'LIFE OR LIMB' - NO REFUSAL POLICY

Purpose:

This policy outlines clinical guidelines for the process of identifying and transferring patients whose life or limb is threatened, to an appropriate receiving institution capable of providing for the patient's care needs (see Appendix A– Diagnoses requiring acute care ≤ 4 hours with District Hub Responsibility and Regional Hospital Expectations).

Preamble:

The 4 Hub Hospitals in the North East LHIN receive many requests for patient transfers. There are varying degrees of urgency for these patients. A subset of these patients present with conditions that potentially cause loss of life or limb, and can only be cared for at specific sites because of the nature of the care they require and/or the complexity and severity of their condition.

The resources required to take care of these 'Life or Limb' patients need to be made available in the most expeditious fashion, in order to optimize patient outcome. (includes accepting physician, timely acceptance at the hospital and timely ambulance transfer)

This document and the attached Appendices can be used internally within each hospital in the North East LHIN as a guide to understand where the capabilities exist to care for 'Life or Limb' patients.

External to individual hospitals, this document can be used by CritiCall and by hospitals in the North East LHIN and by hospitals in surrounding LHINs to determine the best site for referral if the capacity to deal with 'Life or Limb' does not exist for any reason within their own hospital or LHIN.

This policy outlines how patients get referred and transferred to the most appropriate level of care in the North East to receive the care they require in the timeliest manner. This policy is specifically identified in the above protocol for those patients *who need to access care within four hours*, if they cannot get it at the hospital at which they are currently located. These patients are considered to be 'Life or Limb'. (For patients requiring attention in next 24-48 hrs. please use your usual referral process)

Scope:

This document provides a regional guideline for all hospitals in the North East LHIN. This document is to be used by referring and receiving physicians, hospital staff and by CritiCall.

Hyperlinks & Bookmarks

Appendix A	Life and Limb No refusal Policy – NE LHIN District Hub Hospital and Regional Hospital Expectations
Appendix B	"Usual" Inter-Hospital Repatriation Protocol – NE LHIN
Appendix C	Tracking the Success of the NE LHIN Life and Limb Policy
Appendix D	Transfer Data to go with patient at time of transfer

Statement:

Hospitals within the North East LHIN accept the mandate, as part of a system of hospital based care, to provide care for patients considered 'Life or Limb' within the capability, resources and mandate of their hospital.

Necessitating access to accommodate 'Life or Limb' patients (surge capacity, transfer and repatriation, etc.) requires an admitting process that is clearly outlined and closely monitored. Patient safety is considered the priority and concurrently safety of staff needs to be respected. Each hub hospital will have a clear and streamlined internal process for their accepting physicians to contact, once the accepting specialist has a 'life or limb' patient.

There are a small subset of patients who are 'Life or Limb' whose condition is such that they can only be managed at regional tertiary and quaternary care institutions because of the complexity and/or severity of their condition. In order to maintain the capacity to respond in a timely manner, coordination among hospitals capable of managing care for 'Life or Limb' is necessary to minimize the impact on any one institution. Partnerships to enable timely referral and repatriation to increase bed access for 'Life or Limb' patients are considered paramount.

As such, no patient considered 'Life or Limb' will be refused treatment by North East LHIN designated hospitals except in the circumstances whereby accepting the patient would potentially compromise the safety or pose a risk to the patient/staff (e.g. human resources are at that time are unavailable to accept that patient).

Guiding Principles:

- Patient safety is the priority
- Physicians will call CritiCall and declare that a patient is "Life or Limb"
- Transfer of patients will be based upon urgency of situation, and match the needs of the patient with availability of resources
- Intent is to transfer the patient to the closest appropriate institution utilizing the most efficient and expeditious mode of transport
- No receiving hospital capable of providing a patient's needs shall refuse a patient, unless acceptance of the patient would potentially compromise patient's(s) care. For example, extenuating circumstances e.g. LHIN moderate surge conditions, receiving care team incapacitated.
- A "full ICU or CCU" is not a reason to refuse a patient (unless at 15% Moderate Surge as declared by LHIN)
- CritiCall-will be the contact for the referring physician, who will identify that this is a "life or limb" 4 hour emergency patient. CritiCall will initiate all calls to expedite referral between referring physician and most appropriate receiving physician/service (using the framework in Appendix A)
- LHIN geographic boundaries will not limit a patient's access to appropriate care in another LHIN if required.
- The consultant on the receiving service will have the responsibility of determining the final triage decision (e.g. this is a true 'life and limb 4 hr emergency' that needs emergent transfer vs. a patient where transfer could be delayed)

Goals:

There are three main goals of the Policy:

1. To ensure transfer of critically ill patients to closest, most appropriate regional care institution in the most efficient, expedited, and safest manner possible
2. To ensure timely consultation with a receiving physician to improve access to required critical care services
3. To optimize resources required to provide critical care services to a Life or Limb patient (transport, physician consultation, critical care beds, surgical suites/teams etc.)

Referral Process:

1. Referring physician **contacts CritiCall** and declares a critically ill "Life or Limb" situation. Refer to the attached guidelines (Appendix A –"Life or Limb'" definitions that require care within 4 hours).

2. All 4 northeast Hub Hospitals (North Bay, SSM, Timmins and Sudbury) have confirmed that they are 'no refusal' in case of life or limb injury within their hospital scope of practice. (see Appendix A)

3. CritiCall will facilitate a timely consultation with the most appropriate physician (based on diagnosis) who is on-call at the closest, most appropriate institution (Appendix A – outlines District Hub and Regional roles)

The first consultant on the receiving service has to be connected by phone with the referring physician at the start of the referral to ensure the request for emergent transfer is appropriate for the patient in question. Once the accepting specialist confirms this is a 'life or limb' 4 hour emergency, arrangements will begin to transfer the patient by ambulance quickly.

4. The accepting specialist will then contact their hospital point of contact for emergent admissions, and advise that a 'life or limb emergency patient' will be coming. (each hub hospital will have clear, user friendly, internal processes for their physicians to follow, once these patients are accepted – and the hospital will have informed their physicians of the policy.)
If the receiving physician is not an ICU physician, and there is likelihood that an ICU bed is required, the receiving physician will immediately contact the ICU physician on-call for the institution and advise there is a 'Life or Limb' situation, and that an ICU bed is required.

5. If the receiving physician(s) firmly believe that the necessary resources are not available (does not include no bed unless hospital in Code Orange situation), or accepting transfer will place patient(s)/staff at inappropriate risk, then the physician would not accept the patient.
At that point CritiCall (in conjunction with NE hub hospital partners) will determine the next appropriate institution within the NE capable of caring for the patient. CritiCall will then contact that hospital's specialist about the referral.

Evaluation:

A log of patients will be kept by CritiCall of all declared 'life or limb patients'. This log will be reviewed regularly reviewed by the Criticall, NE Critical Care Lead and Hub Chiefs of Staff for:

- appropriateness of admission
- contingencies required for treatment
- time to referral/acceptance/transfer/treatment
- arrival time of patient to receiving hospital
- treatment outcome
- impact on services
- complaints/concerns/QA opportunities

The Critical Lead will also send a quarterly report to the LHIN CEO and NE hospitals on effectiveness of the system. The quarterly report will also be presented to the Critical Care Secretariat for discussion at the quarterly Critical Care LHIN Leader meeting.

Review Process:

This is a new policy for the NE LHIN hospitals being implemented in June 2011. In October (after about 4 months) the policy will be reviewed by the LHIN and NE hospitals to be sure that is working effectively.

Keys to Success:

- all four hub hospitals meet their obligations for their "District Responsibilities" and HRSRH meets their regional obligations.
- All four hub hospitals identify strategies to ensure their core specialty services are covered. (District Hospitals and Regional need to make back-up arrangements beforehand when coverage gaps are anticipated)
- Timely transfer by ORNGE or land alternative is imperative for timely patient care.
- A clear Repatriation Policy (Appendix B) to all referring hospitals (large, medium and small) – within 24 hrs. all repatriations should occur unless a hospital in Moderate Surge crisis. (usually means will accept all patients within 24 hrs. even if means an overcapacity bed.
- Regular review by LHIN Critical Care lead (together with CritiCall and Hub Hospitals) to be sure that the life and limb patients are being accepted in a timely manner, and that repatriation policy working effectively.

Appendix A: Life and Limb No refusal Policy – NE LHIN District Hub Hospital and Regional Hospital Expectations

District Referral Responsibilities	HRSRH – Sudbury	Sault Area Hospital	North Bay Gen Hosp	Timmins Hospital
Hub Hospitals will meet the core specialty " 4 hr life & limb emergencies" for their district as if they presented to their ER No refusal unless in surge or provider illness	Referral Base: Manitoulin Espanola Elliot Lake *Blind River [& at times Parry Sound]	Referral Base: Thessalon *Blind River Wawa Hornepayne	Referral Base: Sturgeon Falls Mattawa New Liskeard Englehart *Kirkland Lake	Referral Base: Hearst Chapleau Cochrane Kapuskasing Iroquois Falls *Kirkland Lake Sm. Rock Falls Matheson [& at times Weeneebayko]
General Surgery /Gastroenterology (GI bleed with shock; pancreatitis-severe +/- abscess; perforated viscous +/- septic shock and multisystem failure; toxic colitis; wound dehiscence; cholangitis, liver failure) Complications of Liver Transplant	Yes Extra LHIN to transplant center	Yes Extra LHIN to transplant center	Yes Extra LHIN to transplant center	Yes Extra LHIN to transplant center
Endocrinology (internal medicine or Intensivist) (diabetic ketoacidosis, hypo/hyperglycemic coma, pituitary apoplexy, adrenal crisis, myxedema coma)	Yes	Yes	Yes	Yes
Respirology (				

internal medicine or intensivist) (Refractory asthma; respiratory failure including CHF; severe pneumonia; severe cystic fibrosis: severe cor pulmonale; unstable pulm embolism)	Yes	Yes	Yes	Yes
Neurology (internal medicine or intensivist) (meningitis; encephalitis; acute stroke; status epilepticus)	Yes	Yes	Yes	Yes
Hematology – **non- malignant** (internal medicine) (Severe hemophilia; DIC)	Yes	Yes	Yes	Yes
Ophthalmology (acute glaucoma; severe endopthalmitis; severe orbital cellulitis; ruptured globe)	Yes	Yes	Yes	Yes
Orthopedics Multiple large bone fractures; compound fractures; fracture with compartment syn.; fracture with vasc. compromise; Major Pelvic Fractures Fracture with Major Vascular Tear	Yes Yes (NE region) Yes (NE region)	Yes No No	Yes No Yes- usually	Yes No No
Plastics	Yes – for district	Yes – for district	No	No

(major burns, major limb amputations for re-implantation) - both of these usually go to a Southern Ontario major referral centre)	** at this time there is no regional plastics initiative – so this area may be problematic in the short term.			
Spine -see Regional Programs -Neurosurg				
Urology (obstruction +/- sepsis; torsion; necrotizing gangrene; renal trauma; acute priapism)	Yes	Yes	Yes	Yes
Obs/Gyne (Severe dystocia; obs labour; cord prolapse; amniotic embolism; multiple gestation; fetal distress; PIH severe; severe PID +/- DIC; severe pelvic bleeding; uterine rupture; severe post gyne- surg complications;	Yes	Yes	Yes	Yes
Nephrology Acute Emergency Dialysis *Note:* *4 hr emergency go to hub hospital supporting their Satellite Dialysis Program*	**HRSRH** Referral Base: Manitoulin Espanola Elliot Lake Parry Sound New Liskeard Englehart *Hearst *Kapuskasing *Kirkland Lake	**SAH** Referral Base: Thessalon Blind River Wawa Hornepayne	**North Bay Hosp** Referral Base: Sturgeon Falls Mattawa	**Timmins Hospital** Referral Base: Chapleau Cochrane Iroquois Falls Sm. Rock Falls Matheson Weeneebayko *Hearst *Kapuskasing *Kirkland Lake
Pediatrics				

All hub hospitals provide good pediatrics support to their district—but all may request back-up and referral to one of the 4 designated Pediatric Hospitals Extramural Intensivist lines for emergencies)	Yes	Yes	Yes	Yes
Diagnostic Imaging (emergency CT and MRI as indicated by clinical presentation)	Yes	Yes	Yes	Yes

REGIONAL REFERAL PROGRAMS

	HRSRH Sudbury *Accepts for all NE LHIN for regional mandates*	Sault Area Hospital Referral Base: Thessalon Blind River Wawa Hornepayne	North Bay General	Timmins and District
Cardiology				
Cardiology for pacemakers temporary and permanent	Yes	Yes	Yes	No
Cardiology for interventions (unstable ACS; angioplasty; cardiogenic shock for IABP)	Yes	No	No	No
Cardiology for angiography	Yes	Yes	No	No
Cardiac Surgery (critical valve leak, etc.)	Yes			
Vascular Surgery				

(ruptured/leaking abdominal or thoracic aneurysm; major vascular injury)	Yes	Yes for ruptured abd. aneurysm and major vascular injury	No	No
Thoracic Surgery (massive hemothorax; massive hemoptysis; ruptured esophagus; intrathoracic airway obstruction; empyema; strangulated diaphragmatic hernia) Lung Transplantation Emergencies	Yes No- refer to Transplant Centre	No No	No No	No No
Neurosurgery (intracranial bleed; closed head; C spine fracture; epidural hematoma; tumour with acute ICP; acute hydrocephalus; acute cord compression**)**	Yes (follows neuro surg framework) At times aneurysm will be redirected to coiling center	No	No	No
T and L Spine Fractures (operative management)	Yes Not always available – at times referral to alternate Prov Spine Centre	No	No	No
Multi Trauma	Yes	No	No	No
Major Burns	No	No	No	No

	However HRSRH Trauma TTL will provide emergency assistance if there is delay to Burn Centre			
Oncology (Malignant airway obstruction; acute leukemic crisis)	Yes	Yes – limited capability		

Appendix B: "Usual" Inter-Hospital Repatriation Protocol – NE LHIN
North East Repatriation Protocol

Purpose
The NE hospitals recognize that in any given week all of our hospitals (large, medium and small) find themselves in a minor surge, with admitted patients waiting in emergency. (i.e. the hospital is over their acute medical bed census by ~ 10%)

The NE hospitals also recognize that it is important for the Level 3 District and Regional Referral centres to be open to accept transfers of emergency patients requiring specialist *care, and they currently endeavour to accept patients, even when in minor surge overcapacity for their acute beds. (and keeping timely flow through Critical Care beds very important)*

For the sustainability of the District and Regional hospitals to accept critical referrals when they are in minor surge overcapacity, there needs to be a reliable and timely outflow of patients back to District and Level 1-2 hospitals, hence this policy.

Expectations:
All North East hospitals need to repatriate patients back to their hospitals, even if it means they will be overcapacity for their acute bed numbers. (They will accept and follow the similar overcapacity protocol principles that they do for emergency patients requiring admission in their ED)

Procedure:

1- Discharge planner (or equivalent) from sending hospital will contact the clinical leader responsible for transfers at receiving hospital.
2- The receiving hospital will accept the patient within 24 hrs. of the request. (Including weekends; Unless meets exceptions listed.)
3- ORNGE notified to arrange transfer expeditiously.

Exceptions:

- i) the repatriated patient needs a critical care bed, and the receiving hospital already has used all their minor surge ICU beds (15% overcapacity) – and has no potential (green) transfers to ward.
- ii) the repatriated patient needs a ward bed, and the hospital is 15% overcapacity of their acute bed complement. Hospital in CODE ORANGE.
- If the LHIN has invoked Moderate Surge, then LHIN Moderate Surge Policy is to be followed.

Additional Note for Smaller hospitals (< 50 acute beds)

- be prepared to repatriate back 'ward' patients from Level 3 hospitals.

If less than 15 acute care beds– be prepared to go 2 pts. overcapacity on ward

If have 15-25 acute care bed– be prepared to go 3-4 pts. overcapacity on ward

If have 25-50 acute care bed– be prepared to go 4-5 pts. overcapacity on ward

Appendix C: Tracking the Success of the NE LHIN Life and Limb Policy

The VP Medical Affairs at HRSRH will work with CritiCall to track all the life and limb patients. During the start-up phase there will be bimonthly reports to the NE LHIN and NE hospitals on the success and challenges of the project. First report expected September 2011.

The report will cover:

- appropriateness of referral
- contingencies required for treatment
- time to referral/acceptance/transfer/treatment
- arrival time of patient to receiving hospital
- treatment outcome
- impact on other services
- complaints/concerns/QA opportunities
- any resource allocation issues

Appendix D: Transfer Data to go with patient at time of transfer

1. **Physician to physician contact will have occurred.**

2. **A clear transfer note, with hx, diagnosis, relevant investigations and treatment summary will accompany the patient at time of transfer.**

3. **Diagnostic imaging will be i) copied on disc to accompany patient and ii) be loaded on the PACS system at the receiving hospital.**