Adult COVID-19 Site Planning, Cohorting, HLOC Transport and Repatriation Procedure

Site:
• **Environment**:
  ○ Island Health acute care facilities
	Scope:
	• **Audience:** Island Health acute care leaders and care providers caring for adults who are suspected or confirmed for COVID-19.
	• **Indications:** To provide guidance for COVID-19:
	  ○ Site planning
	  ○ Cohort unit set-up and patient placement
	  ○ Higher Level of Care (HLOC) transport
	• **Exception:**
	Modification to these guidelines may be required in the event of surge capacity, shortage of staff, beds or laboratory capacity.
	  ○ For Pediatrics see Pediatric Covid-19 Site Planning, Cohorting, HLOC Transport and Repatriation Procedure

Need to know:

- These guidelines must adhere to established Island Health Policy for Life, Limb or Threatened Organ and Higher Level of Care -Inter-facility Transfer

Jump to:

Site Planning

Each Island Health hospital will have two isolation plans:

- **Respiratory Isolation Beds** for all admitted patients requiring droplet/contact additional precautions, including those waiting for a differential diagnosis pending nasopharyngeal (NP) swab results.
    - Persons under Investigation (PUI) can stay at their current location unless there is a need for Higher Level of Care (HLOC) transport.
- **COVID-19 Beds** for all admitted patients who are PUI or confirmed for COVID-19.
    - COVID-19 positive patients can stay at their current location if they are expected to be admitted for less than 24 hours, are imminently dying, or require HLOC.

What you need to do	What you need to know
1. Designate 2 beds (at minimum), preferably private rooms, for PUI or confirmed COVID-19 patients.	• Use the beds for medical patients when there are no PUI or confirmed COVID-19 patients. • All PUI and confirmed COVID-19 patients must be placed on Droplet and Contact Precautions (IPAC guideline)
2. Identify at least one negative pressure room for Aerosol Generating Medical Procedures (AGMPs) within the unit or immediately adjacent to the designated beds.	• The room does not need to be blocked to admissions, but must be able to be made available for PUI or confirmed COVID-19 patients within 20 minutes. • Smaller and rural settings to connect with IPAC to formulate a plan when AGMPs for COVID-19-positive patients are necessary on their site.
3. Place PPE dispensers and alcohol-based hand rub (ABHR) outside the rooms for donning prior to entry.	
4. Post Additional Precautions signage on the door or the wall next to the door.	Droplet and Contact Precautions Poster
5. Remove any excess items prior to admitting the patient.	Limiting items in rooms to ONLY those supplies/ equipment needed for patient care helps mitigate contamination risk and limits wasteful discard of supplies.
6. Segregate clean and dirty areas with a workflow that prevents cross-contamination.	• If dedicated clean/dirty areas are not available, there should be 3 feet/1 meter of separation between clean and dirty items. • Clean items should be easily identifiable to

	prevent cross-contamination (i.e., use a 'clean means green' label).

Cohort Unit Set-up (CVH, NRGH, and RJH only)

- Island Health has identified three stages of COVID-19 Surge Capacity Planning. The following facilities have been designated as Cohort Hospitals to support Stage 1 and 2 of the COVID-19 Surge Capacity Planning. Plans for Stage 3 will be communicated if the need arises.
  - **NORTH ISLAND:** Comox Valley Hospital (CVH) Cohort receives all COVID-19 positive admissions with M1-M3 and CO MOST status
  - **CENTRE ISLAND:** Nanaimo Regional & General Hospital (NRGH) Cohort receives all COVID-19 positive admissions from Geography 2 and C1/2 MOST status patients from Geography 1
  - **SOUTH ISLAND:** Royal Jubilee Hospital (RJH) Cohort receives all COVID-19 positive admissions from Geography 3 and 4
- When there are **two or more patients confirmed with COVID-19 at a site**, the *Pandemic Response Coordination Committee* will direct a designated Cohort Hospital(s) to create a closed Respiratory Investigation Unit, which will function as an "Outbreak Unit."

What you need to do	What you need to know
1. Upon direction from the *Pandemic Response Coordination Committee*, establish a Cohort Unit. This will be communicated via unit manager, or site leadership.	• Cohort Unit Preparation Checklist • Leader/Educator Cohort Unit Orientation Guide
2. Implement the zone methodology.	Transitioning Between Pandemic Zones: Acute COVID-19 Cohort Units
3. Restrict access to Cohort Units with visible signage outside the unit, closed doors, and ABHR at the entrance.	
4. Require staff to sign in at the beginning of their shift.	Staff will be designated to that unit for the entire shift and should avoid visiting other units.
5. Arrange for non-clinical staff to support clinical staff so they do not have to leave the patient space.	The role of support staff may include PPE buddies fetching equipment, supplies, etc., to help conserve PPE and contain pathogens to the unit.
6. Ensure all isolated units/beds follow precautions and enhanced cleaning procedures.	This should already be in place during high pandemic activity, but as activity declines, it may need to be ordered for individual beds/rooms.

7. Escalate to *Pandemic Response Coordination Committee* for direction if admissions exceed clinical isolation capacity or care delivery limitations of unit/area/facility.	

HLOC Transport Considerations

What you need to do	What you need to know
1. Consider patients COVID-19 risk/status. • Patients who present with cold or fever and **do not** fit the classical picture for COVID-19 should **NOT be cohorted** unless they test positive for COVID-19.	COVID-10 risk categories (green, yellow, red) are outlined in the AGMPs and PPE Requirements: Patients Suspected, Confirmed or at Risk of COVID-19 Guide.
2. Consider risk of COVID-19 spread during transport (to environment and care providers)	• *Are we confident this will stay contained on transport?* • *Is this a closed system patient?* • *Do we have the right care providers available?* • *Do we have the required PPE available?*
3. Consider staffing and resourcing required to transport the patient.	• *What clinical staffing/medical escorts will be required to accommodate the transport?* • *What external resourcing will be needed to accommodate transport (BCEHS, etc.)?* • *Can transport of a medically stable patients be organized during the day when decision makers are easily accessible?* • *Are community acute care sites able to manage and hold patients using contact and droplet precautions in a private room until transport has been arranged?*
4. Consider transport benefit to the patient.	• *Is the patient to be imminently discharged or are they imminently palliative (next 12-24 hours)? If yes, there is no benefit to transport.* • *Will they likely worsen?* • *Do they have other comorbidities which would preclude further treatment?* • *Is the patient receiving palliative care?*

	• *Does the patient require tertiary services (dialysis, proning, ECMO, etc.)*
5. Consider the patient's wishes.	• *Does the patient have an Advance Directive?* • *What is their MOST status?* • *Is the patient full code (C1 and C2) and do they wish to be intubated?* • *Does the patient agree to be transported to a designated Cohort location? If not, may need to escalate to PRCC for resolution.*

6. Consider needs of surgical patients.
   - All surgical procedures must adhere to Infection prevention and control protocol for surgical procedures during COVID-19 - Adults (BCCDC/Ministry of Health).
   - Most COVID-19 positive pre-op surgical patients can be transported to a designated Cohort location.
   - Specific situations that require a plan of care be developed preoperatively by the MRP, receiving provider and the local care team to ensure appropriate post-op management/care on the receiving Cohort Unit include:
     - **Emergency surgeries and other emergent procedures** where the MRP deems it is not safe to delay surgery:
       - Perform surgery at current location.
       - If post-op stay is expected to be less than 48 hours, keep patient at current location.
       - Where the post-op stay is expected to be greater than 48 hours, and the patient is deemed stable and safe to move, transport to most applicable Cohort location.
     - **Where there are specific equipment or clinical requirements** that may prevent the surgery from being performed at the closest designated Cohort location:
       - Pre-operatively, consult with the Medical Director for Surgery to determine best course of action.

7. Consider needs of other patient groups:
   - **Obstetric and perinatal patients:**
     - Requiring hospitalization for COVID:
       - Cohort all patients with gestational age of 20 weeks or greater at VGH, on a medical floor to reduce exposure to antepartum patients.
       - Patients at Gestational Week 19 or less can be cohorted at their local cohort site
         - Obstetrics will provide care and consultation to these patients.
     - Maternity patients who are COVID positive or suspected, and medically stable:
       - No need to formally cohort these patients, as they do not need hospitalization
       - May need assessment in hospital for obstetrical indications. They can be assessed locally with proper precautions.

        - If they go into labour, they can be cared for at local hospital.
    - Maternity patients, with fever in labour
        - Care for these patients at local hospital
        - Exception – Lady Minto, Port Hardy/MacNeil – because of limited resources, these patients are currently transferred if fever in labour (not covid risk specific) to the next level of care
- **Gynecological surgery patients:**
    - Cohort Geography 1 and 2 patients at NRGH.
    - Cohort Geography 3 and 4 patients at VGH.
- **Neurosurgery patients:** Cohort at VGH.
- **ERCPs:**
    - Cohort Geo 3 and 4 patients at VGH.
    - Cohort Geo 2 patients at NRGH.
    - Geo 1 patients: Manage referrals on an individualized basis.
- **Urgent Ambulatory outpatients:** Continue services as usual.
- **Long-term care residents from Island owned and operated and affiliate sites who are positive for COVID-19**: Transport to closest designated Cohort location.

Arrange HLOC Transport

1. Once the decision is made to transport the patient**,** arrange for transport following the *COVID-19 Transfer Decision Algorithm (Appendix 1)* and inaccordance with the *COVID-19 Transport Contingency Plan.* • Transport may occur later than usual to accommodate operational requirements.	• COVID-19 Transfer Decision Algorithm (Appendix 1) • COVID-19 Transport Contingency Plan
2. Determine most appropriate bed placement.	• Bed Placement of Admitted Patients with Suspected/Confirmed COVID-19 (Algorithm)
3. Safely transport to HLOC or designated Cohort location or transfer to most appropriate clinical care unit at current location as soon as possible.	• CERT Team Patient Transport • Acute Care Adult In-Patient Precautions, Activities & Restrictions

Repatriation: Inter-facility Transfer

- COVID-19 positive palliative patients may be repatriated on a case-by-case basis.

1. Repatriate patients according to established repatriation procedures once: • Island Health interim guidelines for *Interim – Discontinuing Additional Precautions in Suspect and Confirmed COVID-19 Patients* are met, or • As approved by both the Medical Microbiologist and Medical Health Officer.	• Interim – Discontinuing Additional Precautions in Suspect and Confirmed COVID-19 Patients • Repatriation Inter-facility Transfer Procedure
2. Ensure excellent handover communication during repatriation of all resolved COVID-19 patients.	• IDRAW - Information Transfer and Communication at Handovers

Persons/Groups Consulted:

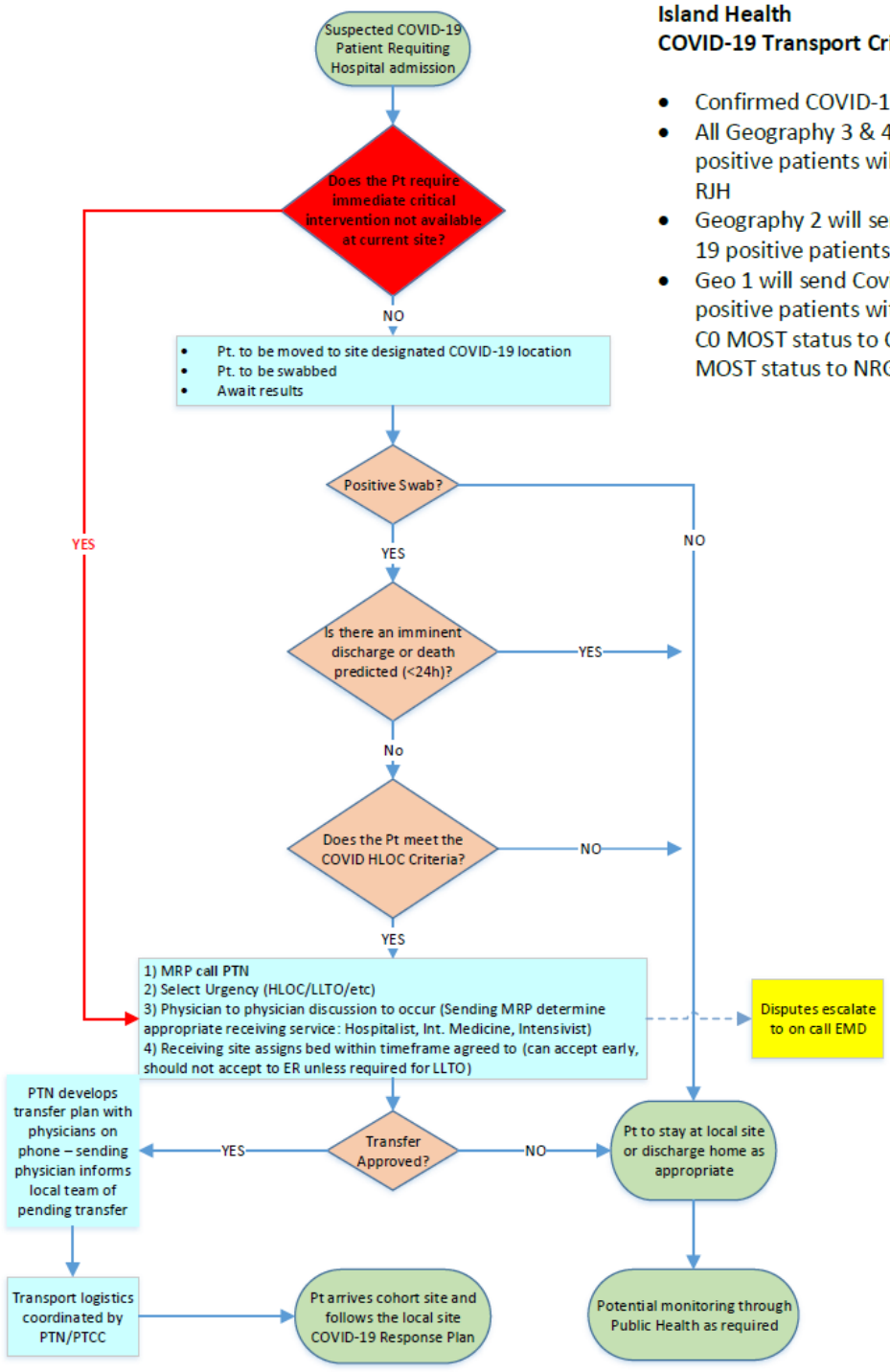
- Manpreet Khaira, Director, Restorative Wellness, Geo 4
- Matthew Erickson, Director Acute Utilization & Flow, Geo 4
- Kerry Morrison, Director, Strategic Initiatives Geo 4
- Dr. Pamela Kibsey, Division Director, Microbiology / Medical Director, Infection Control, Laboratory Medicine, Pathology & Medical Genetics
- Lisa Young, Director, Infection Prevention and Control
- Dr. Omar Ahmad, Department Head, Emergency & Critical Care Medicine, RJH
- Dr. Gordon Wood
- Dr. Jennifer Grace, Executive Medical Director, Geo 1
- Dr. Tracey Stephenson, Medical Director, Access and Transitions
- Marko Pelijhan, Executive Director, Geo 4
- Elin Bjarnarson, Vice President, Clinical Operations, South
- Site Clinical Operations Directors
- Site Directors
- Robyne Maxwell, Director, Renal, Trauma and Cancer Care Strategy

Resources

- COVID-19 Intranet webpages
- Infection prevention and control protocol for surgical procedures during COVID-19 - Adults (BCCDC/Ministry of Health)

- Infection prevention and control for coronavirus disease (COVID-19): Interim guidance for acute healthcare settings(Government of Canada)
- Infection Control Guidelines on the Management of Critical Adults with COVID-19 (BCCDC/Ministry of Health)

Appendix 1: Transfer Decision Algorithm



Island Health
COVID-19 Transport Criteria

- Confirmed COVID-19 positive
- All Geography 3 & 4 Covid 19 positive patients will cohort at RJH
- Geography 2 will send all Covid-19 positive patients s to NRGH
- Geo 1 will send Covid-19 positive patients with M1-3 & C0 MOST status to CVH, C1&2 MOST status to NRGH