Chapter 7: Health Services

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Chapter 7: Health Services

1.0 Introduction

The delivery of health care services in Renfrew County & District will be greatly challenged throughout an influenza pandemic. Health care capacity issues are already significant and will be further stressed with health care provider absenteeism and the increased volume of patients seeking health care for influenza.

Chapter 7 addresses the issues that will be faced by the health care system during an influenza pandemic emergency response. It is common knowledge that there is very little surge capacity available in the system. Human resource shortages will be a major issue during a pandemic emergency response.

Many of the health service issues require provincial planning direction e.g. hospital admission and discharge criteria, licensure issues for health care workers and triage guidelines. Consistency in the delivery of health care services across Renfrew County & District and the province of Ontario is essential. Renfrew County & District Health Unit will continue to work with key stakeholders to support local planning of health services.

2.0 Acute Care Facilities

There are five acute care hospitals in Renfrew County. The issues facing acute care facilities in planning for influenza pandemic are complex and multi-factorial and cannot be dealt with solely at a local level. Provincial direction is needed to ensure a consistent approach to these issues.

Individual facilities will need to plan for triage of patients ill with influenza, while continuing to see patients with other urgent medical problems. This will be complicated due to limitations of space and absenteeism of health care providers. Facilities will require direction and consistent triage criteria from the Ministry of Health and Long-Term Care (MOHLTC) to enable this planning. Figure 7.1 provides information from the Ontario Health Plan for an Influenza Pandemic on acute care facility surge capacity.

There is a need for clear and consistent guidelines for admission to and discharge from hospital as well as admission to and discharge from intensive care units. Ventilator capacity will be saturated very early into the pandemic so hospitals will need to follow criteria for ventilator use. The MOHLTC is developing these criteria to guide individual facilities. In addition, plans are underway to stop non-essential services.

Consistent with the mode of transmission of influenza, recommendations are for the use of droplet and contact precautions in hospitals, including the use of the following personal protective measures:

- Surgical masks covering the nose and mouth of a worker who is providing direct patient care (within one meter)
- Protective eyewear when providing direct care
- Hand hygiene – proper washing of hands and use of gloves
- Minimizing direct contact with patient where appropriate
- Gowns where clothing may become contaminated

Renfrew County & District Health Unit may assist with education in hospitals regarding personal protective equipment. Facilities will need to plan for space to accommodate influenza patients and place them away from patients without influenza and those at high risk of severe complications of influenza.

Facilities will need to develop strategies to maximize staff through redeployment of staff away from non-urgent work, offering full-time work to part-time staff, using recent retirees, etc. There will be a need to develop occupational health policies for fitness-to-work and return-to-work criteria for staff who develop influenza during the pandemic, as well as other supports such as psychosocial support, child care, etc.

There will be a need for facilities to consider traffic and visitor control policies and general security of the facility. Security will need to be planned for vaccine and antiviral medication supplies within the facility. It is anticipated that supply chains will be disrupted during the pandemic. An eight week stockpile of supplies is recommended. Hospitals currently are dependent on volunteers for many of the services that they provide. Volunteers may not be available during a pandemic. Hospitals should establish a clear understanding regarding deployment of students during a pandemic with schools/colleges/universities who place students in the facility. Renfrew County & District Health Unit provides education and support to hospital partners as they proceed with planning for the influenza pandemic. Renfrew County & District Health Unit continues to investigate reports of febrile respiratory illness and manage outbreaks of febrile respiratory illness in acute care facilities. The approach to management of these outbreaks may change once the characteristics of the pandemic are identified.
See www.baycrest.org/Family_Information/Pandemic_Information/8741_8748_TAHSN.asp for a guide to hospital planning.

Figure 7.1:

Ontario Health Plan for an Influenza Pandemic September 2006

RENFREW COUNTY & DISTRICT HEALTH UNIT

POPULATION (NUMBERS AND DISTRIBUTION)					
	0-18 yrs	19-64 yrs	65+ yrs	Total	% Total
Non-high risk	**21,574**	**52,781**	**9,702**	**84,057**	**83.32**
High risk	**1,475**	**8,878**	**6,468**	**16,821**	**16.67**
Totals	**23,049**	**61,659**	**16,170**	**100,878**	**100**

DEATHS (NUMBER OF CASES)						
Gross attack rates				Distribution by age group (% of total): Most likely		
	15 %	25 %	35 %		% High Risk	%Total
0-18 yrs most likely	0	1	1	0-18 yrs	**0**	**0**
minimum	**0**	**0**	**0**			
maximum	**5**	**8**	**12**			
19-64 years most likely	19	32	45	19-64 yrs	**37**	**41**
minimum	**3**	**5**	**6**			
maximum	**36**	**60**	**85**			
65+ yrs most likely	27	44	62	65+ yrs	**47**	**59**
minimum	**26**	**43**	**60**			
maximum	**33**	**55**	**77**			
TOTAL: Most likely	46	77	108	Totals	84	**100**
Total minimum	**29**	**48**	**66**			
Total maximum	**74**	**123**	**174**			

HOSPITALIZATION (NUMBER OF CASES)						
Gross attack rates				Distribution by age group (% of total): Most likely		
	15 %	25 %	35 %		% High Risk	% Total
0-18 yrs most likely	6	11	15	0-18 yrs	**1**	**3**
minimum	**3**	**5**	**7**			
maximum	**27**	**45**	**63**			
19-64 yrs most likely	114	190	266	19-64 yrs	**9**	**60**
minimum	**17**	**35**	**49**			
maximum	**124**	**207**	**290**			
65+ yrs most likely	71	118	165	65+ yrs	**23**	**37**
minimum	**51**	**84**	**118**			
maximum	**89**	**149**	**209**			
TOTAL: Most likely	191	319	446	Totals	33	**100**
Total: minimum	**71**	**124**	**174**			
Total: maximum	**240**	**401**	**562**			

Ontario Health Plan for an Influenza Pandemic September 2006

OUTPATIENT VISITS (NUMBER OF CASES)						
Gross attack rates				Distribution by age group (% of total): Most likely		
	15 %	25 %	35 %		% High Risk	% Total
0-18 yrs most likely	2,045	3,408	4,771	0-18 yrs	**3**	**25**
minimum	**1,708**	**2,847**	**3,986**			
maximum	**2,381**	**3,969**	**5,556**			
19-64 yrs most likely	4,758	7,929	11,101	19-64 yrs	**8**	**59**
minimum	**3,416**	**5,693**	**7,970**			
maximum	**7,262**	**12,103**	**16,944**			
65+ yrs most likely	1,255	2,092	2,929	64+ yrs	**7**	**16**
minimum	**1,184**	**1,974**	**2,764**			
maximum	**1,948**	**3,247**	**4,546**			
TOTAL: Most likely	8,058	13,429	18,801	Totals	18	**100**
Total: minimum	**6,308**	**10,514**	**14,720**			
Total: maximum	**11,591**	**19,319**	**27,046**			

3.0 Long-Term Care Homes

There are approximately 10 Long-Term Care Homes in Renfrew County & District. Long-Term Care Homes will need to address many of the same issues that will face acute care facilities e.g. supply chain disruption; health care provider absenteeism; lack of volunteers; and use of Personal Protective Equipment (PPE). In addition, provincial criteria regarding interfacility transfer of ill residents with will need to be developed.

There will be a need for Long-Term Care Homes to plan to manage residents in place, even if more serious illness develops in order to minimize transfers to acute care facilities. Discussions between long term care and acute care facilities can help delineate the type of support the hospitals can provide to long-term care facilities during a pandemic in order to prevent the need for hospital admissions. Additional support from community physicians and nurse practitioners for long-term care facilities may also help minimize transfers to acute care.

Residents and their family members will need to be asked about the possibility of taking residents home for care. This will create spaces in the long-term care facility for people who can be discharged from hospital to the facility, and for members of the community who urgently need admission to the facility. Residents and their family members will also need to review the level of care that will be available for residents in the long-term care facility who are ill, specifically as it relates to the possible unavailability of acute care transfers.

Renfrew County & District Health Unit is available to provide education and support to our Long-Term Care partners. The Ministry of Health and Long-Term Care has developed a planning guide for facilities to use and assist in their individual planning (see Figure 7.1). Febrile respiratory outbreaks are reported to Renfrew County & District Health Unit. Refer to A Guide to the Control of Respiratory Outbreaks in Long-Term Care Facilities, Public Health Branch Ontario Ministry of Health and Long-Term Care (October 2001)

The management of these outbreaks may change once the characteristics of the pandemic are identified.

Figure 7.2:

19A. Long Term Care Home Tools

Contents

1. Long-Term Care Home Pandemic Preparedness Checklist

Long-Term Care Home Pandemic Preparedness Checklist

Task/Activity	Yes/No	Action Required
1. Planning		
1.1 Does the LTCH have an influenza/respiratory infection outbreak plan?		
1.2 Is the influenza plan reviewed/updated regularly?		
1.3 Does the LTCH have an influenza pandemic plan or a section in its influenza/respiratory infection outbreak plan that deals with the potential impact of an influenza pandemic?		
1.4 Does the LTCH have an emergency or disaster plan?		
1.5 Has the LTCH developed plans to ensure continuity of services in the event of internal emergencies (e.g., lack of water, hydro, food, and natural gas failure) related to a disruption of community services?		
1.6 Are emergency/continuity plans reviewed/updated regularly?		
1.7 Does the LTCH have an evacuation plan?		
1.8 Is the evacuation plan reviewed/updated regularly?		
1.9 Does the LTCH have a collaborative planning relationship with other health care organizations in the community (e.g., local public health unit, emergency medical services, CCAC, acute care hospitals)?		
1.10 Have the planning partners developed criteria to determine where and how people will be cared for in the event of a pandemic?		
2. Chain of Command/Command Centre		
2.1 Does the LTCH have an interdisciplinary pandemic planning committee and/or a pandemic outbreak management team that include representatives from administration?		
2.2. Does the LTCH have a designated Infection Control Professional (ICP) and back up and a designated Occupational Health and Safety representative and back up who are known to staff and available 24/7?		
2.3 Are all staff aware of their roles/responsibilities during a pandemic outbreak?		
2.4 Is there a designated area in the facility that staff can obtain information on/be alerted to a potential influenza pandemic?		
2.5 Is there a chain of command for implementing the pandemic plan? (i.e., if an administrator is not available, who is next in command?)		
2.6 Is there a designated assembly point where all personnel report? Does it change if staff are involved in resident care or have administrative responsibilities?		
2.7 Does the LTCH have a designated command centre?		
2.8 Have provisions been made (e.g., space, equipment, communications) for extra people who may come to the Command Centre to provide services (e.g., volunteers and outside agencies)?		
3. Resident Needs		
3.1 Does the LTCH have an up-to-date assessment of residents' care needs?		
3.2 Has the LTCH identified residents who could be cared for in other settings if necessary?		

3.3 Has the LTCH identified residents at high risk of complications from influenza and identified strategies to reduce their risk?		
3.4 Is information from ongoing resident assessments incorporated into the resident assessment plan?		
3.5 Does the resident assessment plan specify the skill/expertise required to meet the resident's needs?		
4. Critical Services		
4.1 Has the LTCH identified services that must be maintained during a pandemic?		
4.2 Has the LTCH identified services that could be reduced or curtailed?		
4.3 Does the LTCH have a mechanism to contact outside services (e.g., physiotherapy, occupational therapy, dental services) in the event of a pandemic outbreak?		
5. Antivirals and Vaccine		
5.1 Does the LTCH have adequate capacity to store antivirals?		
5.2 Does the LTCH have access to an initial supply of antivirals?		
6. Supply Chains		
6.1 Has the LTCH identified the supplies required during an influenza pandemic (see Chapter 10A for equipment and supplies template)?		
6.2 Does the home have contracts with local suppliers to provide medical equipment?		
6.3 Will these suppliers be able to fulfill contracts during an influenza pandemic? If not, does the LTCH have a back-up source of supply?		
6.4 Does the LTCH have access to an adequate supply of commonly used pharmaceuticals? (e.g., Ciprofloxacin, Doxycycline, bronchial dilators)		
6.5 Has the LTCH identified and established relationships with other health care facilities outside the region as a means of accessing possible sources of needed pharmaceuticals, equipment, supplies, and staff?		
6.6 Has the LTCH made arrangements to obtain and transport supplies for life sustaining supplies (e.g., for hemodialysis and peritoneal dialysis)?		
7. Human Resources		
7.1 Has the LTCH identified the skills that will be required during a pandemic?		
7.2 Has the LTCH identified the skills that existing staff– including administrative and non-patient care staff can provide?		
7.3 Does the LTCH have a staffing contingency plan in case 20 to 35% of staff fall ill?		
7.4 Does the LTCH have a policy for addressing work refusal?		
7.5 Has the LTCH identified potential outside sources of human resources? (e.g., nursing agencies, other community organizations, volunteers, family members)		

7.6 Has the LTCH developed plans to support staff during a pandemic (e.g., child care, transportation, psychosocial support, meals, accommodation, assistance with pet care)?		
7.7 Has the LTCH developed a plan for cohorting staff?		
8. Communications		
8.1 Has the LTCH established a communication system with the local public health unit and other partners?		
8.2 Does the LTCH have a plan for communicating with staff, residents, volunteers and family members during a pandemic, including the person/s responsible for notifying staff and families?		
8.3 Does the LTCH have alternative methods of internal and external communication if main method of communication is not available?		
8.4 Is there an organized runner, messenger system as back-up for communication system and power failures?		
8.5 Has the LTCH established a designated area for media?		
8.6 Have key personnel been designated to control and take care of the needs of the media?		
8.7 Has the LTCH designated a media spokesperson? Is there a plan for this person to coordinate messages with the local public health unit?		
8.8 Has the LTCH developed procedures for handling requests for information from the media? Are these provisions consistent with the Public Health Information and Privacy Act (PHIPA)?		
9. Security		
9.1 Does the LTCH have the ability to lock down so entry and exit to all parts of the facility can be controlled? Has this process been tested?		
9.2 Have arrangements been made to meet and escort responding emergency service personnel?		
9.3 Have steps been taken to minimize and control points of access in the building and areas without utilization of lock down procedures?		
9.4 Does the LTCH have the ability to communicate with individuals immediately outside the Home in the event access is restricted?		
9.5 Does the LTCH security plan recognize the extent of the security problems for the individual facility? These considerations include the uniqueness of the physical plant, geographic location, entrances.		
9.6 If outside staff is required to meet the residents' needs during a pandemic, are their credentials verified?		
10. Traffic Flow and Control		
10.1 Have provisions been made for internal traffic that allow for movement of residents through corridors and staff movement throughout their areas? (e.g., designated unit/home area staff room instead of communal room)		
10.2 Does the LTCH have plans to restrict access in affected areas of the home?		
10.3 Will elevators be staffed and controlled?		
10.4 Is there a designated entrance and exit for both vehicles and people?		
10.5 Has the LTCH made provisions for deliveries (i.e. supplies and equipment)?		

10.6 Is there authorized vehicle parking?		
10.7 Has the LTCH made arrangements for signs to direct authorized personnel and visitors to proper entrances?		
11. Surveillance		
11.1 Does the LTCH promote annual immunization of staff and residents?		
11.2 Does the LTCH routinely assess residents for febrile respiratory infection (FRI) and/or influenza-like illness (ILI) when applicable?		
11.3 Does the LTCH encourage staff to report FRI or ILI symptoms?		
11.4 Does the LTCH currently screen visitors for FRI or ILI?		
11.5 Does a process exist to notify infection control designate within 24 hours when an outbreak is suspected?		
11.6 If so, is this process clearly communicated and readily available to all key staff in the organization?		
12. Education and Training		
12.1 Does the pandemic plan specify who is responsible for the training program?		
12.2 Does the plan include methods for ramp up and quick training for new and altered roles (e.g., have policies and procedures been made, have job action sheets been developed)?		
12.3 Does the LTCH have ongoing, mandatory pandemic training programs?		
12.4 Does the LTCH provide pandemic education material at staff orientation to raise staff awareness?		
12.5 Does the program provide ongoing pandemic education to keep staff informed and procedure/practices up to date?		
12.6 Does the hospital/healthcare facility routinely provide training on the proper donning and removal of personal protective equipment?		
13. Visitors		
13.1 Does the plan include a mechanism to deal with anticipated increases in visitors seeking to gain entrance?		
13.2 Has the LTCH made provisions to handle medical and emotional situations resulting from the anxiety and shock of the pandemic situations?		
13.3 Have personnel been designated to control and take care of issues that arise due to visitors?		
13.4 Does the facility have a plan to reduce the risk of visitors entering the facility during a pandemic (e.g., security, signage, restricted access)?		
14. Issues Related to High Mortality		
14.1 Does the LTCH have a system for the safe-keeping of personal items removed from residents who have died?		
14.2 What is the mortuary capacity of the facility? Is offsite surge morgue capacity available (e.g., assess community capacity with local funeral homes)?		
15. Relocation of Residents and Staff		

15.1 Has the LTCH made plans to relocate residents and staff to an immediate area of safe refuge within the LTCH in the event the area must be evacuated (i.e., to facilitate the isolation of residents with ILI)?		
15.2 Has the LTCH made arrangements with other LTCHs and other services to relocate residents if the LTCH is unable to meet residents' needs (e.g., transfers between hospitals and Long-Term Care Homes, local LTCH partnering to support each other by delegating certain resident care activities to one organization while the other focuses on the care of ILI/FI residents)?		
15.3 Has the LTCH identified temporary locations where residents and staff could be housed in the event of an evacuation (e.g., a power failure)?		
15.4 Does the LTCH have a plan for the transportation required to move people to a temporary location?		

4.0 Community Physicians and Community Health Centres

Approximately 80 physicians practice medicine within Renfrew County & District. They have a mixture of practice types including solo, group, and hospital-based practices. Many physicians have hospital affiliations. However, the Ontario College of Family Physicians estimates that approximately 30% of its members do not have hospital privileges.

In Renfrew County & District there are three community health centres with five site locations. Community health centres provide a primary health care service utilizing physicians, nurse practitioners, nurses and other health care providers.

Pandemic influenza raises numerous issues for physicians and community health centres. In the event of a pandemic, health care providers will encounter illness amongst themselves, family members, staff and colleagues. There will be an increased burden on their practices due to large numbers of ill patients and decreased numbers of staff members due to illness. Physicians will require access to antivirals and vaccine, once the latter becomes available, for themselves and their front line staff. There will be an increased demand for personal protective equipment that will likely be in short supply late in the pandemic. Enhanced infection control in the office or hospital setting will require increased manpower. Mechanisms for patient triage will have to be sorted out, hopefully well in advance of the pandemic. Systems for timely communication between local public health and the health care system must be in place. Physicians will also have concerns regarding compensation and disability coverage.

Renfrew County & District Health Unit wishes to enhance communication with local physicians and community health centres and involve them in pandemic influenza planning as appropriate.

Renfrew County & District Health Unit will continue to outreach to physicians to provide information and determine their needs.

5.0 Other Health Practitioners
(Pharmacists, Dentists, Midwives, Chiropractors)

To date very little planning has occurred with these groups. Renfrew County & District Health unit will need to consider how to consult with these groups.

6.0 Community Care Access Centre

Community Care Access Centres (CCACs) provide an access point to health and personal support services to help individuals live independently at home. Community Care Access Centre will need to address many of the same issues that will face acute care facilities e.g. supply chain disruption; health care provider absenteeism; lack of volunteers; and use of PPE. CCAC will need to communicate with acute care facilities regarding early hospital discharge as a strategy to increase acute care bed capacity.

7.0 Alternate Care Sites

As directed by the Ontario Health Plan for an Influenza Pandemic September 2006, alternate care sites will be temporary additions to the health care delivery system, and will be planned and managed at the local level. Each community is encouraged to establish an Influenza Assessment, Treatment and Referral Centre Advisory Committee to oversee the development of their centres. Membership should include: community-based health care providers, hospitals, public health, municipal emergency management services, municipal public works, policing services, and the volunteer sector. Many communities in Renfrew County & District are well on their way to establishing such committees to work together on pandemic planning, one item of which is alternate care sites.

Figure 7.3 exerpted from the Ontario Health Plan for an Influenza Pandemic September 2006 describes the role of Community-Based Influenza Assessment, Treatment and Referral Centres.

Figure 7.3: