NSM LHIN Respiratory and Gastrointestinal Outbreak

Transfer & Repatriation Guiding Document

Transfer Process Guidance

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 Homes (LTCH) and the Acute Care Facility (ACF), the sample transfer algorithm in the MOHLTC guidance document has been adapted for use in the North Simcoe Muskoka Local Health Integration Network (NSM LHIN).

Acute Care Process Guidance

LTCH 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), where available, should be consulted when appropriate to assess changing non-acute care needs.

Repatriation Process Guidance

The process of resident repatriation details varies by organization, but is typically conducted by either the patient care unit or a member of the patient flow team 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 (DOC) or designate 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 within 24 hours.

The decision whether an admitted resident is eligible to return to the LTCH should be made by the ACF and the LTCH. If the unit to which the admitted resident is returning to is part of an outbreak and the resident is on the outbreak line list, the transfer can take place as long as the PHU (Public Health Unit) is notified. However, if the resident is not part of the line list, the PHU must be consulted before a final decision can be made on whether the resident will be returning to a unit or facility in an outbreak. Please see the algorithm for further details.

Line List – list of patients potentially exposed to organism causing outbreak illness.

The algorithm is developed for use 7-days a week. In the interest of ensuring that a patient/resident is transferred from an ACF to LTCH in a safe manner, it is recommended that transfers occur between 0700 and 1700 as mutually agreed between the ACF and LTCH. It is important to note that many important services (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 transfer of residents.

Responsibilities

Each organization is responsible to ensure that a key stakeholder/decision maker is available to participate in the repatriation conversations as needed. The Roles and Responsibilities can be found in Table 2 – Roles and Responsibilities.

Table 2 – Roles and Responsibilities

Facility/ Organization	Individual	Responsibility	Availability	Process Level
LTCH	DOC or Designate IPAC Coordinator	Responsibility for admission decision to LTCH.	24/7	Primary
	Medical Director	Consultation with DOC or Designate regarding clinical repatriation decision making.	M-F Day time hours	Consultation
	IPAC Coordinator* (if applicable)	Consultation with DOC regarding outbreak management practices	M-F Day time hours	Primary
ACF	Flow Coordinator*	Responsibility for contacting LTCH to initiate repatriation conversation.	M-F Day time hours	Primary
	Flow Manager*	Escalation support when indicated	M-F Day time hours	Escalation
	Most Responsible Physician	Accountable for identifying estimated discharge date. Consultation with LTCH medical director if required.	24/7	Primary
	Infection Control Practitioner or designate	Available for consultation by Flow Coordinator	24/7	Consultation
	IPAC Manager	Consultation and communication between Flow, PHU, and LTCH related to IPAC practices	M-F Day time hours	Escalation
	Clinical Manager	Escalation support when indicated	M-F Day time hours	Escalation
	Off Hours Supervisor*	Escalation support when indicated	24/7	Escalation
PHU	Communicable Disease Surveillance Unit (CDSU) Liaison	Accountable for providing outbreak management guidance and clarification with DOC Lead escalation teleconference.	M-F; 0830-1630	Primary
	Manager	Consultation and communication between ACF and LTCH related to PHU outbreak management recommendations.	M-F; 0830-1630	Escalation
	Medical Officer of Health	Consultation with DOC regarding clinical repatriation decision making.	M-F; 0830-1630 705-721-7520	Consultation
	On Call	Consultation with DOC regarding clinical repatriation decision making.	After Hours 1-888-225-7851	Consultation

*Similar roles exist within different institutions with different titles

Communication

An internal process to identify key individuals to participate in an escalation phone call should also be developed by each organization. In a case where there are questions that cannot be answered or there is disagreement, the PHU CDSU Liaison will coordinate a teleconference to include the individuals in the table below. In the event that clarity is not reached with the first teleconference, a second teleconference will be set to include the same individuals as the primary, but add the escalation individuals. A decision to repatriate should be escalated where there is disagreement with rationale, not the decision per se. *There will often be situations where a resident will not be accepted for repatriation – either based on the current outbreak status or the guidance being provided from established policies and procedures, internal IPAC practices, or guidance from the PHU.*

First Teleconference	Second Teleconference
• LTCH - DOC or designate - IPAC Coordinator • ACF - Flow - IPAC Practitioner • PHU - CDSU Liaison *Or others as deemed appropriate.	• LTCH - DOC or designate - IPAC Coordinator • ACF - Flow and/or Clinical Manager - IPAC Practitioner & Manager • PHU - CDSU Liaison & Manager *Or others as deemed appropriate.

Placement Considerations

The decision whether an admitted resident is eligible to return to the LTCH should be made by the ACF and the LTCH. If the unit to which the admitted resident is returning to is part of an outbreak and the resident is on the outbreak line list, the transfer can take place as long as the PHU (Public Health Unit) is notified. However, if the resident is not part of the line list, the PHU must be consulted before a final decision can be made on whether the resident will be returning to a unit or facility in an outbreak. Please see the algorithm for further details.

Where the decision is unclear, multiple resources exist to assist in the decision making, including (but not limited to) the list of stakeholders in Table 2 – Roles and Responsibilities.
It is encouraged to consider the resident repatriation (non line-listed) after one incubation period has passed, taking into consideration the organism, unit/facility epidemiology, resident risk factors, effectiveness and thoroughness of outbreak measures, and past outbreak management experiences.

Protected Patient/Resident

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
  - Patient/Resident has been prescribed, and has started taking ≥1 dose of oseltamivir, OR
  - Resident has been infected with documented same strain as OB stain.

- Influenza B
  - Patient/Resident has been prescribed, and has started taking ≥1 dose of oseltamivir, OR
  - Patient/Resident has been infected with documented same strain as OB strain.

- Vaccine Preventable Disease (e.g. measles, shingles…)
  - Patient/Resident has documented appropriate immunization recommendations or met age related immunity assumptions as per the Canadian Immunization Guide {4}.

- Norovirus
  - Resident has recovered from laboratory confirmed illness within 2 weeks. {5}

Residents that have documented vaccination for the documented OB strain may have some protection. However, for the purposes of this guiding document will not be considered a Protected Patient/Resident.

Patient/Resident Information

Information and engagement of patients/residents/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 can be utilized to guide conversations or used 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.

Appendices

Figure 1 – Sample ACF Patient Communication Guide

Your residence (name of Long Term Care Home/Retirement Home) is currently experiencing a higher than usual number of cases of (name of organism and/or symptoms) and has declared an outbreak. Homes often restrict return of residents to affected areas during outbreaks to prevent the outbreak illness in a returning resident. Despite an outbreak, it may still be possible to return to your Home.

(Name of Acute Care Facility) in partnership with your Home and Public Health carefully consider many factors to assess each return, such as:

- the status of the outbreak at the Home or a specific unit has been carefully reviewed
- the patient/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 Home and therefore has now developed immunity (blood tests, nose swabs, or other tests may sometimes be required)
- the patient/resident is protected from the outbreak through appropriate measures (for influenza this may include immunization and antiviral medications)

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

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Please incorporate the following Patient and Family Feedback regarding the above script during all communications:

- Please make this a conversation and not a letter when you communicate I am returning home (LTC) – “If I feel you really care about me, then I am comfortable and at ease. Talking with me is much better than a letter – it makes me feel you care. Talking to me with a smile and in a caring way also matters.”
- Please have someone I know from my home talk this over with me in person while I am in hospital, to ensure they fully understand what I am going through and to let me know what my home is doing to ensure I am safe when I return. I want to ensure I won’t become ill if I return home.
- Please provide me and/or my SDM with a hard-copy of a checklist of things completed for me to be safe when I return home.
- During our discussion, please ensure a family member or SDM is present as well as my physician, some-one from my home and the Nurse Manager and Discharge Planner from the Hospital
- Provide me and my family member/SDM the name of the “go to-contact person” at the home to contact if I have any questions once I return home.

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) Central Local Health Integration Network Patient Transitions during Outbreaks Sub Group Narrative.

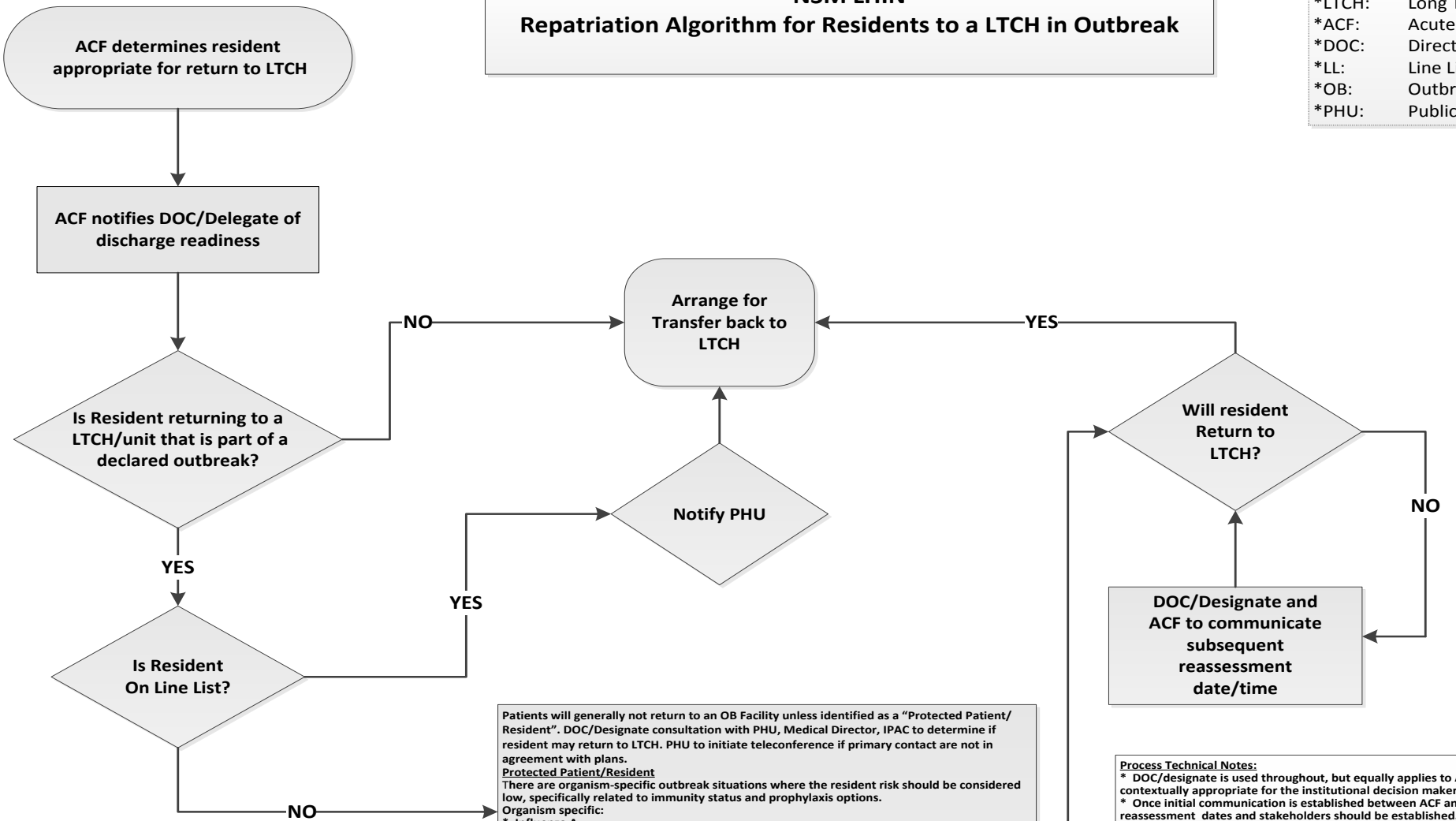
(4) Canadian immunization Guide – http://www.phac-aspc.gc.ca/publicat/cig-gci/index-eng.php

(5) K. Simmons, M. Gambhir, H. Leon and B. Lopman. "Duration of Immunity to Norovirus Gastroenteritis," *Emerging Infectious Diseases,* vol. 19, no. 8 pp. 1260-1267, August 2013

NSM LHIN
Repatriation Algorithm for Residents to a LTCH in Outbreak

Abbreviations

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



Patients will generally not return to an OB Facility unless identified as a "Protected Patient/ Resident". DOC/Designate consultation with PHU, Medical Director, IPAC to determine if resident may return to LTCH. PHU to initiate teleconference if primary contact are not in agreement with plans.

Protected Patient/Resident

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Process Technical Notes:

* DOC/designate 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 0830-1630 as determined by the LTCH.

Additional DOC/Designate Consideration 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.

Adapted from CLHIN Admitted Resident Communication During Outbreaks.

Note: Refer to NSM LHIN Outbreak Transfer & Repatriation Guiding Document.
October 20, 2015