnaire, as per Appendix I.

We recommend knowing effectively where they are, what is the assisted population, what are the services offered, and what human resources each LTCF can count on (Figure 2).

Figure 2- Situational Diagnosis of Long-Term Care Facilities for the Elderly



The purpose is to:

a) Identify ALL public, philanthropic, and private long-term care facilities or residences for the elderly throughout Brazil;

b) Know the profile of the residents regarding gender, age, comorbidities presented, degree of functionality (if they are independent, partially dependent ,or totally dependent) and legal guardian, as the case may be;

c) Verify the necessary Covid-19 prevention measures in each of these institutions;

d) To know the assisted population in terms of functionality and definition of therapeutic proportionality, which will subsidize the formal indication of palliative care in case of acute health problems (e.g. a Covid-19 infection);

e) Know the resources available and accessible the Unified Social Assistance System (SUAS) and the Unified Health System (SUS) of reference of each institution, including the Home Care Service ("Best at Home" project of the federal

government), to offer training in geriatric and palliative care to these institutions, via videoconference.

f) Provide tools for functional assessment of the elderly and suggestions for therapeutic proportionality in cases of severe Covid-19 infections;

g) Promote basic Covid-19 preventive actions in these institutions;

h) In suspected or confirmed cases of residents of these institutions, provide appropriate health treatment according to the functionality of each individual, as well as the definition of therapeutic proportionality that should be provided to each of them, preferably in the LTCF (if possible) in partnership with local Home Care Services.

A suggested questionnaire to be applied to the LTCF is available in Exhibit I.

Axis II - CONTACT WITH FAMILY MEMBERS

Elderly people with different social relationships and family arrangements reside in the LTCFs. This document is based on the Brazilian Federal Constitution (1988), which underlies the National Policy for the Elderly (1994), and the Statute for the Elderly (2003).

All ties must be preserved to ensure the health and well-being of all elderly people. Elderly people with active family ties suffer greatly from social distancing, lack of human warmth and affection from their relatives.

It is extremely necessary, in this time of pandemic, to protect the most vulnerable people who are part of a high-risk group. Therefore, we recommend suspending external visits to LTCFs, including family and friends. The LTCF must inform all its means of communication: telephone number, social media, among others, to maintain an active, engaged, social network that is very concerned with their loved ones and thinking about the welfare of the elderly, and we reiterate the pressing need for contacts with:

- Families of residents, who have good relationship ties;

- Families, without active ties, with distant relationships or abandonment;

- Elderly people with no family members and with a legal guardian;

- Elderly people with extended family network, social support network made up of friends, neighbors, people from the community (volunteers, neighborhood associations, support groups, among others).

The institutions should also:

- Keep residents informed at all times about the Covid-19 measures adopted, explaining such measures to prevent the spread of the virus;

- Promote contact with family and friends of residents, using the available means of communication;

- Promote measures to minimize harmful emotional issues arising from social distancing, mitigating the longing for family and friends.

In this sense, some activities may bring joy and well-being to the residents:

a) First, all employees of the institution should talk lovingly with the elderly, to listen and cater to their demands;
b) Promote clear and objective written communication to family members about the pandemic and the need to restrict visits. (by email or instant messaging app);
c) Create an instant messaging group that includes family members of residents, and the Social Worker or other qualified professional to exchange daily information, as well as messages and videos;
d) Encourage the institution's volunteers to send videos in which they sing, tell stories, and pass on messages of encouragement;
e) Promote meetings with small groups, maintaining the minimum distances required, for small lectures on COVID-19.

AXIS III - INTEGRAL CARE

Covid-19 requires an adequate response from the infected organism, which is causally related to the functional capacity, indicator of the vitality of an elderly person. The greater number of comorbidities present and the degree of functional dependence, the greater the chance of unfavorable outcomes. That is why the first part of care is to assume all health promotion and preventive measures also in the institutionalized population.

In the context of Covid-19, considering the need for social distancing and restriction of visits to LTCFs, actions to promote health and prevent aggravation should be promoted amongst the residents, such as
- Encouraging them to practice physical exercise;
- Holding collective socialization activities, with the caveat of respecting the recommended physical distance, if the group activities cannot be cancelled;
- Promoting healthy eating and habits;
- Prevention of communicable diseases (such as sexually transmitted infections and pneumococcal diseases);
- Prevention and control of non-communicable diseases (such as diabetes mellitus and hypertension), as well as
- Control of chronic medication.

Together, these actions aim to preserve functionality, seeking to prevent the worsening of conditions or the establishment of chronic conditions that may cause decline or compromise the autonomy and independence of elderly people.

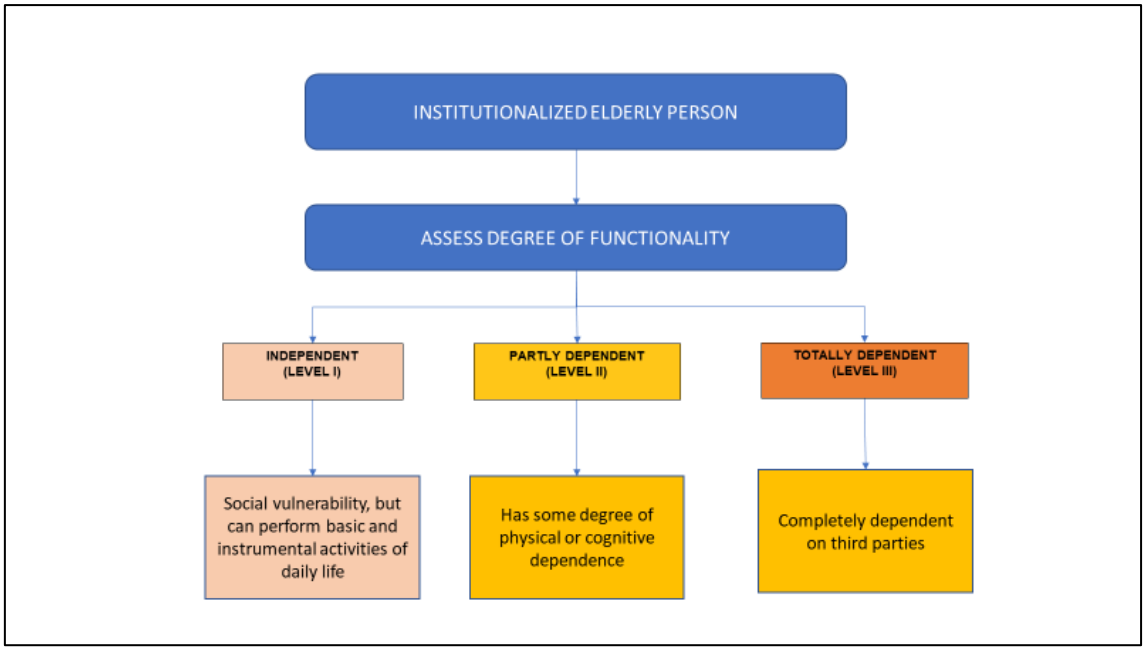
Knowing the residents' functionality is part of the health condition assessment process and will help in the definition of coping strategies, prevention, and proportional treatment, in case of Covid-19. Different functional evaluation tools are available. The Ministry of Health offers the “Elderly Person’s Health Booklet” to identify the risks of fragility and to monitor the clinical and social vulnerability of

residents. Other instruments such as the Mini-Mental State Exam (MMSE), the Timed Up and Go Mobility Test (TUG), the Katz Index of Independence in Activities of Daily Living (ADL), and fragility assessment (such as the Clinical Fragility Scale) are also useful in this process.

RDC 283/2005, which regulates the operating standards, defines three degrees of functional dependence of institutionalized elderly people (Figure 4). However, the differentiation proposed in RDC 283/2005 presents a gap in the differentiation between Grade II, in which the person is dependent for up to 3 ADL, and Grade III, in which the person is already dependent for all activities.

In this sense, it is recommended that LTCF professionals conduct an individualized multidimensional assessment of each resident, according to the availability and training of the team of professionals.

Figure 3 - Diagram to evaluate the degree of functionality, according to RDC 283/2005 - Anvisa.



Where: ***ACTIVITIES OF DAILY LIVING (ADL)**: can eat alone, bathe, dress, go to the bathroom alone, walk, transfer themselves without help, go to and get out of bed without help.

INSTRUMENTAL ACTIVITIES OF DAILY LIVING (IADL): can use the telephone, shop, prepare meals, use transportation by themselves, take and manage their medications, manage their financial resources without help.

Some activities are proposed in Figure 4 to reduce the negative impact of social distancing, according to the degree of functionality of the elderly person.

Figure 4 - Suggestion to reduce the negative impact of social distancing, according to the degree of functionality of the elderly person.

DEGREE OF FUNCTIONALITY:	DESCRIPTION	PROPOSED ACTIVITIES
Level I (independent)	Elderly people that walk and/or with preserved cognition	- Encourage a healthy lifestyle by avoiding sedentary behavior. Encourage physical activities such as getting up from the chair/sofa every 2 or 3 hours, taking a walk after meals (15 minutes), etc. - Stretching in small groups of no more than 4 people, maintaining a safe distance of at least 1.5m between residents; - Play music that has some identification with institutionalized elderly people (e.g. boleros, soap opera songs like Stupid Cupid - Celly Campello 1959); - Exposure to sunlight for at least 1 hour before 10 a.m. or after 4 p.m; - Stimulate walking and balance with short walks within the Institution, using masks; - Read books; - Ensure routine and leisure activities; - Promote intergenerational and social-family activities mediated by digital devices.
Level II (semi-dependent)	People in wheelchairs and with preserved cognition	- Groups of up to 4 seniors, keeping the recommended distance, with active exercises (self-execution); - Interventions with stimuli through music, smells, and taste; - Conversations on topics that stimulate memory and cognition; - Reading poems/stories; - Intergenerational and social-family activities mediated by digital devices. - Respiratory exercises; - Ludo therapy.
Level III (dependent)	Bedridden and without cognition preserved	- Musical and olfactory stimuli; - Simple exercises (effective and focused on ventilatory expansion); - The position in bed must favor lung work, moving to avoid decubitus ulcers, and mobilization of inferior limbs; when possible, sit up and sunbathe. - Lung diffusion protocol with positioning in bed (optimization of breathing).

In institutional care, the goal must be to preserve the best level of physical, cognitive, and mental health. Thus, alternatives for maintaining the relationships of the elderly should be prioritized, by making video calls and phone calls so that they can have conversations with relatives or caregivers.

The institutionalized population is vulnerable and the care team should prioritize attention to smokers, carriers of chronic-degenerative diseases (Parkinson's disease; Alzheimer's disease, and other types of dementia; rheumatoid arthritis and other osteoarticular diseases; renal failure; diabetes mellitus; hypertension, heart failure and other cardiovascular diseases).

In this sense, given the heterogeneity of human resources and care in the LTCFs throughout Brazil, it is essential to define criteria of care in the institution itself or for removal and safe return of the residents to their original unit to assist in the management and treatment of residents in situations of suspected or confirmed Covid-19 cases. Some objectives of care should be clear, as shown in Figure 5.

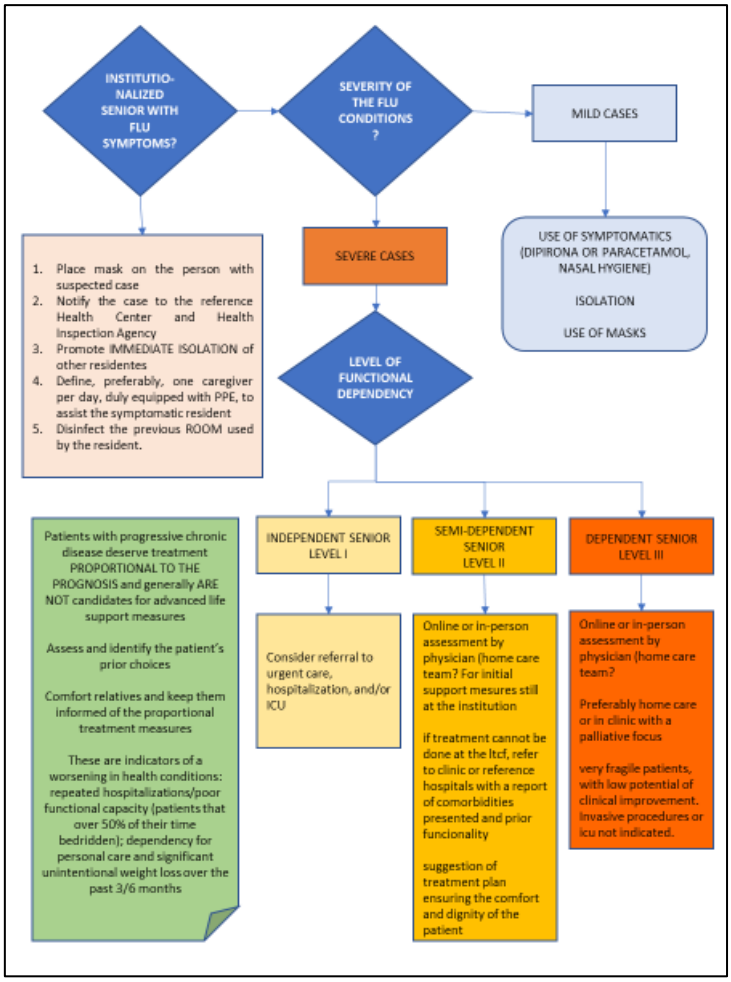
Figure 45 - Types of Cases and Objectives of Care

TYPE OF CASE	• OBJECTIVES OF CARE
Suspected Case	• Avoid contaminating other seniors and employees • Use all recommended personal protective equipment (PPE) • Promote the immediate isolation of the resident in a private room • Place mask on the resident • Notify suspected case to the local health authority
Positive Case	• Avoid contaminating other seniors and employees • Use all PPEs • Promote the immediate isolation of the resident in a private room • Notify confirmed case to the local health authority
Suspected Case or Positive Case of Light Severity	• Avoid contaminating other seniors and employees: Use all personal protective equipment (PPE) and reinforce social distancing and respiratory distancing for droplets. • Notify confirmed or suspected case to the local health authority • Use symptomatic medication to treat runny nose, cough, sore throat as long as there is no impairment of the resident's general condition.
Suspected Case or Positive Case of Clinical Severity	• Protection of life. • Avoid contaminating other seniors and employees: use all personal protective equipment (PPE) and reinforce social distancing and respiratory distancing for droplets. • Notify the local clinical authority (the LTCF's Physician) or Health Clinic ascribed to the LTCF. • Activate the Palliative Care Reference Team or the MDCT, if any, OR • Referral to the emergency clinical service by calling the Mobile Emergency Assistance Service ("SAMU").
In all cases	• Participation of family members in joint decisions.

Figure 6 presents a diagram with information and measures that may be appropriate to the reality of the various philanthropic and public institutions. In this context, for such actions to be effective, it is necessary to ensure that the LTCF has

the physical structure, human resources, equipment, and supplies (PPEs, drugs) to maintain isolation of the elderly with Covid-19 and to have agreed with the health authority of the territory the flowchart of referral of suspected and confirmed Covid-19 cases.

Figure 5- Diagram for management of suspected or confirmed cases, according to the degree of dependence and therapeutic proportionality.



Attention: Age cannot limit access to care. Always verify the existence of Advance Directives, but the decisions must be shared with the social assistance team and the legal guardian. The health system should offer ALL opportunities for invasive treatment and palliative care of the elderly, provided there is indication, integral care, and appropriate location, regardless of age.

However, in the integral care of frail seniors or those with multiple chronic morbidities with low potential for improvement in the face of this serious infection, the focus should be on therapeutic proportionality. This means offering to these individuals ALL possible treatments to ensure dignity, comfort, and flawless control of symptoms through access to palliative care.

Among the institutionalized elderly, the presence of conditions such as heart failure, pulmonary diseases, renal failure, cancer, and neurodegenerative syndromes (dementia syndromes) may compromise their independence, their ability to express themselves, and limit their autonomy.

Despite all these life-threatening situations, there is a lack of training for LTCF teams - caregivers, doctors, nurses, physical therapists, speech therapists, nutritionists, occupational therapists, physical educators, social workers, among others - related to the particularities of the elderly person's health and palliative care.

One of the fundamental stages of treatment is to establish at what stage of the illness the person is. In palliative care, defining the phase of the disease and the prognosis is what will direct the actions.

In the case of elderly people with dementia, with no capacity for verbal interaction, the conduct of professionals and caregivers should involve a warm approach, valuing comforting speech and delicate touch, to provide tranquility and confidence to the senior. Remember that soft music is a great resource.

Regarding Covid-19, the following symptoms may need to be managed during the course of the disease: dyspnea (shortness of breath); cough and hypersecretion; pain; fever; delirium; active process of death.

Also, considering that the patients in question are elderly people with chronic diseases and comorbidities, it may also be necessary to manage: intestinal constipation; convulsive crises; nausea and vomiting. For each of these symptoms, bibliographical references are presented (Annex II) which contain flowcharts on general comfort measures, specific measures, and drug treatment.

Finally, despite the use of appropriate treatment, there may be refractory symptoms, which in some cases will require palliative sedation measures.

Another essential care in the process of terminality is the care with the spiritual dimension of life. It is not about religion, but the feeling of transcendence. However, the first step is to be open to capturing the perception of the institutionalized person: the awareness of the approach of death, the fear of death, the capacity for interaction. Propose a review of that person’s life story: value their achievements and seek to understand the flaws and omissions. This approach can support the consequent disconnection from life to favor a path of gradual detachment, governed by the reality of death.

Try to help the elderly person resolve any outstanding issues, with special attention to reconciliations. Whenever possible, include the presence of relatives. Do not ever disregard hope:

> "Hope is made up by the fact that, in it, love is backed up by power. The one who is hoping, is betting, in some way that not even they understand well, that the values for which they live and die, in the present, will live, will resurrect, will be reborn... Thus hope is raised, daughter of power and love" - A free translation of Alves (1981, p. 115).

AXIS IV - CONTAGION PREVENTION

It is recommended to institute a *Standard Operating Procedure of Action for Control of Covid-19*, with the **purpose** of guiding the institutional community - staff, family members, and residents of the LTCF on the necessary control measures.

Executors: All LTCF staff.

Description of Activities:

1. **Receipt of materials**

Deliverers of materials or good must not enter the institution.

All materials must be delivered to the reception at a distance of 1 meter from the employee who receives them and, before storage, their packaging must be cleaned with alcohol 70% and the external packaging used for the delivery of the materials must be discarded.

2. **Guidelines for employees**

The person should enter the institution through the main entrance; after entering, the employee will go to the locker room, preferably through another door, if available, away from the elderly, going to the sink to wash their hands and changing their shoes and clothes in the locker room or taking a full shower when there is place for this (Figure 7).

Figure 6- Measures to take before, during, and after going to work at the LTCF

All caregivers and other professionals must wear a surgical mask while they are at the LTCF. The scrubs and shoes will be of exclusive use at the LTCF, and must not be used in any case to go out.

Suggestion: During the pandemic, colorful long-sleeved pajamas can be worn, which are easy to wash and can be left at the LTCF to be processed when the laundry finishes washing the residents' clothes.

3. Hand Washing

All LTCF areas must have available: sinks with liquid soap and paper towels and a full dispenser of 70% alcohol gel.

All caregivers should be trained in hand washing and application of 70% alcohol gel several times a day.

All elderly residents should be encouraged to wash their hands and receive alcohol gel in their hands every 2 hours, before meals, and after using the bathroom.

For this purpose, we recommend the available material prepared by the Ministry of Health on frequent hand hygiene to prevent the spread of the virus. [https://www.conasems.org.br/material-da-campanha-de-prevencao-ao-COVID-19/].

4. Barrier Measures

Application of carpets or cloths with 30% sodium hypochlorite solution (bleach) in all entrances to the home, especially when employees arrive.

5. Sanitization

Handles and wheelchair grips, handrails and walkways should be cleaned with a 70% liquid alcohol solution twice a day. The institution's coordination will appoint the people in charge of sanitization for both shifts.

6. General prevention.

Reinforcement in food and hydration, with greater supply of fruit.

Schedule Influenza and Pneumococcal vaccines in the calendar, and the Epidemiological Departments should **reduce bureaucracy and facilitate the application of Pneumo 23 in institutionalized elderly.**

Change the dynamics of meals, defining smaller groups of residents to go to the cafeteria at different times, to respect the distance of 1 to 2 meters between residents.

Put up informative posters throughout the LTCF on the importance of hygiene measures and distance.

AXIS V - EARLY DETECTION OF CASES

The manifestation of suspected cases in employees and elderly residents will be monitored by daily observation of their health status by the manager or by someone designated by them.

- Elderly people with chronic diseases should be monitored so that they remain compensated and should be considered a priority for immediate clinical evaluation;

- Flu symptoms: cough, runny nose, sneeze, sore throat;
- Other symptoms: vomiting or diarrhea;
- Beware of unusual warning signs such as: acute mental confusion, agitation, drowsiness, prostration, respiratory distress, absence of fever, difficulty in walking, falls, decreased food ingestion, dysphagia, incontinence, myalgia, malaise, headache, increased propensity to develop tachypnea - very rapid breathing;
- Tachypnea - very fast breathing is an early sign of respiratory infection in the elderly (RR > 24 bpm);
- Closer attention is required to check for a possible occurrence of loss of smell, considering the greater susceptibility to sensory deficit in the elderly;
- Many institutionalized elderly people have dementia, a history of stroke or other health problems that can mask the manifestations of COVID-19 infections;
- Probably higher incidence of delirium, as well as mental confusion. In the presence of infections, people with lower brain reserves such as the elderly with significant brain atrophy may result in epileptic seizures.

Any significant change in the clinical status relative to the baseline of elderly people with chronic diseases without immediate explanation may be caused by COVID-19.

If an individual is tested positive by RT-PCR or acute-phase immunoglobulin, testing the entire LTCF including its staff is recommended. New diagnostic tests may be performed and have their periodicity established according to the number of new cases in the institution.

Necessary Supplies:

- Oximetry (if the LTCF has an oximeter) values between 90% - 89% with respiratory distress (shortness of breath);

- Infrared body thermometer;

- Blood pressure monitor. Beware of lower BP values, suggestive of a more serious infection;

- Laboratory tests to confirm COVID-19.

AXIS VI - ISOLATION OF SYMPTOMATIC RESIDENTS

The symptomatic elderly person should wear a mask for 14 days of isolation and be installed in an airy room, preferably with a bathroom, to avoid circulation inside the LTCF.

Assistance of a trained employee is recommended - preferably assign the same person to look after the suspected case throughout the day. In the presence of any symptomatic resident, isolation measures should be reinforced, with little traffic in common environments, splitting up task times, reinforcement of social distancing, use of masks, increased hygiene, assessment of the clinical status of the symptomatic person and the resident population, with even greater attention.

Isolation outside the institution will take place if there is a backup hospital or specific location defined by the municipality or by the institution that is intended to receive this population.

The treatment strategy should be defined early for all institutionalized seniors, according to their functionality, as proposed, including the indication of palliative care, within or outside the LTCF.

The criteria for removal from the institution must be known and defined with the team and with the family members or legal guardian, considering the expressed will of the resident, as presented in the next section.

AXIS VII - HOSPITALIZATION

The clinical criteria of severity that justify the transfer from the LTCF to a hospital or emergency unit are presented in Figure 8.

Figure 7- Identification of the Clinical Criteria of Severity that would justify the transfer of the suspected or confirmed case from the LTCF.

<table>
<tr><td rowspan="8">a. Symptoms of flu-like syndrome:
Fever above 38°C (measured or referred) or an increase of 1.1°C in basal temperature
+
Coughing or shortness of breath or sore throat</td><td rowspan="8">+</td><td>b. O_2 saturation < 95%</td></tr>
<tr><td>OR</td></tr>
<tr><td>c. Sign of respiratory distress or increased basal respiratory rate (shortness of breath or difficulty breathing / snoring, severe sub/intercostal retraction / central cyanosis);</td></tr>
<tr><td>OR</td></tr>
<tr><td>d. Worsening of the underlying chronic conditions;</td></tr>
<tr><td>OR</td></tr>
<tr><td>e. Hypotension (systolic pressure below 90mmHg and/or diastolic pressure below 60mmHg)</td></tr>
</table>

Source: prepared by the authors.

In addition, the following should be considered as indicative of greater severity in the elderly person:

- Presence of hypoactive or hyperactive delirium as a sole sign of complication;

- Reduction of basal saturation of the elderly, if possible (previous measures);

- Interruption of food ingestion;

- Deterioration of gait, and

- Temperature: single measurement > 37.8°C; repeated measurements > 37.2°C; increase > 1.1°C from baseline as indicative of fever.

The discussion of the **Advance Directives** and the indication of **Palliative Care** should always be considered:

- If the LTCF has a qualified team to provide care or has access to a palliative team, the palliative measures may be applied at the LTCF itself, upon access to the necessary supplies and medicines;

- If such human and technical resources are not available, but having already been defined the proportionality of care, this should be communicated in writing to the team that will receive the patient at the hospital or emergency service, so that unnecessary measures that will do more harm than good are not applied.

As part of the integral care for the institutionalized elderly person, the desire of the senior and their relatives must be identified:

a. Is there an Advance Directive?
    a. Document containing all the necessary documentation to fulfill the desire of the elderly and/or family members.
b. Can the LTCF sustain Full Palliative Care?
    a. Team composed by doctor, nursing and technical team trained for Palliative Care. If not, would there be access to a support team in Palliative Care? If not, follow the treatment flow at a emergency unit.
c. Does the LTCF have conditions to prevent the contamination of other elderly people and employees?
    a. Is there a reserved environment destined to palliative care at the LTCF? If not, follow the flow of care in an emergency unit or direct hospital admission, if possible.

Another critical point to be considered refers to the activation of Emergency Transport Units, which will correspond to the type of health service activated:

a) Public: Mobile Emergency Assistance Service - referral to the respective treatment unit;
b) Private: Health Carriers.

If the elderly person needs to be admitted, a report must be presented detailing expressly:

a) Onset of Symptoms
b) Vital signs
c) Previous Diagnosis (chronic diseases)
d) History of medications used

e) Level of care according to the proportionality identified by the LTCF team.

If the elderly person is discharged, a Transition Care report must be presented, expressly detailing:

f) Onset of Symptoms
g) Vital signs
h) Previous Diagnosis (chronic diseases)
i) History of medications used during hospitalization
j) Hospital discharge prescription.

The return to the LTCF of elderly people who were hospitalized due to COVID-19 will be allowed if the positivity of the immunological healing test (IgG) is demonstrated; after 14 days of hospitalization and being 72 hours asymptomatic without clinical signs of decompensation due to other causes. In the impossibility of access to the immunological healing test, consider exclusively clinical criteria. In the latter case, they must complete the 14 days of isolation at the LTCF, from the date of onset of symptoms, respecting the known biological cycle of the disease.

AXIS VIII - WHAT TO DO IN CASE OF DEATH

Although the issues related to death and burial are defined by the municipalities, LTCFs must respect the orientation of the Ministry of Health (MOH) regarding the handling of bodies in the context of COVID-19 and other general issues related to these deaths.

The MOH recommends NOT holding wakes and funerals of patients confirmed or suspected of having Covid-19, due to the gathering of people indoors. In this case, the risk of transmission is also associated with contact between family members and friends. This recommendation should be observed during periods with indication of social distancing and quarantine.

Reference should be made to the document **Body-Handling in the Context of the New Coronavirus - COVID-19 - Version 1** and widely disseminated to the LTCFs. The item 3- BODY HANDLING IN THE CONTEXT OF COVID-19, subitem 3.2, clearly expresses:

> *DEATH AT HOME AND HOUSING INSTITUTIONS*
> *The family/guardian or management of long-stay institutions that report the death should receive instructions to refrain from handling the bodies and avoid direct contact;*
>
> *Immediately after the death is reported, in the case of a suspected COVID-19 case, the attesting physician should notify the health surveillance team. The health surveillance team should investigate the case:*
>
> *Verify the need to take samples to establish the cause of death (if the patient is a suspected case). The removal of the body should be done by a health team, observing the individual precautionary measures, as described above;*
> *The body should be wrapped in sheets and plastic bag (this bag should prevent leakage of bodily fluids);*

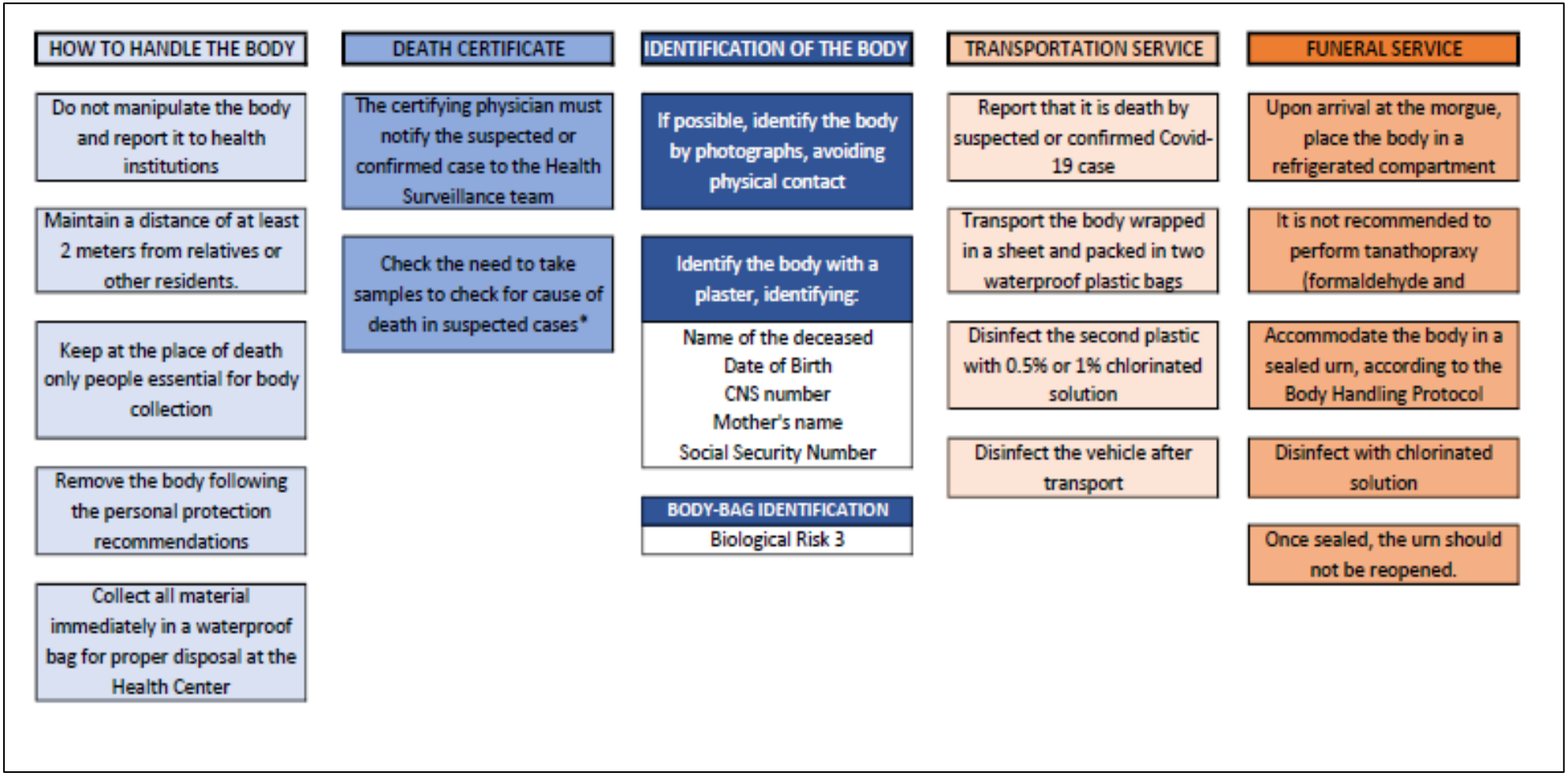
People living with the deceased should receive instruction for disinfection of environments and objects (use of chlorine solution 0.5% to 1%);

The transport of the body to the morgue should observe the precautionary measures and be carried out, preferably, in a funeral vehicle or other similar vehicle.

After transport, the vehicle must be sanitized and disinfected. At the morgue, the recommendations should be followed as described for the handling of bodies of deaths that occurred in hospital environment.

Figure 9 presents flowcharts to guide the processes within the LTCF, for transport, body preparation, and burial in case of death of a suspected or confirmed COVID-19 case in the LTCF.

Figure 8- Flowchart of Body Handling in the Context of COVID-19



*See Death Certificate

Source: Prepared by the authors.

The issuance of the Death Certificate should also follow the guidelines of the MOH (Figures 10 and 11).

Figure 9- Instructions for filling out the Death Certificate, in the context of COVID-19.

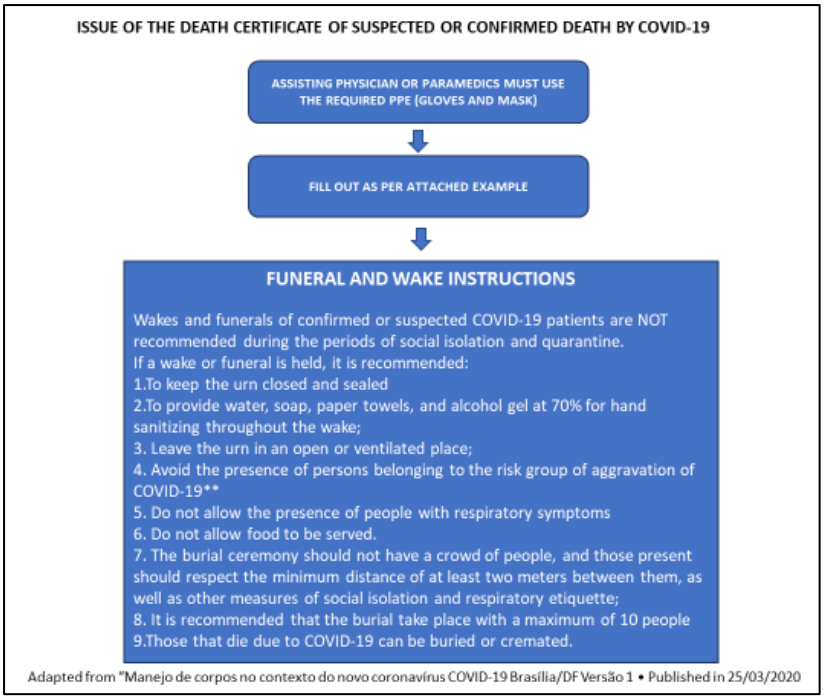
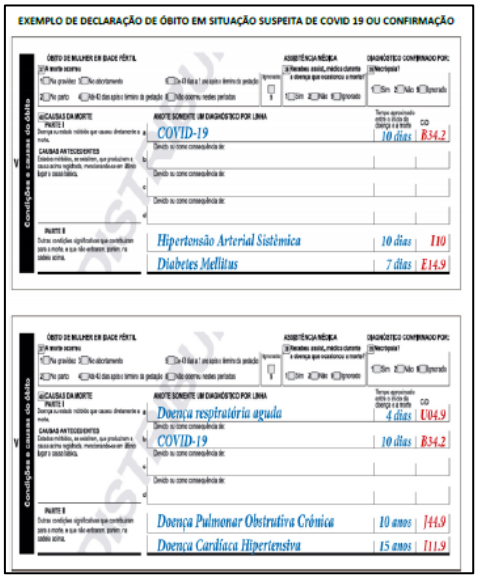


Figure 10- Example of a Death Certificate, in the context of COVID-19.



IX - SUMMARY OF LTCF BEST PRACTICES

Professional good practices in an interdisciplinary team working in a LTCF are characterized by the sharing of interventions and ethical postures required for interdisciplinarity. Interdisciplinary practices in LTCFs should focus on the following characteristics:

- Professionals from different areas working in the same professional space in a continuous relationship, aiming at a common goal.

- Search among professionals for the best available therapy.

- Permanent exchange of information and procedures between the teams on duty and other members working in the institution.

- Respect between the teams.

- Ethics and attention to the care given to the elderly at the LTCF.

- Perfect execution of the protocols prepared by ANVISA regarding biosafety[1]: personal hygiene of professionals, hygiene of the institutional environment, disinfection of materials for procedures, disinfection of the spaces used by the elderly, and other technical operational procedures stated in Brazilian laws.

- Use the integral care health plan for institutionalized elderly people (known as "P.A.I.S.I"). This instrument allows for easier visualization of health resources and their articulation with the network of public and private services offered in that particular programmatic area. The P.A.I.S.I must infer the state of health of all the elderly with their respective pathologies, degree of dependence, and seek health resources always starting with primary care, then secondary and tertiary care. The Elderly Health Booklet can be used to record relevant information and monitor the health of the elderly person.

- Recognize, record, and notify the sentinel events set forth in items 7.3 of ANVISA/RDC No. 283/2005. Sentinel events should be immediately notified, as they represent important markers in the dynamics of operation of a LTCF and/or in the health of the elderly residents. Thus, for example, when a resident presents flu symptoms, in the context of Covid 19, this is an important marker for observation, isolation of the Unit, and the use of strategies recommended by the MOH in view of the LTCF's conditions.

Brazil has public and private institutions providing Long-Term Care. The characteristics of public institutions are clear, while in the private field there is a certain ignorance of reality, with geriatric clinics, homes incorporated as micro and small companies, as well as traditional welfare institutions, which idealize their actions, guided by moral duty and grounded on philanthropy, benevolence, and volunteerism. Therefore, the professional staff available is directly affected by the organizational form of these institutions.

The elderly assistance services should provide training for all professionals working at LTCF (whether employees or outsourced) on how to prevent the transmission of infectious agents.

All professionals who work at LTCFs must be trained and capacitated on the correct and safe use of PPE, including respiratory protection devices (e.g. face shield, surgical masks, and N95/PFF2 masks or equivalent).

[1]For Covid-19, the level of biosecurity is NB 4- It groups together agents that cause serious diseases for humans and represent a serious risk for professionals working at LTCFs and for the community, which spreads and can cause death.

Strictly follow the guidelines of TECHNICAL NOTE No. 04/2020 and 05/2020 GVIMS/GGTES/ANVISA which are aimed at health services and LTCFs.

LTCF managers should make sure that LTCF employees and support staff have been trained in and have practiced the proper use of PPE before starting to care for the elderly in the unit, including the services provided in the case of suspected or confirmed case of infection by the new coronavirus, including attention to the correct use of PPE, sealing tests of the N95/PFF2 mask or equivalent (when its use is necessary), and the prevention of contamination of clothing, skin, and environment during the process of removing that equipment.

Despite the establishment of the amount and type of professionals required for LTCFs, there are several LTCFs that are not able to maintain a diversified staff or an appropriate number of professionals, and compose their teams according to their financial conditions, so we have highlighted some procedures listed in the technical notes of ANVISA that require some phytosanitary and hygienic procedures during this pandemic period, which are presented in Figure 12.

Figure 11- Main Safety Guidelines for Professionals, According to the Type of Service Provided.

PROFESSIONALS WHO WORK IN DIRECT CONTACT WITH THE ELDERLY PERSON		
PROFESSIONALS	**HYGIENE GUIDELINES**	**USE OF PERSONAL PROTECTIVE EQUIPMENT RECOMMENDED**
Caregiver Nursing Technician Nurse Physician Social Worker Psychologist Rehabilitation Professionals	Hand hygiene with water and liquid soap **OR** 70% alcohol solution;	- Protective goggles or face shield; - Surgical mask; - Waterproof jumpsuit; - Surgical gloves; - Cap (for procedures that generate aerosols) **Note**: professionals should replace the surgical mask with a N95/PFF2 mask or equivalent, when attending to elderly people who need orotracheal aspiration, non-invasive mechanical ventilation, or other procedures that generate aerosols.
SUPPORT STAFF		
PROFESSIONALS	**HYGIENE GUIDELINES**	**USE OF PERSONAL PROTECTIVE EQUIPMENT RECOMMENDED**
Helpers (caregivers)	Hand hygiene with water and liquid soap **OR** 70% alcohol solution;	- Cap (for procedures that generate aerosols); - Protective goggles or face shield; - Surgical mask; - Waterproof jumpsuit; - Surgical gloves;

Reception and security	Hand hygiene with water and liquid soap **OR** 70% alcohol solution;	- Surgical mask (if it is not possible to maintain a distance of one meter from patients with flu symptoms) **Note**: use during the work shift, change the mask if it is humid or dirty.
Kitchen and food	Hand hygiene with water and liquid soap **OR** 70% alcohol solution;	- Cap; - Protective goggles or face shield; - Surgical mask; - Waterproof jumpsuit; - Rubber gloves with long arms; - Knee-high waterproof boots
Hygiene and environmental cleanliness	Hand hygiene with water and liquid soap **OR** 70% alcohol solution;	- Cap (for procedures that generate aerosols); - Protective goggles or face shield; - Surgical mask; - Waterproof jumpsuit; - Rubber gloves with long arms; - Knee-high waterproof boots

Source: prepared by the authors.

We strongly recommend creating an Integrated Operational Standard encompassing health and social assistance policies that allows for:

- A georeferenced treatment of LTCFs by the Basic Health and Social Assistance Units;

- Organizing, in an Urgent manner, the personal files and medical records of residents at each LTCF, identifying the elderly residents, main comorbidities, medication they use, family or institutional contacts for emergency cases or transfers to basic health units or hospitals, accompanied by as much information as possible;

- The definition of therapeutic proportionality to assist in treatment definition;

- The participation of elderly people in the civil protection protocols to face the pandemic.

Professionals who work with elderly people, who reside temporarily or permanently in a regulated establishment, whether public, private, or mixed, where they receive full quality social and health services, including LTCFs, which take in people with moderate or severe dependence, should:

- Internalize the principles to be adopted in accordance with the Inter-American Convention on the Protection of the Human Rights of Older Persons and other national and international legislation aimed at defending the rights of older people.

- Understand that all time, knowledge, and attitudes with the incorporation of new knowledge are crucial factors in preserving lives, whether of elderly people or of all who are providing care.

Figure 13 presents a summary of emergency actions that constitute good practices in institutional care and that should take place in each LTCF.

Figure 12- Good Practices to be Followed in Institutional Care, in the context of COVID-19.

<table>
<tr><th colspan="2">GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE</th></tr>
<tr><td>TRAINING</td><td>Although the institution may not have a complete staff of specialized professionals, regardless of its composition, ALL staff must guide their actions with human dignity as their principle.
It is essential to train the professionals who work at the LTCF on all the themes listed as best practices corresponding to their work at the LTCF. They make up the preventive measures needed to prevent the spread of Covid-19. Training should include:
All caregivers;
- The entire nursing, rehabilitation, and medical team, where there is such a team;
- All support professionals, especially those who:
- Clean the environments;
- Receive objects, supplies, toiletries, and medicines;
- Handle and produce food for the elderly residents.
- Access to training can be via video conference, online classes, short educational videos, guidelines in the form of booklets and folders, among others.</td></tr>
<tr><td rowspan="2">PREVENTION</td><td>IMMUNIZATION OF THE INSTITUTIONAL COMMUNITY</td></tr>
<tr><td>Of LTCF residents:
- Examine the vaccination card of each resident to ensure that all elderly people are up to date with all available vaccines, especially those related to infectious respiratory diseases, according to the vaccination calendar of the elderly, defined by the National Immunization Program (known as “PNI”) of the Ministry of Health.

- Work with local Health Department to provide vaccination against infectious respiratory diseases, 2020 campaign , of all elderly residents at the LTCF.

- Examine the general conditions/indications for vaccination of each elderly resident and promote vaccination within the LTCF to avoid moving the elderly.</td></tr>
</table>

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
PREVENTION	**IMMUNIZATION OF THE INSTITUTIONAL COMMUNITY**
	Of the LTCF team: - Ensure that professionals and caregivers working at the LTCF are up to date with all available vaccines, especially those related to infectious respiratory diseases - 2020 campaign. - Make the appropriate referrals to the Health Units of the municipality for vaccination of the team.
CONTAGION PREVENTION	**SOCIAL DISTANCING OF THE WHOLE INSTITUTIONAL COMMUNITY**
	- Provide total social distancing, including restriction of movement of residents and group activities. - Establish shifts and schedules for the elderly to leave their rooms for walking around in common areas, sunbathing, and meals. - Reduce the time of residents in the common areas of the institution to avoid agglomerations, ensuring a minimum distance of 1 meter between them. - Provide appropriate amount of time for the cleaning and disinfecting of the environment. - Provide supplies for recommended practices of prevention and control of infections such as 70% alcohol gel in the residents' rooms and common areas (cafeteria, corridors, living rooms, etc.). - Guide and supervise proper hand washing of residents and professionals; - Provide conditions for hand hygiene with water and liquid soap: with washbasin/sink, liquid soap dispenser, paper towel holder, paper towel, trash can with lid and opening without manual contact. - Help the elderly who can't wash their hands.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
CONTAGION PREVENTION	SOCIAL DISTANCING OF THE WHOLE INSTITUTIONAL COMMUNITY
	- Instruct residents on the use of hygiene and respiratory etiquette when coughing and sneezing, using their elbow or tissue and hand hygiene immediately after; - Provide tissues for use by the residents when complying with the respiratory etiquette. - Avoid sharing of personal objects by residents (towels, sheets, plates, cutlery, glasses). - Put up posters with instructions on hand hygiene, respiratory hygiene, and cough etiquette at the accesses and at strategic locations within the institution.
	Leaving the institution for health treatment of residents: - Residents should not leave the LTCF, except for health treatment and medical follow-up; - In case of need, the use of a non-professional face mask by the resident is recommended; - In cases of need for referral or transfer to medical treatment facility of symptomatic residents with respiratory infection, the use of a common surgical mask is recommended during the entire transfer.
	What to do with symptomatic residents: - Keep residents with suspected case or diagnosis of Covid-19 isolated in single rooms. If this is not possible, keep residents with symptoms of respiratory infection in the same room or in nearby areas. - The elderly with symptoms of respiratory infection should be kept isolated from others, but if they have to leave the room, ALWAYS wear (common) surgical masks. - Perform activities at different times than other seniors, when possible.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
CONTAGION PREVENTION	**SOCIAL DISTANCING OF THE WHOLE INSTITUTIONAL COMMUNITY**
	Policies and procedures for LTCF visitors that apply to all visitors: - Implement careful screening of visitors for fever or respiratory symptoms: people with symptoms will not be allowed into the institution; - The visitors that are allowed in should be instructed on the importance and frequency of hand hygiene and must wear a face mask throughout the visit, and remain restricted to the room or other location designated by the institution.
	ONLY ESSENTIAL VISITORS, THOSE WHO VISIT PEOPLE IN TERMINAL SITUATIONS, ARE ALLOWED. DECISIONS ON VISITS TO RESIDENTS UNDER PALLIATIVE CARE SHOULD BE MADE ON A CASE-BY-CASE BASIS.
	Guidance for service providers: - Question service providers on arrival about respiratory infection symptoms (cough, fever, shortness of breath) and if so, do not allow that professional in. - Instruct service providers, at the LTCF reception, to perform hand hygiene with water and liquid soap OR 70% alcohol gel and ask that they put on a mask before entering the residents' area. - Install at the LTCF reception: wash-basin/sink with liquid soap dispenser, paper towel holder, paper towel, trash can with lid and opening without manual contact, AND/OR 70% alcohol gel dispenser. - Provide disposable masks, if the service provider does not have one.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
NURSING STAFF, CAREGIVERS, LAUNDRY, KITCHEN, RECEPTION	
CONTAGION PREVENTION	**General guidelines on clothing, bathing and the need for PPE:** - Shower, if possible, or wash your hands, change clothes (for internal daily use only at the LTCF), as soon as you arrive at work, before having contact with the elderly; - Perform frequent hand hygiene; - Use mobile phone only when strictly necessary and perform hand hygiene with 70% alcohol gel when arriving at the LTCF; - Do not greet with kisses and hugs; - Tend to the needs of residents with the least possible physical approach and touch; - Train all professionals to use, remove, and dispose of PPE and sanitize their hands before and after using the PPE. - Shower, if possible, or wash your hands, change clothes (for use outside of the LTCF), when leaving the work shift. - **Cleaning professionals** should use the recommended PPE when cleaning environments: cap, goggles or face shield, surgical mask (common), apron, long-armed rubber gloves, and waterproof boots
	If the professional becomes symptomatic: - Report immediately if you have symptoms of cold or flu and leave work immediately, reporting the case to the basic health unit of reference.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
NUTRITION	
CONTAGION PREVENTION	**Safe food preparation** To avoid food contamination, it is essential to train the professionals who handle and produce food for the elderly. Good hygiene keeps the risk of infection away. Simple measures can help keep the coronavirus away from the kitchen and food: • Clean your hands before eating or handling any food; • Countertops, sinks, dishes and other utensils must always be clean and dry, without food residues; • Refrigerators, freezers, ovens, stoves and other household appliances need to be regularly cleaned with water, soap and sanitizers or bleach. The same goes for the walls, floor, and ceiling. These procedures prevent the presence of undesirable bacteria and viruses and reduce the risk of cross-contamination, i.e. the transfer of an infectious agent from contaminated food or contaminated surfaces to uncontaminated food. The persistence time of the virus varies on different materials that may be in the kitchen. Some scientific studies with other types of coronavirus indicate their permanence on metal, plastic, and glass for up to nine days, while other researches point to shorter times: 24 hours on cardboard and three days on metal or plastic. Viruses are inactivated in about one minute by contact with 62-71% ethyl alcohol, 0.5% oxygenated water, or 0.1% sodium hypochlorite. For foods that will be eaten raw, such as leafy vegetables, it is recommended to remove the outer or damaged leaves, to separate the leaves one by one, to wash them with abundant drinking water and to leave them in immersion, for 15 minutes, in a solution of bleach (one tablespoon of bleach diluted in one liter of water), washing them afterwards with running drinking water again.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
CONTAGION PREVENTION	**NUTRITION**
	For non-leafy vegetables and fruits, even those to be eaten without the peel, the procedure must be the same. Commercial chlorine-based products for vegetable disinfection are efficient. **Attention:** Do not use bleach that contains other substances in its composition, because they can be toxic to the human body. The correct cooking and frying of the food eliminate any presence of the virus. However, further contamination after heating must be avoided, especially if the food is not reheated before consumption. It is important not to leave cooked items in contact with other raw materials to avoid cross contamination Whenever possible, opt for cardboard packaging. After all, it is believed that the virus resists for less time on paper than on plastic or aluminum. And disinfect the packages before opening them, with soap and water or alcohol gel. And before, during and after a pandemic, do not consume products with violated packaging. When buying food products, clean all packaging and surfaces before storing them in the refrigerator or pantry, and wash your hands thoroughly when finished.
	ENVIRONMENT
	- Do not circulate with residents indoors, prefer open and ventilated places; - Provide natural ventilation in rooms; - Clean and disinfect surfaces that may be contaminated, including those near the elderly (bed railings, chairs, bedside tables and dining trays) and surfaces frequently touched in the resident's environment, bedrooms, and bathrooms (toilet, sinks, flush handles) and high-touch surfaces (door handles, light switches, tables, countertops, support bars, etc.).

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
CONTAGION PREVENTION	**ENVIRONMENT**
	- Materials for collective use must be submitted to cleaning and disinfection after use. - Carry out the cleaning and disinfection of equipment for clinical use (stethoscopes, sphygmomanometers, thermometers, etc.) and of utensils (e.g. plates, cups, cutlery, etc.) before and after each use; - Maintain ongoing communication with family members to provide up-to-date information on the residents.
	ISOLATION AREA FOR SUSPECTED OR CONFIRMED COVID-19 CASES
	- Provide materials for exclusive use, such as thermometers, pressure gauges, etc., whenever possible, to use with people in isolation due to suspected or confirmed COVID-19 case. - Provide, near the entrance of the residents' areas, a place for storage and placement of PPE. - Keep a pedal waste bin near the exit door of the room for proper disposal of PPE by professionals.
	EARLY DETECTION OF SUSPECTED CASES
	- Inform medical and nursing staff as soon as you notice signs and symptoms of flu, so that the resident can be sent to the isolation area. **Access to tests for identification of COVID-19 - residents and professionals** - Perform PCR tests to identify suspicious cases and serological tests at collection centers, preferably in a drive-through scheme, where people with mild symptoms will undergo serological testing for antibodies against SARS-CoV-2 and will receive the result by phone within 36 hours, as reported by the MoH. - Include residents and LTCF professional staff as priority groups for this testing.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
INTEGRAL CARE	**TREATMENT FLOW FOR LTCFS**
	- Each Institution should organize shifts with health professionals and social Workers to monitor and make arrangements in case of occurrence of cases; - The Institution Manager should report daily all occurrences and evolution of suspect/confirmed cases to the Health Unit of reference and MOH. - Upon the appearance of the first respiratory symptoms, the manager of the Institution must immediately report this to the Medical Department of reference and refer the resident for clinical evaluation; - In confirmed cases, with presence of mild respiratory symptoms, keep resident in an isolation room, perform standard precautions, restrict stay, and monitor clinical conditions for 14 days; -In cases of severity and/or worsening of the symptomatic respiratory condition and unstable general condition, transfer the resident to a specialized health service in an Urgent and Emergency manner, with the use of a common surgical mask during the entire transfer; -In cases of severity and/or worsening of the symptomatic respiratory condition and unstable general condition, maintain hospital treatment with monitoring of the clinical condition and stabilization of symptoms for release from hospital; - In cases of post-hospitalization readmission, the resident should remain in external isolation for 14 days and be examined for symptoms of respiratory infection, and, if necessary, implement appropriate isolation measures; - Elderly people who are monitored at the Basic Health Unit of reference should continue treatment.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
INTEGRAL CARE	**PALLIATIVE CARE**
	- Promote team training and continuing education for caregivers, in simple and effective language, creating opportunities for discussion about myths and fears present in the institutional community. - Attention to the pressing existential needs of the elderly at the end of their lives. - Be sure to capture the patient's perception: the awareness of approaching death; the fear of death; the ability to interact. - Try to have the elderly's relatives present, as possible. **Emergency resources:** **Human resources:** - Medical reference with knowledge in the management of the elderly in a terminally ill situation. - Nurse, nurse technician, caregiver. - Involve the multiprofessional reference team that is available. A list with the respective references and telephone numbers for calling on the professionals as needed should be available at the LTCF. **Supplies:** - PPE (cap, N95 and surgical mask, googles, face shield, long gloves and waterproof scrubs), thermometer, oximeter, stethoscope and sphygmomanometer, pneumatic mattress, and sunflower oil. - Medication kit: Dipyrone (capsule and ampoule), paracetamol, tramadol, codeine, pregabalin, phenobarbital (cp and amp), morphine (cp and amp), haloperidol (cp and amp), hyoscine (cp and amp), ipratropium for micro-nebulization, midazolam (amp), clonazepam (drops), dexamethasone (cp and amp), and bisacodyl (cp). - Serum therapy kit: serum support, cotton, micropore, spatula, jelco, tourniquet, alcohol) - Oxygen therapy kit: 02 concentrator, nasal catheter, 02 mask, 02 latex, micro mask, aspirator. Regarding medication, it is important to define the storage, organization, and dispensing strategy, so pharmaceutical support is important for this.

GOOD PRACTICES TO BE FOLLOWED IN INSTITUTIONAL CARE	
INTEGRAL CARE	**SPIRITUAL CARE**
	- Remember that most institutionalized elderly people have a religious faith and it is the duty of the professional or caregiver to provide the specific spiritual assistance of each elderly person. - Make it easier for religious rituals to be held according to the will of the elderly and their families. -If a religious counselor and/or relative cannot be present, it is the duty of the professional or caregiver to accompany the elderly person in their prayers, whatever the faith (or lack thereof) of the professional or caregiver. - If the senior does not have a religious faith, that must be respected, and spirituality should be treated as a way of searching for meaning in their life that is coming to an end. - The dimensions of the suffering of the elderly at the end of their life catalyzes the process of successive losses and can lead to feelings such as sadness, hostility, anger, revolt, and guilt, and professionals and caregivers should help with the expression of such feelings, acknowledging and understanding them.

Source: prepared by the authors.

Oral Health in the Context of the Pandemic.

Regarding the oral health of the institutionalized elderly, in these times of COVID-19 pandemic, we have 3 points to consider: oral hygiene of the elderly, prostheses, and when to seek the dentist.

About oral hygiene:

- The first measure of care should be with the elderly's brushes, which should be individually wrapped, and in containers with caps. The caregiver should sanitize their hands before the process and wash the brush thoroughly before storing it;

- Independent elderly people should do the brushing only under the supervision of the caregivers, who should be trained to guide them.

- If the elderly person cannot brush their teeth on their own, the caregiver should brush it for them, preferably at bath time. As in this case the caregiver's contact will be very close to the elderly, they will need to be adequately protected, wearing a mask and gloves. Hygiene should be done on the remaining teeth and tongue.

Regarding the hygiene of prostheses:

- In the case of independent seniors: the person will do it themselves, under the supervision of the caregiver who must be trained to help them;

- For the other elderly: the process should be carried out by the caregiver, preferably at bath time. The caregiver must sanitize their hands with soap and water to perform the cleaning of the prostheses. The cleaning should be done on both sides of the prosthesis and not only on the surface with the teeth, also using a toothbrush. It is not desirable that the brush for sanitizing the prosthesis be the same one that the elderly use for their own brushing.

Remember that before placing the prosthesis in, the teeth that remain in the mouth and tongue must be cleaned (if the elderly still have it). In this case, the caregiver must also protect themselves, using mask and gloves, due to the proximity to the elderly.

When to use dental services

On March 20, 2020, the Ministry of Health and the Federal Council of Dentistry established that elective dental care should be suspended, maintaining emergency care.

Oral health professionals, members of multiprofessional teams in Primary Health Care, should act in the Fast-Track Covid-19 (rapid screening) actions. Therefore, the elderly should seek the service only in acute cases (emergency): toothache, abscesses, dental trauma, among others.

X - INVOLVING THE INSTITUTIONAL COMMUNITY IN THE REDUCTION OF THE SPREAD OF COVID-19 IN LTCF

To reduce the spread of COVID-19, it is key to achieve a better response to the disease and to take more assertive measures: to care for those who care and involve the entire institutional community in this common goal.

Why take care of those who care?

The task of caring is not easy; many people leave their own lives aside to dedicate themselves to others. Illness that causes dependence for daily life activities, whatever it may be, affects the life of the caregiver and the family as a whole. There is an accumulation of tasks that result in the need for role reorganization and adaptation in various realms, often even with the need to adapt the environment as well.

In the institutional realm, caring in times of COVID-19 means dealing with fears, uncertainties, greater rigor in hygiene measures. In this sense, this pandemic worsens the physical and psychological condition of the caregiver. In addition, it is not uncommon for changes to be created in the financial and social life, and in relationships within the home. A person, in this case the caregiver, ends up assuming a much greater responsibility, being responsible for looking after themselves and, with the new condition, a third person, be it a family member, a friend, a neighbor or anyone who can no longer be self-sufficient in their own life. Consequently, this caregiver will postpone, replace, or cancel their own life plans, in the personal and even professional realms.

Considering all the accumulation of responsibilities of these professionals, it is necessary to promote actions that minimize the effects and damages such as:

- Promote the physical and psychological wellbeing of these professionals;

- Avoid bringing new responsibilities to these professionals, such as the purchase of PPE and other materials needed in this time of pandemic;

- Be mindful of mourning, in case there are deaths at the LTCF;

- Promote actions to prevent depression.

Why involve the institutional community in the reduction of the spread of Covid-19?

Considering experience accrued with health systems, these are complex and involve health professionals and other stakeholders. Users of these systems play an essential role as co-producers of their own health and, in fact, represent the only consistent factor along the continuum of care.

Patient involvement is increasingly recognized as an integral part of health care and a critical component of safe, people-centered services. Engaged patients are better able to make informed decisions about their treatment options. Moreover, resources can be better used if they are aligned with patient priorities and this is critical to the sustainability of health systems worldwide (WHO, 2016).

During the 72nd World Health Assembly (2019), WHO reinforced patient safety as a global health priority and adopted resolution WHA72.6 "Global Action on Patient Safety", with the goal of transforming the movement into a social action where patients demand

safer health care. This is a strategic moment because this action has been recognized globally as a powerful political tool that will drive the global patient safety agenda in the coming years. Governments will be increasingly pressured to prioritize patient safety; funding agencies and foundations will be encouraged to direct resources to the development of safer health systems; research institutions will intensify studies in this area; universities will focus on forming future leaders through education and training in patient safety; and health services will ensure the safety of their users (WHO, 2019a).

WHO has also established the Patient for Patient Safety program, with the aim of giving voice to the patient, their family, and the community at all levels of health care, through engagement and empowerment. The Program aims to encourage people to be co-responsible for their own safety during care and to strengthen partnerships between patients, families, and the community with health professionals (WHO, 2019b).

In Brazil, the Ministry of Health, through the National Patient Safety Program, recognized the importance of this strategy and launched, in 2014, the reference document that presents the six axes of the Program; among them, the involvement of citizens in their own safety (BRAZIL, 2014).

It appears that the traditional patronizing model of care, in which patients have little voice, is evolving into a patient-centered model of care. From this perspective, patients and health professionals work in partnership towards the common goal of preventing disease and improving health. Moreover, the patient-centered care model provides for respect of individual patients' preferences, needs, and values and the assurance that their values will guide all clinical decisions (AHRQ, 2019).

Involving the institutional community in reducing the dissemination of COVID-19 is important because (PATIENT ENGAGEMENT ACTION TEAM, 2017):

- **It is the right thing to do:** the partnership between health professionals and residents/families shows respect, values ideas and experiences, and enables them to take an active role in planning and implementing actions aimed at reducing the dissemination of COVID-19. Health professionals are morally obligated to involve these people in decision-making, either as team members and/or as partners in improving the safety and quality of services provided at the LTCF or throughout the health system.

- **It is the safest thing to do**: as respected partners, residents can improve the quality and safety of care and, thus, help reduce the spread of COVID-19 because:

  - They know their symptoms and their responses to prevention strategies and treatments better than anyone else.

  - They are always present in their own care, unless prevented by factors beyond their control.

  - They are the first to know or feel when a symptom changes or when they experience some impact of prevention and treatment measures, and can communicate them to the team.

  - The courage and resilience of these people can inspire and energize the LTCF team in the strategies to reduce the dissemination of COVID-19.

- They tend to have different ideas of the processes, that professionals often do not have because they are focused on doing the work.

- **Allows for innovative solutions**: residents can offer unique perspectives on decisions about their own health and treatment, for processes related to the care provided in the institution, or for the broader political decisions that shape health systems. They are experts in their own care and are experienced users of the healthcare system. Moreover, residents and family members involved in the processes and decision-making have a better understanding of treatment plans and assist in the rational use of resources.

- **It is an expectation and a standard to be followed**: in several countries, governments and health care institutions are promoting patient and family-centered care, allowing patients to take on more active, informed, and influential roles. For example, the new Canadian accreditation standards require patient involvement in governance, leadership, and service provision. Current accreditation standards are requiring organizations to implement policies and practices to support patient involvement and to move toward person and family-centered care.

How to involve the institutional community in the reduction of the spread of Covid-19?

The involvement of residents and their families in the efforts to reduce the spread of COVID-19 should focus on three areas: engaging residents and their families in detecting the risks of spreading the disease; empowering residents and their families to ensure safe care; and emphasizing the involvement of residents and their families in prevention strategies as a means to improve the safety culture at LTCF (Figure 1). Based on WHO recommendations (WHO, 2016), the following actions can be taken:

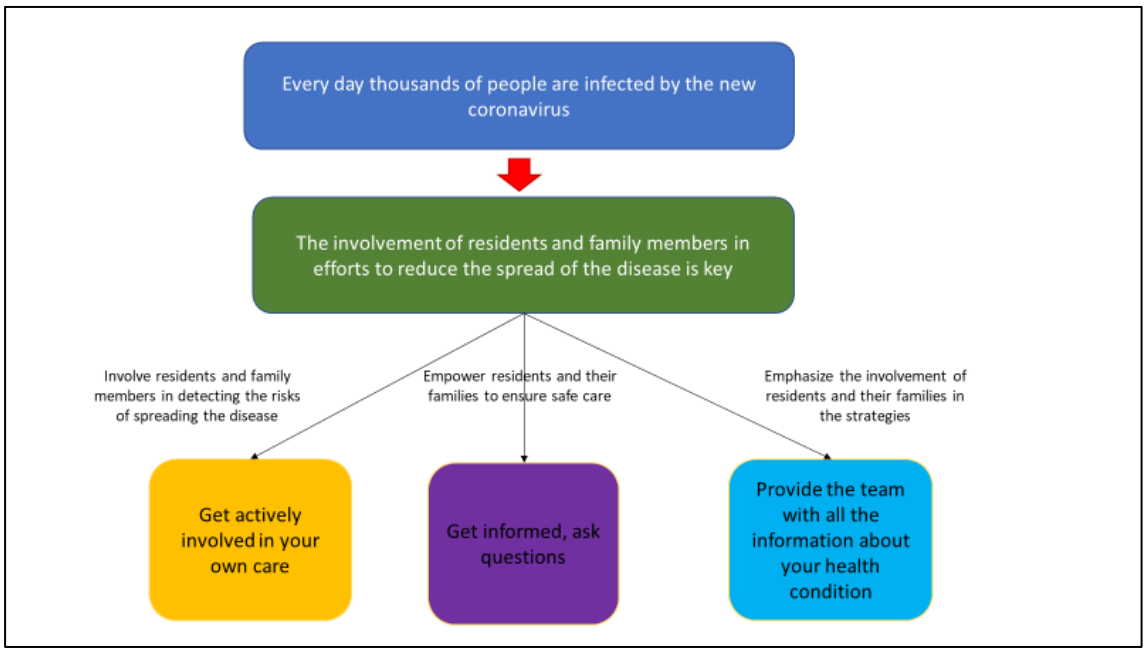
1. **Obtain information on the experience of the resident and their relatives in fighting the spread of COVID-19.** This information can be obtained through surveys, informal online feedback, , or focus group discussions. Feedback on the experience of the resident and their family members in this process provides important information about needs, preferences, and values. Such information can assist the LTCF team in reviewing strategies and actions aimed at preventing and fighting the spread of COVID-19, in addition to improving the quality and safety of the assistance provided.

2. **At the organizational level, residents and family members should be involved in the creation of strategies and action plans aimed at reducing the spread of COVID-19**, for example, as members of advisory committees. They can also be involved in the dissemination of tools, information, and educational materials to the community.

3. **Educate and train residents and family members to recognize health needs and seek timely treatment.** It is important to encourage them to ask questions or talk about their concerns. Involving residents and family members in the design and development of educational tools and materials helps improve their understanding of the problem and encourages them to adhere to the recommendations.

Figure 14 presents a strategy for involving the institutional community in the their own care to reduce the spread of COVID-19.

Figure 13- Strategy to involve residents and family members in reducing the spread of COVID-19.



Source: Prepared by the authors.

In 2016, the UK National Health Service proposed a framework to assist health professionals in involving patients and family members in care processes (SAFETY PATIENT ENGAGEMENT IN PATIENT SAFETY GROUP; YORKSHIRE QUALITY AND SAFETY RESEARCH GROUP; YORKSHIRE QUALITY AND SAFETY RESEARCH GROUP, Ltd., 2016). Such a structure can be used in the current context to improve the involvement of the institutional community in reducing the spread of COVID-19 (Figure 15).

Figure 14- Framework to assist LTCFs and health professionals in involving residents and family members in the reduction of the spread of COVID-19.

	INFORMATION Healthcare professionals hold the power	**INVOLVEMENT** Residents have an active role, but health professionals have the power of decision	**PARTNERSHIP OR SHARED LEADERSHIP** Residents share the power with health professionals
PERSONAL SAFETY The engagement occurs in the context of the care provided to the resident It usually occurs in real time while the resident is under the care of the team, but it can also occur after discharge, when the resident can further influence the care provided in the institution.	• Residents and family members receive information about Covid-19 in the context of health care. • Communication is one-way from the health professional to the residents and their relatives	• Residents and family members are asked about strategies to prevent the spread of Covid-19 in the context of health care. • Communication is two-way from the health professional to the residents and their relatives. • The process is led by the health professional.	• Residents and relatives work together to improve the safety of care. • Communication is two-way from the health professional to the residents and their relatives.
HEALTH PROFESSIONAL SAFETY Engagement occurs in the context of health professional safety.	• Residents and family members receive information about Covid-19 considering the safety of the health professional. • Communication is one-way from the health professional to the residents and their relatives.	• Residents and family members are questioned about strategies to prevent the dissemination of Covid-19 considering the safety of the health professional. • Communication is two-way from the health professional to the residents and their relatives. • The process is led by the health professional.	• Residents and family members work together to improve the safety of care considering the safety of the health professional. • Communication is two-way from the health professional to the residents and their relatives.
SYSTEM SAFETY Engagement takes place in the context of the LTCF's safety and this can take place at the national or international policy level as well as at several LTCFs simultaneously	• Residents and family members receive information about Covid-19 considering the safety of the LTCF. • Communication is unidirectional from the LTCF to the residents and their families.	• Residents and family members are questioned about strategies to prevent the dissemination of Covid-19 considering the safety of the LTCF. • Communication is two-way between the LTCF and the resident and their family. • The process is led by the LTCF.	• Residents and family members work together with the LTCF to improve the safety of care provided considering the safety of the LTCF. • Communication is two-way between the LTCF and the resident and their family.

Source: adapted from SAFETY PATIENT ENGAGEMENT IN PATIENT SAFETY GROUP; YORKSHIRE QUALITY AND SAFETY RESEARCH GROUP; YORKSHIRE QUALITY AND SAFETY RESEARCH GROUP, Ltd., (2016)

Institutional practices need to be reviewed and adapted to the current context, which is known to be dynamic and challenging for managers, teams, residents, volunteers and family members.

XI – RELEVANT LEGAL ISSUES

1. ISOLATION OF THE INSTITUTIONALIZED ELDERLY WITH SUSPECTED OR CONFIRMED CASES OF COVID 19, WITHOUT THE NEED FOR HOSPITALIZATION; CO-FUNDING FOR IMPLEMENTATION OF PUBLIC POLICIES SUCH AS THE INSTALLATION OF A TEMPORARY SHELTER FOR SITUATIONS THAT ARISE DURING THE PANDEMIC AND EVALUATION OF SUSPENSION OF NEW ADMISSIONS OF THE ELDERLY AT THESE INSTITUTIONS DURING THAT PERIOD.

The seriousness of the moment faced by public health around the world, as the result of the new coronavirus (Covid 19), classified as a pandemic by the World Health Organization led the Brazilian National Congress to recognize a state of public calamity in Brazil, and led states and cities to declare a public health emergency.

Additionally, Law 13,979/2020, which establishes the measures to deal with the internationally relevant public health emergency resulting from the coronavirus responsible for the 2019 outbreak, established concepts such as quarantine and isolation.

In relation to the LTCF, the Ministry of Health and State and Municipal Health Offices have issued technical notes with guidance and recommendations for measures designed to prevent and control infection by the new coronavirus, in order to minimize the risk of contamination and spread of the virus at these establishments. These notes refer to the use of isolation and of quarantine.

This concern is the result of the fact that these locations are home to elderly residents with advanced ages, often in fragile health, dependent on care, some with diseases such as diabetes, high blood pressure, as well as cardiovascular and respiratory illnesses, and who therefore belong to risk groups with higher chances of complications and death in the event they become infected by the virus that causes COVID 19. Add to all this the fact that they share spaces for sleeping, meals and other activities together, thereby increasing the chances of catching and passing on the virus.

LACK OF SPACE TO ISOLATE SUSPECTED AND CONFIRMED CASES OF COVID 19 THAT DO NOT REQUIRE HOSPITALIZATION

For symptomatic respiratory cases that are compatible with the flu-like syndrome, the aforementioned standards recommend ISOLATION until a diagnosis has been made. The note issued by Anvisa and by MMFDH mention well-ventilated individual rooms, with a separate bathroom from others (since there is a possibility that the virus may be eliminated in the feces and some patients present with diarrhea), for residents with suspected or confirmed diagnoses of Covid 19.

There is no doubt that there are very few institutions that can meet these standards, since a large part of them do not have individual rooms available, nor bathrooms that can be used only by those with suspected or confirmed contamination by the virus. It

is is important to note that LTCFs generally have already occupied collective rooms (the lack of available room in these institutions is a routine national problem), and in most cases there are only collective bathrooms, which greatly increases the risk of contagion.

Delegating the solution to this problem to the LTCFs; that is, expecting them to provide adequate space for isolation, would be the same thing as exposing the elderly to death, given the total unfeasibility of building adequate isolation spaces at these institutions; therefore, this position (of delegating the responsibility for these solutions to the LTCFs) is unthinkable and irresponsible.

It should be noted that when we speak of an isolation location, such a place must also have the necessary equipment and materials to care for these elderly patients, and a larger number of professionals should be indicated for the institutions that contain such places, since proper technique recommends that patients in isolation be monitored for 24 hours by professionals chosen for this task.

There is no doubt that this reality does not only affect public institutions, but also private ones, whether they are for-profit or non-profits (philanthropic). We must remember that many of the private institutions are small, with scarce resources and few professionals, and thus also deserve attention from the government.

Aligned with this understanding, the Ministry of Citizen Rights and the MMFDH, through Technical Note SEI/MC 7224617, case no. 71000.018129/2020-74, established the need for risk mapping and a contingency plan, to be adopted by the Social Assistance Offices and by the Long Term Care Institutions.

According to this note:

> "The Social Assistance Offices and each receptive service, including those offered by civil society organizations (CSO), shall identify the possible risks referring to the coronavirus pandemic in light of local reality and the specific characteristics of the users and of the service, to prepare contingency plans focused on mitigating the effects of the occurrence of the risks identified."

Such plans should contain strategies that establish procedures and actions to be taken in response to the occurrence of each risk, so that rapid and effective responses can be given to undesired events that may occur during the public health emergency period.

Among the situations that need to be mapped out in accordance with the reality of each service, the following are especially relevant:

i. The possible need for temporary unplanned replacement of direct care professionals, in order to ensure the continuity of care and attention necessary for those admitted, in the event that may professionals leave at the same time, due to suspected or actual contamination by the CORONAVIRUS, or because they are among the risk group for this illness.

ii. The need to provide reserved spaces that are appropriate for use by those admitted who are infected or suspected of being infected by the CORONAVÍRUS.

According to the orientation above, together with each of the long-term care facilities for the elderly, whether public or private (the latter for the reasons already listed), the city government shall prepare a contingency plan containing the procedures and actions to be taken, emphasizing how the temporary and unplanned replacements will be made of the professionals directly involved in caring for the elderly (when these professionals are removed from their positions due to suspected or confirmed infection) and isolation cases, which do not require hospitalization.

We suggest that these temporary isolation locations be checked to confirm that they will comply with the technical notes prepared to date (spacing between beds, private rooms, separate bathrooms, trained professionals, adequate hygiene materials, PPE, etc.).

Together with local government, the LTCF must also demand this CONTINGENCY PLAN, indicating its reality and needs, as well as the adoption of necessary actions, notifying the Prosecutor's Office in the event there are any omissions by the city and the state.

In regard to the adequate isolation location, a temporary unit may be used, including on a regional level, to receive the elderly coming from other municipalities where low demand would not justify a separate unit in the respective municipality, with inter-municipal agreements established to define how each of them will contribute.

Under the current scenario, it is undeniable that these spaces should be created, and they may even serve to quarantine those who are going to be admitted to an LTCF (new admittances or return of the residents after a hospitalization), for those elderly persons who live with another family member and the latter becomes infected by the virus, and the elderly person needs to get away from that family member, etc.

THE OBLIGATION OF THE FEDERAL, STATE AND MUNICIPAL GOVERNMENT IN REGARD TO TEMPORARY SHELTERS, PROVISION OF PROFESSIONALS, PERSONAL PROTECTION EQUIPMENT, HYGIENE MATERIALS.

The Social Assistance Policy is concerned with providing protection for life, reducing damage and preventing the occurrence of social risks. To achieve these goals, it has the normative obligation to guarantee, among other things, protection, offering a network of services, including short, medium and long term shelters, and support and assistance in the event of circumstantial risks, including by offering assistance through material goods and funds, in a temporary manner, called occasional benefits.

Within the context of a public calamity and emergency such as the present scenario of community spread of COVID 19, as well as with the advancing curve of infected persons, which creates an imminent risk of mass death among the elderly, social assistance managers must ensure that the affected population has access to the basic services available, and that their fundamental rights are ensures, such as the right to life and to health, during and after the crisis.

This responsibility also belongs to the State Government. Pursuant to Article 13 of Law 8742/93, it is the responsibility of the State to allocate funds to the municipalities, to share in the payment of occasional benefits, according to the criteria established by the State Social Assistance Councils, and to provide, together with the Municipalities,

assistance actions of an emergency nature, and to monitor and evaluate the social assistance policy, assisting municipalities in carrying it out.

CNAS Resolution no. 33/2012 also establishes shared responsibility between states and municipalities in performing social assistance actions of an emergency nature.

Therefore, the State must present the SUAS emergency plan for the epidemic, with the transfer of state co-funding resources to the municipalities, issuing technical orientation, technical support to municipal managers in the planning and implementation of emergency actions, in the training of technical teams, and other actions.

According to Article 15 of Law 8.742/93, each municipality must take emergency assistance actions and aid with funding the improvements for social assistance management, services, programs, and projects at the local level. In addition, according to CNAS Resolution no. 33, they must ensure performance of the social assistance policy, in line with the enforcement guideline.

In summary, all the entities of the federation, in accordance with their powers, assume responsibilities for managing the system and for guaranteeing its organization, quality and results in the provision of the social and assistance services, programs, projects and benefits that will be offered by the socio-assistance network.

This means that in order to implement the isolation location (temporary shelter) and the pool of people that can be marked for temporary unplanned replacement of professionals who work directly with elder care, funds may be allocated by the Union, States and Municipalities.

All government actions in the assistance area are conducted with funds from the social security budget (Article 195 and 204 of the CF/88). The co-funding resources for providing social assistance are allocated to the national social assistance fund (FNAS), and funds for the states, municipalities and Federal District are allocated to their respective funds, as budget units.

In regard to federal co-funding, it is important to note that the Ministry of Citizenship, published Administrative Ruling no. 337/20 to combat the coronavirus. Article 4 of that ruling states: “the use of financial resources transferred to the state, municipal, and Federal District assistance funds is authorized as support for management through the SUAS management index (IGD/SUAS), in the organization and performance of actions designed to prevent and mitigate risks and social consequences resulting from the needs created by the coronavirus pandemic.”

To complement that Administrative Ruling, no. 01, of 4/2/2020 was published, which regulated the use of federal co-funding resources, which may be used to carry out the measures in question.

It is also important to remember that municipalities can request federal co-funding for special high complexity social protection services in situations of public calamities and emergencies, as established in CNAS Resolution no. 109, and which can make it possible to set up temporary shelter, provide professional care and materials to meet the needs detected.

Therefore, the emergency measures indicated above must be performed by the states and municipalities, including with federal co-funding (see next section).

For admissions of new residents, it is essential to safeguard the safety of the elderly already at the location. Considering the risks of contamination by the coronavirus for residents and employees at the time of admission, and the fact that many institutions may be operating with a reduced number of employees, with a short supply of PPE, gloves, masks, caps, nurse materials and other necessary items, and thereby, under serious operational difficulties, technical note no. 07/2020 – COSAPI/CGCIVI/DAPES/SAPS/MS should be followed, which recommends precautions be taken in terms of contact during the first 14 days.

Institutional admissions for the elderly should be suspended whenever there is insufficient appropriate space for isolation.

The admission of new residents shall be accompanied by the respective Municipal Health Office (SMS), and performed with the utmost caution, with routine medical exams and testing for the novel coronavirus, with technical assistance from the SMS. Whenever one is present, the physician responsible for care at the LTCF shall comment in a specific report on whether the LTCF has the technical and operational conditions to receive the elderly applicant.

Lastly, as the basis for implementation of the aforementioned public policies (isolation location, team of professionals in the event of their absence at the LTCFS, provision of PPE), we indicate Article 230 of the Federal Constitution, which refers to the duty of the State to support the elderly, defending their dignity and well-being and ensuring their right to life, as well as Article 3 of the Statute for the Elderly, which refers to the principle of the absolute priority in the guarantee of the rights to life, health and dignity of the elderly. This principle includes the preference by this segment of the population, in receiving protection and help, in having preference in the drafting and performance of public social policies and the favored receipt of public resources in the areas related to vulnerable groups, as is now the case for the institutionalized elderly, who face the risk of suffering serious harm to their health and even death, if effective measures are not taken to avoid the exponential infection of the elderly who reside in the LTCFS.

XII – FUNDING

ACCESS TO PUBLIC FINANCIAL RESOURCES. REQUESTS FOR HUMAN RESOURCES AND MATERIALS TO STATES AND MUNICIPALITIES. REQUESTS FOR FUNDING FROM THE STATE AND MUNICIPAL FUNDS FOR THE ELDERLY; SOCIAL AND HEALTH CARE ASSISTANCE.

Assertive measures and united efforts are needed to respond to the Covid-19 pandemic, in support of the elderly who are institutionalized. In this regard, and as a result of the declaration by the National Congress last March of a state of public calamity, together with the restrictions on people's movement and recommendations of home confinement, the Committee of Defense of the Rights of the Elderly (CIDOSO) has deliberated and correctly requested that funds from the 2020 Budget amendments approved by the Committee of Defense of the Rights of People, allocated to the Ministry of Health (MS) and the Ministry of Women, Family and Human Rights (MMFDH) be immediately releases and allocated to the LTCFs.

Request for human and material resources for the Municipalities and States.

"Public Co-funding"

It is well known that charity LTCFs play a relevant role of public interest within the scope of Special High Complexity Social Protection. Considering that a very small proportion of LTCFs are public, it is the structure of the philanthropic LTCFs that actually account for the institutionalization of the elderly for the Single System of Social Assistance (SUAS).

However, co-funding by the Union of the services provided by LTCFs is extremely small. The reference amounts for the Minimum High Complexity I (PAC) payment have not bee adjusted since 2007 (MDS Administrative Ruling no. 460/2007). Special attention is needed from the Ministry of Citizenship to adjust these amounts for inflation. The situation is not different in regard to the financial share of the state governments. It can clearly be seen that there is no budgetary policy focused on this modality of services (institutional care).

It is necessary to trace the flows as the funds are released to pay expenses and for capital, directly to the LTCFs with the control and monitoring of the State and Municipal Councils on the Elderly, and when they do not exist, these flows should be monitored by the Health and Social Assistance Councils;

In regard to the Municipalities, aid with public funds varies greatly from place to place, and is still insufficient in light of the high costs associated with caring for the institutionalized elderly. In relation to the per capita amounts formalized in the collaboration terms (partnerships within the scope of Law no. 13,019/2014) in most cases they remain at the discretion of the municipal government. In other words, the budget allocations for co-funding of the services offered by the philanthropic LTCFs are not planned together with these institutions.

We cannot ignore the fact that, as has been occurring in Europe and in the United States, there have already been cases in Brazil in several states (Rio, São Paulo, Santa Catarina) of COVID 19 infection in elderly residents and in professionals who work at the LTCFs, which further increases the urgency to adopt effective and immediate measures at these institutions, which will also be put into place through the use of resources.

In light of the unfavorable situation, it is suggested that non-profit LTCFs present cost spreadsheets, accounting statements, activity reports and specific legal opinions to the municipal government.

Also recommended is contact with the Municipal Councils on Social Assistance and the Elderly, the Prosecutor's Office and the State and Municipal Accounting Courts, so that they can find solutions together with the federated entities (Union, States and Municipalities) in order to:

1) Avoid possible risk of lack of care to institutionalized elderly persons;

2) Prepare a work plan, in accordance with Article 22 of Law 13,019/14, Article 50 of the Statute for the Elderly, CNAS Resolution no. 109/2009, the basic operational standards of the SUAS, and other legislation that ensures that quality services be provided by the LTCF;

3) Render accounts, in compliance with Articles 63/72 of Law 13,019/2014;

4) Guarantee that the necessary transparency is given to the partnerships signed and to the respective work plans, by both the public entity and the LTCF, pursuant to Articles 10, 11 and 12 of Law 13,019/2014;

5) Give the greatest possible publicity to the public call process, adopting clear, objective and simplified procedures that guide interested parties and facilitate and increase the access of participants.

Although there is no legal impediment that would prevent Municipalities and States from providing a technical team (human resources), furniture and equipment to the non-profit LTCFs, there is also no public interest in doing so. Nevertheless, the institutionalization of the elderly during the Covid-19 pandemic requires that the residents have a separate/independent structure for isolation in cases of flu-like syndrome, fever and other symptoms. During this pandemic, this measure is extremely necessary because the elderly and others with multiple underlying conditions are at risk for infection by the coronavirus. It is known that many of the institutionalized elderly with multiple underlying conditions often have low immunity, co-morbidities and dementia. They are more susceptible to a worsening of their conditions when they are affected by Covid 19.

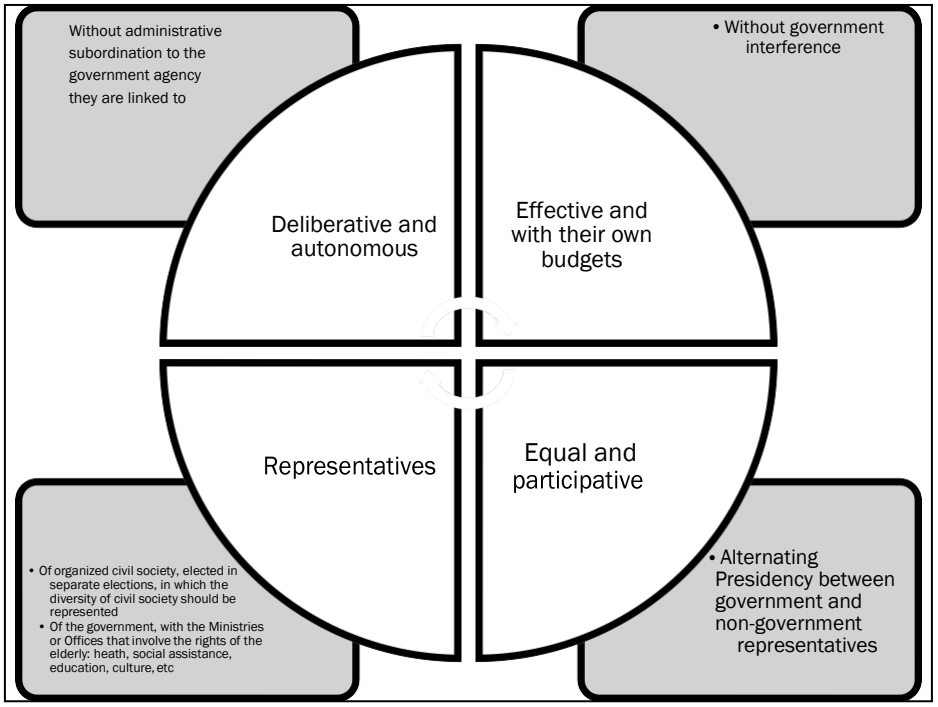
In this regard, a recent and praiseworthy example of solidarity at this time of calamity was the allocation from the Diffuse Interests Redress Fund of the State of São Paulo (FID), in response to a request submitted by the São Paulo Prosecutor's Office, which decided to transfer R$ 20 million to the State Health Office in order to finance measures designed to fight the spread of the coronavirus.

Upon their return to activities, we strongly recommend that the Federal, District, State and Municipal Legislatures create a Parliamentary Front of the Elderly Assistance Entities.

The issue of the Committees of Rights and the Funds

One of the weaknesses of the National Policy for the Elderly (1994) was the veto against creation of the National Committee for the Rights of the Elderly. This weakness help lead to its suppression by Presidential Decree no. 9.893/2019, of June 27, 2019. In spite of its arbitrary and legally questionable dissolution, the experience accumulated with committees for rights shows the need and relevance of these collegiate bodies. Experience and the legislation also show us that we need councils for rights with certain characteristics, as shown in Figure 16.

Figure 16 – Characteristics Necessary for an Effective Council for the Defense of the Rights of the Elderly.



Source: Prepared by the authors.

It must be noted that the Councils for the Rights of the Elderly are essential actors in the primordial process of improving and carrying out the public policies aimed at this important segment of the Brazilian population. They were created to call on organized civil society to join the debates on topics inherent to the Rule of Law.

The diversity and extent of their legal attributions enables their specific work to actually create a fairer and more participative society with the elderly. From this perspective, the Councils are veritable citizenship-building instruments!

Another undeniable achievement of the Councils was the creation of funds for raising money to be used by the Council itself for the benefit of the elderly. The National Fund for the Elderly (FNI), created by Federal Law 12,213/2010, authorized Individuals and Legal Entities to deduct from their income tax contributions made to the FNI or to state, district or municipal funds for the elderly.

The National, State, District and Municipal Funds for the Elderly are instruments for raising, transferring and using funds intended to provide financial support for the implementation, maintenance and development of plans, programs, projects and actions focused on the elderly, in order to ensure the social rights or the elderly and to create the necessary conditions to promote their autonomy, integration and effective participation in society.

Each Fund serves its specific area: the entire country, in the case of the FNI; the entire State (if it is a State Fund), the Federal District or the respective Municipality. In addition, the overriding purpose of the Councils and their respective Funds is to encourage participation by people and their actions through legally organized entities and institutions that are registered at the Councils for the rights of the elderly. Legally, each fund must be:

- Administratively linked to the respective Ministry or Office to which the Council is administratively linked;

- Registered at the National Registry of Legal Entities; the description of their principal Economic Activity, among those listed in their founding or amending documents, must be the one that provides the greatest amount of revenue received or expected.

In relation to the Fund, following are the powers of the Councils for the

Elderly: I – Each year, prepare and approve the resource allocation plan for the Municipal Fund for the Elderly, containing the definition of the priority actions and programs to be implemented within the scope of the National/ State/Municipal/District Policy for the Elderly, and, as applicable, within the scope of the State and National Policy for the Elderly, in accordance with the goals established for the period and with the respective annual or multi-annual plan of the Office to which the Municipal Council on the Rights of the Elderly is administratively linked;

II – Establish the parameters and guidelines for use of the resources;

III – Accompany and evaluate the employment, performance and financial results of the Fund.

IV – Evaluate and approve the annual balance sheet of the Fund;

V – Request, at any time, and at their discretion, the information necessary to accompany, control and evaluate the activities under the responsibility of the Fund;

VI – Mobilize the different segments of society in the planning, use and control of the Fund;

VII – Accompany the programs developed with resources from the Fund, requesting audits from the Executive Branch whenever necessary;

VIII – Monitor and verify, onsite and at any time, the progress of the programs, projects and actions financed by the Fund;

IX – Approve agreements, adjustments, accords and/or contracts to be signed involving FMPI funds;

X – Publish in the Official Gazette, and/or post at locations of easy access to the community, all the resolutions of the Council referring to the FMPI.

It should be noted that the Fund constitutes a specific budgetary unit, and it is an integral part of the General Budget of the Union/ State/ Municipality Federal District, and its funds will be used to finance programs and actions, whether governmental or non-governmental, to develop the policies, programs and actions designed to support the rights of the elderly, allocated through deliberation (prioritizing, deciding where and how much to spend, authorizing the expenditure) of the state, federal district and municipal councils on the rights of the elderly. The distribution of the resources from the Fund to the areas considered to be priorities by the state, federal district and municipal councils of the Rights of the Elderly is done through the Fund Application Plan, which is prepared and passed by the Councils.

Unfortunately, Constitutional Amendment no. 95/2016, which refers to the limits on public spending, and which greatly hampers public policies, by submitting them to chronic and progressive underfunding, also affected the National Fund for the Elderly (FNI). As a result, the FNI can only use the sums available in its budget for the 2020 fiscal year, which is less than the amounts in some municipal funds. However, the amount collected in previous fiscal years by the FNI is approximately eight (80) million reais, held by the Ministry of the Economy. This considerable sum may be used for this good purpose. However, in order for this to occur, it will be necessary to present a Constitutional Amendment, in order to redefine or exempt the FNI from the effect of Constitutional Amendment no. 95/2016 and articulate support and votes to obtain the qualified majority of the votes of federal representatives and senators, since this impediment was caused by the Constitutional Amendment. This work should be done by the CIDOSO in the Chamber of Deputies.

Attention: Situations for allocation of resources collected in the Funds: for the District, State and Municipal Funds that are not affected by Constitutional Amendment no. 95, which refers to the limit on public expenditures, the Councils have the prerogative of managing the resource and deciding where to spend it.

The use of the resources of the Fund for the Elderly requires prior deliberation by the Plenary Session of the Councils. The resources from the District, State and Municipal Funds for the Elderly must have their own separate records, so that cash availability, revenues and expenses are accurately and individually identified.

The Councils have the exclusive right to deliberate on the use of the resources in their respective funds.

We emphasize that all the entities that promote actions in the field of care for the elderly and that wish to receive funds must ask to be registered, in their

municipality, at the Council for the Defense of the Rights of the Elderly, and in its absence, at the state council.

Knowledge of the content of Article 47 of the Statute for the Elderly, Law no. 10.741/2003, in regard to the care policy guidelines, is essential:

I- Basic social policies, established in Law no. 8842, of January 4, 1994;

II- Social assistance policies and programs of a supplementary nature, for those who need them;

III – Special services for the prevention and care of victims of negligence, mistreatment, exploitation, abuse, cruelty and oppression;

IV – Service of identification and locating of relatives or those responsible for the elderly abandoned in hospitals and long-term institutions;

V – Legal and social protection for entities for the defense of the rights of the elderly;

VI – Mobilization of public opinion to encourage participation by thedifferent segments of society in care for the elderly.

According to the Do You Want Advice Guide (2016), the origin and raising of resources for the Fund for the Rights of the Elderly may come from:

- Resources from government budgetary allocations;
- Allocations from the different spheres of government;
- Donations from individuals or legal entities;
- Fines levied in accordance with Law 10,741 of October 1, 2003 – Statute for the Elderly (see Title IV, Chapter IV; Title V, Chapter III, Art. 83 to 84 and Paragraph; and Title VI, Chapter II);
- Resources resulting from investment of funds (pursuant to the relevant legislation) on the financial market;
- Other forms of Raising Funds.

In relation to the legislation in effect, according to this Law 13,797 of January 3, 2019, Articles 2-A and 4-A were added to the Law, thereby amending Law no. 12,213, of January 20, 2010, to authorize individuals to make donations to the funds controlled by the Municipal, State and National Councils on the Elderly directly in their Individual Annual Income Tax Returns.

Individuals can donate directly to the funds controlled by the Municipal, State and National Councils for the Elderly in their annual tax returns beginning in the 2020 fiscal year, 2019 calendar year. This donation can be deducted up to the amount of 3% of the Income Tax owed, as calculated in the return. This deduction is also subject to the limit of 6% of the Income Tax owed as calculated in the return, together with the donations made directly to the Funds controlled by the Municipal, State and National Councils for the Rights of the Elderly, and during the calendar

year, by the Municipal, State and National Councils. This measure will enable increased actions to ensure quality of life for the elderly.

In order for civil society entities and government agencies to have access to the Fund, the nation, state, municipal and federal district councils will issue public notices inviting the establishment of partnerships with government and non-government entities. These instruments are governed by Federal Law no. 13,019, of July 31, 2014, which established the Regulatory Framework of Civil Society Organizations (MROSC) and Decree no. 8726, of April 27, 2016, which regulates it.

This Law established the legal regime governing partnerships between the public administration and civil society organizations, under a regime of mutual cooperation, in order to achieve public interest and reciprocal goals, through activities or projects previously determined in work plans placed in collaboration statements; it defines guidelines for the development, collaboration and cooperation policy with civil society organizations; and alters Laws 8429, of June 2, 1992, and 9790, of March 23, 1999. (Wording given by Law no. 13,204, of 2015)

The State and Municipal Councils on the Elderly, on Social Assistance and on Health have autonomy to deliberate on the transfer of money from the respective Funds. During this pandemic, it is essential that the institutionalized elderly population, which is extremely vulnerable to catching the coronavirus, hospitalization and death, be included on the agenda of these Councils.

For the most part, the nonprofit LTCFs serve the elderly who are vulnerable and weak. For this reason, it is essential that the Council assume its role as the defender of the rights of the elderly, and act to promote access by LTCFs to raw materials, in addition to reinforcing the need for contracting of the services necessary to preserve the health and lives of the elderly residents.

In this regard, it may be necessary for council members to reevaluate the allocation plan for their funds, taking into consideration the current situation, rethinking allocations that can be put off and directing funds towards the weak institutionalized elderly, especially those who live in philanthropic or even private institutions that do not have sufficient physical and human resources.

The council is responsible for discussion and determining the new use plan, considering the funds to be allocated to the LTCFs in their area, noting that the amount that will be transferred to the institution or for each institutionalized elderly person will be submitted for voting by all council members. Due to the need for social distancing, the Council meetings and deliberations should be held virtually, in compliance with all prudence and transparency.

If the Council votes to transfer a sum to the LTCFs, this must still be in line with the entity responsible for the Social Assistance Policy, since that entity will be in charge of the operations to make the transfer. The quickest process is through an existing partnership between civil society organizations (OSC) and the municipality, where there will be a new work plan, with the addition of the preventive action goals.

For those OSCs without a signed partnership with the municipality, it will be necessary to sign a Development Statement, for the emergency period, with a work plan, to conduct prevention and control measures to avoid the proliferation of infection by the coronavirus at the LTCFs. It should be noted that those municipalities with more than one non-profit LTCF must transfer the resources with the same rule on amounts for both, in accordance with Law 13,019/2014.

In order for transfers to be made to LTCFs, they must: be registered at the Social Assistance Council for the Elderly (in the case of resources from the Fund for the Elderly), and they must also show that their statutes are in line with the law.

It is worth emphasizing that the funds transferred to the LTCF are under the management of the Government, and that accounts must be rendered after the period established for use of the funds. Therefore, the work plan must be transparent in regard to the use of the funds and the format for rendering accounts, in accordance with Chapter IV, Sections I and II of Law no. 13,019/14, including after the period determined for use of the funds.

It is recommended that LTCFs contact the councils for the rights of the elderly to better clarify the criteria for allocation of monies from the Fund. On the other hand, it is important that the Public Policies and Rights Council have updated information on the situation of the LTCFs within this context of a pandemic, so that an understanding can be reached to provide resources for preventive actions to be taken at these locations. Additionally, even if funds have already been allocated, the Council can review the Usage Plan, prioritizing those actions.

It is important to note that projects are considered to be the group of activities or actions to be carried out within a certain period of time, according to the legislation in effect, which covers programs of promotion, protection and defense of the rights of the Elderly, and which prohibits the funding of programs and actions of an ongoing nature, according to the legislation in effect.

Another crucial point is knowledge by the Council of the group of LTCFs. How many are there? How many people reside in each one? This information is essential for the Council to move forward in the discussion, and even to know if there are funds available to reach all of them located there.

In this regard, following is a suggestion for a formal step by step procedure for reviewing the use of the Fund, based on the recent experience of Belo Horizonte (MG). Exhibit III contains a copy of a Resolution passed by the City Council on the Elderly of Belo Horizonte/MG and published in the Official Gazette of the Municipality on that case.

Figure 17 – Suggested step-by-step measures to access resources from the Municipal Fund for the Elderly by an LTCF that does not have a partnership with the municipality (Development Statement exclusively intended for use of funds for the prevention of Covid-19).

The Council is aware of the condition of the LTCFs in the municipality
The Council believes it is recommendable to allocate funds for prevention of Covid to the LTCF
The Council deliberates to allocate part of the resources in the Fund for the elderly population that is institutionalized in the municipality
CMI issues and approves a Resolution, and publishes it in the Official Municipal Press.
CMI sends all the documentation for the administrative proceeding to the Municipal Office of Social Assistance (SMAS).
SMAS and the Municipal Social Assistance Manager evaluate the documentation and approve the transfer, within the scope of Law no. 13.019/2014
The Municipal Legal Department evaluates the documentation and issues a favorable legal opinion.
The LTCF sends a detailed official letter and work plan to the Municipal Council for the Elderly (CMI) for use of the funds.
SMAS issues and publishes a Notice of Waiver of Public Call, invoking Article 30, section II.
The LTCF and the Municipality execute a Development Statement (partnership).
The municipality transfers the financial resources to the specific bank account of the LTCF.
The municipality notifies the LTCF that it will receive the funds and provides details on how to render accounts on the use of the funds
The Council monitors the use of the funds.

Figure 18 – Step by step actions to access the Municipal Fund for partner LTCFs (Amendment).

The Council is aware of the condition of the LTCFs in the municipality
The Council believes it is recommendable to allocate funds for prevention of Covid to the LTCF
The Council deliberates to allocate part of the resources in the Fund for the elderly population that is institutionalized in the municipality
The work plan of the partner LTCF receives an amendment with the goal to prevent Covid-19
SMAS publishes the Amendment Statement in the Official Municipal Gazette
The LTCF and the Municipality execute a Development Statement (partnership).
The municipality transfers the financial resources to the specific bank account of the LTCF.
The municipality notifies the LTCF that it will receive the funds and provides details on how to render accounts on the use of the funds
The Council monitors the use of the funds.

In the event there is resistance, and in order to facilitate the understanding of council members, of municipal secretaries of social assistance and health, and of the municipal attorneys, we are adding a legal opinion on this subject (Exhibit III).

Final Considerations.

Through this brief group project we hope that government representatives, legislators, council members and directors and managers of the LTCFs are able to forge a path forward together, so that all the means possible can be used to protect the institutionalized elderly and the employees of these institutions.

In addition to these agreed upon measures, attached is a legal opinion written by Attorney Cláudio Stucchi, with the contributions of the members of group no. 9, to provide guidance on use of the money from the Social Assistance, Elderly and Health Funds, where they exist.

XIII - GLOSSARY

BIOETHICS: refers to the interdisciplinary study that deals with matters related to life and death, thus the team must base themselves on the fundamental principles of the rights to: independence, beneficence, no wrong-doing, and justice, while caring for the residents and also with family members and the team. If there is a situation of a struggle between life and death, one must work with the understanding and acceptance of death, of the dimension of our primordial nature, which the knowledge thereof reifies the existence of human dignity in the face of the limits of medical science, of oneself and of those who are cared for.

BIO-SAFETY: refers to the set of actions aimed at preventing, minimizing or eliminating risks inherent to research, production, teaching, technological development and service provision activities, to secure the health of humans and animals, preserve the environment, and ensure the quality of results (Teixeira & Valle, 1996)[2].

CONFIRMED CASE: person that has gone through medical evaluation/triage and fits the clinical criteria and/or tested positive for the virus.

DISCARDED CASE: person that presented symptoms but, upon examination, the doctor identified another illness, such as the flu.

SUSPECTED CASE: anyone that has presented COVID-19 symptoms and/or has had contact with someone that has the illness.

INSTITUTIONAL COMMUNITY: the group of people involved in the institution's life: residents, family members, professionals, and visitors.

COVID-19: The official name of the disease called by the new coronavirus (WHO, 2019). In other words, the person that presents the main symptoms such as cough, fever, shortness

[2]Biosafety must be based on the classification set by CTNBio. Classification of Human and Animal Etiological Agents Based on Risk - Exhibit I of Law 8.974/95, Appendix 2, Normative Instruction N. 7, of June 6, 1997, Ministry of Science and Technology - Technical Bio-safety Commission - CTNBio.

of breath may have CoVID-19, the disease caused by Sars-Cov-2 (acronym that refers to the name of the coronavirus that causes this disease).

PALLIATIVE CARE: approach characterized by relieving the human suffering associated to the disease threatening the continuity of life. This suffering may be related to physical, psychological, social, and spiritual issues. Thus, it involves early identification, in-depth assessment, and treatment of those symptoms. This care improves the quality of life, dignity, and comfort, and also has a positive influence on the course of the disease, allowing for the patient and the family to be accompanied.

DISINFECTION: it is the process that eliminates most of the organisms that cause diseases. Some factors impair the operation's effectiveness, such as dilution errors; inadequate temperature and PH; prior cleaning poorly performed; insufficient exposure time to the disinfectant.

SOCIAL DISTANCING: this means reduced interaction by the people of a community to reduce the speed of transmission of the virus. During distancing, there is reduced contact with other people, however it is important to maintain activities, social relationships, and mental health care.

EDUCATION: addresses a pedagogy that transforms reality, that is, a pedagogy that transforms praxis, centered on the four pillars of knowledge and continuing education: Learn to Know, Learn to Do, Learn to Live Together, and Learn to Be.

PERSONAL PROTECTION EQUIPMENT (PPE): all device or product of individual use used by professionals or residents, aimed to protect against risks that may threaten their health and safety.

FUNCTIONALITY: The World Health Organization's functionality model adopts a biopsychosocial approach, reflecting the interaction between the several health dimensions (biological, individual, and social) described in the components: bodily function and structure, activity, and participation. In this sense, a function or disability in a domain represents an interaction between a health condition (illness, trauma, injury) and contextual factors (environmental and personal factors).

VULNERABLE OR RISK GROUP: People who can develop the most severe condition of the disease and, therefore, are more likely to die due to the infection: the elderly and people with other associated diseases, such as heart disease, diabetes and people with other respiratory problems such as asthma and bronchitis. These groups must have priority treatment and in testing for the virus.

LONG-TERM CARE INSTITUTION FOR THE ELDERLY: it is the legally constituted governmental or non-governmental organization that provides comprehensive care with specialized services aimed at promoting and social protection, maintaining physical and emotional health, personal care and social and family life for the elderly. From a human rights perspective, long-term care facilities for the elderly must ensure, in every manner, conditions of well-being for their residents, through the guarantee of all their rights.

SOCIAL ISOLATION: it is a measure that aims to separate sick people (with respiratory symptoms, suspected or confirmed cases of coronavirus infection) from non-sick people, to prevent the virus from spreading. Isolation may take place at the LTCF, at the patient's residence, or in a hospital, according to the clinical status of the person. This action may be prescribed by a doctor or an epidemiological surveillance agent and has a maximum term of 14 days.

CLEANING:it is the activity that removes dirt visible to the eyes. Usually, this action is done with water, detergent, and fiber (when done in environments), thus removing dirt or residual fat (thinner organic material).

GUIDANCE: it refers to the professional's knowledge about the needs of the institutional community and serves as a basis for planning the daily actions to be performed, in this case, in the fight against COVID 19. For example: does the LTCF's manager and team know the problems related to COVID-19? Are there COVID-19 prevention protocols in place directed to the residents, teams, and deliverers? Do the managers and the team of the LTCF discuss with the community the procedures used in the LTCF?

ASYMPTOMATIC BEARER: Person infected by the coronavirus but that has not developed the symptoms of the illness. According to health agencies, most cases of COVID-19 do not show symptoms, which makes it difficult to account for the actual number of cases and increases the need for precautionary and hygiene measures.

PCR TEST: It is one of the types of tests for specific identification of the coronavirus, with a very high level of precision, so much so that it is called the "gold standard". The result takes longer: normally 3 to 4 days and, now, with the high demand, up to a week.

FAST TEST OR FAST KITS: quicker and less precise ways to identify the presence of the virus. They can be used as a form of screening: those who are not at risk, such as young people, can test and stay at home without bringing risk to the elderly and more sensitive people. The sample for analysis can be collected with a cotton swab in the airways or by collecting blood. The result is ready in up to 30 minutes, and it may be ready within only 10 minutes.

BIBLIOGRAPHICAL REFERENCES

ALCÂNTARA, A.de O. & GIACOMIN, K.C. (March, 2013). Fundo Nacional do Idoso: Um instrumento de fortalecimento dos Conselhos e de garantia de direitos da pessoa idosa. Revista Kairós Gerontologia,16(1), pp. 143-166. Online ISSN 2176-901X. Print ISSN 1516-2567. São Paulo (SP), Brazil: FACHS/NEPE/PEPGG/PUC-SP

ALVES, Walquiria Cristina Batista. **Guia para oficina de dança marujada: perspectivas da educação física para melhoria da marcha e do equilibrio na pessoa idosa.** Programa de Mestrado Profissonal em Ensino em Saúde - Educação Médica do Centro Universitário do Estado do Pará. Belém: Twee, 2019.

APRAHAMIAN, I., CEZAR, N.O. DE C., IZBICKI, R., LIN, S.M., PAULO, D.L.V., FATTORI, A., BIELLA, M.M., JACOB FILHO, W., AND YASSUDA, M.S. (2017). Screening for Frailty With the FRAIL Scale: A Comparison With the Phenotype Criteria. J. Am. Med. Dir. Assoc. 18, 592–596.

ARANTES, R.C. Diretrizes para a gestão do envelhecimento ativo e com qualidade de vida para idosos brasileiros. In: Lina F, Calábria L, Alves W, organizers. Envelhecimento: um olhar interdisciplinar. São Paulo: Hucitec, 2016. p.188-214.

BAILE WK, BUCKMAN R, LENZI R, et al. SPIKES-A six-step protocol for delivering bad news: application to the patient with cancer. **Oncologist**. 2000; 5 (4): 302-11.

BRASIL - Ministério da Justiça e Cidadania. Quer um Conselho? Guia prático para a criação de conselhos e fundos estaduais e municipais de defesa dos direitos da pessoa idosa. National Council for the Rights of the Elderly - Brasilia: Ministry of Justice and Citizenship, 2016

BRAZIL, National Congress. **Legislative Decree N. 6, 2020**, for the purposes of Article 65 of Complementary Law N. 101, of May 4, 2000, as requested by the President of the Republic, submitted through message N. 93, of March 18, 2020. Available at: http://www.planalto.gov.br/ccivil_03/portaria/DLG6-2020.htm. Accessed on: April 2, 2020.

BRAZIL, Ministry of Health, Department of Primary Health Care. **Technical Note – SVS/SES – RJ n.º 12/2020 and Item 2.5.1 of Technical Note COSAPI/CGCIVI/DAPES/SAPS/MS n. º 07/2020.** Available: http://189.28.128.100/dab/docs/portaldab/documentos/notatecnica62020COSAPICGCIVIDAPESSAPSMS02abr2020COVID-19.pdf. Accessed on: April 12, 2020.

BRAZIL, Ministry of Health. **The Elderly Person's Health Handbook.** Brasília, 2017. Available at: https://portalarquivos2.saude.gov.br/images/pdf/2017/setembro/27/CADERNETA-PESSOA-IDOSA-2017-Capa-miolo.pdf. Accessed on: April 2, 2020.

BRAZIL, Ministry of Health. Treatment Protocol for the New Coronavirus. In: **Saúde Md**, editor. 2020.

BRAZIL, Ministry of Social Development and Fight Against Hunger. ORDINANCE N. 90, SEPTEMBER 3, 2013, **Provides for the parameters and procedures related to federal co-financing for the provision of the Protection Service in Situations of Public Disasters and Emergencies.** Available at: https://www.mds.gov.br/webarquivos/arquivo/assistencia_social/Portaria_90_03092013_Situacao_Calamidade.pdf. Accessed on: April 2, 2020.

BRAZIL, Department of Primary Health Care. **Protocol for the clinical management of coronavirus (COVID-19) in Primary Health Care.** Brasilia, March 2020.

Brazil. National Health Surveillance Agency (ANVISA). Technical Note nº 05/2020 GVIMS/GGTES. **Guidelines for the Prevention and Control of Infections with the new coronavirus (SARS-Cov-2) in Long-Term Care Facilities for the Elderly.** Brasilia, March 24, 2020. Brasília, [Internet]. 2020. [Accessed on: April 02, 2020. Available at: https://www20.anvisa.gov.br/segurancadopaciente/index.php/alertas/item/nota-tecnica-n-05-2020-gvimsggtes-anvisa-orientacoes-para-a-prevencao-e-o-controle-de-infeccoes-pelo-novocoronavirus-sars-cov-2-ilpi. Accessed on: April 2, 2020.

BRAZIL. National Health Surveillance Agency (ANVISA).**Resolution SES n.º 2013**, of March 20, 020 and Technical Note GVIMS/GGTES/ANVISA n.º 04/2020. Available at: http://portal.anvisa.gov.br/documents/33852/271858/Nota+T%C3%A9cnica+n+04-2020+GVIMS-GGTES-ANVISA/ab598660-3de4-4f14-8e6f-b9341c196b28. Accessed on: April 2, 2020.

BRAZIL. **Law N. 10.741, of October 1, 2003.** The Elderly Act. Official Gazette of the Union, Brasilia, Oct. 3, 2003. Available at: http://www.planalto.gov.br/ccivil_03/leis/2003/l10.741.htm. Accessed on: April 2, 2020.

BRAZIL. Law No. 12,213 of January 20, 2010 - Establishes the National Fund for the Elderly and authorizes the deduction of donations made to Municipal, State and National Fund for the Elderly from the income tax due by individuals and companies; and amends Law No. 9,250, of December 26, 1995. Available at:

http://www.planalto.gov.br/ccivil_03/_Ato2007-2010/2010/Lei/L12213.htm Acesso em: April 2, 2020.

BRAZIL. **Law No. 13,797 of January 3, 2019** - Amends Law No. 12,213, of January 20, 2010, to authorize individuals to make donations to funds controlled by the Boards Available at: http://www.planalto.gov.br/ccivil_03/_ato2019-2022/2019/lei/L13797.htm Accessed on: April 2, 2020.

BRAZIL. Ministry of Citizenship, Ministry of Women, Family and Human Rights. PUBLIC NOTE issued on 3/20/2020 - **Corona virus Prevention Measures in Inpatient Facilities** - PROCESS No. 71000.018129 / 2020-74 Clinical management protocol MS nº 8. Brasilia, March 20, 2020. Brasília, [Internet]. 2020.Available at: http://www.crianca.mppr.mp.br/arquivos/File/legis/COVID19/nota_publica_mmfdh_prevencao_COVID19_acolhimento.pdf. Accessed on: April 2, 2020.

BRAZIL. Ministry of Health. Health Care Department - Department of Programmatic and Strategic Actions. **Technical guidelines for the implementation of a Line for Comprehensive Health Care for the Elderly in the Unified Health System - SUS.** Brasília: Ministry of Health, 2018. Available at: http://bvsms.saude.gov.br/bvs/publicacoes/linha_cuidado_atencao_pessoa_idosa.pdf . Accessed on: April 12, 2020.

BRAZIL. **Joint Ordinance No. 1, of April 2, 2020** - National Secretariat for Social Assistance (SNAS) - provides for the use of Federal Co-financing resources in meeting emergency demands to fight the Coronavirus (COVID-19) under the Unified Social Assistance System. Official Gazette of the Union, Brasilia, April 3, 2020. Available at: http://www.in.gov.br/en/web/dou/-/portaria-conjunta-n-1-de-2-de-abril-de-2020-251067584. Accessed on: April 12, 2020.

BRAZIL. **ORDINANCE N. 90, SEPTEMBER 3, 2013,** Provides for the parameters and procedures related to federal co-financing for the provision of the Protection Service in Situations of Public Disasters and Emergencies. Official Gazette of the Union, Brasilia, Sept. 4, 2013. Available at: https://www.mds.gov.br/webarquivos/arquivo/assistencia_social/Portaria_90_03092013_Situacao_Calamidade.pdf. Accessed on: April 12, 2020.

BRAZIL. **Resolution N. 109, of November 11, 2009** - National Council of Social Assistance (CNAS). Approves the National Typification of Social Assistance Services. Official Gazette of the Union, Brasilia, Nov. 25, 2009. Available at: http://www.mds.gov.br/cnas/legislacao/resolucoes/arquivos-2009/cnas-2009-109-11-11-2009.pdf/view. Accessed on: April 12, 2020.

BRAZIL. **Resolution N. 33, of December 12, 2012** -National Council of Social Assistance (CNAS) - Approves the Basic Operational Norm of the Unified Social Assistance System (NOB/SUAS). Official Gazette of the Union, Brasilia, January 3, 2013. Available at: http://www.mds.gov.br/cnas/legislacao/resolucoes/arquivos-2012/arquivos-2012/. Accessed on: April 12, 2020.

CLOS, Michelle Bertóglio. Cuidado de idosos institucionalizados: o desafio da integralidade. **Estudos sobre Envelhecimento,** V. 28, N. 69, Dez. 2017. Available at: https://www.sescsp.org.br/files/artigo/85b2b2b2/00b7/4910/a07e/19c9e601c272.pdf. Accessed on: April 13, 2020.

CONASS, 2020. Available at: http://www.somiti.org.br/arquivos/site/comunicacao/noticias/2020/COVID-19/documentos/cuidados-paliativos-no-idoso-com-suspeita-de-COVID-19-conass.pdf Acesso em: April 13, 2020.

COSTA, E. F. A.; MONEGO, E. T. Avaliação Geriátrica Ampla (AGA). **Revista da UFG**, v. 5, n. 2, dez. 2003. Available at: <https://revistas.ufg.br/revistaufg/article/view/49768/24439>. Accessed on: April 12, 2020.

DADALTO L. **Testamento Vital**: São Paulo: Editora Foco, 2020.

D'ADAMO H, YOSHIKAWA T, OUSLANDER JG. Coronavirus Disease 2019 in Geriatrics and Long-term Care: The ABCDs of COVID-19**. J Am Geriatr Soc.** 2020.

GAUR S; DUMYATI G; NACE DA, et. Al. Unprecedented Solutions for Extraordinary Times: Helping Long-Term Care Settings Deal with the COVID-19 Pandemic. **Infect Control Hosp Epidemiol**. 2020:1-8.

HIGH KP; BRADLEY SF; GRAVENSTEIN S; MEHR DR, et al. Clinical practice guideline for the evaluation of fever and infection in older adult residents of long-term care facilities: 2008 update by the Infectious Diseases Society of America**. J Am Geriatr Soc.** 2009;57(3):375-94.

KIMBALL, A., HATFIELD, K.M., ARONS, M., JAMES, A., TAYLOR, J., SPICER, K., BARDOSSY, A.C., OAKLEY, L.P., TANWAR, S., CHISTY, Z., et al. (2020). Asymptomatic and Presymptomatic SARS-CoV-2 Infections in Residents of a Long-Term Care Skilled Nursing Facility - King County, Washington, March 2020. MMWR Morb. Mortal. Wkly. Rep. 69, 377–381.

MACIEL, MG. Fiocruz - Paliative Care - Guidelines for Health Professionals. Available at: https://www.fiocruzbrasilia.fiocruz.br/wp-content/uploads/2020/04/Sa%C3%BAde-e-Mental-e-Aten%C3%A7%C3%A3o-Psicossocial-na-Pandemia-COVID-19-cuidados-paliativos-orienta%C3%A7%C3%B5es-aos-profissionais-de-sa%C3%BAde.pdf Acesso em 10 de abril de 2020.

MAIO, Iadya Gama. **Pessoa idosa dependente:** políticas públicas e cuidados intermediários ao idoso no Brasil e a atuação do Ministério Público. Curitiba: Juruá, 2016.

MC MICHAEL TM; CLARK S; POGOSJANS S, et al. COVID-19 in a Long-Term Care Facility - King County, Washington, February 27- March 9, 2020. **MMWR Morb Mortal Wkly Rep**. 2020; 69 (12): 339-42.

MELEIRO, Maricelma Rita. **As Instituições de Longa Permanência para Idosos sob a perspectiva de um novo modelo**. Revista Jurídica ESMP-SP, vol. 9, São Paulo, 2016. Available at: http://www.esmp.sp.gov.br/revista_esmp/index.php/RJESMPSP/article/view/295. Accessed on: April 12, 2020.

MORAES, Edgar Nunes. **Atenção à Saúde do Idoso:** aspectos conceituais. Brasília: Organização Pan-Americana da Saúde, 2012.

PRÁTICA DE ATIVIDADE Física durante o Distanciamento Social. Available at: https://www.diabetes.org.br/COVID-19/pratica-de-atividade-fisica-durante-o-distanciamento-social. Accessed on: April 11, 2020.

ROCKWOOD, K., SONG, X., MACKNIGHT, C., BERGMAN, H., HOGAN, D.B., MCDOWELL, I., AND MITNITSKI, A. (2005). A global clinical measure of fitness and frailty in elderly people. CMAJ Can. Med. Assoc. J. J. Assoc. Medicale Can. 173, 489–495.

STUCCHI, Cláudio. A falta de políticas públicas para idosos com demência. Available at: http://www.previnerconsultoria.com.br/index.php/component/content/article/47-artigos-do-terceiro-setor/119-artigo-a-falta-de-politicas-publicas-para-os-idosos-institucionalizados-que-sofrem-com-demencia.html. Accessed on: May 1, 2014, p.2. IN ABREU, Célia Barbosa; VAL, Eduardo Manuel. **Políticas Públicas de Saúde para Idosos com Alzheimer**. Available at: www.univali.br/periodicos. Accessed on:

WANNMACHER, Lenita. Medicina paliativa:cuidados e medicamentos. **Report** Pan American Health Organization / World Health Organization. Vol. 5, Nº 1, Brasília, December 2007. Available at: https://www.paho.org/bra/index.php?option=com_docman&view=download&alias=518-medicina-paliativa-v-5-n-1-2007-8&category_slug=uso-racional-medicamentos-685&Itemid=965.

WATANABE, Helena Akemi Wada; DI GIOVANNI, Vera Maria. Instituições de Longa Permanência para Idosos (ILPI). In: **Envelhecimento & Saúde** (Boletim do Instituto de Saúde), p. 69-71, São Paulo, Abr. 2009.

WHO. **Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises.** 2018. Available at: https://www.who.int/servicedeliverysafety/en/. Accessed on: April 13, 2020.

EXHIBITS

ANNEX I - SUGGESTED QUESTIONNAIRE FOR THE DIAGNOSIS OF THE LTCFs SITUATION WITH REGARD TO COVID19

Goal: identify the EMERGENCY needs of Long-Term Care Facilities (LTCF) to address the COVID-19 pandemic.

DIAGNOSIS OF THE SITUATION OF LTCFs WITH REGARD TO COVID-19				
Name of Institution:				
Address:				
City:	State:	Telephone:		
CNPJ (Taxpayer Registry Number):				
1. Type:				
( ) Philanthropic	( ) Private	( ) Public		
2. Person Technically Accountable for the LTCF				
Name:	Profession:			
Phone number (mobile) of the person technically accountable for the LTCF?				
3. Basic Health Care Unit (clinic) of reference of the LTCF				
Name:	Telephone:			
Name of professional for contact:	Telephone:			
4. How many seniors can the LTCF assist?	Total:			
5. How many elderly people are residing at the LTCF?				
Men:	Women:	Total:		
6. Level of functional dependence of the resident population according to RDC 283/2005				
Level I:	Level II:	Level III:		
7. How many of these elderly are "bedridden" (i.e, require help for transfer)?	Total:			
8. What is the maximum number of seniors per room?				
( ) 1	( ) 2	( ) 3	( ) 4	Other:
9. How many people work at the LTCF?	Total:			
10. How many of these are carergivers?	Total:			
11. Did any caregivers need to be put on leave from work because of Covid-19?	Total:			
12. If so, was there a replacement?	( ) Yes	( ) No		

13. How many health professionals work at the LTCF?		Total:	
14. Did any of them need to be put on leave from work because of Covid-19?		Total:	
15. If so, was there a replacement?		( ) Yes	( ) No
16. Are ALL workers/employees performing the proper hygiene DAILY at the entrance/reception ?		( ) Yes	( ) No
17. If not, state the reason:			
( ) Was not aware of the need	( ) Is aware, but it can't be done	Other:	
18. Are ALL LTCF workers and employees wearing "common" masks (for the protection of the other) during working hours?		( ) Yes	( ) No
19. If not, state the reason:			
( ) Was not aware of the need	( ) Is aware, but it can't be done	Other:	
20. Is it possible to achieve a minimum distance of 2 meters between each senior in the common areas?		( ) Yes	( ) No
21. If not, state the reason:			
( ) Was not aware of the need	( ) Is aware, but it can't be done	Other:	
22. Is active screening of flu signs and symptoms of workers and employees being performed EVERY DAY at the entrance/reception of the LTCF?		( ) Yes	( ) No
23. If not, state the reason:			
( ) Was not aware of the need	( ) Is aware, but it can't be done	Other:	
24. Are personal protective equipment (PPE) being used in accordance with Technical Note GVIMS/GGTES/ANVISA No. 05/2020?		( ) Yes	( ) No
25. Are there individual rooms available at the LTCF for the isolation of suspected or diagnosed cases?		( ) Yes	( ) No
26. If so, how many?		Total:	
27. If not, state the reason:			

( ) Was not aware of the need	( ) Is aware, but it can't be done	Other:	
28. If there are suspicious or confirmed cases of COVID-19 among the elderly residents, does the LTCF have or will it be able to adopt the measures for prevention/control of infection according to Technical Note GVIMS/GGTES/ANVISA nº 05/2020?		( ) Yes	( ) No
29. If so, for how many?		Total:	
30. If not, state the reason:			
( ) Was not aware of the need	( ) Is aware, but it can't be done	Other:	
31. If there are suspect or confirmed cases of Covid-19 among the elderly residents, can the waste from the care of these elderly people be treated as category A1, according to RDC no. 222 of Anvisa?		( ) Yes	( ) No
32. If not, has this been informed to the Health Center?		( ) Yes	( ) No
33. Are the families of the elderly being actively and periodically informed about their situation and the measures adopted by the LTCF?		( ) Yes	( ) No
34. If not, state the reason:			
35. Are the families of the elderly being actively and periodically informed about their situation and the measures adopted by the LTCF?		( ) Yes	( ) No
36. If not, state the reason:			
37. Have influenza and pneumonia vaccines been made available to ALL elderly residents at the LTCF?		( ) Yes	( ) No
38. If not, state the reason:			
39. Has the flu vaccine been made available to ALL caregivers and professionals who work at the LTCF?		( ) Yes	( ) No
40. If not, state the reason:			
41. In the last three months, has the LTCF received at least one visit from the health agency for health inspection purposes?		( ) Yes	( ) No

42. Do you need technical-scientific support for the implementation of the COVID-19 prevention and control measures in your LTCF?	( ) Yes	( ) No
43. Do you need Personal Protective Equipment (PPE) for the implementation of the COVID-19 control and prevention measures?	( ) Yes	( ) No
44. Do you need more information about the treatment flow in the health system (clinic/hospital) for elderly residents with flu/respiratory syndromes?	( ) Yes	( ) No
45. Are you facing difficulties in the access to medicines for continuous use for the elderly residents?	( ) Yes	( ) No
46. Are you facing difficulties to maintain the proper nutrition of the elderly residents?	( ) Yes	( ) No
47. Is the LTCF performing admission or readmission after hospitalization of elderly people during the pandemic?	( ) Yes	( ) No
48. If so, is the recommended period of 14 days of isolation being fulfilled?	( ) Yes	( ) No
49. If it's not being fulfilled, state the reason:		
( ) Was not aware of the need	( ) Is aware, but it can't be done	Other:
50. Name of the person responsible for completing the questionnaire:		
Position:		Date:
Suggestions:		

ANNEX II - MANAGEMENT OF THE MAIN SYMPTOMS OF PATIENTS IN PALLIATIVE CARE DUE TO COVID-19

A vast literature on palliative care is available online.

We suggest consulting some handbooks (in Portuguese):

1- VAMOS FALAR DE CUIDADOS PALIATIVOS? - SBGG

https://sbgg.org.br/wp-content/uploads/2015/05/vamos-falar-de-cuidados-paliativos-vers--o-online.pdf

1. O QUE SÃO CUIDADOS PALIATIVOS? - SBGG

http://sbgg.org.br/wpcontent/uploads/2014/11/1421326099_Folder_Online_SBGG_.pdf.

2. MANUAL FIOCRUZ DE CUIDADOS PALIATIVOS: ORIENTAÇÕES AOS PROFISSIONAIS DE SAÚDE

https://renastonline.ensp.fiocruz.br/sites/default/files/arquivos/recursos/saude-e-mental-e-atencao-psicossocial-na-pandemia-covid-19-cuidados-paliativos-orientacoes-aos-profissionais-de-saude.pdf

3. MANUAL DA ASSOCIAÇÃO NACIONAL DE CUIDADOS PALIATIVOS:

https://www.santacasasp.org.br/upSrv01/up_publicacoes/8011/10577_Manual%20de%20Cuidados%20Paliativos.pdf

4. CUIDADOS PALIATIVOS – GUIA DE BOLSO

https://5c9c40b3-e3fb-4828-b295-217bf3a54e79.filesusr.com/ugd/f59eea_0d17e53c81144d069f00e16d53137731.pdf

5. CUIDADO PALIATIVO – CREMESP

http://www.cremesp.org.br/library/modulos/publicacoes/pdf/livro_cuidado%20paliativo.pdf