Central LHIN

Patient/Resident Transitions during Outbreaks Guidance Document

Central LHIN Patient/Resident Transitions during Outbreaks Working Group

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Ontario
Local Health Integration Network

Working Group Members

This document was developed through the collaborative efforts of the following working group members:

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Intended use of this document:

The Patient/Resident Transitions during Outbreak Guidance document was initially developed by this working group as a strategy to support patient transitions between Hospitals and Long Term Care Homes, and alleviate the overcrowding and surge conditions experienced by hospitals during the Holiday Period. The tool, however, has been determined to be effective beyond the Holiday Season, and is intended for use year round.

Preamble

General guidance for resident/patient movement between institutions is available from the Ministry of Health and Long-Term Care (MOHLTC) in their outbreak management documents [1, 2]. To clarify and guide the decision making for the Long Term Care Home (LTCH) and the Acute Care Facility (ACF), the sample transfer algorithm in the MOHLTC guidance document has been adapted by a sub-group of the Central Local Health Integration Network (CLHIN) Holiday Planning Working Group. This guide is not intended to replace existing outbreak management protocols; rather, it is intended to support the communication between organizations to facilitate resident repatriation to their LTCH during an outbreak.

Acute Change in Resident Status

LTCHs should make every effort to manage patients with changing care needs in the home where clinically and contextually appropriate rather than transferring to an ACF. The existing process for emergent situations where an LTCH resident requires immediate medical care should not be affected by unit or facility outbreak status (e.g. call 911). In efforts to ensure residents remain in the LTCH, the Nurse-Led Outreach Team (NLOT) should be consulted when appropriate to assess changing non-acute care needs.

Repatriation Guidance

The process of resident repatriation details varies by organization, but is typically conducted by either the patient flow coordinator/discharge planner or the patient care unit charge nurse at the ACF, upon direction from the most responsible physician that the patient is stable and ready for discharge. The ACF will then contact the Director of Care/Assistant Director of Care (DOC/ADOC) at the LTCH.
Residents who are transferred to an Emergency Department, and subsequently not admitted to the ACF, should be transferred back regardless of outbreak status as soon as possible.
The decision whether an admitted resident returns to the LTCH is made by the DOC. There are opportunities for the DOC to consult the medical director and public health unit (PHU) to support his/her decision. The ACF should also have a conversation with the Resident.
The process map is developed for use 7-days a week between the hours of 0830-1630 to coincide with the typical hours where a DOC or their delegate is on site. In the interest of ensuring that a patient/resident is transferred from and ACF to LTCH in a safe manner, it is recommended that transfers occur between 0900 and 1700 as mutually agreed between the ACF and LTCH. It is important to note that many important services (primary physicians, medical assessment, nursing assignments, pharmacy availability) are extremely limited after hours and on weekends for the LTCH and may place residents at risk if essential services are unavailable. It is the responsibility of the ACF to ensure that proactive measures are in place to identify patients for discharge in a timely manner to ensure the safe and timely transfer of residents. This includes timely notification to LTCH of resident discharge status, availability of discharge prescriptions, dressing supplies, etc.

Responsibilities

Each organization is responsible to ensure that a key stakeholder/decision maker is available to participate in the repatriation conversations as needed.

Table 1 - Roles and Responsibilities

Facility/ Organization	Individual	• Responsibility	Availability	Process Level
LTCH	DOC	• Responsibility for admission decision to LTCH.	M-F: 0830-1630	Primary
	ADOC/Manager on-call	• Delegate for DOC after hours.	24/7	Back-up
	Medical Director	• Consultation with DOC regarding clinical repatriation decision making.	M-F: 0830-1630	Consultation
	IPAC Coordinator* (if applicable)	• Consultation with DOC regarding outbreak management practices.		Escalation
ACF	Flow Coordinator*	• Responsibility for contacting LTCH to initiate repatriation conversation	M-F: 0830-1630	Primary**
	Unit Charge Nurse	• Communication with Flow Coordinator and/or LTCH regarding patient discharge readiness (see Flow Coordinator)	24/7	Primary**
	Flow Manager*	• Escalation support when indicated.	M-F: 0830-1630	Escalation
	Most Responsible Physician	• Accountable for identifying estimated discharge date. • Consultation with LTCH medical director if required.	M-F: 0830-1630	Primary
	Infection Control Practitioner	• Available for consultation by Flow Coordinator	M-F: 0830-1630; 24/7 On-Call	Consultation
	IPAC Manager	• Consultation and communication between Flow, PHU, and LTCH related to IPAC practices.	M-F: 0830-1630	Escalation
	Clinical Manager*	• Escalation support when indicated.	M-F: 0830-1630	Escalation
PHU	Investigator	• Accountable for providing outbreak management guidance and clarification with DOC • Lead escalation teleconference.	M-F: 0830-1630; 24/7 On-Call	Primary
	Manager	• Consultation and communication between ACF and LTCH related to PHU outbreak management recommendations.	M-F: 0830-1630	Escalation
	Associate Medical Officer of Health	• Consultation and recommendations.	M-F: 0830-1630	Consultation

*Similar roles exist within different institutions with different titles.
**May be responsibility of flow coordinator depending on ACF

PHU Contact Information

- York Region
  - Monday to Friday, 0830-1630: (905) 830-4444 x 73588
  - After hours and stat holidays: (905) 953-6478
- Toronto
  - Monday to Friday, 0830-1630: (416) 338-7790
  - After hours and stat holidays: (416) 392 – CITY (2489)
- North Simcoe Muskoka
  - Monday to Friday, 0830-1630: 705-721-7520 or 1-877-721-7520
  - After hours and stat holidays: 1-888-225-7851

Communication

In all cases of resident repatriation, usual communication processes will be used to initiate transition of care. In individual cases where there are questions that cannot be answered or where there is disagreement in the decision that is made, the PHU investigator responsible for the outbreak will coordinate a teleconference, at the request of any primary stakeholder, to include the individuals in the table below. An internal process to identify key individuals to participate in an escalation phone call should be developed by each organization.
In the event that clarity or consensus is not reached with the first teleconference, a second teleconference will be set to include the same individuals as the first, but add the escalation individuals. A decision to repatriate should be escalated where there is disagreement with the rationale, not the decision per se, as there will often be situations where a resident will not be accepted by the DOC for repatriation –based on current outbreak status or the guidance being provided from established policies and procedures, internal IPAC practices, or guidance from the PHU.

First (Primary) Teleconference	Second (Escalation) Teleconference

• LTCH
  ○ DOC
• ACF
  ○ Flow
  ○ IPAC
• PHU
  ○ Investigator
	• LTCH
	  ○ DOC
	  ○ IPAC Coordinator
	• ACF
	  ○ Flow and/or Clinical Manager
	  ○ IPAC Manager
	• PHU
	  ○ Manager

Placement Considerations

The decision to accept a resident repatriation request from an ACF is at the discretion of the DOC. This does not mean that the DOC will always make the decision in isolation, as there may be multiple considerations and stakeholders involved influencing that decision.
Where the decision is unclear, multiple resources exist to assist the DOC to make the decision, including (but not limited to) the list of stakeholders in

Table 1 - Roles and Responsibilities.
It is encouraged to consider the resident repatriation (non line-listed) after one incubation period has passed without any new cases, taking into consideration the organism, unit/facility epidemiology, resident

risk factors, effectiveness and thoroughness of outbreak measures, and past outbreak management experiences. Further, if a resident is considered 'protected', then the resident should return to the LTCH.

Protected Patient

There are organism-specific outbreak situations where the resident risk should be considered low, specifically related to immunity status and prophylaxis options.
Organism specific:

- Influenza A
    - Resident has been prescribed, and has started taking ≥1 dose of oseltamivir[1], OR
    - Resident has been infected with documented same strain as OB strain, OR has
    - Resident has documented vaccination (with appropriate seasonal match) for documented OB strain (if appropriate with established OB management guidelines).
- Influenza B
    - Resident has been prescribed, and has started taking ≥1 dose of oseltamivir[2], OR
    - Resident has been infected with documented same strain as OB strain, OR
    - Resident has documented vaccination (with appropriate seasonal match) for documented OB strain (if appropriate with established OB management guidelines).
- Vaccine Preventable Disease (e.g. measles, shingles…)
    - Resident has appropriate immunization recommendations or met age-related immunity assumptions as per Canadian Immunization Guide.
    - Resident has documented titres consistent with immunity.
- Norovirus
    - Resident has recovered from laboratory confirmed illness within 2 weeks [3].

Resident/Patient Information

Information and engagement of residents/patients/substitute decision-makers is integral to ensuring satisfaction within system transitions and facilitating transparency and informed decision making. A sample letter based on the MOHLTC outbreak guidelines is suggested for use as a template for each ACF to develop contextually and brand-relevant information to facilitate informed decision making and transparency. The sample can be found in Figure 1- Sample ACF Patient Letter.

[1] http://www.e-therapeutics.ca; Oseltamivir is well absorbed and converted to active metabolite within the GI tract, therefore, no specific time period has been determined as needed to elapse before considering a patient/resident as protected.
[2] See above.

Appendices

Figure 1- Sample ACF Patient Letter

Dear Patient,

Your residence _____ (insert name of LTCH) is currently experiencing a higher than usual number of cases of _____ (insert organism or symptoms) and has declared an outbreak. Homes often restrict the return of residents to affected areas during outbreaks in order to prevent the transmission of the outbreak illness in a returning resident.

Despite an outbreak, it may still be possible to return to your facility.
The Hospital, in partnership with your facility and the local public health unit carefully consider many factors to assess each return, such as:

- the status of the outbreak at the facility or a specific unit has been carefully reviewed
- the resident will not be exposed to the outbreak as the outbreak is in another unit
- the returning resident was already exposed to the outbreak before leaving the facility and therefore has now developed immunity (blood tests, nose swabs, or other tests may sometimes be required)
- the resident is protected from the outbreak through appropriate measures (for influenza this may include immunization and antiviral medications)

If you have questions about being in a facility during an outbreak, you can ask questions before leaving the hospital or upon your return to the facility.

Sincerely,

Contact Person Name
Title
(XXX) XXX-XXXX extension XXXX

Table 2 - References

[1] Ministry of Health and Long-Term Care, "A Guide to the Control of Respiratory Infection Outbreaks in Long-Term Care Homes," Queen's Printer for Ontario, Toronto, September 2014.

[2] Ministry of Health and Long-Term Care, "Control of Gastroenteritis Outbreaks in Long-Term Care Homes," Queen's Printer for Ontario, Toronto, October 2013.

[3] K. Simmons, M. Gambhir, J. Leon and B. Lopman, "Duration of Immunity to Norovirus Gastroenteritis," *Emerging Infectious Diseases,* vol. 19, no. 8, pp. 1260-1267, August 2013.

[4] http://www.e-therapeutics.ca accessed November 20, 205 to review pharmacokinetics of oseltamivir.

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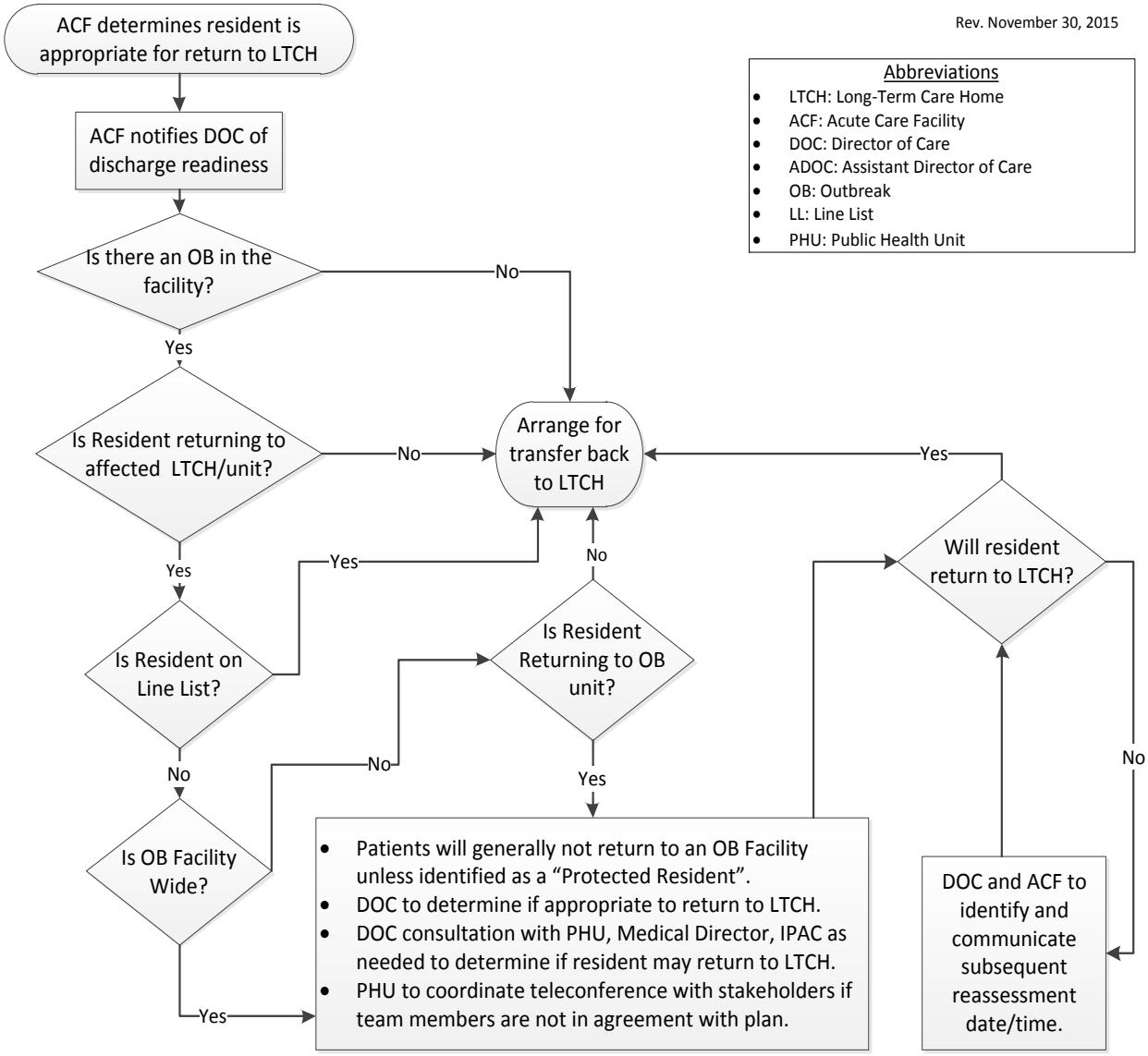

Abbreviations

- LTCH: Long-Term Care Home
- ACF: Acute Care Facility
- DOC: Director of Care
- ADOC: Assistant Director of Care
- OB: Outbreak
- LL: Line List
- PHU: Public Health Unit

Process Notes:

- DOC is used throughout, but equally applies to ADOC or Manager On Call as contextually appropriate for the institutional decision maker.
- Once initial communication is established between ACF and LTCH, subsequent reassessment dates and stakeholders should be established.
- This algorithm is intended to guide communication 7 days a week, 0830-1630.
- Resident transfers should occur between 0900-1700 as determined by the LTCH.
- Patient Transfer Authorization Centre approval may be required for transfers between ACF and LTCH.
- ACF notification to LTCH process is guided by usual internal communication process (i.e. discharge planner will initiate contact with LTCH DOC).

Protected Resident:

- Flu A: Resident has been prescribed, and has started taking ≥1 dose of oseltamivir, OR, has been infected with documented same strain as OB strain, OR has documented vaccination (with appropriate seasonal match) for documented OB strain (if appropriate with OB management guidelines).
- Flu B: Resident has been prescribed, and has started taking ≥1 dose of oseltamivir, OR, has been infected with documented same strain as OB strain, OR has documented vaccination (with appropriate seasonal match) for documented OB strain (if appropriate with OB management guidelines).
- Vaccine Preventable Disease (e.g. measles, shingles…): Resident has documented titres consistent with immunity and/or has appropriate immunization recommendations or met age-related immunity assumptions as per Canadian Immunization Guide.
- Norovirus: Resident has recovered from laboratory confirmed illness within 2 weeks.

Additional DOC Considerations for Placement:

- Repatriation should be considered after one incubation period with no new transmission, if epidemiologically appropriate.
- Once identified for discharge, returning to LTCH is in the best interest of the Resident.
- Each OB must be assessed individually (affected units, number of patients, time elapsed since last case, etc.) to facilitate repatriation decision making.
- Consultation with PHU may facilitate decision making by the DOC.

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