HNHBB EMERGENCY STANDARD OF CARE IMPLEMENTATION

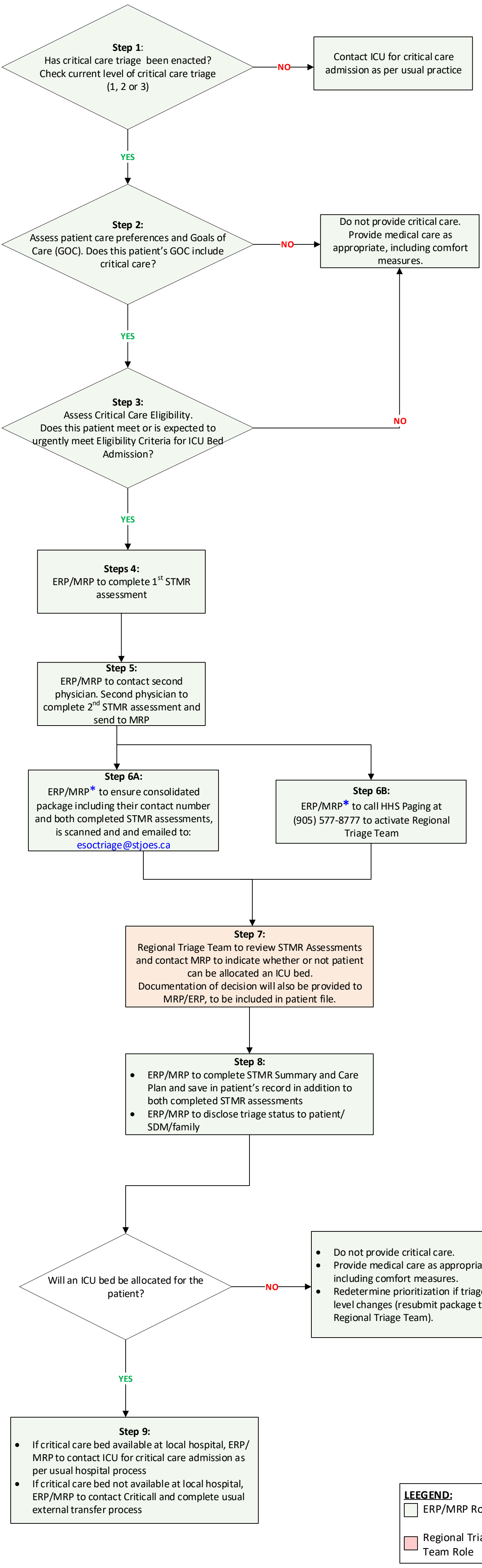
Package for Local Hospitals & Physicians

TABLE OF CONTENTS

HNHBB EMERGENCY STANDARD OF CARE IMPLEMENTATION

Date: 04-16-2021

HNHBB Hospital & Regional Triage Team – STMR Assessment Exchange and Communication Workflow



NOTES:

* Local hospitals encouraged to provide on-site administrative support for ERPs/MRPs in scanning/emailing documents and contacting HHS paging.

** Instructions for Creating, Scanning and Sharing STMR assessments package with Regional Triage Team provided on page 3 of this package.

***Instructions for process to contact HHS paging and activate Regional Triage Team provided on page 4 of this package.

Date: 04-16-2021

FOR HNHBB HOSPITALS AND PHYSICIANS - INSTRUCTIONS FOR CREATING, SCANNING AND SHARING STMR ASSESSMENTS PACKAGE WITH REGIONAL TRIAGE TEAM

1. Both completed STMR assessments and the contact information of the ERP/MRP (phone number, email address) to be scanned into 1 consolidated package.
    a. At ERP/MRP's discretion, a smartphone scanning application such as "Genius Scan" can be utilized.

2. Genius Scan can be utilized to scan documents using a smart phone if scanning from the local unit printer/workstation set up cannot be completed expeditiously.

3. Genius Scan is available for free download on both iPhone and Android platforms, is easy-to-use and compiles multiple pages together into 1 resulting PDF document that can be sent by email.
    a. **IMPORTANT:** The document package submitted to the Regional Triage Team email address (esoctriage@stjoes.ca) must be scanned documents and not photos/images.
    b. **IMPORTANT:** If utilizing Genius Scan from a physician's smartphone, please ensure that the application is not set up to upload into your cloud storage and ensure to delete all created files immediately from your phone post-email out of the package.

4. ERP/MRP to ensure package is emailed to the Regional Triage Team at esoctriage@stjoes.ca and follow the below-listed steps to call HHS paging to active the Regional Triage Team.
    a. **IMPORTANT:** If emailing scanned package from a physician's smartphone, please ensure to utilize your McMaster, PHRI or any HNHBB hospital email address under the OneMail network to submit the package.
    b. **IMPORTANT:** Please do not utilize a non-secure email (Hotmail, Gmail, Yahoo etc.) for submission of these document packages.

5. The Regional Triage Team will contact the ERP/MRP using the provided physician contact number to indicate whether or not the patient can be allocated an ICU bed. The Regional Triage Team will also provide written documentation of the outcome to the ERP/MRP via the email address utilized to submit the package.
    a. **IMPORTANT:** ERP/MRP to ensure a copy of this written documentation is printed and saved in patient's record.

6. ERP/MRP to ensure a call is made to HHS paging to activate the Regional Triage Team once package submission is complete. Please see below for instructions.

Date: 04-16-2021

FOR HNHBB HOSPITALS AND PHYSICIANS - INSTRUCTIONS FOR CONTACTING HHS PAGING TO ACTIVATE REGIONAL TRIAGE TEAM

1. To activate the Regional Triage Team once the document package is submitted, please contact HHS Paging at: **(905) 577-8777**

2. This single new number into the HHS Main Switchboard (with priority) has been created exclusively for use during critical care triage (and this specific Emergency Standard of Care process) only.

3. Callers will hear “You have reached the Answering Service” when they call to activate the Regional Triage Team.

4. HHS Switchboard agents will answer and will know to page out an on-call alert to the Regional Triage Team members.

5. Following review of document package, the ERP/MRP will receive a call from the Regional Triage Team using the provided contact number as detailed in the instructions above.

Date: 04-16-2021

REQUIRED STMR ASSESSMENT AND SUPPLEMENTAL DOCUMENTS

The following documents will be required for the ERP/MRP during Emergency Standard of Care implementation:

Documents required to be completed by ERP/MRP/2nd Physician and saved in patient's record:	Ontario Hospitals STMR Assessment (OCCCCC) Current version approved 04-16-2021
Document required to be completed by ERP/MRP post-outcome shared by Regional Triage Team and saved in patient's record:	STMR Assessment Summary and Care Plan (OCCCCC) Current version approved 02-03-2021
Reference Document for Physicians when completing STMR Assessment:	Clinical Assessment Tools for Ontario STMR Assessment (OCCCCC) Current version approved 01-06-2021

Please note: These documents may change with emerging evidence, please refer to the below link for the most updated version of each document:

https://macdrop.mcmaster.ca/s/cjQtgsqkBdnBcCd?path=%2F

Additional extensive resources related to the Emergency Standard of Care and its implementation can also be accessed there.

Date: 04-16-2021

ADDITIONAL GUIDANCE FOR HNHBB HOSPITALS & PHYSICIANS

Utilization and completion of STMR assessments on current patients:

- At current state (outside of provincially-declared Critical Care triage), Short Term Mortality Risk assessments can only be completed for current patients within Emergency Standard of Care simulations.
- STMR assessments for current patients that are completed and saved in patient's record can only occur once the Emergency Standard of Care is enacted by the Ontario Critical Care COVID Command Centre (OCCCCC).

Critical Care Triage in the Emergency Department (pg. 11-12 OCCCCC Guidance document)

- Where possible, decisions to intubate should be made AFTER patient has STMR assessment according to this standard of care. This should include the appropriate use of temporizing measures to support oxygenation and the utilization of resources (i.e. HCP staff/residents) to gather relevant information required for a rapid triage process.
- **Urgent decision-making:** If time does not permit the completion of a full STMR assessment because of the acuity of the patient's illness, clinicians should continue to follow the standard of care that would exist in non-surge situations. The patient should be offered critical care if it aligns with their goals of care, and clinically appropriate and is available. If critical care is not consistent with their goals of care or is not clinically appropriate (independent of any triage consideration) or not available, the patient should be offered standard of care given their clinical context (i.e. medical management and/or palliative care).
- In urgent contexts where an STMR can't be completed, it is suggested that the ED physician consult with a second physician (if available) prior to intubation (if possible) to confirm the standard of care, especially if resource pressures make it difficult to provide treatment in alignment with the patient's known goals of care (i.e. critical care is unavailable).

Requirement of consent of patient/family/substitute decision-maker in case of inter-hospital transfers:

- Ministry of Health Memorandum to Ontario Hospitals (April 9th 2021) - Emergency Order (O. Reg. 272/21: Transfer of Hospital Patients) under the Emergency Management and Civil Protection Act to Facilitate Transfers of Hospital Patients to Alternate Hospital Sites in Response to COVID-19 Major Surge Events.
- Allows hospitals to facilitate the transfer of a patient inter-regionally (when necessary) through a temporary, emergency-based removal of individual consent requirements. As soon as possible following the conclusion of a major surge event, the receiving hospital will be required to facilitate repatriation of the patient back to their original hospital or another suitable care location that is consented to by the patient or their substitute decision-maker.
- Requirement of consent for withdrawal of critical care still exists.

Date: 04-16-2021

HNHBB GUIDANCE ON SHORT-TERM MORTALITY RISK (STMR) ASSESSMENTS

- Triage Adjudication relies on a Short-Term Mortality Risk (STMR) Assessment conducted independently by two physicians. The details of STMR Assessment are described extensively in the ESoC document and supported by extensive resources here: https://macdrop.mcmaster.ca/s/cjQtgsqkBdnBcCd?path=%2F#pdfviewer

- The major distinction between the process as described in these resources and within HNHBB is the use of Regional Triage Adjudication and a Regional Triage Team. Practically-speaking, this means that the physicians conducting STMRs do not participate in the adjudication as to whether or not ICU admission will be offered to a particular patient. The role of the physicians is in clinical assessment, communication of the Regional Triage Team's determination, and the care of the patient.

- In addition to the above, the following principles guide processes related to STMR Assessment in HNHBB:
  - An STMR Assessment is not to be implemented in the pre-hospital setting.
  - STMR should be completed only when adequate time permits to safely implement without impacting care. However, where appropriate, aggressive temporizing measures should be used to allow for an STMR to be completed.
  - Each local institution is recommended to establish an internal working group to oversee the socialization, education, training, and simulation of STMRs, and preparation for implementation. The Regional Triage Review Committee will support them in this work.
  - The first STMR Assessment is to be performed by the ERP/MRP (the service who determines the patient might require critical care).
  - Other professionals (RN, RPN, PA, NP, Residents, Medical Students, etc.) may support in the accumulation of the information (participating in medical history review, chart review, Goals of Care discussions, etc.), but the MRP is solely responsible for inputting the information and generating the STMR score, and is ultimately responsible for the STMR Assessment.
  - A separate physician, who would not be the MRP to the patient, should independently perform the second STMR Assessment.
  - Although it may be beneficial for the second physician to be an intensivist, this might not be feasible given the available intensivist resources at individual institutions. Therefore, it is recommended that the second physician has sufficient critical care knowledge and/or expertise to competently complete the STMR Assessment.
  - Each local institution should therefore determine a list of individuals who could be responsible for completing STMR Assessments as the second physician.
  - Local institutions can determine whether or not they will have teams of physicians available to perform STMR Assessments to support this process within existing resource. Given the work associated with STMR Assessments, consideration should be given to provider wellbeing, including risk of burnout, fatigue, psychological distress and moral injury. The Regional Triage Review Committee can regionally support local efforts through coaching or 'train the trainer' model if needed.
  - Sub-specialist support (cardiology, neurology, neurosurgery, oncology) is anticipated to be needed to support MRPs in STMR Assessment. An analysis of sub-specialty workforce capacity in HNHBB will be conducted to determine whether sufficient resource exists, and to assess the feasibility of a layered consultative approach, whereby institutions access consultation within their local network, and pursue regional consultation resources if needed.

Flow Map for Serious Illness Goals of Care Conversation

You would not be surprised if the patient were to die within the next year

or

Patient qualifies for end of life goals of care conversation

↓

Patient preparation

Provide patient with **Talking with Your Clinician about the Future** letter and identify the patient's Substitute Decision Maker

Clinician preparation

Use **Scripting for Goals of Care Planning** document

↓

Use **Serious Illness Goals of Care Conversation Guide** to support development of Goals of Care

↓

Complete physician orders reflecting **Code Status**
Document **Goals of Care** in Patient Health Record

If patient does not meet criteria for Critical Care

↙ ↘

NO and Currently NOT receiving Critical Care

↓

Provide Patient/SDM with **Your Future Health Care During COVID-19 Surge**
(**Yellow banner** for **withholding** CPR and critical care)

NO and currently receiving Critical Care

↓

Provide Patient /SDM with **Your Future Health Care During COVID-19**
(**Blue banner** for **withdrawing** critical care)

Date: 04-16-2021

Goals of Care Resources and Standards

Goals of Care conversations can be challenging, as they require a considerable amount of a clinician's time invested in discussion with a patient, exploring their values, beliefs, wishes and desires, and in tailoring a treatment plan to meet not only their requests, but to achieve outcomes that are desirable to the patient.

This ought to occur at various stages along the patient journey. It is undertaken ideally in the outpatient setting where a patient who has control of his/her faculties can navigate these decisions with the support of a practitioner with whom they have established rapport and a trusting, therapeutic relationship. This is advanced care planning (ACP), which should inform GoC discussions. The first cohort of patients who should have this undertaken is one with a higher chance of mortality, given their underlying medical conditions.

These decisions should be made by the patient, with their loved ones either involved or party to their decisions. Often the lack of transparency with, or lack of instruction of the substitute decision maker, leads to contravention of the patient's wishes.

Whilst this happens, a multitude of cases fall onto the shoulders of secondary care clinicians. These clinicians do not have the benefit of time in establishing this level of trust. There is usually urgency in making decisions about care and limitations. These discussions usually happen after an event where the patient's physiology has failed and they require inpatient admission and intervention. It would be easy to misconstrue good intentions on the part of the clinician. At this stage, the patient may be represented by their substitute decision maker.

As with advanced care planning, when having goals of care discussions, the physicians' gestalt is an important contributor in order to best counsel the patient on the likelihood of achieving their desired outcomes and self-defined quality of life. This is underpinned by training, knowledge and experience. For those who feel they would benefit from resources, the following tools can serve as a guide:

https://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf

https://www.goldstandardsframework.org.uk/cd-content/uploads/files/PIG/NEW%20PIG%20-%20%20%2020.1.17%20KT%20vs17.pdf

The benefit of this undertaking is that patients may tailor their care to their needs, wishes and goals, allowing for their desired outcomes. They may opt out of aggressive measures or guide a transition to comfort alone should medical therapy be less fruitful than desired. This in turn, would likely reduce the moral hazard experienced by clinicians should the threshold of a major surge and rationing of care become necessary.

Medical professionals in community settings should continue to be encouraged to have these conversations with their patients to prepare them when faced with complications, including a situation requiring Emergency Department or hospital intervention. In a hospital setting, it is essential that anyone admitted with a serious illness (or with their SDM if the patient is incapable) have these conversations with their treating team as soon as possible and that those conversations be documented in an easily accessible format. Consent for specific interventions, such as resuscitation, should be included in these discussions.

HNHBB organizations will need to prepare their clinical staff for having GoC conversations in the context of ESoC and should utilize educational, simulation and practice mechanisms that are already in place. Ensuring easy access to the above resources should be a part of this strategy, supplemented by organization-specific resources that would be beneficial to patients, families and clinical staff.

RESOURCES FOR HEALTHCARE PROVIDERS:

1. Person-Centred Decision-Making, Ontario Palliative Care Network: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/OPCNGocPCDMProviderResource.pdf
2. Approaches to Goals of Care Discussions, Ontario Palliative Care Network: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/ApproachesToGoalsOfCare.pdf
3. Speak Up Ontario Resources for Health Care Providers: https://www.speakupontario.ca/resources-for-health-care-providers/
4. Goals of Care Guide/Template: https://www.speakupontario.ca/wp-content/uploads/2020/04/GoC-template-Oct-2019-final-document-1.pdf
5. VitalTalk: https://www.vitaltalk.org/guides/covid-19-communication-skills/
6. Goals of Care and Code Status in the Emergency Department, Speak Up Ontario: https://www.speakupontario.ca/wp-content/uploads/2020/05/ED-GOC-conversations-.pdf
7. How to Talk End-of-Life Care with a Dying Patient (Short Video): https://www.youtube.com/watch?v=45b2QZxDd_o&app=desktop
8. https://macdrop.mcmaster.ca/s/cjQtgsqkBdnBcCd?path=%2F

PATIENT RESOURCES:

1. Making Decisions About Your Care: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/OPCNGocPatientResource.pdf
2. Advance Care Planning, Goals of Care, and Treatment Decisions & Goals of Care: https://www.ontariopalliativecarenetwork.ca/sites/opcn/files/OPCNGocFAQ.pdf

3. What is Palliative Care?, Canadian Virtual Hospice: https://www.virtualhospice.ca/en_US/Article/What+Is+Palliative+Care_/What+Is+Palliative+Care_.aspx
4. Canadian Virtual Hospice: https://www.virtualhospice.ca/en_US/Main+Site+Navigation/Home.aspx

COVID-SPECIFIC RESOURCES:

1. Pallium Canada: https://www.pallium.ca/pallium-canadas-covid-19-response-resources/
2. GoC Guide for Clinicians (Severe Illness), Speak Up Ontario https://www.speakupontario.ca/wp-content/uploads/2020/04/GOC-FECoMo-COVIDSevere-Hospital-2.pdf
3. GoC Guide for Clinicians (Mild Illness), Speak Up Ontario https://www.speakupontario.ca/wp-content/uploads/2020/04/GOC-Healthy-COVID-3.pdf
4. COVID Ready Communication Playbook, VitalTalk: https://www.vitaltalk.org/guides/covid-19-communication-skills/
5. Essential Conversations: Utilizing Advance Care Planning & Serious Illness Tools During COVID-19 and Throughout the Patient Journey, Pallium Canada: https://www.youtube.com/watch?v=6D89fNdQz7E&feature=youtu.be
6. Serious Illness Conversations with High-Risk COVID-19 Patients (Webinar), Providence Health Care: https://www.youtube.com/watch?v=pX3LR96k5w8

CONSENT AND CAPACITY:

1. Substitute Decision Maker Hierarchy, Speak Up Ontario: https://www.speakupontario.ca/resource/the-substitute-decision-maker-hirearchy/

CONVERSATION FLOW		SUGGESTED SCRIPTING
Set up the conversation • Introduce need to have conversation • Ask permission	SET UP	"I am worried that you are declining/taking a turn for the worse. I'd like to talk about what may be ahead for you as your illness progresses. Is this okay?" **IF talking with SDM**- use "your loved one"
Revisit goals of care if patient is a full code requesting critical care as part of care plan	GOALS OF CARE	"We previously spoke about your goals of care. In our last conversation, you voiced that you would want to be transferred to critical care should your condition deteriorate. I'd like to discuss this further with you" **If no previous GOC discussion** - "You are currently a full-code which means our team will attempt to revive you if your heart stops. I would like to discuss this further with you"
Disclosure of Current Situation Tailor information to patient preferences Allow silence, explore emotion	SHARE	"Your condition is getting worse/unstable, and we are worried your health could decline and you could suddenly deteriorate." **IF talking with SDM -** "Your loved one has had a decline in their condition that warrants a discussion with you and the medical team"
Future care management	FUTURE CARE	"We will do everything we can to help you through this. We will continue to provide you with ongoing medical treatment, and manage your symptoms so you remain as comfortable as possible." **IF talking with SDM** "We want to reassure you that your loved one will continue to receive care to manage their medical condition, and their symptoms, and we will also focus on keeping them as comfortable as possible"
Disclose of Critical Care Triage Process During Surge	DISCLOSE	"As a result of COVID 19 there is a major surge in very ill patients. This is stretching our health resources. This means that not everyone who needs critical care can receive it at this time. Health care providers across Ontario have to make extremely difficult decisions so processes and tools have been put in place to help make these challenging decisions" "Because of this, only patients who have a good chance of survival will receive critical care. Looking at your situation, even if you receive critical care, your chance of survival unfortunately is low. For this reason, we will not send you to the ICU. I know this must be very difficult to hear, I am so deeply sorry. But I want to reassure you that your symptoms will be controlled and we will continue to provide you with care."

Provision of patient information materials	WRITTEN MATERIAL	"We understand this must be very difficult for patients and their families. I have a letter and an FAQ for patients and families that explains about these critical care decisions. I can also take a few moments to help explain how these hard decisions are being made. Would you like to know more about this process?"
If patient requests more information about how the decision was made	ONTARIO CC TRIAGE	"This is a time of great uncertainty. With more people coming into hospital with acute healthcare needs, the need for critical care is greater than our available resources. Across the province, every hospital is working together to try to use resources in a way that is fair for everyone, and minimizes deaths." "A process is being used across Ontario to help hospital staff and physicians decide who should be admitted to the ICU based on their likelihood of surviving the next year. No one is given preferential treatment based on who they are."
Critical Care triage decision	STMR SCORING	"We recognized your condition was worsening. You were medically assessed by two physicians using a standard scoring tool. The tool considers your diagnosis and prognosis and underlying conditions. Based on these two medical opinions, critical care is not an option for you at this time." "If more resources become available, we will re-evaluate your medical status to determine your options."
Closing the Conversation	CLOSURE	"I just want to stress that we will continue to provide you with care to help you get better, as well as managing your symptoms and providing care that focuses on keeping you as comfortable as possible." "Our medical teams are doing their very best to care for all patients and families during these challenging times. Staff are available to provide spiritual and social support through this process." "I am here with you" "We are in this together "
Documentation		As per your facility standards

Your Health Care During COVID-19 Surge

Dear Patient and/or Family member:

We are providing you with this letter in follow up to the discussion you had with the physician/medical team about your care or the care of your loved one in hospital. We recognize it is incredibly difficult to be in hospital either as a patient or as someone who cares about a patient in hospital, especially during the current COVID-19 pandemic.

With more people coming into hospital with acute healthcare needs, there has been an increase in the number of patients requiring life-saving interventions. Healthcare resources, including staff and equipment, are unfortunately limited. The need for critical care, including breathing assistance, respirators and/or critical care hospital beds is greater than our current available resources. Across the province, every hospital is working together to try to use resources in a way that is fair for everyone.

Consequently, health care providers across Ontario have to make extremely difficult decisions as the demand for critical care and life saving equipment is higher than the supply of our available resources. Not everyone who needs critical care can receive it at this time. Hard choices have to be made to provide critical care to those people who are most likely to survive. In this way the most lives can be saved with the limited resources available. An Ontario-wide critical care triage protocol is being used to help hospital staff and physicians decide which patients are most likely to benefit from critical care. This Ontario-wide approach helps to ensure these hard decisions are made fairly, equitably and consistently across the province, using the best available evidence.

You/your loved one has been medically evaluated using this critical care triage protocol. As communicated to you by your physician, given your/your loved one's illness and health history, it has been determined that you/your loved one has a poor chance of survival if they become critically ill. As a result, critical care treatment and cardio-pulmonary resuscitation (CPR) will not be provided.

We are so deeply sorry. We acknowledge and respect that this is very difficult information to receive. We want to assure you and your family that although critical care treatment will not be offered, hospital staff will continue to provide you/your loved one with ongoing medical treatment, comfort care and symptom relief. Staff are also available to provide psycho-spiritual care and social support through this process.

Our medical teams are doing their very best to care for all patients and families during these challenging times. Should you or your family have any questions about this situation, your treatment team will do their very best to answer them for you.

The Ontario Adult Critical Care Triage Process:

Summary of Differences Between the "Emergency Standard of Care"

and the "Critical Care Triage Protocol"

This summary articulates the differences between the document entitled *"Adult Critical Care Clinical Emergency Standard of Care for Major Surge*" (ESoC) that was sent to all Ontario hospitals on January 13, 2021 by the Ontario Critical Care COVID-19 Command Centre (OCCCCC), and the *"Adult Critical Care Triage and Resource Allocation Protocol for Major Surge"* (Critical Care Triage Protocol). The Critical Care Triage Protocol will be released by the OCCCCC in the event that the Ontario Cabinet approves an Executive Order to allow withdrawal of critical care without consent.

This summary is organized around the following questions:

- **What is the Emergency Standard of Care (ESoC) for Major Surge?**
- **Where does the ESoC apply?**
- **How could the withdrawal of critical care without consent become possible?**
- **Why is it problematic that the ESoC does not permit withdrawal of critical care without consent?**
- **What is the "Adult Critical Care Triage and Resource Allocation Protocol for Major Surge" (Critical Care Triage Protocol) and how does it differ from the ESoC?**
- **What resources and supports are available to help enact the Critical Care Triage Protocol?**
- **How do I support patients/SDMs when a patient is not offered critical care or withdrawn from critical care on the basis of the Critical Care Triage Protocol?**

Extensive resources and tools have been developed to assist physicians, health professionals and administrators to enact the Critical Care Triage in hospitals across Ontario. These resources are available at: https://macdrop.mcmaster.ca/s/cjQtgsqkBdnBcCd?path=%2F

What is the Emergency Standard of Care (ESoC) for Major Surge?

On January 13, 2021 the Ontario Critical Care COVID-19 Command Centre (OCCCCC) released to all hospitals a document entitled " (ESoC). It delineates a critical care triage process that includes explicit protections of human rights, supports transparency and procedural fairness, and enables evidence-based decisions about the *offering* of critical care to patients who develop critical illness during a major surge in COVID cases through the implementation of the Short Term Mortality Risk Assessment tool (STMR). The ESoC would apply to ALL patients requiring admission to critical care (COVID and non-COVID) once triage in invoked.

The ESOC was developed by medical and bioethical experts, in consultation with many stakeholders. It was released in January 2021 to help hospitals and health professionals to prepare for a major surge. *It can only be enacted at the direction of the OCCCC, after ALL reasonable efforts have been made to ensure access to critical care for every patient who needs and wants it*, for example, by transporting patients to hospitals with more critical care capacity and adding additional ICU bed capacity.

Read this editorial for an explanation of the rationale for a provincial critical care triage process: https://hospitalnews.com/triage-in-critical-care-a-protocol-to-protect-lives-and-principles

Watch this video for more information about the ESoC: *Ontario Critical Care COVID Practice Rounds (OC3PR) from CCSO on the Emergency Standard of Care - January 23rd, 2021*: https://www.youtube.com/watch?v=xatBYgXZHt4&t=24s

Where does the ESoC apply?

The ESoC creates a standard of practice for **admission** to critical care in the context of a major surge in critically ill patients. The ESoC requires two physicians to complete the STMR for a patient *on the hospital ward or in the Emergency Department* who is likely to become critically ill, to determine whether the patient is prioritized for critical care based on their likelihood of survival.

The ESoC cannot be applied outside of the hospital by EMS.

The ESoC cannot be applied once the patient is intubated or admitted to ICU. This is because the ESoC does *not* empower physicians to withdraw critical care from patients in the ICU based on their STMR and the current level of triage without consent. The ESoC still requires consent of the patient or substitute decision maker (SDM) to withdraw critical care, based on the Ontario *Health Care Consent Act (1996).*

How could the withdrawal of critical care without consent become possible?

A state of emergency was declared in Ontario on April 7, 2021, making the *Emergency Management and Civil Protection Act* (1990) the prevailing legislation. This empowers the provincial Cabinet by order-in-council to temporarily suspend the operation of a provision of a statute when certain criteria are met, and to set out a replacement provision. These powers can modify the requirements of the *Health Care Consent Act* (1996) through an *Executive Order* such that consent will not be required from patients or SDMs to withdraw patients from critical care if they no longer meet prioritization criteria at the current level of triage. The Executive Order would provide legal protection for people (physicians, health professionals and administrators, etc.) who act in accordance with the directions of the OCCCCC regarding critical care triage.

Why is it problematic that the ESoC does not permit withdrawal of critical care without consent?

If the triage approach can only be applied at the time of admission, three problems arise:

1. **Inequitable access to critical care:**

   The ESoC would allow ICU to be withheld from those patients who have a high likelihood of dying even with critical care, based on the STMR assessment. However those patients who were already admitted to ICU will not be subjected to the same rules; they will continue to receive critical care regardless of their mortality risk. *This is fundamentally inequitable.* It creates a first-come, first-served system of access that privileges those who get sick earlier and have better access to hospitals. Equity would dictate that the same rules should apply to all critically ill individuals.

2. **More preventable deaths:**

   Without the ability to apply the STMR consistently to all patients already in the ICU, more preventable deaths will occur. This will happen in two ways, illustrated through a case example:

   > *The ICU is full and there is no more capacity to increase staffed beds or to transfer patients (regional or even provincial-wide capacity reached). The ESoC is triggered by the OCCCCC. Patient A has end-stage pancreatic cancer and is already in the ICU due to COVID-related complications; their STMR predicts >80% likelihood of dying within 12 months. Patient B suffers a motor vehicle accident and arrives at the emergency department needing surgery and a short stay in the ICU; their STMR predicts <30% chance of death within 12 months if critical care is provided.*

In the case above, Patient B will die due to lack of access to critical care. This is a *preventable death* because ICU resources could have saved their life if an Executive Order had enabled ICU staff to withdraw critical care from Patient A who is very likely to die even with critical care.

3. **More Triage:**

   If critical care triage through the STMR can only be applied at the time of admission, the OCCCCC must invoke the ESOC *before all of the ICU beds are full*, so that there is some capacity remaining to allow patients with high likelihood of survival—like Patient B—to gain access to ICU if they arrive later in the surge. By invoking triage earlier than necessary more people could be denied access to life-saving ICU care overall, leading to more preventable deaths.

What is the "Adult Critical Care Triage and Resource Allocation Protocol for Major Surge" (Critical Care Triage Protocol) and how does it differ from the ESoC?

The Critical Care Triage Protocol is a standard of care for management of a major surge in critically ill patients, approved by the OCCCCC. It is identical to the ESoC in most ways: it follows the same guiding ethical principles; contains the same explicit human rights protections; it has the same decision-making processes and procedural protections, and the STMR clinical criteria for admission to ICU are the same. Like the ESoC, the Critical Care Triage Protocol can only be enacted at the direction of the OCCCCC.

The only substantive difference is that *the Critical Care Triage Protocol is enacted in the context of an Executive Order allowing for the application of the STMR triage criteria to patients already admitted to critical care.* It allows for the withdrawal of critical care without consent of patients/SDMs for patients who are not prioritized for continuing critical care (i.e. those most likely to die within the next year) given the current level of triage based on their STMR assessment. Thus, the Critical Care Triage Protocol facilitates more fair and equitable access to critical care for all patients who develop critical illness over the course of a major surge, and has the potential to save more lives.

The challenge of this approach is that some patients may have life-sustaining measures withdrawn without consent, and this will lead to difficult conversations and conflicts with patients and family members in the ICU.

What resources and supports are available to help enact the Critical Care Triage Protocol?

Extensive resources and tools have been developed to assist physicians, health professionals and administrators to enact the ESoC and the Critical Care Triage Protocol in hospitals across Ontario. These resources are available at: https://macdrop.mcmaster.ca/s/cjQtgsqkBdnBcCd?path=%2F

Available resources include:

- Up-to-date versions of OCCCCC approved policies, forms and clinical decision-making tools
- Goals of Care and Communication Resources: scripts for engaging in goals of care conversations and disclosing triage to patients/SDMs; training videos for communicating with patients/SDMs about triage; palliative care resources
- Critical Care Triage and STMR Education Resources: a narrated slide deck explaining the ESoC and Triage Protocol; a video simulating an STMR assessment; FAQ documents that can explain triage to patients/SDMs and other health professionals

How do I support patients/SDMs when a patient is not offered critical care or withdrawn from critical care on the basis of the ESoC or Critical Care Triage Protocol?

All healthcare professionals have a role in providing psycho-social support to patients and families. Whenever possible, teams should try to align the care plan with the patient's wishes. Asking patients/SDMs about goals of care and wishes, should the patient become critically ill, is one important way to build trust. Critical care should only be offered to those patients who want it.

Even if a patient is not prioritized for critical care, it is essential to reassure patients/SDMs that the patient will continue to receive palliative care, medical management and symptom relief. The interprofessional team can talk with the patient/SDM about what can still be done to offer comfort and care to the patient, even if critical care isn't an option. Palliative care consultation may be helpful.

The MacDrop resources folder contains a script to support conversations about the triage process with patients/SDMs, and a video that demonstrates this conversation. Hospitals should ensure psycho-social supports are available to patients and families, including social work, spiritual care, patient relations, palliative care, etc. These supports can enable virtual visits with families, provide emotional support, facilitate rituals and spiritual care, and ensure the questions and worries of the patient/family are addressed.

Critical Care Triage for Major Surge

Frequently Asked Questions for Health Professionals

How is COVID-19 affecting our health system?

Demand for critical care currently outweighs our supply of available resources. Normally, when somebody develops a critical illness and would benefit from intensive care, the medical team would offer critical care and cardio-pulmonary resuscitation (CPR). A major surge in demand for critical care means that some who may have otherwise benefitted from critical care may not receive it, and as a result, some will die. All hospitals in Ontario are following the same strict guidelines to reduce preventable deaths to the greatest extent possible.

What is critical care triage and when will it come into effect?

Critical care triage is a system used to decide which patients receive critical care when resources are scarce. The purpose of critical care triage is to allocate available resources in a way that will minimize preventable deaths. Critical care triage is used as a last resort, and does not extend beyond the COVID-19 pandemic emergency. It is only enacted when there is a major surge in demand for critical care resources and patients can't be moved to other ICUs or new critical care beds can't be opened to make space for more patients. The *Ontario Health Critical Care COVID-19 Command Centre, together with regional and hospital partners, will decide when to initiate critical care triage throughout the province.*

How are critical care triage decisions made?

Deciding which patients receive critical care resources during a major surge due to the COVID-19 pandemic can create significant distress for patients and health care providers. A transparent and accountable process to make fair decisions has been created to minimize discrimination and ensure fairness as much as possible. This system is being applied to all patients (both COVID and non-COVID) and hospitals across Ontario.

Patients who are eligible for critical care will be assessed by two physicians according to the *Short Term Mortality Risk (STMR) assessment tool for critical illness*. The tool estimates a patient's likelihood of surviving for 12 months using a variety of clinical tools. The greater the surge in critically ill patients, the greater the likelihood of survival required for a patient to gain admission to ICU.

Information about a patient's underlying illness, disease, or disability will **not** be taken into consideration unless they directly impact their likelihood of surviving the next year. For example, critical care is **not** allocated based on a patient's overall life expectancy, or simply because of their age. Each patient needing critical care will be assessed using the same tool, regardless of their underlying illness. Only if both physicians agree that the patient has a poor chance of surviving their critical illness at the current triage level, is critical care not offered.

Are some people given preferential treatment (e.g. essential service workers)?

No one is given preferential treatment based on who they are. The critical care triage process was created to align with the Ontario Human Rights Code. Decisions about critical care must not consider age, sex, socioeconomic status, race, disability accommodation assistance, or the cost of future care. Independent of a patient's likelihood of surviving in the next year, critical care triage must not consider disease, disability, or overall life expectancy. Further, assumptions cannot be made about a patient's quality of life–only the patient can decide what quality of life is acceptable.

Why is it important to talk to my patient about their goals and wishes now?

We would like to continue to honour the wishes, values and beliefs of all patients to the greatest extent possible under these difficult circumstances. Your patient's condition can change quickly and without warning. It is important to discuss with your patient or their substitute decision maker their health preferences and wishes before they get into a crisis, to ensure the patient receives the care they want and avoids any unwanted or non-beneficial treatments. All health care professionals with a therapeutic relationship with a patient can support care planning by encouraging proactive, collaborative and values-based, end-of-life discussions.

If my patient is receiving critical care now, can it be withdrawn based on this triage process?

A patient receiving critical care may only have that care withdrawn if they or their substitute decision maker provides consent, except under special circumstances. If the Government of Ontario issues an Executive Order to temporarily amend the health care consent law, this could change. If the government issues this Executive Order, patients receiving critical care would be reevaluated regularly, according to the Short Term Mortality Risk (STMR) assessment tool. If a patient in the ICU has a high chance of dying in the context of triage, their physician will talk to the patient and family about the possibility of withdrawing critical care.

If critical care is withdrawn, the patient will continue to receive medications and nursing care to keep them comfortable. They may be moved out of the ICU to a more appropriate place in the hospital. Social and spiritual support will be offered, and, to the extent possible, visits with family will be supported, either virtually or in person.

What happens if my patient does not qualify for critical care?

All patients, regardless of triage status or illness, will receive access to non-critical care, including appropriate medical treatments to maximize outcomes, and comfort care and symptom management. Every effort will be made to support clear and transparent communication with your patient and their family about the available resources and care options that align with their goals of care.

Can a patient appeal the critical care triage decision?

The critical care triage process requires a second medical opinion. If the two physicians assessing the STMR of the patient disagree on the prognosis, the more optimistic medical opinion will prevail. Due to the timeliness of these decisions, there is no other formal mechanism for appeals of critical care triage decisions. Patients and substitute decision makers are encouraged to discuss their questions and concerns with their most responsible physician. Other concerns about the triage process should be directed to the Office of Patient Experience or equivalent.

Where can I find the critical care triage forms and documentation?

Blank copies of STMR forms can be accessed from your hospital ward or ICU. In most hospitals, the STMR forms are completed in paper format, and kept with the patient's code status documentation.

What are the roles of staff and residents in the critical care triage process?

Staff and residents are not expected to conduct STMR assessments, yet all staff and residents have roles to play in supporting critical care triage and a positive patient experience by:

- delivering care and symptom management and providing comfort
- identifying patients who would benefit from goals of care conversations
- preparing patients and families to engage in goals of care discussions with their team
- ensuring documentation of patient wishes are clear and up to date
- proactively identifying patients who are at high likelihood of becoming critically ill
- supporting rigor in critical care triage assessments (helping with clinical assessments)
- providing psycho-emotional support to patients and families
- providing support to their healthcare colleagues facing very challenging circumstances

What resources can help support communications with patients?

Information for patients and families, as well as conversation guides and educational resources for staff about the critical care triage process are available in a provincial resource library. Specifically, a conversation guide, Patient and Family FAQ, and training video have been developed to support discussions with patients regarding why they will not receive critical care in the context of triage. Staff can consult with Spiritual Care/Chaplains, Social Work and Palliative Care as appropriate to support patients and families through these difficult circumstances.

Critical Care Triage for Major Surge

Frequently Asked Questions for Patients and Families

How is COVID-19 impacting our health system?

Demand for critical care currently outweighs our supply of available resources. Normally, when somebody develops a critical illness and would benefit from intensive care, the medical team would offer critical care and cardio-pulmonary resuscitation (CPR). A major surge in demand for critical care means that some who may have otherwise benefitted from critical care may not receive it, and as a result, some will die. All hospitals in Ontario are following the same strict guidelines to reduce preventable deaths to the greatest extent possible.

What is critical care triage and when will it come into effect?

Critical care triage is a system used to decide which patients receive critical care when resources are scarce. The purpose of critical care triage is to allocate available resources in a way that will minimize preventable deaths. Critical care triage is used only as a last resort, and does not extend beyond the COVID-19 pandemic emergency. It is only enacted when there is a major surge in demand for critical care resources and patients can't be moved to other ICUs or new critical care beds can't be opened to make space for more patients. The *Ontario Health Critical Care COVID-19 Command Centre, together with regional and hospital partners, will decide when to initiate critical care triage throughout the province.*

How are critical care triage decisions made?

Deciding which patients receive critical care resources during a major surge of critical illness due to the COVID-19 pandemic can create significant distress for patients, families and health care providers. A transparent and accountable process to make fair decisions has been created to minimize discrimination and ensure fairness as much as possible. This system is being applied to all patients (both COVID and non-COVID) and hospitals across Ontario.

Patients who are eligible for critical care will be assessed by two physicians according to the *Short Term Mortality Risk (STMR) assessment tool for critical illness*. The STMR tool estimates a patient's likelihood of surviving for 12 months using a variety of clinical tools. The greater the surge in critically ill patients, the greater the likelihood of survival required for a patient to gain admission to ICU.

Information about a patient's underlying illness, disease, or disability will **not** be taken into consideration unless they directly impact their likelihood of surviving the next year. For example, critical care is **not** allocated based on a patient's overall life expectancy, or simply because of their age. Each patient needing critical care will be assessed using the same tool, regardless of their underlying illness. Only if both physicians agree that the patient has a poor chance of surviving their critical illness at the current triage level, is critical care not offered.

Are some people given preferential treatment (e.g. essential service workers)?

No one is given preferential treatment based on who they are. The critical care triage process was created to align with the Ontario Human Rights Code. Decisions about critical care must not consider age, sex, socioeconomic status, race, disability accommodation assistance, or the cost of future care. Independent of a patient's likelihood of surviving the next year, critical care triage must not consider disease, disability, or overall life expectancy. Further, assumptions cannot be made about a patient's quality of life–only the patient can decide what quality of life is acceptable.

Why am I being asked to think about my/my patient's goals and health preferences now?

We would like to continue to honour the wishes, values and beliefs of all patients to the greatest extent possible. When people become acutely ill, their health can change quickly and without warning. None of us knows what tomorrow will bring. It is important to think about your health preferences and communicate your wishes to your health care team and your substitute decision maker before getting into a crisis situation. The healthcare team wants to ensure you receive the care you want, if it is available, and not receive care that is unwanted or is not beneficial.

If I/my patient is receiving critical care, can it be withdrawn as part of the triage process?

A patient receiving critical care may only have that care withdrawn if they or their substitute decision maker provides consent, except under special circumstances. If the Government of Ontario issues an Executive Order to temporarily amend the health care consent law, this could change. If the government issues this Executive Order, patients receiving critical care would be reevaluated regularly, according to the Short Term Mortality Risk (STMR) assessment tool. If a patient in the ICU has a high chance of dying in the context of triage, their physician will talk to the patient and family about the possibility of withdrawing critical care.

If critical care is withdrawn, the patient will continue to receive medications and nursing care to keep them comfortable. They may be moved out of the ICU to a more appropriate place in the hospital. Social and spiritual support will be offered, and, to the extent possible, visits with family will be supported, either virtually or in person.

What happens if I/my patient does not qualify for critical care?

All patients will continue to receive medical care to help them recover, as well as, comfort care, and symptom management (including for pain and shortness of breath). Every effort with be made to support clear and transparent communication about available resources and options, and to align the care plan with the patient's wishes and values.

If I/my patient is not offered critical care, can I appeal the decision?

The critical care triage process requires a second medical opinion. If the two physicians assessing the patient disagree, the more optimistic medical opinion will prevail. Due to the timeliness of these decisions, there is no formal mechanism for appeals of critical care triage decisions.

Patients and substitute decision makers are encouraged to discuss critical care triage decisions with their physician. If there are concerns that there was an error in applying the *Short Term Mortality Risk (STMR) assessment tool for critical illness*, please raise this with your physician so it can get addressed. Any other concerns about the triage process should be directed to the Office of Patient Experience or equivalent.

Will family be allowed to visit?

We recognize family member and caregiver presence is important, and we will make every attempt to connect patients with their loved ones. A limited number of visitors are permitted in order to keep everyone safe and reduce the spread of COVID-19.

If a patient is at imminent end of life, the Clinical Manager or delegate, in partnership with the patient and essential caregivers/ support persons, will determine the best options for caregiver/support persons to visit, either virtually or in person.

Who can give me support?

The healthcare team is here to support you if you have any questions or concerns. Social Workers can provide emotional support and discuss options with you and your family. Spiritual care/chaplains can provide spiritual support. And palliative care can provide options around symptom management and comfort. Your healthcare team is here to support you through all points of your care journey.