

BACKGROUND

As the health care system prepares for a surge of demand related to the community spread of COVID-19, it is important that all hospitals that care for psychiatric inpatients follow some common principles as it relates to the psychiatric inpatient capacity issues and the COVID-19 pandemic. This document is meant to support local preparation for COVID-19 pandemic planning, and ensure appropriate responses across the Toronto region and sub-regions to support access to essential care for people with psychiatric illnesses.

OBJECTIVES

1. To ensure a coordinated response across the healthcare system and maintain access to essential psychiatric services.
2. To enable all hospitals with inpatient psychiatric units to coordinate resources and respond to system needs in relation to severe COVID-19 disease burden and possible decreased psychiatric bed capacity.
3. To support the temporary need for local hospital and sub-regional capacity to provide isolation and treatment units for COVID+ psychiatric patients.

PURPOSE

This document describes the escalated approaches that all Toronto Region Hospitals with dedicated psychiatric inpatient units should implement in preparation for 1) potential closure of a proportion of psychiatric in-patient beds; 2) increased volumes of COVID+ psychiatric patients; and 3) reduced ECT availability. Categories of preparation include:

- Local Pandemic Plan for internal psychiatric bed and ECT availability and usage.
 - This will include communicating levels of risk to planning tables to support system-wide readiness
- Clear data and communication plans for early recognition of “at risk” hospital units or services in order to mobilize sites able to host psychiatric patients, if needed.
- Support for safe patient transfer across sites for current psychiatric in-patients and repatriation agreements.

PLANNING PRINCIPLES

- It is assumed that each local hospital has developed their own internal pandemic plan for bed and operational capacity and self-identified triggers for action. Each hospital will ensure that internal options related to planning and managing COVID requirements have been fully explored and implemented prior to utilizing system based resources and transfers.
- Each hospital will determine criteria for potential repurposing of their in-patient psychiatric unit(s) in the context of increased demand for inpatient beds for COVID+ patients. This will involve a phased approach, with each site reporting daily on the psychiatric daily bed census as follows:
 - Green: 100% of beds are run as psychiatric.
 - Yellow: Proportion of beds (<50%) used for non- psychiatric care related to COVID-19 complications or increasing surge numbers on medicine wards.
 - Red : >50% of psychiatric beds are repurposed or unit closes to psychiatric admissions.
- It is strongly recommended that all sites maintain essential psychiatric bed capacity. Should closure of psychiatric beds and transfer of psychiatric patients to other sites be needed, ensure internal capacity and HR readiness to re-open psychiatric beds and repatriate transferred patients once volume of COVID+ patients decrease and psychiatric inpatient units re-open to full capacity.
- Commit to participation in the daily bed call to ensure situational awareness, and maintain connection with the Toronto Regional Hospital Operations Table to allow for action as needed.
- Build on existing transfer and repatriation protocols following the daily bed call to ensure timely, seamless, and safe transfer of patients across care settings, if needed.

RECOMMENDED APPROACH

The following recommendations should be used to operationalize the planning principles above:

1. Local and sub-regional internal capacity and staffing model
 - a. All hospitals to determine current psychiatric bed capacity and operational plans, and decide on potential need for usage of psychiatric beds for non-psychiatric patients, considering the following scenarios:
 - i. Increased volumes of COVID+ non-psychiatric inpatients
 - ii. Increased volumes of COVID+ psychiatric inpatients with various levels of needs to maintain safety (e.g. psychosis, agitation, suicidality).
 - iii. Need for isolation of COVID+ patients
 - iv. Maintenance of beds for underserved populations, including child and youth, geriatrics, youth and adults with eating disorders and people who are homeless.
 - b. Sub-regions (Central, East, North, West) to coordinate planning to enable local provision of essential psychiatric care, considering
 - i. Increasing volumes of COVID+ psychiatric inpatients.
 - ii. Need for isolation of suspected or confirmed COVID+ psychiatric patients with various levels of need for psychiatric care (e.g. psychosis, suicidality, behavioral dyscontrol) within sub-region.
 - iii. Consideration of pre-admission / observation units of psychiatric patients, or access to rapid testing of all psychiatric inpatients to determine COVID status, based on feasibility in each sub-region.
 - iv. Potential for redeployment of physicians to ensure physicians work at site of greatest need.
2. CAMH internal capacity and staffing model
 - a. Ensure clear and timely communications to allow for enhanced bed capacity at CAMH to be able to assume a percentage of transitioned in-patient psychiatric volumes of various levels of psychiatric need from sites at-risk or closed to psychiatric patients, prioritizing the Central sub-region.
 - i. CAMH will work with the assumption that this may equal up to a maximum of 30-40 transferred patients based on current volumes and CAMH ED pressures. Additional transfers could be accommodated contingent on support with placing current cohort of approximately 90 ALC patients presently occupying CAMH beds.
 - ii. CAMH will work with the assumption that transfers will be for presumed COVID- psychiatric patients to select observation/treatment units, with limited capacity for suspected or confirmed COVID+ psychiatric inpatients to Isolation Units that are being deployed. Capacity will be determined based on needs internally and at a system level once bed capacity has been exceeded at a sub-regional level.
 - b. CAMH will determine internal staffing plan to ensure adequate RN, MD and inter-professional support resources to allow for safe care for all transitioned patients across need levels (e.g. psychosis, suicidality, behavioral dyscontrol) and request redeployment of sub-regional resources if needed.
3. Transfer mechanisms and internal process based on “yellow” scenarios
 - a. When a hospital identifies that their internal trigger has been met and they are at high risk for any psychiatric in-patient bed closure within 72 hours, recommendations are as follows:
 - i. Change current bed status to “yellow” on the Daily Bed Call to alert of need for action.
 - ii. Organize huddle of Toronto Region hospital partners within 48 hours to enable direct communication between key stakeholders and ensure safe disposition plans made for all current psychiatric in-patients (huddle will include Toronto Region hospital chiefs or designates, operations leads, CAMH staff and leadership, inpatient directors).

- iii. Actively reassess all currently admitted inpatients to determine those that can safely be discharged home with outpatient follow up.
 - iv. If continued in-patient stay is required, determine best location for transfer, preferably within sub-region, based on clinical criteria and level of psychiatric need (i.e., ACU/ICU, general vs sub-specialty service) and type of room required (i.e., Contact + Droplet precautions).
 - v. Organize transfer including communication of respective inpatient medical teams with appropriate mechanisms to ensure seamless and safe transition of patients across care settings with repatriation agreements.
3. Escalation and decision-making for “red” scenarios
- b. When a hospital identifies that their internal trigger has been met and they are at risk of the psychiatric unit closing >50% of inpatient psychiatric beds, recommendations are as follows:
 - i. Change current bed status to “red” on the Daily Bed Call to alert of need for action.
 - ii. Organize an emergency huddle of Toronto Region hospital partners to discuss the implications of potential closure to organize a system-level response (huddle will include chiefs, operations leads, CAMH staff and leadership, inpatient directors).
 - iii. Analyze impacts and capacity to absorb patients from the redeployed unit.
 - iv. If continued in-patient stay is required, determine best location for transfer, preferably within sub-region, based on clinical criteria and level of psychiatric need (i.e., ACU/ICU, general vs sub-specialty service) and type of room required (i.e., Contact + Droplet precautions).
 - v. Identify redeployment plan of requesting hospital clinical resources to support transfer at system-level.
 - c. Where there are concerns over reductions in overall psychiatric capacity across the sub-region, with inability to meet demand at the systems level, the group will identify recommendations to be escalated and resolved within the Toronto Region Operations Table.
4. Care across the continuum
- a. COVID testing in hospitals with inpatient psychiatric units:
 - i. Psychiatric units should follow hospital and provincial guidance on COVID-19 testing
 - ii. All patients with symptoms consistent with COVID-19 should be tested
 - iii. All staff with symptoms consistent with COVID should notify occupational health and be offered testing
 - iv. Testing of asymptomatic patients or staff may be warranted if there is evidence of an outbreak or nosocomial transmission – public health and infection prevention and control should be consulted if an outbreak is suspected and will help guide testing
 - b. For all in-patient psychiatric patients with suspected or confirmed COVID+ status appropriate isolation and disposition is required including accommodations to address local physical plant limitations (e.g. use of commodes, seclusion, etc.).
 - c. Clear guidelines are recommended for specialty psychiatric hospital settings that may need to transfer medically unstable COVID+ psychiatric inpatients to general hospital units.
 - i. Liaise transferring and receiving medical teams to ensure appropriate mechanisms are in place for safe transfer to be defined by the Toronto Region Operations Table. Final approval for transfer lies with the receiving hospital.
 - d. All sites will be asked to maintain access to urgent and emergent psychiatric consultation clinics and follow-up activity through ambulatory clinic (virtual or in-person as required) to ensure that access to high quality care along the continuum is maintained.
 - e. All hospitals and sub-regions are encouraged to maintain ECT capacity, to decrease the need of admission /readmission of treatment refractory patients. Requirements, anticipating service reductions, include:
 - i. Revised admission / continuation of ECT treatment criteria
 - ii. Identification of hospitals providing ECT and status of service (e.g., open /reduced/

- closed) and volume of treatments possible
 - iii. Process to review / prioritize patients for continued ECT services
 - iv. Process to safely transport patient for receipt and recovery of ECT treatment
 - v. Process to monitor volumes, availability and impacts (e.g., staffing shortages, etc.
 - vi. Should ECT services be at risk of being stopped at a local level, with sub-regions unable to support the continuation of services, the hospital would advise the inpatient psychiatric group immediately. At this point, an emergency huddle would be called to identify system-level recommendations for decision making at the Toronto Region Planning Table.
 - f. All hospitals providing Assertive Community Treatment or Intensive Case Management would be expected to continue providing essential community based services, to prevent hospital readmissions and facilitate discharges from inpatient psychiatric beds.
 - g. All hospitals are encouraged to collaborate with community providers that may be able to offer additional supports to patients with serious mental illness at risk of decompensation upon reduction of in-person ambulatory and community based services (e.g. assertive community treatment, intensive case management).
 - h. All hospitals are also encouraged to provide additional ambulatory and virtual care supports to patients of community organizations to prevent their decompensation and need for acute psychiatric care.
5. Communication pathways and standards for clinical care
- a. Continued dialogue across Toronto region hospitals is needed to ensure situational awareness, coordinated planning and support as well as sharing of best practices.
 - b. Participation in daily bed call will continue, to review
 - i. # of unoccupied beds and activity
 - ii. admission and transfer requirements
 - iii. categorization of site risk
 - iv. physician and staffing capacity
 - c. Weekly teleconferences will be arranged to discuss emergent issues and ensure timely exchange of information across sites including the status of ECT service availability.
 - d. Clinical best practices and guidelines will be distributed to support consistent evidence-based practice for COVID+ psychiatric care.

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APPENDIX 1. MANAGEMENT OF COVID-19 IN IP PSYCHIATRIC UNITS

A. New Psychiatric Admissions with Negative COVID-19 Screens

Admissions will be made to inpatient psychiatric units in accordance with local hospital management protocols.

B. COVID-19 Positive Psychiatric Admissions

- Admissions will be made to presenting hospital unit in accordance with local hospital IPAC and COVID-19 management protocols.
- Accommodations will be made to address physical space limitations (e.g. use of commodes, seclusion, etc.) within each local hospital where possible.

C. Requirements

- Communication of local and sub-regional availability including # of beds available (general inpatient, single room, incl. seclusion, PACU/PICU)
- Regular communications across Toronto region regarding patient census
- COVID-19 census (positive and persons under investigation or PUIs)
- # of new admissions (ED and planned), transfers accepted, discharges
- Limitations in capacity due to staffing shortages; patient acuity; physical space
- Contact # for coordinating transfers
- Identification of risk (e.g., to transfer out of hospital as necessary due to COVID-19 patient volumes escalating); requires categorization of risk
- Communications of local pandemic strategies where inpatient psychiatric units will be impacted (e.g., escalation or decreasing inpatient psychiatric unit capacity)
- Status of ECT services

APPENDIX 2. GUIDANCE DOCUMENTS FOR PSYCHIATRIC MANAGEMENT IN THE CONTEXT OF COVID+

A. Code White



A1. Unity Health -



A2. Unity Health -



A3. Unity Health -



A4. CAMH Pandemic

Code White Special_1 Code White Special_2 Code White Special Pr Code White Guideline

B. Screening and Isolation



B1. UHN - Covid
Screening and Isolation

C. Seclusion and Restraint



C1. CAMH -
Guidelines for Use of

D. Non-Compliance with Testing



D1.
Non-Compliant-Patient

E. Community Management of Patients with Serious Mental Illness



E1. Guidelines for
Community Home visits