

Policy Brief

Ethical Recommendations for Mobile SARS-CoV-2 Vaccination Teams in Long-Term Care Homes

Key Messages

Mobile vaccination teams visiting long-term care homes will have an important role in providing vaccination coverage for some of the most vulnerable population sub-groups. However, based on the experiences of German mobile diagnostic teams during the first COVID-19 pandemic wave, the deployment of mobile vaccination teams to care homes for older adults and people with disabilities is expected to raise various ethical challenges. These individuals are the most vulnerable to disease and death and, therefore, likely to have high or the highest priority in the vaccination strategy. Besides organizational barriers, the success of the vaccination strategy will also depend on the capacity and ethical competency of well-trained inter-professional teams. Regardless of public expectations and hopes, vaccination programs must not fall into the trap of pandemic exceptionalism by ignoring or overriding established principles of biomedical ethics. Hence, in all their activities, the principles of respect for individuals' autonomy and for trust have to be balanced with a population perspective which aims at a broad vaccination coverage. Policy makers, nursing representatives and those implementing the vaccination programs are called on to reflect upon, consider and integrate some practical ethical guidance into the planning and training of mobile vaccination teams.

Background

To protect against a severe course of COVID-19 or death, and to contain the SARS-CoV-2 virus, the widest possible dissemination of the vaccine deserves priority from a public health perspective. In Germany, this dissemination is based on the legally binding *Coronavirus-Impfverordnung* (German Coronavirus vaccination regulation), issued by the Federal Ministry of Health (BMG 2020). Informed by the drafted vaccination recommendations of the German Standing Committee of Vaccination (STIKO) at the Robert Koch-Institute (STIKO 2021), the *Coronavirus-Impfverordnung* gives, among other groups, the highest priority to residents in institutionalized long-term care. To manage the distribution of the vaccines, people living in long-term care facilities will be reached by mobile vaccination teams, conducting field vaccination (Weigl 2020). During the on-site implementation, these teams may encounter conflicts between a population-based commitment to high vaccination coverage and respect for the individuals' autonomy. The latter may also conflict with the principle of beneficence; something that we know to be beneficial for the person may be resisted by the same individual.

Given the prevailing scarcity of resources (such as vaccine doses, qualified healthcare personnel and vaccination infrastructure) efficient procedures and criteria for the distribution of the vaccines need to be considered (Schröder-Bäck et al. 2020; for ethical guidance on the global level: Venkatapuram et al. 2020). Thus, vaccination programs are subject to further ethical considerations, including fair allocation, ad-hoc prioritisation and rationing (covered in detail, e.g., by Verweij 2009). Hence, mobile vaccination teams need to be able to deal with the challenges that can arise from such underlying conflicts while urgently distributing vaccines to vulnerable, often cognitively impaired individuals, in an environment of high political and public expectations. Moreover, previous experience with mobile teams in regard to testing for SARS-CoV-2 has revealed challenging conditions for interprofessional teamwork (Hunger, Schumann 2020). It is assumed that mobile vaccination teams will operate under similar circumstances and face similar challenges. However, the undertaking will be further complicated by requirements related to storage (need for a special freezer, highly perishable once processed) (FDA 2020), dosing schedule (mostly two doses at intervals of several weeks) and an invasive

route of administration (WHO 2020). Although explicitly tailored to long-term care, the following recommendations might also be applied to future deployments of mobile medical teams during the pandemic and beyond.

Purpose and Method

This policy brief identifies ethical issues and reflects upon the ethical challenges that result from the special conditions under which mobile vaccination teams operate in homes for older adults and people with disabilities. While this brief is based on experiences in Germany, the reflections, conclusions and recommendations set forth can be applied beyond this particular national context. The recommendations presented here foster and promote ethically competent interactions with the vulnerable groups and responsible allocation of scarce resources.

Reflections

In order to increase public health benefit, vaccination of the population is of highest priority in order to reduce harm resulting from the Covid-19 pandemic. However, even a highly effective and efficient vaccine program in pursuit of the common good is subjected to ethical constraints. Many of these constraints stem from the tension between the common or social versus individual goods. Issues related to justice include the fair and equal access to the vaccine, and special consideration of vulnerable groups, including socially or otherwise disadvantaged groups. However, these principles which underlie the whole vaccination program are particularly challenged by classical biomedical ethics, foremost the principle of respect for an individual's autonomy. As the prioritized groups belong to the most vulnerable individuals due to their medical conditions or age (STIKO, DER, Leopoldina 2020), respecting their autonomy, also by transparent and open information on the vaccine, should not, at the least, increase their vulnerability. Lastly, operating in a transparent, trustworthy manner while balancing population benefit and respect for individuals' autonomy is a challenge on its own. This requires special ethical competence. Hence, the ethical considerations, presented in no hierarchical order, at stake are:

- population benefit, here understood as the protection of health for as many people as possible (Childress et al. 2002),
- justice, i.e. the fair distribution and allocation of resources and benefits (Schröder-Bäck et al. 2020),
- respect for individual autonomy (guaranteed, i.a., by informed consent) (Beauchamp, Childress 2019, pp. 118ff.),
- development and maintenance of trust (Childress et al. 2002),
- transparency (Childress et al. 2002) and openness (Daniels, Sabin 1998).

In the following, we primarily focus on questions of autonomy, as they are particularly pertinent in the settings of mobile teams visiting care homes.

Planning of the Vaccination Program

Respect for autonomy requires appropriate information: The individual decision for or against the vaccination should be based on an adequate understanding of the intervention. Before the implementation of the vaccination program, appropriate information about the vaccine, preferably in simple language, must be provided to everyone concerned (e.g., based on the *RKI-Aufklärungsmerkblatt* (information leaflet); RKI 2020). Aside from medical risks and benefits, this information should cover eligibility criteria and the background for prioritized vaccination to further the population's understanding of the prioritisation criteria and enhance the perception of the prioritisation as being fair (STIKO, DER, Leopoldina 2020). The need to get two doses of the vaccine, as well as the related difficulties in getting access to the vaccination (once refused) outside of the program has to be highlighted. Moreover, it is important to provide information about who is carrying out the procedure, cost coverage, and liability. Ideally informed consent by the individual or their legal representative will be obtained before the vaccination day. If possible, the residents' general practitioners should be involved in the process, e.g., by providing medical information. Furthermore, at this stage, persons who are not eligible for the vaccination due to a medical condition must be identified.



Dependency requires participation and respect for autonomy: Even well-intended vaccination campaigns run the risk of overriding an individual's autonomy, especially when engaging with vulnerable individuals. Vulnerability not only encompasses physical health, but needs to be acknowledged in its psychological, social and cultural dimensions (Rogers 2014). Under pandemic conditions, elderly individuals and those with disabilities may have suffered from months of social isolation, and many have experienced social marginalization as well (Abbasi 2020; Deutscher Ethikrat 2020). Moreover, remaining contact restrictions may have increased their dependency on professional caregivers, and potentially have aggravated prevailing asymmetric power relationships (e.g., by being dependent on the home management's handling of visitation arrangements or permission to leave the nursing home). It is likely that the individual's caregivers and proxies will focus on the promised benefits of the vaccine, and, thus, aim at protecting the person's physical health on the costs of their psycho-social well-being or autonomy. Hence, decision-makers and nursing home management should consider involving residents or residents' representatives in the planning phase and invite them to continuously provide feedback in order to improve the implementation process to ease reluctance, fear or doubt. Their contribution could help to continuously improve both the understanding of their attitude towards workflow and person-centeredness of the vaccination programs (DGP 2020). From the start, this participatory approach has to be complemented by adequate training of the mobile teams, e.g., in person-centered communication.

On-site Implementation

Cognitive impairments require special awareness: Even if persons (or their proxies) have consented to receive the vaccination beforehand, there is still the need for obtaining current in-person, informed consent on-site. Thus, a conflict between prior affirmative consent and actual (verbal or presumed) refusal can arise. Persons may refuse consent verbally or nonverbally, e.g., by becoming agitated. In this situation, it should be taken into account that decision-making could have been influenced by the individual's caregivers and/or proxies, that it can be influenced by the possibly intimidating presence of mobile teams, and that the use of personal protective equipment impairs personal, non-verbal and therefore trustful communication (Hampton et al. 2020). As the



vaccination is voluntary, a setting must be guaranteed in which vulnerable individuals can make a decision for or against the vaccination free from undue influences or pressure. Since it is particularly challenging to communicate with and obtain informed consent from older adults with cognitive impairments (e.g., dementia) and people with certain mental disabilities, this will require special training for members of mobile teams. The risk of misunderstandings and forced decisions can be also reduced if someone who knows the person well (e.g., proxies or the general practitioner) is available by telephone on the day of the vaccination. In the case that the job position is filled, the nursing home's ethics consultant might be involved additionally or alternatively. An informed refusal by the person or their surrogate must be respected.

Distributive justice requires ad-hoc prioritization: Surplus vaccine doses may occur under certain circumstances. Moreover, particular challenges may arise given that certain vaccines are particularly heat-sensitive or become non-viable if not used within a narrow time frame when preprocessed. Given the relative scarcity of vaccines, discarding leftovers is unacceptable, and timely alternative usage, or a clear storage plan for surplus supplies should be found. Such proceedings should be clarified in advance to ensure mobile teams are not put in a position to make on-site decisions. Furthermore, clear responsibilities have to be assigned for deciding upon on-site alternative usage. In these instances, transparent, open communication with all parties involved is of particular importance. If existent, the ethics consultant should be called in, too. Any ad-hoc resolution must consider the legal regulations and recommendations valid at that time.

Debriefing and Feedback-Loops

Dynamic working conditions require continuous training and ethical competence: Regular training based on lessons learned should be part of every stage of the implementation process. In line with the outlined ethical and organizational challenges and the lessons learned from mobile testing teams, the following methods (as further described in Hunger, Schumann 2020) may contribute to efficient teamwork and the team members' competency development: understanding of team processes and shared guiding principles, short training sessions (e.g., on new guidelines) with room for discussion and regular feedback rounds to continuously formulate and integrate lessons

learned into the workflow. Moreover, the teams should be prepared to provide answers to medical questions and critical issues related to the vaccination strategies (e.g., on how to deal with nursing home residents who have refused a vaccination and may therefore pose a risk to others).

Recommendations and Conclusion

This policy brief has been written to address the specific issues and ethical challenges that arise for mobile SARS-CoV-2 vaccination teams in long-term care homes. To support the mobile teams in responding appropriately to the ethical challenges presented here, the following recommendations should be integrated into training approaches and workflow concepts for mobile vaccination programs. We recommend:

- to adapt the vaccination strategy, developed for a broader public, to the specific context and needs of older adults and people with disabilities. This includes special responsibilities in informing decision-making processes. Obtaining informed consent in advance could unburden nursing home staff and improve the on-site workflow.
- to closely involve nursing home management in developing and implementing the vaccination program during all stages.
- to define and clarify in advance criteria on how to manage leftover vaccine doses (alternative usage or storage plan, clear proceedings, assignment of responsibility), especially for alternative on-site usage, and to communicate these criteria transparently.
- to pay special attention to the training of mobile vaccination teams enabling them to be sensitive to ethically challenging situations and respond to them in a reflective manner.
- to include basic knowledge regarding communication with this population in the training, e.g., person-centered communication. Healthcare personnel's communication competencies are a core prerequisite for ethically and legally sound informed consent.



- to provide regular debriefings and feedback rounds for mobile vaccination teams to improve interprofessional collaboration and efficient teamwork.
- to continuously integrate lessons learned into further guidance and plans for mobile vaccination teams.

Following these recommendations in the planning and implementation of vaccination strategies supports mobile teams in the politically charged endeavor of field vaccinations. It also contributes to the general acceptance of those programs amongst vulnerable groups by improving individual-centered decision-making. Moreover, this brief can serve as a basis for further reflection on follow-up programs for mobile teams, particularly the organisational (and related ethical) challenges when visiting vulnerable individuals living at home.

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