Northwest Territories Health and Social Services Authorities COVID-19 Response Team's (ACRT)

Pandemic Response Plan for Health Services

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Abbreviations

A-F
ACRT - Authorities Covid Response Team
ALC - Alternate level of care patient
BP - Blood Pressure
CPHO - Chief Public Health Officer
CHC - Community Health Centre
DBP - Diastolic Blood Pressure
DI - Diagnostic Imaging
DHSS - Department of Health and Social Services
ECU - Extended Care Unit
EOC - Emergency Operations Centre
EMO - Emergency Measures Organization
F/P/T - Federal/Provincial/Territorial

G-O
GoC - Goals of Care
GNWT - Government of the Northwest Territories
HRHSSA - Hay River Health and Social Services Authority
HSSA - Health and Social Services Authority
IPAC/OH&S - Infection Prevention and Control Committee/Occupational Health & Safety
LPN - Licensed Practical Nurse
LTC - Long Term Care
MDR - Medical Device Reprocessing
MLT - Medical Laboratory Technician
NAS - National Antiviral Stockpile
NESS - National Emergency Strategic Stockpile
NTHSSA - Northwest Territories Health and Social Services Authority
OCPHO - Office of the Chief Public Health Officer

P-Z
PSW - Personal Support Worker
PT – Physiotherapist
RN - Registered Nurse
RR - Respiratory Rate
RT - Respiratory Therapist
SBP - Systolic Blood Pressure
SN - Student Nurse
SOB - Shortness of breath
SPO2 - Oxygen saturation percentage
STH - Stanton Territorial Hospital
TCSA - Tlicho Community Services Agency
WSCC - Workers' Safety and Compensation Commission

Overview

Overview: Northwest Territories (NWT) Health System Response to COVID-19

Introduction

The three Northwest Territories Health and Social Services Authority's staff have been working diligently to ensure appropriate plans and measures are in place to address and prepare for COVID-19 in the NWT. This plan brings together work from across all three HSS authorities and represents a collaborative plan and approach to providing care in the context of COVID-19 for health services across the NWT. It represents the best current planning for how we would use our limited resources to address surges in demand, and how we would scale our resources as needed. There remain many unknowns related to COVID-19 but one thing that will remain true throughout the pandemic is that following the advice of public health officials, to limit contact with other people, physical distance, and ensure good respiratory and hand hygiene – amongst other advice – remains the best strategy to help us limit the impact of COVID-19. Every resident has a role to play in our response, and each individual's behaviour and choices can impact our outcome as a territory.

COVID-19 is a global pandemic with a high number of patients requiring hospitalization and intensive care likely to exceed the usual capacity of the healthcare system. This is compounded by the reality of a worldwide demand for scarce healthcare personnel, equipment, and supplies. Numbers of existing frontline healthcare workers will become ill from the virus itself and be unable to provide care, further reducing the available workforce. Urgent reorientation of resources is underway to maximize the ability to respond, recognizing traditional operations and the usual standard of care may not be possible.

A coordinated approach across the NWT healthcare system is critical to ensure all resources are managed in alignment to achieve the best possible outcomes for patients, staff, and the residents of the territory. To achieve this goal, a staged response plan has been put into place. These four response stages for the NWT are adapted from and aligned to Alberta's pandemic response[1], enabling common language and effective communication with the NWT's closest tertiary care resource. The COVID-19 pandemic implementation plans for health and social services and facilities throughout the NWT align with this staged approach and an overview of each of those plans is provided in this document.

Despite these measures, as the number of cases of COVID-19 increases, the demand for healthcare resources such as inpatient beds, ventilators, personnel, air ambulance transport, and personal protective equipment may exceed what is available. Difficult decisions, including priority for potentially life-saving care, require advance discussion and a framework that aligns with societal values. To assist with making difficult decisions both at an organizational and individual level, two frameworks have been adapted from Alberta: the *Authorities COVID-19 Operations Ethical Decision Making Framework* and the *NWT Scarce Resource Approach*, which provides context for the adoption of Alberta's Critical Care Triage during Pandemic or Disaster in Alberta. These documents are available in the appendix.

These documents ensure that decisions are based on a shared and accurate understanding of the relevant information and fully consider the appropriate individual and societal values. The Ethical Decision Making Framework is intended for use by decision-making groups within the Authorities COVID-19 Response Team (ACRT). Decisions made in the development of this pandemic plan were not always easy, and when faced with these challenges, this framework was applied. The scarce resource

[1] *Critical Care Triage during Pandemic or Disaster in Alberta.* (Draft). Alberta Critical Care Network, March 2020.

triage approach based on Alberta's Critical Care Triage document will be used by the *Scarce Resource Triage Committee, to assist with making the difficult decisions regarding the allocation of critical resources during the pandemic.*

Scope and Purpose

This document provides the COVID-19 response plan for all healthcare services in the Northwest Territories which are provided by the Northwest Territories Health and Social Services Authority (NTHSSA), Tlicho Community Services Agency (TCSA), and the Hay River Health and Social Services Authority (HRHSSA). These organizations are collaborating to provide a system-wide response and are organized under the *Authorities COVID-19 Response Team* (ACRT).

It is recognized the three health and social services authorities in the Northwest Territories are responsible for delivering both health and social programs. The scope of this document is limited to health services only and how these services will be organized throughout the phases of pandemic response. The focus of this plan is to provide clarity for employees, patients and public regarding the approach for caring for patients with COVID-19, the health and social services system's staged approach to respond to a surge in COVID-19, and the structures in place to support decision making in a complex environment through a pandemic. The Authorities response and support for NWT pandemic response initiatives, such as; surveillance, public health measures and psychosocial supports are not captured in this document but detailed in other planning documents.

Principles of Health Services Pandemic Response Planning

Response stages and planning are built on the following six principles:

1. **Pandemic Response has become the Government's Primary Priority:** There is no other threat that poses such an immediate and widespread risk to the population and this requires response from the whole of government. It must be a primary strategic priority that *the Government of the Northwest Territories will focus its efforts to minimize the number of infections and deaths from COVID-19 by supporting critical business functions and redirecting necessary resources to support the health system.*

2. **All Response Activities are Coordinated**
   The ACRT and Territorial Emergency Operations Centre (EOC) are structured to have the authority, information, and expertise required to make all decisions related to health system pandemic response.

3. **All Resources are System Resources**
   All facilities, staff, and equipment across the NWT must be managed as system resources and utilized in the most appropriate manner and location. No one facility or program should be seen to "own" any supplies, equipment, or staff.

4. **Focus the Response within Capabilities**
   The ability of the health system to respond to increases in demand or reductions in supply are limited to the following categories of action:

Mobilize & Maximize Staff

Add additional staff resources into the health system or reallocate staffing resources to areas as required, including moving staff to different communities. This also includes ensuring all staff can work to their maximum scope or in an expanded role, such as granting additional physician privileges, allowing registered nurses to provide virtual care outside of their usual communities, and granting temporary licensure for graduate nurses. Staff may be asked or mandated to work overtime.

Mobilize Patients

Move patients from their current location to a place where care can be provided. This can include moving critical patients to a central location (such as Stanton Territorial Hospital), moving non-critical patients to another location (such as Inuvik Regional Hospital or Hay River Regional Health Centre), or transfers out of territory based on other jurisdiction capacity.

Mobilize Other Resources

This includes acquiring or redistributing supplies and equipment throughout the health system, such as personal protective equipment (PPE) or mechanical ventilators. May include utilizing external resources, non-medical staff, and/or delegate all appropriate tasks away from the health system to allow a focus on patient care and health system operations. This also includes the use of major external organizations such as the military to provide large-scale support for the response.

Triage Care Decisions

Demand for health services may greatly exceed available supply despite other mitigating actions. When the demand for ICU beds, ventilators, staff, medevacs, or other scarce resources outstrip available supply, decisions on how to prioritize these resources will need to be made. The NWT must also be prepared for other jurisdictions to enact these same restrictions.

5. **Concentrate Critical Surge Capabilities in Yellowknife**
   There is a worldwide shortage of additional healthcare staff, equipment, and supplies. Attempting to increase the amount of trained staff and specialized equipment in too many locations across the NWT may result in communities competing with each other for the same scarce resources. Recruitment of additional staff will be focused in Yellowknife as it will receive the majority of patients requiring hospitalization and has the only hospital with an Intensive Care Unit equipped to care for critically ill patients. Staff can be deployed to other communities as required from this centralized pool.

6. **Apply Values to Decision Making**
   COVID-19 response decisions are made according to the values-based *Authorities Pandemic COVID-19 Organizational Level Ethical Decision Making Framework.* The purpose of the framework is to adopt a set of key values to clarify, justify, and support pandemic-related organizational level decisions and to ensure consistency and transparency in decision making across the organization. The values that make up the ethics decision-making tool are commonly

recognized in pandemic planning and are similar to previously developed pandemic ethics frameworks. [2]

The goal of the framework is to ensure decisions have been made based on a shared and accurate understanding of the relevant information and that the appropriate values have been thoughtfully considered and weighed against each other. Decisions of such magnitude made by healthcare decision-makers are in the public interest and rest on ethically and publicly defensible considerations rather than on arbitrary criteria or unchecked biases. Examples of decisions made specific to this NWT COVID-19 Response plan can be found in the appendix.

Roles and Responsibilities

Responding to COVID-19 involves multiple levels of responsibility. Planning and response efforts should be aligned with the mandate and expertise of the organization and documented to ensure an effective response that minimizes the duplication of efforts.

Department of Health and Social Services

DHSS has the responsibility within the GNWT to lead and coordinate pandemic planning, implementation, response, and recovery. Other departments within the GNWT may be called upon to provide services, lend personnel and equipment, provide transportation, provide facilities, and assist with communications. Emergency response activities required during a pandemic that do not fall under the mandate of the DHSS will be led and coordinated by the NWT Territorial Planning Committee of which DHSS is a member participant.

The CPHO has been delegated authority by the Minister of Health under the NWT *Public Health Act*[3] to implement measures to protect the public health. As such, the CPHO provides clinical public health direction to the HSS Authorities for responding to pandemic COVID-19 in the NWT. The OCPHO, the Population Health Division, and the Health Emergency Planner have established relationships with PHAC and collaborate with F/P/T counterparts in responding to public health emergencies. Key to pandemic response, the Health Emergency Planner provides oversight of National Antiviral Stockpile (NAS) and National Emergency Strategic Stockpile (NESS) supplies in the NWT and collaborates with the HSS Authorities on mobilizing these resources, as well as contacting PHAC to access further NAS and NESS supplies. The Health Emergency Planner also plays a key role in participating on the Territorial Planning Committee and communicates pandemic situational awareness to GNWT departmental counterparts in Emergency Response.

[2] *2009 Pandemic Influenza Ethics Framework.* Alberta Health Services & Covenant Health, 2009; *Alberta's Ethical Framework for Responding to Pandemic Influenza.* AH & AHS, 2016; *Provincial Ebola Task Force.* BC Provincial Health Office, 2005; *Stand on Guard for Thee.* Joint Center for Bioethics, 2005.
[3] *Public Health Act* S.N.W.T. 2007,c.17. Available at: https://www.justice.gov.nt.ca/en/files/legislation/public-health/public-health.a.pdf. Accessed April 16, 2020.

NWT Health and Social Services Authorities

The role of the HSS Authorities (Tlicho Community Services Agency, the Hay River Health and Social Services Authority, and the Northwest Territories Health and Social Services Authority), is to provide care and services to residents of the Northwest Territories. HSS Authorities adhere to the NWT COVID-19 planning guide[4] and also develop and implement plans specific to their operational circumstances.

Under the NWT *Public Health Act*, the CPHO provides clinical direction to health and social services providers in response to a public health threat. Senior Management and Clinical leadership within the HSSAs are responsible for ensuring staff implement this direction and are supported to meet surveillance, diagnosis, treatment, and reporting requirements as legislated under the *Public Health Act* and its applicable regulations. The HSSAs also collaborate with the DHSS in disseminating information and education to the public.

Command Response Structures

Emergency Operations Centre

The Emergency Operations Centre (EOC) is the central command and communications point designed to support emergency response, business continuity, and crisis communications activities. Senior staff members meet at the EOC, either virtually or in-person to prepare for an impending event or to manage the response to an ongoing incident. The EOC is comprised of:

- **Co-Commanders:** responsible for overall direction of the response and coordinating the divisions of the EOC;
- **Operations Division:** responsible for the coordination of (in this instance) healthcare delivery at the operational (headquarters) and tactical (front-line) levels throughout the crisis;
- **Personnel Division:** responsible for all Human Resource allocations and functions;
- **Logistics and Supply Division:** responsible for the acquisition, allocation and transportation of equipment, material, etc.;
- **Finance, Policy and Administration Division:** responsible for providing financial, legal, policy, and administrative support to both the operation and the EOC itself.

The Co-Commanders and the four latter divisions within the EOC are structured to support the ongoing needs of NWT healthcare operations.

Territorial Emergency Management Organizations

The EOC is coordinated with the Territorial Emergency Management Organization (EMO), led through the Department of Municipal and Community Affairs, at both the territorial and the regional levels. Regionally the COOs are participants in the regional EMOs focusing on addressing challenges that occur within each region. A member of the ACRT participates in the Territorial EMO, supporting and setting standards and direction for the emergency response. Regional EMOs are further aligned with regional health operations pandemic response through the NWT health and social services authorities' CEO / COO. Requests for military resources for large-scale response will be made via the EMO.

[4] *Northwest Territories COVID-19 Pandemic Planning Guide*. DHSS. February 28, 2020.

Authorities COVID-19 Response Team (ACRT)

To align the response of the NWT healthcare system, an Authorities COVID-19 Response Team (ACRT) was established. This brings together leads from clinical, operations, and logistics areas from across the three health authorities. The leads collaborate on system planning and work with their respective local teams to ensure operational planning and readiness is carried out. The Executive Leads report to the EOC Commander.

Supporting Informed Decision Making

Informed operational decisions require accurate and timely information allowing both front-line managers and senior leaders to have a clear understanding of the current status and risks they are required to address. With the complexity and scale of this response, relying on traditional methods to report information has proven cumbersome and unmanageable.

To support real time information sharing for informed decision making, status dashboards have been are launched for priority areas such as acute care, community health, and personal protective equipment (PPE) stock levels.

Dashboards will highlight indicators such as current service levels, staffing risks, and logistics risks. Colour-coded descriptors and definitions provide a quick overview while also providing links to more detailed information. These visuals are easily shareable through websites and emails to ensure wide viewership. Development and deployment of these dashboards is an internal capability of the ACRT.

Planning Assumptions

This response plan is written with the following assumptions to guide the ability of the health system to respond and some of the specific risks to be considered:

- Essential healthcare services, as defined by each program area, will continue to be provided as safely as possible.
- The ability for the health system to scale a response is constrained by resource limitations:
    - Healthcare Providers: Current healthcare personnel shortages in the NWT will be exacerbated by the pandemic. Obtaining sufficient additional nursing and physician resources from outside of the territory may not be possible, and numbers of staff may be unable to work if infected by COVID-19.
    - Equipment: Specialized medical equipment, such as ventilators, are in short supply globally. A limited number of additional ventilators are available for redeployment within and to the NWT.
    - Transportation: The NWT's geography creates long transfer times to facilities. A limited number of air ambulances are available.
- Outbreaks may occur in different communities at different times with varying rates of transmission and severity.
- External financial and non-healthcare human resources will be made readily available.
- The NWT will continue to provide care to residents of the Kitikmeot communities in Nunavut.

- The ability for Alberta to accept patients for transfer may be limited based on the current severity of the COVID-19 pandemic in the province at the time.
- External resources for large-scale response, such as military, are subject to availability at the time of request.

Section 1: Pandemic Response Stages

Territorial Pandemic Response Stages

Territorial Response Stages Summary

Stage	Summary Description
1	**Minor:** Isolated cases with initial hospital admissions to Stanton Territorial Hospital (STH). Existing resources are insufficient requiring reallocation and reduction of non-essential services. **Goals:** Sentinel surveillance: Detect and contact trace initial isolated cases, prevent community transmission by promoting public health measures from the Office of the Chief Public Health Officer, reduce in-person health encounters by replacing with virtual care where appropriate, and maintain evidence-based health activities.
2	**Moderate:** Community transmission is occurring requiring active management of system resources to respond to increasing needs. Expect delays of critical patient transfers. Continued admissions to STH. **Goals:** All activities should aim to reduce the rate of infection in the territory during community transmission ("flatten the curve") to maintain sustainability of resources and delay progression to Territorial Response Stage 3. This may include activities such as maintaining "clean" communities (where no known COVID-19 cases currently exist), reducing in-person health services in affected communities to urgent care only, etc.
3	**Major:** Increasing critically ill patients are being admitted for active care requiring Inuvik Regional Hospital to accept admissions of patients with moderate symptoms for active care. **Goals:** Maintain capacity at STH to delay or avoid progression to Territorial Response Stage 4. This includes providing inpatient care for moderate cases at the Inuvik Regional Hospital, and early discharge planning and other measures to keep inpatient beds available. **Any external resources available are prepared for activation**
4	**Critical:** Some or all of critical system resources exceed maximum capacity. **Scarce resource allocation decisions required.** **Goals:** Use all available resources and external agency supports to return to Territorial Response Stage 3 as quickly as possible to minimize scarce resource allocation decisions. **Any external resources available are activated.**

Activation of Territorial Response Stages

The Executive Leads of the ACRT are a dyad consisting of the Territorial Medical Director and the Director of Health Services. ***The Executive leads are responsible for determining and communicating the Territorial Response Stage.***

The acceleration of increasing cases of COVID-19 has followed a similar pattern around the world. When community spread occurs, cases of COVID-19 increase exponentially, meaning they can double every day or few days. Knowing how the disease rapidly spreads, Territorial Response Stage decisions may be made in advance of reaching particular trigger thresholds.

Declaring a change in Territorial Response Stage may be due to any critical system resource reaching a trigger point including hospital admissions, decrease in staffing resources, air ambulance saturation, or equipment shortages. There will also be variations depending if an outbreak is occurring in one community or region or across the entire territory at once. The NWT healthcare system must also continue to provide regular care for patients to ensure other health needs are met and to prevent short and long-term complications of other illness and injury.

Territorial Response Stage 1 - Minor

Territorial Response Stage 1 –MINOR-	
Description	Isolated cases with initial hospital admissions to STH. Existing resources are insufficient requiring reallocation and reduction of non-essential services. Providing necessary resources may include extended work hours, cancellation of vacations, and the reallocation of staff to other care areas.
Goals	Sentinel surveillance: Detect and contact trace initial isolated cases, prevent community transmission by promoting public health measures from the Office of the Chief Public Health Officer, reduce in-person health encounters by replacing with virtual care where appropriate, and maintain evidence-based health activities.
Activation Triggers	First COVID-19 hospital admission

Territorial Response Stage 1: Actions

COVID-19 Care

- Active treatment at STH only
- Comfort (palliative) care requiring inpatient admission will occur at STH, Inuvik, or Hay River. Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements.

STH Capacity Changes

- ICU increases from 4 to 6 as needed
- Medicine increases from 25 to 28 as needed
- Peds unit designated for COVID-19 patients as needed (8 beds)
- Total ICU: 6 | COVID-19 Beds: 36 | Other Beds: 30
- **Total STH Inpatient Beds: 72** (Excludes Extended Care)

Note: *No planned increase in inpatient beds for Hay River, Inuvik, and Fort Smith throughout stages. Surge capacity focused in Yellowknife due to limited resources. All changes in facility capacity are dependent on staffing.*

Inpatient Service Changes

- Stanton Territorial, Inuvik Regional Hospital, and Hay River Regional Health Centre postpone elective and non-urgent surgeries and endoscopic procedures, reassessed weekly. No change to Alberta Health Services (AHS) repatriations. No changes for MDR anticipated.

Other Service and Facility Changes

- **Long Term Care:** All group activities are postponed and no visitors permitted to LTC facilities. Implementation of daily resident temperature checks for early detection and isolation. Additionally, the implementation of daily temperature checks for all staff. Plan includes increasing staffing by 2 additional Licensed Practical Nurses (LPNs) and Personal Support Workers (PSWs), per site, if possible.

- **Primary and Community Care:** Regular or reduced services (based on staffing), encourage virtual care.

- **Public Health:** Reduced Services - communicable disease management, contact tracing, childhood immunizations and adult immunizations, postpartum care to high risk clients and primiparous women, sexually transmitted infection testing and follow up.

- **Home Care:** Normal Services. Patient screening completed virtually prior to home visits. Accommodate collection of lab work from non-home care patients to support primary care needs.

- **Lab:** Regular Services, dependent on Alberta capacity for referred tests, staff shortages, reagents & testing supplies, and transportation.

- **Diagnostic Imaging:** Priority 1 and 2 and time sensitive, including cancer investigation exams are booked. Departments are open to outpatients. COVID-19patients or suspected seen through the COVID-19 stream. Routine ultrasound, CT, bone density and mammography exams suspended due to reduced staffing *(Note – these services could be resumed if adequate staff available).*

- **Rehab:** Prioritize care for Level 1 & 2 patients, offer virtual options for Levels 3-5.

- **Logistics**: All patient movement to be coordinated through Med-Response. Consider charters for non-emergency patient movement. Staff Stanton Warehouse 24/7 (or on call).

Territorial Response Stage 2 - Moderate

Territorial Response Stage 2 – MODERATE-	
Description	Community transmission is occurring requiring active management of system resources to respond to increasing needs. Expect delays of critical patient transfers. Continued admissions to STH. Increasing numbers of critically ill patients are presenting regularly, and significant targeted strategies must be implemented to meet demand. Delays expected for transfers of critical patients. This requires utilization of additional staff resources including utilization of non-critical care trained staff.
Goals	All activities should aim to reduce the rate of infection in the territory during community transmission ("flatten the curve") to maintain sustainability of resources and delay progression to Territorial Response Stage 3. This may include activities such as maintaining "clean" communities (where no known COVID-19 cases currently exist), reducing in-person health services in affected communities to urgent care only, etc.
Activation Triggers	Community Transmission

Territorial Stage 2: Actions

- **COVID-19 Care**
  Active treatment at STH only
  Comfort (palliative) care requiring inpatient admission will occur at STH, Inuvik, or Hay River. Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements.

- **STH Capacity Changes**
  ICU increases from 6 to 8 as needed
  Additional units designated for COVID-19-only care
  Total ICU: 8 | COVID-19 Beds: 49 | Other Inpatient Beds: 17
  Total STH Inpatient Beds: 74 (Excludes Extended Care)
  All changes in facility capacity are dependent on staffing

- **Inpatient Service Changes**
  Stanton Territorial, Inuvik Regional Hospital, and Hay River Regional Health Centre continue to postpone elective and non-urgent surgeries and endoscopic procedures, reassessed weekly. No change to AHS repatriation. All changes in facility capacity are dependent on staffing. No changes for MDR anticipated.

Other Service and Facility Changes

- **Long Term Care**: Approach varies depending on local staffing and whether there is a positive case in the facility. Move Alternate Level of Care (ALC) from STH/IRH/Hay River to Ft Smith/Norman Wells or as designated by the Continuing Care Team. No change for ALC dialysis patients in Yellowknife unless Hay River can be staffed.

- **Primary and Community Care:** Mostly virtual care, including virtual assessment of COVID-19-related symptoms. In communities with community transmission, reduce non-essential services and consider separating routine (non-COVID-19) care from COVID-19 care where able. Community Health Centres provide services depending on current local impact of COVID-19 infections and staffing level.

- **Public Health:** Essential Services including childhood immunizations due to territorial pertussis outbreak. Mobilization of resources for contact tracing based on community need.

- **Home Care:** Essential Services. Focus on supporting early discharge from hospital. No longer support collection of lab work for non-home care patients.

- **Lab:** Limit non-essential outpatient services. Dependent on Alberta capacity for referred tests, staff shortages, reagents & testing supplies, and transportation.

- **Diagnostic Imaging:** Reduce access to outpatient services to urgent and semi-urgent imaging requests. Priority 1 and 2 and time sensitive exams to continue. COVID-19 patients (or suspected) seen through the COVID-19 stream. Will consider opening YPCC to COVID-19patients

- **Rehab:** Prioritize care for Level 1 & 2 patients, offer virtual options for Levels 3-5.

- **Logistics:** Staff at Stanton Warehouse 24/7 (on call)

Territorial Response Stage 3 - Major

Territorial Response Stage 3 –MAJOR-	
Description	Increasing critically ill patients are being admitted for active care requiring Inuvik Regional Hospital to accept admissions of patients with moderate symptoms for active care. A large number of critically ill patients are presenting regularly and all feasible strategies must be implemented to attempt to meet demand. Expanding staff utilization to include increased numbers of non-critically care trained nursing staff, and Allied Health staff within a modified team model of care. Any space where mechanical ventilation is possible is utilized. Hospitalized patients are accommodated in non-traditional space. **Any external resources available are prepared for activation**
Goals	Maintain capacity at Stanton Territorial Hospital to delay or avoid progression to Territorial Response Stage 4. This includes providing inpatient care for moderate cases at the Inuvik Regional Hospital, and early discharge planning and other measures to keep inpatient beds available.
Activation Triggers	Approximately half of available COVID-19 inpatient beds (n=24) at STH are full.

Territorial Stage 3: Actions

- **COVID-19 Care**
  Active treatment at STH, moderate patients from Beaufort Delta and Sahtu admitted to Inuvik Regional Hospital.
  Comfort (palliative) care requiring inpatient admission will occur at STH, Inuvik or Hay River.
  Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements.

- **STH Capacity Changes**
  STH plans for maximum capacity of 88 total inpatient beds.
  Additional units designated for COVID-19-only care
  Medicine unit increases from 28 to 40 by doubling some rooms
  Total ICU: 8 | COVID-19 Beds: 63 | Other Inpatient Beds: 17
  Total STH Inpatient Beds: 88 (Excludes Extended Care)
  All changes in facility capacity are dependent on staffing

- **Inpatient Service Changes**
  Consider moving all expectant mothers from Inuvik to Yellowknife (approximately 10-12/month). Change to AHS repatriation considering using all acute care beds outside of STH. All changes in facility capacity are dependent on staffing. No changes for MDR anticipated.

Other Service and Facility Changes

- **Long Term Care:** - Approach varies depending on local staffing and whether there is a positive case *in* facility.

- **Primary and Community Care:** Mostly virtual care, including virtual assessment of COVID-19-related symptoms**.** Primary care requests will be triaged by a practitioner. In Yellowknife, consider separating routine (non-COVID-19) care at Frame Lake Community Health Centre (FLCHC) from COVID-19 care at Yellowknife Primary Care Clinic (YPCC). Staff redeployed to acute care sites as needed. No additional primary care facilities operated without external resources such as military.

- **Public Health:** Emergency Services. COVID-19 and other communicable disease contact tracing and containment with resources deployed territorially where required, which may include virtual support.

- **Home Care:** Essential Services. Focus on supporting early discharge from hospital.

- **Lab:** Emergency services. Anticipate limitations from Alberta for referred tests, staff shortages, reagents & testing supplies, and transportation.

- **Diagnostic Imaging:** Priority 1 and 2 exams continue for CT and ultrasound.

- **Rehab:** Prioritize care for Level 1 & 2 patients, 24-hour support for all acute care sites.

- **Logistics:** Staff Stanton Warehouse 24/7 (or on call)

Territorial Response Stage 4 - Critical

Territorial Response Stage 4 –CRITICAL-	
Description	Some or all of critical system resources exceed maximum capacity. **Scarce resource allocation decisions are required.** Critically ill patient demand exceeds available capacity and human resources. All feasible strategies to maximize staffing resources, staffing functions, supplies and equipment and access to mechanical ventilation will have been used prior to initiation of using this triage process. **Any external resources available are activated.**
Goals	Use all available resources and external agency supports to return to Territorial Response Stage 3 as quickly as possible to minimize scarce resource allocation decisions.
Activation Triggers	**Active scarce resource allocation decisions are required.**

Territorial Stage 4: Actions

- **COVID-19 Care**
  Active treatment at STH, moderate patients from Beaufort Delta and Sahtu admitted in Inuvik. Comfort (palliative) care requiring inpatient admission will occur at STH, Inuvik or Hay River. Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements.

- **STH Capacity Changes**
  STH already operating at maximum bed capacity of 88, however an additional 4 beds in the ED can be used for ventilated patients for a total of 92 inpatient beds.
  Designate all available beds for COVID-19 care
  Total ICU: 8 (plus 4 ED) | COVID-19 Beds: 80 | Other Inpatient Beds: 0
  Total STH Inpatient Beds: 88 (92 including 4 ED beds for ventilated patients, excludes Extended Care)
  All changes in facility capacity are dependent on staffing

- **Inpatient Service Changes**
  Consider AHS repatriations to Hay River depending on staffing and appropriateness. All changes in facility capacity are dependent on staffing. No changes for MDR anticipated.

Other Service and Facility Changes

- **Long Term Care:** Approach varies depending on local staffing and whether there is a positive case in the facility.

- **Primary and Community Care:** All primary care requests will be triaged by a practitioner. Depending on staffing, all urgent care may be directed to emergency departments.

- **Rehab:** 24-hour support for acute care only.

- **Public Health:** Emergency Services.

- **Home Care:** Essential Services. Focus on supporting early discharge from hospital.

- **Lab:** Emergency services. Anticipate limitations from Alberta for referred tests, staff shortages, reagents & testing supplies, and transportation.

- **Diagnostic Imaging:** Emergency Services.

- **Logistics:** Staff Stanton Warehouse 24/7 (or on call)

Territorial Response Stages: Summary of Actions from Across Facilities & Services

Inpatient Operations

Response Stage	1: Minor	2: Moderate	3: Major	4: Critical
Active Treatment: COVID-19	Stanton	Stanton	Stanton Inuvik *(BD/Sahtu Moderate Care Patients)*	Stanton Inuvik *(BD/Sahtu Moderate Care Patients)*
Comfort Care: COVID-19	Stanton / Inuvik / Hay River Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements	Stanton / Inuvik / Hay River Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements	Stanton / Inuvik / Hay River Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements	Stanton / Inuvik / Hay River Consideration of community palliative care in other locations would be case by case based on community staffing and case requirements
Repatriation	Stanton	Stanton	Stanton	Hay River if suitable
Inpatient Operations	**Bed increases dependent on securing staff*			
Stanton **ICU** **Covid** **IP Non-COVID** **Total**	ICU 4→6 Medicine 25→28 beds Suspend elective and non-urgent surgery/endo **6** **36** **30** **72**	ICU 6→8 beds Designate additional units to COVID-19. **8** **49** **17** **74**	Consider OBS patients from IRH. **8** **63** **17** **88**	Use 4 beds in ED* if needed for vents. Scarce Resource Decision Making process implemented **8** **84** **0** **92***
Inuvik 14 beds at all stages	COVID-19 comfort care	COVID-19 comfort care Move ALC out No increase of beds	COVID-19 comfort care and moderate active Consider transfer OBS to STH.	Scarce Resource Decision Making process implemented
Hay River 12 beds at all stages	Accept comfort care	Accept comfort care Move ALC out	Accept comfort care. Consider increasing dialysis capacity for 2 ALC patients.	↑Acute care if capacity
Fort Smith 6 beds at all stages	Prepare to accept ALC	Accept ALC	Accept ALC	Accept ALC

Ventilator Capacity

Important notes about ventilation capacity:

- **Ventilator specs**
  Not all ventilators are equivalent. Only high-level ventilators are adequate to safely ventilate patients with severe acute respiratory distress syndrome (ARDS). General or transport ventilators are inadequate for providing ventilatory pressures required for ARDS over long periods of time. These are only appropriate for short-term ventilation (eg. for transportation between sites) or for weaning ventilation for patients whose condition is improving.

- **Personnel**
  It is critical to recognize that the physical presence of a ventilator machine does not necessarily imply ventilation capacity in a facility. Safe management of invasive ventilation requires a specific high level of skill, which is not possessed by most healthcare providers. Provision of mechanical ventilation is dependent both on availability of a ventilator machine *and* staff with appropriate level of training and expertise.

- **Other considerations**
  Stanton Territorial Hospital, Inuvik Regional Hospital, and Hay River Regional Health Center possess anaesthesia machines which may be appropriate for ventilation in some cases. However, it is critical to also consider the need to maintain availability of anaesthetic machines for emergency surgical capacity. Thus, while it may be appropriate to repurpose and/or move some anaesthetic machines to increase system mechanical ventilation capacity, many will need to remain available to the ORs in which they are currently located.

Ventilator type and capability	**Location**			
	STH	**IRH**	**HRHC**	**Air Ambulance**
High-level Appropriate for severe ARDS	11*	-	-	-
General/Transport Appropriate for short-term/transport/weaning only	6	1	1	4
Anaesthesia In ORs	4	2	1	-
*Additional 3 have been ordered (to increase the total to 14), awaiting delivery				

Outpatient Care

Response Stage	1: Minor	2: Moderate	3: Major	4: Critical
Outpatient Care				
Primary & Community Care	Regular or reduced services, encourage virtual care	Mostly virtual, reduce non-essential services	Care limited to current primary care facilities. If external site required, need external help. All appt requests triaged by practitioner. Consider cohorting routine/non-COVID-19 care. Redeploy staff to acute care sites as needed.	Same as Stage 3. No separate offsite "clean" (non-COVID-19) ED in Yellowknife unless by military/external partners
Public Health	Reduced services	Essential services	Emergency services	Emergency services
Home Care	Regular Services. Support collection of bloodwork for primary care.	Essential Services Support early discharge	Emergency Services Maximize early discharge	Emergency Services Maximize early discharge
Midwifery	YK: 1 midwife providing pre/postnatal care and early discharge support. FS, HR continue pre/postnatal care.	Continue pre/postnatal care to support early discharge from hospital	Continue pre/postnatal care to maximize early discharge	Continue pre/postnatal care to maximize early discharge
Lab	Regular Services subject to limitations of staff, supplies, or AB capacity.	Limit non-essential OP. Dependent on AB	Emergency Services	Emergency Services
DI	No Travel Services	Limit non-essential OP	Emergency Services	Emergency Services
Rehab	Prioritize Level 1 & 2 pts Virtual options for 3-5	Prioritize Level 1 & 2 pts Virtual options for 3-5	Prioritize Level 1 & 2 24h support for acute care	24h support for acute care only

Long Term Care

Response Stage	1: Minor	2: Moderate	3: Major	4: Critical
Long Term Care	Goal to provide 2 extra LPNs per site ASAP	Dependent on facility cases and staffing	Dependent on facility cases and staffing	Dependent on facility cases and staffing
Fort Smith Northern Lights Seniors Care Home (NLSCH) 28 TAC + 2 Respite	Regular Services	Able to receive ALC (currently 2 respite beds)	Dependent	Dependent
Behchoko Jimmy Erasmus Seniors Home (JESH) 16 TAC + 2 Respite	Regular Services	Able to receive ALC (currently 1 respite beds)	Dependent	Dependent
Hay River Woodland Manor (WLM) 23 TAC + 2 Respite	Regular Services	Able to receive ALC (currently full)	Dependent	Dependent
Norman Wells Sahtu Dene Necha Ko LTC Facility 22 TAC + 3 Respite	Regular Services	Able to receive ALC Relocate 5 patients from across NWT here	Dependent 2 transitional care beds could be activated	Dependent
Inuvik Inuvik Regional Hospital LTC 22 TAC + 3 Respite	Regular Services	Able to receive ALC	Dependent	Dependent
Fort Simpson Elder Care Home 16 TAC + 2 Respite	Regular Services	Able to receive 1 ALC	Dependent	Dependent
Yellowknife Stanton ECU 10 TAC + 1 Respite +1 Additional	Regular Services +1 bed = 12 total.	Able to receive ALC	Dependent	Dependent
Yellowknife AVENS Manor: 27 TAC + 2 Respite Cottages: 26 TAC + 2 Respite	Regular Services. ALC patients received, currently full.	Regular Services	Dependent	Dependent

Staffing & Logistics

Response Stage	1: Minor	2: Moderate	3: Major	4: Critical
Staffing				
RNs - STH	Additional PCC staffed days M-F. Adjust staffing model, hire additional RNs, extend locums if able. Provide additional staff training.	Reallocate staff as required. Continue additional staff training.	Change of staffing model, increase PSWs. Reallocate staff as required.	Reallocate staff as required
RNs - NWT	Hire 6 CHNs/PHNs in YK for deployment	Deploy RNs as required	Deploy RNs as required	Deploy RNs as required
MDs - STH	Usual staffing, optimizing virtual care	Add 1 hospitalist (FP) +1 nocturnalist (FP-A)	Addition of extra 2 hospitalists (may be FPs or redeployment of specialists) + 2 additional nocturnalists + 1 internist	Redeployment as needed of physicians
MDs - Yellowknife	Usual staffing, optimizing virtual care	Usual staffing, optimizing virtual care	Redeploy to acute care as required	Redeploy to acute care as required
MDs - Communities	Usual staffing, optimizing virtual care and remote locum support	Usual staffing, optimizing virtual care and remote locum support	Redeploy to acute care as required	Redeploy to acute care as required
MLTs-NWT	Casual Recruitment	Casual Recruitment	Re-deploy MLTs to stabilize affected Lab. Deploy MLT's in other roles into the Lab.	Re-deploy MLTs to stabilize affected Lab. Deploy MLT's in other roles into the Lab.
Staff - Other	Nurse manager hired to focus on recruiting. Hire 2 LPNs for each LTC and HCC program. Hire 2 PSW's for each LTC and HCC. Hire PSWs and Student Nurses at STH. All regional acute care sites to increase RN capacity by 2-3. 1 Physiotherapist PT	Roles for A social worker to support the isolation centers, hospital and COIVD clinic discharge of COVID + or COVID suspects, and a RN/CHN to support the isolation centers Hiring a casual Dietitian for 3	To be able to provide 24/7 DI services, 4 more employees are required. +1 Hired, +1 recalled (starting June 1st) for DI. increase of services with an evening shift and maintain the overnight on-call	

	redeployed to IPAC	months to up staff SLP from within current staffing.	coverage.	
Facility Logistics				
Housekeeping	See internal business cont plans	See internal business cont plans	See internal business cont plans	See internal business cont plans
Dietary	See internal business cont plans	See internal business cont plans	See internal business cont plans	See internal business cont plans
Equipment	Beds & vents moved to STH. **O2 concentrators:** 10 x 10 L/min 15 x 10 L/min on order, unknown arrival 30 x 5 L/min on order, estimated by May 1. O2 regulators for H and E cylinders in stockpile Extra O2 tanks for CHCs/LTC	Resupply as required	Resupply as able	Resupply as able
Supplies	Meds: CHC formulary expanded to align with COVID-19 treatment.	resupply as required	resupply as able	resupply as able
Warehousing	STH on call 24/7	STH on call 24/7	STH on call 24/7	STH on call 24/7

Transportation & Patient Movement

Response Stage	1: Minor	2: Moderate	3: Major	4: Critical
Transportation				
Medevac	Activate pandemic response precautions	Alignment of severe and moderate COVID-19 +ve/ Suspected +ve patients transportation needs with regular operations	Daily assessment of patient transportation volumes and critical resource shortages	Alignment of transportation needs with external agency support(s)
Air Transport Other	Procure additional patient transportation options, as needed. Tentative plan in place for movement of ALC patients.	Activate secondary patients transportation protocol/contract	Daily assessment of patient transportation volumes and critical resource shortages	Alignment of transportation needs with external agency support(s)
Ground Transport	Inventory of ground transportation contracts and supply to meet planning needs	Issue protocols and procedures for transporting COVID-19 +ve or Suspected +ve patients	Daily assessment of patient transportation volumes and critical resource shortages	Alignment of transportation needs with external agency support(s)
Equipment & Personnel	Establish staff redeployment office and process. Procure additional equipment required for healthcare facilities across the NWT and begin distribution.	Initiate recruitment and redeployment activities to meet stage 3 / 4 needs. Issue and activate equipment in healthcare facilities across the NWT	Daily assessment of staffing volumes and critical shortages Daily assessment of equipment inventory and critical shortages	Alignment of staffing needs with external agency support(s) Alignment of equipment needs with external agency support.

Role of Infection Prevention and Control and Occupational Health and Safety (IPAC/OH&S)

The Northwest Territories Health and Social Services Authority has policies in place to prevent the spread of infection from patient to patient, patient to staff, staff to patient, staff to staff, and/or to visitors and family members. These policies are based on the principle of routine practices and additional precautions.

The role of IPAC and OHS is to ensure the safety of patients/residents, staff, and the public is protected by mitigating health care-associated-infections, and improves patients/residents outcomes. The NWT health and social services authorities follow the territorial IPAC action plan in the delivery of patient and family center care.

At each of the 4 stages of the NWT COVID Response plan, the Occupational Health and Safety and Infection Prevention and Control (IPAC) Professionals in the NWT are actively engaged in 9 areas:

- **Knowledge Transfer** – the members of the team will ensure all activities and plans in response to the Pandemic are developed following best practices in minimizing the transmission of COVID-19. This includes all surge activities, incident command activities and the allocation of resources including the decisions made when resources are scarce.

- **Assessing Readiness and The Development of Covid-19 Management Plans** – OH&S and IPAC will assess the readiness of the organization in relation to Infectious processes at each stage of the pandemic plan, identifying vulnerabilities and implementing mitigation strategies. This includes reviewing environmental decontamination strategies, surveillance, triage and screening protocols, assessing the alternative use of PPE and inspecting care sites and shelters.

- **Providing 24/7 OHS/IPAC Coverage and Advice** – at each stage the OHS/IPAC team will be available 24/7 for consultation on cases of COVID-19 and mitigation strategies to prevent transmission to patients and staff. As the NWT moves into Stage 3 and 4, 24/7 in person OHS/IPAC Coverage will be available at Stanton Territorial Hospital.

- **Active Participation in COVID-19 Response and Recovery** – throughout each stage the OHS/IPAC team will actively communicate strategies to mitigate transmission internally and with external stakeholders. This includes, but is not limited to, appropriate use of PPE, screening, alternative PPE use, hand hygiene education, implementation of directives from Workers' Safety and Compensation Commission (WSCC), OCPHO and Health Canada.

- **Policy Development Related to COVID-19** – during each stage of the COVID 19 response, policy re-development will be necessary to ensure staff and patient safety. The OHS/IPAC team will actively anticipate these needs and ensure directives and policies are developed expeditiously to guide the work of the teams.

- **Surveillance and Early Identification of COVID-19** – the OHS/IPAC team, along with the Public Health staff, will be the first point of notification of a positive COVID19 result. The OHS/IPAC team will then guide the response and implement measures with the staff and patient that ensure no further transmission. The team will support Public health in the contact tracing and risk of transmission mitigation. The OHS/IPAC team will also monitor any incidents of other transmissible diseases that can present during the COVID19 pandemic (Influenza, pertussis, etc.) to assist in outbreak prevention.

- **Patient Management During COVID-19** – the OHS/IPAC team will be constantly involved with patient movement and management, ensuring the principles of staff/patient safety and infectious disease management are considered when managing patients in all environments.

- **Mitigating Physical Plant Issues/Environmental Cleaning** – the OHS/IPAC team will ensure decontamination of impacted locations is undertaken and cleaning and disinfecting protocols meet national standards related to COVID-19.

- **Provision of Continuous Education** – the OHS/IPAC team will continuously provide education to all staff, clients and others related to the appropriate use of PPE, point of care risk assessments, modes of transmission, all new procedures related to COVID-19 and alternative PPE usage.

Section 2: Providing COVID-19 Care

Providing COVID-19 Care: Overview

Goals of Care

The first consideration in determining a care plan must be the wishes of the individual patient. Having clear discussions and documenting what values and directions patients have regarding their care in the event of a significant illness is paramount. It is important to work with the patient and their family to identify and understand their personal and cultural beliefs and values about medical care and ensure these align with medically appropriate Goals of Care (GoC). All patients should be encouraged to engage in this advanced care planning, with prioritization of discussions with those who are elderly, frail, or have significant medical comorbidities that would predict a poor outcome in the event of severe COVID-19 infection. Documentation of a Goals of Care Designation Order is encouraged for all patients, and mandatory for any admitted to a health facility (including acute or long term care).

Most Appropriate Care Location

It is important to determine the most appropriate location for care based on both the patient's wishes and the patient's likelihood to benefit from particular interventions such as ventilator support. The resources available in the patient's home community weigh into this decision. Provision of inpatient comfort (palliative) care is only planned for Yellowknife, Inuvik, and Hay River, but consideration of community palliative care in other locations would be case by case based on community staffing and case requirements.

Goals of Care (GoC) Designations

GoC are divided into 3 main categories to describe the level of care that is clinically appropriate and consistent with the patient's values and care objectives. A patient's GoC designation may change over time, depending on their wishes and clinical condition.

- **R: Resuscitative Care**
  Medical care and interventions are aimed to cure or control the patient's condition. Attempted resuscitation (such as intubation and chest compressions) and ICU care is provided if the patient desires it and they are likely to benefit.

- **M: Medical Care**
  Interventions aiming to cure or control the patient's condition are provided, but without resuscitative care. ICU care is usually not provided. Locations for care are considered depending on what is medically appropriate and in keeping with the patient's wishes.

- **C: Comfort Care**
  Interventions are undertaken with the goal of symptom relief, rather than curing or controlling the patient's underlying condition. The focus of care is palliative treatment of a patient who has a terminal illness, and support for those close to them. This includes medical care for symptom control and psychosocial and spiritual support in advance of death. Transfer of care location is only considered if required for symptom control.

More details on the GoC and the sublevels within each category are available for staff on the internal OurNTHSSA website.

COVID-19 Severity Definitions

Severity	Description	Location of Care
Mild	Patients with uncomplicated upper respiratory tract viral infection may have non-specific symptoms such as fever, fatigue, cough (with or without sputum production), anorexia, malaise, muscle pain, sore throat, dyspnea, nasal congestion, or headache. Patients may also be present with diarrhea, abdominal pain, nausea and vomiting. Many are afebrile or have low-grade fever. The elderly and immunocompromised may present with atypical symptoms. Symptoms due to physiologic adaptations of pregnancy or adverse pregnancy events, e.g., dyspnea, fever, GI symptoms or fatigue, may overlap with COVID-19symptoms.	Self-isolation at home or in an isolation facility. **Risk factors requiring consultation with Med-Response or Regional Physician:** **SOB:** Any difficulty breathing or new or progressive SOB **Increased RR:** Adults: RR >20 Children 5+: RR ≥30 Children 1 y - 5 y: RR ≥40 Children 6 mo - 11 mo: RR ≥50 **SpO2** <92% **Age** >65 yrs or <6 mo **Medical comorbidities** **ANY** other care provider concerns
Moderate	Patients with initial presentation of moderate symptoms, or with worsening of previously mild symptoms, may require medical intervention to maintain normal physiology, and may be at risk for rapid progression to severe disease. Signs of moderate disease may include: **Hypoxia:** SpO2 <92% on room air **Hypotension** SBP <90 DBP <60 **RR** >30 **Significant SOB:** At rest or minimal exertion **Confusion** without easily reversible cause such as hypoglycemia, ETOH **Modifiers:** Age >65 yrs or <6 mo, medical comorbidities **All such patients should be assessed in person by a physician, with strong consideration given to in-hospital care**.	**Consider admission to hospital** **May require care in health centres while awaiting transport.*
Severe	**Instability of any physiologic system requiring advanced intervention, consider ICU if eligible.**	**Hospital, consider ICU if eligible** **Criteria for ICU Admission:** ● Goals of Care R1, R2, R3 ● intubated ● hypotension unresponsive to fluid resuscitation ● O2 > 6 L/min ● rapid clinical decline

Medical Care for COVID-19

Mild Symptoms: Care Provided

- All patients with mild symptoms will be assessed by a healthcare provider (RN, NP, MD) in person or virtually.
- Patients will be followed by a healthcare provider and receive regular in-person or virtual assessments as required.
- If the condition worsens, patients will be offered care options based on symptom severity and Goals of Care and the patient's wishes

Self-Isolation

- Patients with mild symptoms will be required to self-isolate in accordance with the latest direction from the Office of the Chief Public Health Officer. These guidelines are available at: https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/COVID-19 exposure-algorithm.pdf
- Patients will be asked to self-isolate at home.
- Patients who cannot self-isolate at home will be provided with accommodation in their community, region, or elsewhere in the territory depending on availability. Transportation will be provided.
- Some patients may need to be moved to a different community where they can be monitored more closely. These include patients in a community with no Registered Nurse who:
    - are under 6 months or over 65 years of age,
    - have any shortness of breath, or
    - any serious medical conditions.

  These patients will be assessed for treatment in another community.
- **All patient movement between communities will be coordinated through Med-Response.**
- Discontinuation of self-isolation will be directed in accordance with the latest direction from the Office of the Chief Public Health Officer. https://www.hss.gov.nt.ca/professionals/sites/professionals/files/resources/COVID-19 exposure-algorithm.pdf.

Moderate and Severe Symptoms: Active Treatment and Comfort Care (Palliative Care)

- All patients with moderate or severe symptoms will be assessed in person. If the assessment is not by a physician, a physician will be consulted.

- **Patient Choice**: Patients with moderate or severe symptoms will be offered active treatment or comfort care. A physician will discuss these choices with a patient, and their family if required.

- **Active Treatment** includes Goals of Care levels "R" (Active Resuscitation) and "M" (Medical Care and Interventions, without Resuscitation)

- **Comfort Care (Palliative Care, Goals of Care level "C")** means providing treatment that focuses on managing symptoms, such as pain, but not advanced care such as ICU admission, intubation, or CPR. Comfort care is also called palliative care.
    - Comfort care is provided as close to home as possible including at a hospital or in a community, if staffing allows.

- It is important to note that consideration of community palliative care in other locations besides STH, Inuvik, and Hay River will be on a case-by-case basis depending on community staffing and case requirements, risk to staff, available home supports, and provision of supplies such as medication, oxygen, and PPE.
- A patient can request to amend their Goals of Care designation at any time.

If a Patient Chooses Active Treatment for Moderate or Severe Symptoms

- A physician will determine if the patient requires admission to the hospital, including ICU admission. Admissions for Active treatment will be at STH only during Response Stages 1 and 2. Starting at Stage 3, Active Treatment for moderate symptoms will be offered in Inuvik for patients in the Beaufort Delta and Sahtu regions. All community health centres can provide active treatment while patients are awaiting transportation. Transportation, including by air ambulance, will be provided if needed.

If a Patient Chooses Comfort Care (Palliative Care) for Moderate of Severe Symptoms

- Inpatient comfort care will be provided at STH, IRH, and HRHC. All community health centres can provide comfort care while patients are awaiting transportation. Transportation to the location including by air ambulance, will be provided if needed. It is important to note that consideration of community palliative care in other locations besides STH, Inuvik and Hay River would be case by case based on community staffing and case requirements.

Hospital Care Locations for Active Treatment of COVID-19

All patients requiring hospitalization for active treatment of COVID-19 will be admitted to hospital. Patients will be admitted for active care to STH only during Territorial Response Stages 1 and 2. At the activation of Territorial Response Stage 3, patients from the Sahtu or Beaufort Delta with moderate symptoms who request active treatment will be admitted to Inuvik Regional Hospital (capacity permitting).

Hospital Care Locations for Comfort Care (Palliative Care) of COVID-19

For patients who choose comfort care and require treatment beyond the capabilities of their local health facility, treatment will be provided in Yellowknife, Hay River, or Inuvik. Consideration of community palliative care in other locations besides STH, Inuvik, and Hay River would be case by case based on community staffing and case requirements.

Continued Isolation After Discharge

Patients being discharged from STH who are COVID-19 positive will stay in Yellowknife until they are confirmed negative (as emerging clinical evidence is produced these guidelines will be updated as required). Yellowknife Primary Care/Public Health Unit staff in partnership with the Transitional Care Team at STH will coordinate the follow up required for each patient.

Self-Isolation Approach Summary

Self-Isolation Reason	Location	Timeframe	Requirements
Public returning from travel	Yellowknife Inuvik Hay River Fort Smith	14* days from arrival in the NWT **As guidelines change, the most recent guidance from the OCPHO must be followed for discontinuation of self-isolation*	Self-isolation plan submitted to the OCPHO
Patients with Mild COVID-19 Positive or COVID-19 Suspected Positive (*who can appropriately self-isolate at home)*	At Home	14* days from the start of symptoms or positive test. **As guidelines change, the most recent guidance from the OCPHO must be followed for discontinuation of self-isolation*	COVID Assessment and Isolation form signed by the healthcare provider
Patients with Mild COVID-19 Positive or Suspected Positive *(who cannot appropriately self-isolate at home)*	Designated community self-isolation centre/unit All communities except (due to lack of community nursing presence): -Jean Marie River -Kakisa -Nahanni Butte -Sambaa K'e -Wrigley -Colville Lake -Wekweeti -Tsiigehtchic	14* days from the start of symptoms or positive test. **As guidelines change, the most recent guidance from the OCPHO must be followed for discontinuation of self-isolation.*	COVID Assessment and Isolation form signed by the healthcare provider
Patients Discharged from Hospital (as confirmed negative that require additional self-isolation**)**	Yellowknife	TBD *(as emerging clinical evidence is produced these guidelines will be updated as required)*	TBD Case-by-Case

Patient Flow Diagram

To ensure a coordinated and consistent approach to providing patient care throughout the NWT, the ACRT have developed a patient flow diagram. This diagram outlines the general care pathways for patients with positive or suspected Covid-19 infection based on the severity of symptoms, and if transportation to a different community is required.

See Appendix for Patient Flow Diagram

Ongoing Planning and Contact

As the scope of COVID-19 in the NWT changes the ACRT will continuously review this plan and make necessary changes to meet the demands and developments of the pandemic.

This document has been prepared for general guidance around the NWT Authorities' COVID-19 response for health services and does not constitute health advice. You should contact your healthcare provider for any health issues related to COVID-19.

For questions related to the information contained in this plan please contact:

Northwest Territories Health and Social Services Authority

Phone: 867-767-9107ext 40000

Email: nthssafeedback@gov.nt.ca

Mailing Address

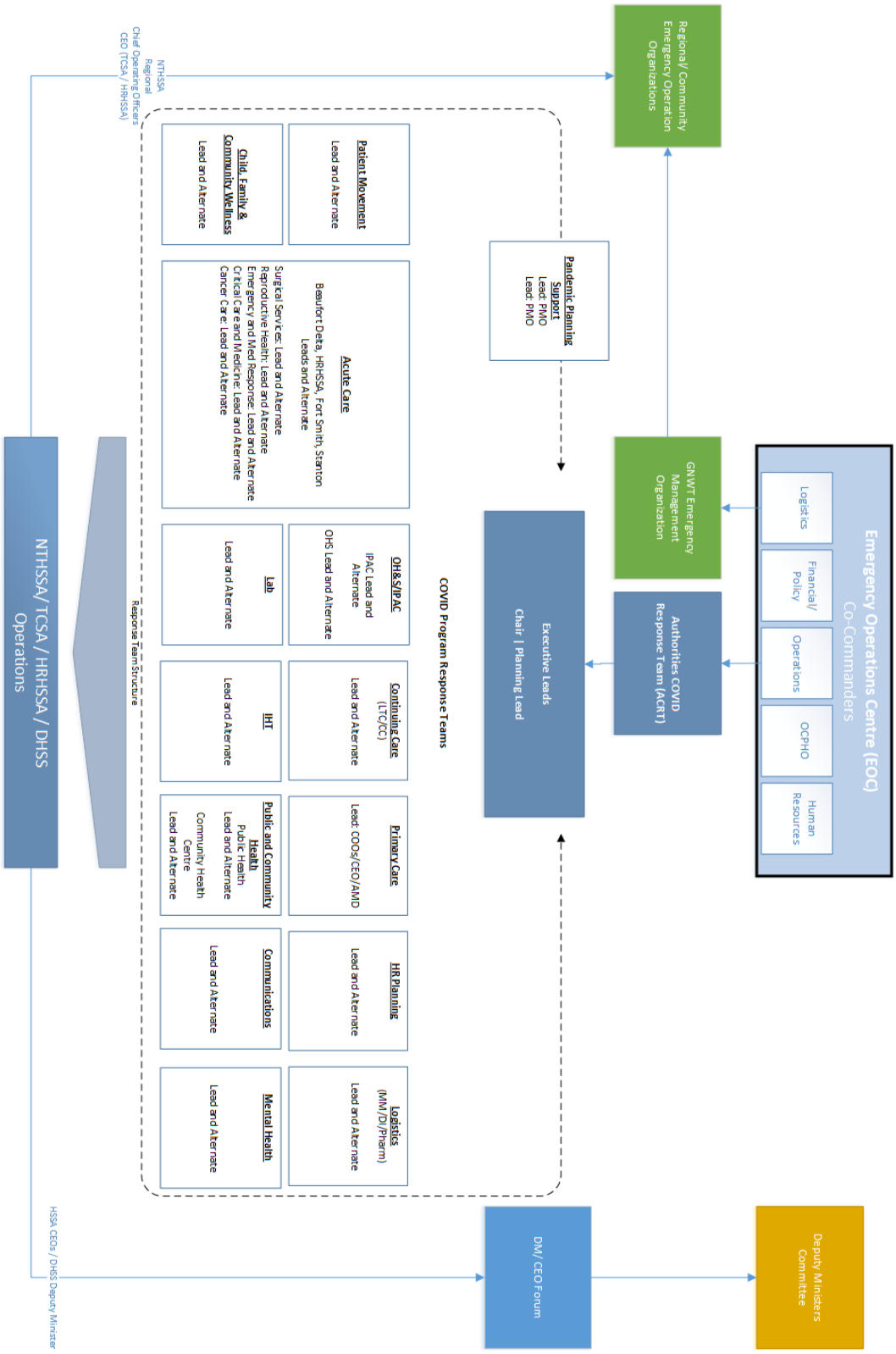
Government of the Northwest Territories

P.O. Box1320

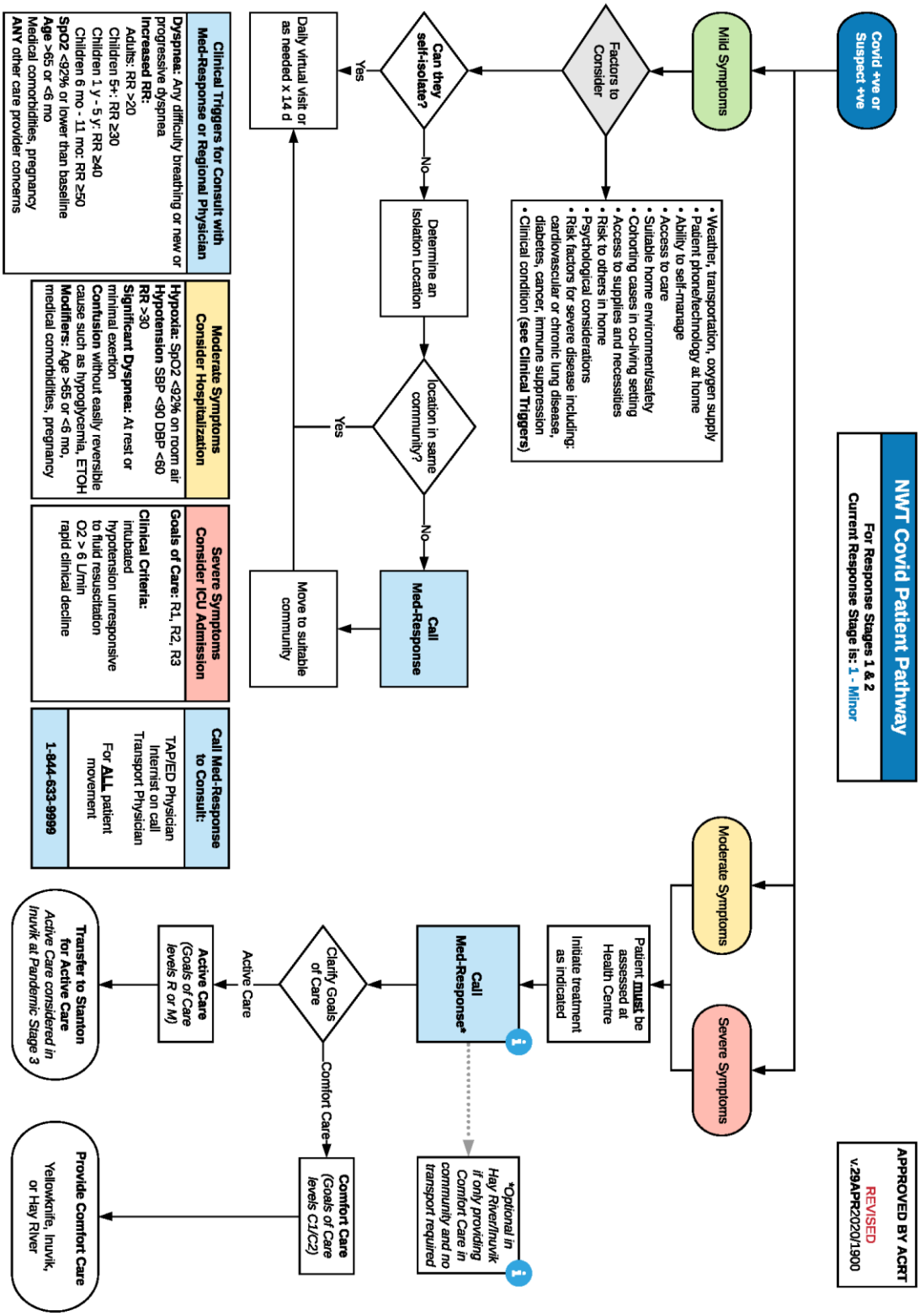
Yellowknife, NT X1A 2L9

Appendices

Appendix: ACRT Organizational Structure



Appendix: Covid-19 Patient Flow Diagram



Appendix: Covid-19 Territorial Ethical Decision Making Framework

NWT HSS
COVID-19
RESPONSE

Northwest Territories
Health and Social Services Authorities

Territorial Ethical Decision Making Framework

NTHSSA • ASTNO

May, 2020

Contents

Preamble

The Northwest Territories Health and Social Services Authority (NTHSSA), Tlicho Community Services Agency (TCSA), and the Hay River Health and Social Services Authority (HRHSSA) collaborated on the development of an Ethical framework for the Northwest Territories. The Territorial Ethical Decision Making Framework was approved and adopted by all three organizations and the NTHSSA Leadership Council in 2019.

On March 11, 2020 the World Health Organization declared a global pandemic due to COVID-19 a clinical illness caused by SARS-Co-2 virus (severe acute respiratory syndrome coronavirus-2). On March 18, 2020, the Minister of Health and Social Services for the NWT declared a Public Health Emergency due to COVID-19

The Territorial Ethical Decision Making Framework provide employees with tools for ethical situations that may arise from the "day to day" care and during "normal" business operation. The document is a solid foundation but it is not designed to provide a framework for the potential challenges faced during a pandemic such as: Scarce Resources and Operational decisions specific to a Pandemic.

Alberta Health Services (AHS) is in the process of developing a Critical Care Triage document for use during a Pandemic or Disaster. This provides clinicians with the tools needed to make clinical decisions during a pandemic. In addition to the Ethical Decision Making Framework, a Scarce Resource document (Appendix A) and an Operational Ethical Decision Making Framework (Appendix B) was developed to be used during the pandemic period.

Introduction to the Territorial Ethical Decision Making Framework:

All decisions made throughout the NWT Health Authorities need to ensure the NTHSSA Vision is supported and the NTHSSA Values are reflected.

NTHSSA Vision

Best Health. Best Care. Better Future

NTHSSA Values

CARE: Caring, Accountable, Relationships, Excellence

Caring: We treat everyone with compassion, respect, fairness and dignity and we value diversity
Accountable: We strive for outcomes that are measured, assessed and reported on.
Relationships: We work in collaboration with all of our stakeholders, partners, and staff
Excellence: We pursue continuous quality improvement through innovation, integration, and evidence based practice.

Ethics and Decision Making

Ethical decisions involve making decisions regarding right and wrong behavior. Such decisions frequently happen in health care and social services, some which profoundly affect the people involved.

When individuals are required to face a difficult ethical decision, it is vital that necessary steps and factors are taken into consideration to ensure all parties involved will come to the best possible solution.

Establishing a decision-making framework and guidelines ensures a systematic and thorough process will be used to make the best possible decisions throughout the NTHSSA.

NTHSSA Ethical Decision Making Principles

Table 1: CORE PRINCIPLES

Core Principles	Definition
AUTONOMY	Respect for Autonomy (respect people's right to self-determination or self-governance such that their views, decisions and actions are based on their personal values and beliefs; the vehicle for this principle in health care and research is generally the free and informed consent process).
BENEFICENCE	Act beneficently toward others (contribute to the welfare of others, which may include preventing harm, removing harm, promoting well-being, or maximizing good).
JUSTICE	Promote justice and fairness (treat people and groups fairly by treating morally relevant cases alike, by promoting fair relations among individuals and social groups, and by ensuring fair and equitable access to resources and opportunities, including fair distribution of benefits and burdens)
NON-MALEFICENCE	Act so as to do no unnecessary harm (avoid causing harm to individuals or groups, or risking harms of significant magnitude and probability)

Table 2: ADDITIONAL PRINCIPLES

Additional Principles	Definition
COMMON GOOD	A specific "good" that is shared and beneficial for all (or most) members of a given community.
COMPLIANCE	Compliance with the law *(This links to the principle of "rights")*
CONFIDENTIALITY	Keep private information confidential (keep identifying personal information as well as confidences secret, unless consent to disclose this information is given by the person to whom it belongs or disclosure is required by law)
CONFLICT OF INTEREST	Disclose conflicts of interest and avoid disqualifying conflicts of interest (disclose both real and perceived conflicts between one's self-interest and/or one's obligations to one or more individuals or groups).
CULTURE	The totality of socially transmitted behavior patterns, arts, beliefs, institutions, and all other products of human work and thought. Culture is learned and shared within social groups and is transmitted by non-genetic means.
DIGNITY	Respect the dignity of morally valuable beings (treat beings in a way that honors their value or worth based on morally significant qualities, e.g., sentience, relationality, rationality).
DISCLOSURE	Disclose information that people or groups have a right to (provide information needed to make an informed decision, and information about errors or adverse events in treatment or research).
DIVERSITY	Respect diversity (accommodate, protect or support differences, including religious, cultural, political and other differences, among people and groups).
INCLUSIVENESS	Involvement/representation of everyone who is part of a problem situation based on the notion that each brings knowledge or expertise needed to address the problem and feel ownership of the solution.
INTEGRITY	Act with integrity (give priority to ethical considerations even when there is a strong drive for self-interest or other desires, or where violating ethical requirements could pass unnoticed)

Additional Principles	Definition
PATIENT-CENTRED or FAMILY-CENTRED CARE	Provide patient-centred or family-centred care (organize and provide therapies, services, interventions and interactions in ways that respect and respond to the patient's or family's values, preferences, decisions or self- identified best interests)
RIGHTS	Protect the rights of individuals and groups (honor legitimate moral and legal claims of individuals or groups). *(This links to the principle of "compliance with the law")*
SAFETY	Ensure safety (avoid injury and reduce risks of harm to patients, research participants, families, staff and other members of the community; promote a culture that reports errors and near-misses and strives to improve the safety of clinical, research and organizational environments)
SOLIDARITY	Requires consideration of the extended community and acting in such a way that reflects concern for the well-being of others
STEWARDSHIP	The careful and responsible management of something entrusted to one's care (e.g., public healthcare dollars)
TIMELY	Ethical issues need to be addressed in a timely manner that is reasonable given the nature and circumstances of a specific the ethical issue
TRANSPARENCY	Make decision-making transparent (communicate and make accessible decisions and their rationales to all stakeholders)
UTILITY	Maximizing the greatest possible good for the greatest possible number of individuals

Health Care & Social Services Ethics

Difficult Choices in Health & Social Services

Individuals in healthcare are sometimes required to make difficult decisions due to complex situations. Through asking the following questions, patients, families and health care providers can have guidance while making difficult choices in regards to treatment choices and patient care.

1. "What is the right thing to do?"
2. "How should this decision be made?"
3. "Is this a reasonable compromise?"

Possible Ethical Issues

- Can a patient and family demand continued medical care which the care team believes to be unethical or futile?
- What if substitute decision-makers make decisions not based on the patient's wishes?
- Is it ever acceptable to hide medication in food for non-compliant patients?
- Should physicians share information about reproductive choices of an adolescent with parents?
- How do we support a pregnant woman who foregoes life-saving treatment for her unborn child?
- How do you tell a client that their decisions and choices are negatively impacting their ability to take care of their children?

Goals of the Territorial Ethics Framework

- Encourage and support the patient and family voice
- Develop resources to help families and healthcare teams understand and access ethics support services
- Promoting ethics education for healthcare and social services providers to become ethics-informed and build strong inter-professional practices
- Embed ethical decision making into our daily practices

Ethics Support

1. Should you face an ethical dilemma, discuss the dilemma with your colleagues, your supervisor or anyone you feel comfortable discussing it with, while not sharing any information that would breach the privacy of the clients.
2. Use the guidelines and the Ethics Frameworkbook on the internal OurNTHSSA website to work through the issue.
3. If you are unable to resolve the issue or you feel that you need further assistance, you can contact the Chair of the Territorial Ethics Committee via phone at (867) 767-9106 ext. 40081 or email at NTHSSA_Ethics@gov.nt.ca.

Territorial Ethics Committee

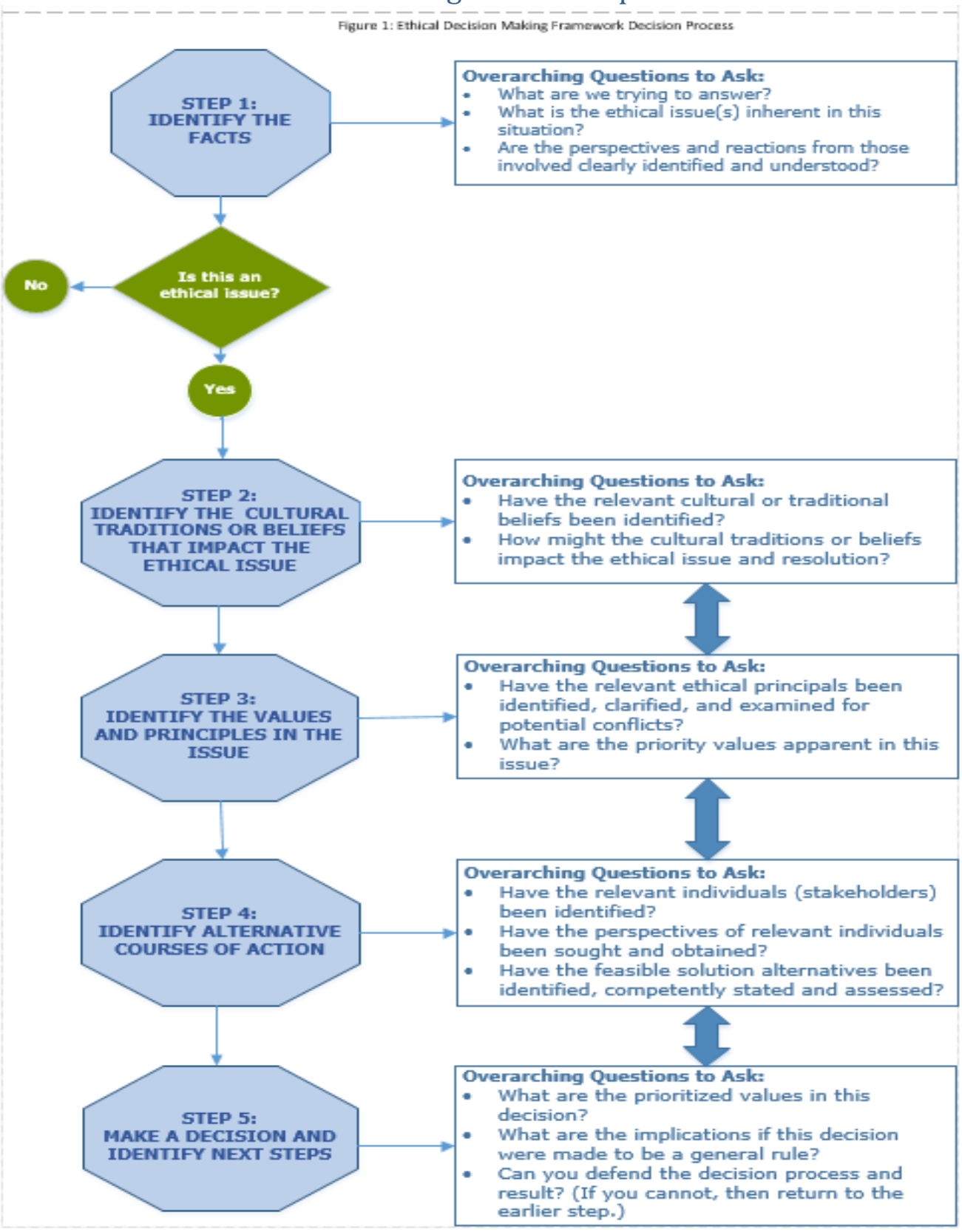
Responsibilities of the Territorial Ethics Committee:

- Reviewing ethical issues, dilemmas and identified concerns relating to health and social services matters, and to provide guidance, recommendations and consultation.
- Providing guidance and support to the development, revision and implementation of procedures and/or processes which impact ethical issues in client/patient, family and community care.
- Providing case consultation and/or reviewing prospective or retrospective ethical concerns.
- TEC can assist patient/clients, families, staff and management in identifying relevant factors in the decision making process.
- TEC members are appointed for a three year term, and meet quarterly.

Territorial Ethics Committee Composition

- The NTHSSA Director of Quality, Safety and Client Experience, who serves as the Committee Chair
- One member from each region within the NTHSSA (total of six) appointed by the TEC Chair
- One member from HRHSSA
- One member from TCSA
- Three public representatives (NTHSSA, TCSA, and HRHSSA)
- One public representative (Spiritual Leader)
- Ad hoc member: Ethicist from Alberta Health Services

Authorities Ethical Decision Making Process Map



Ethical Decision Making Framework Process Steps and Guidelines

Decision Process Steps *(This is an Iterative Process)*	**Description and Guidelines**
Step 1: Identify the Facts	**DESCRIPTION** Identification of the facts and collection of relevant information regarding the potential ethical issue includes a preliminary screening to validate whether the 'problem' is an ethical issue or some other type of issue. If it is an ethical issue then proceed to collect the relevant information and characterize and define the problem. **OVERARCHING QUESTION(S)** ● What is the ethical issue(s) inherent in this situation? ● Are the perspectives and reactions from those involved clearly identified and understood? **GUIDELINES** ***Preliminary Screening: Is the issue an ethical issue?*** The following criteria will inform the question: ● Am I making a decision that will directly impact the well-being of an individual or group of individuals? ● Am I trying to determine the right course of action? ● Am I asking a 'should' question? ● Are values and beliefs involved? ● Are human rights involved? ● Am I feeling confused and/or uncomfortable? ● Am I comfortable this is not a legal issue? If you answered yes to any of these questions, you may be encountering an ethical issue. 1.1 Collect information, characterize and identify the problem. 1.2 Be alert; be sensitive to morally charged situations. Look behind the technical requirements of your job to see the moral dimensions. Use your ethical resources to determine relevant moral standards (see Step 4). Use your moral intuition. 1.3 Identify what you know and don't know. While you gather information, be open to alternative interpretations of events. Within the bounds of patient/client; and institutional confidentiality, make sure that you have the perspective of patients/clients and families as well as health care providers and administrators. While accuracy and thoroughness are important, there can be a trade-off between gathering more information and letting morally significant options disappear. Timely decision making is critical. Identify when the decision needs to be made. Decisions may have to be made before the full story is known.

Decision Process Steps *(This is an Iterative Process)*	**Description and Guidelines**
Step 1: Identify the Facts (Continued)	1.4 State the case briefly with as many of the relevant facts and circumstances as you can gather within the decision time available. ● What decisions have to be made? ● Who will be impacted by the decision? (individuals, family, community, the health and social services system) ● Who are the important decision makers? Remember that there may be more than one decision maker and that their interactions can be important. ● Who are the stakeholders and what role or information do they have regarding the decision making (stakeholders may or may not be decision makers but have valuable information which may impact the decision) ● Be alert to actual or potential conflict–of-interest situations. A conflict-of–interest is "a situation in which a person, such as a public official, an employee, or a professional, has a private or personal interest sufficient to appear to a reasonable person to influence the objective exercise of his or her official duties." These include financial conflicts of interest (e.g. favoritism to a friend or relative). In some situations, it is sufficient to make known to all parties that you are in a conflict-of-interest situation. In other cases, it is essential to step out of a decision-making role. 1.5 Consider the context of decision-making. Ask yourself why this decision is being made in this context at this time? Is there a better context in which to make this decision? Are the right decision makers included? ***Consider the following questions:*** **Clinical (i.e., medical and social services)** ● What is the patient's/client's medical history/diagnosis/prognosis? ● Is the problem acute? chronic? critical? emergent? reversible? ● Is the problem related to an individual, family, community, or all of these? ● What are the goals of treatment or intervention? ● What are the social determinates that may impact treatment or intervention? ● What are the probabilities of success? ● What are the plans in case of therapeutic failure? ● In sum, how can the patient/client be benefitted by medical, nursing, or other care, and harm avoided? **Preferences for Treatment or Intervention** ● What has the patient/client expressed about preferences for treatment/intervention? ● Who is the patient/client (the individual, family, community or all of these)? ● Is the patient/client autonomous (including capability and knowledgeable enough)? ● Has the patient/client been informed of benefits and risks; understood, and given consent? ● Is the patient/client mentally capable and legally competent? What is evidence of incapacity? ● Has the patient/client expressed prior preference, e.g. Personal Directives? ● If incapacitated, who is the appropriate surrogate? Is the surrogate using appropriate standards? ● Is the patient/client unwilling or unable to cooperate with treatment? If so, why? ● Are the patient/client, family, and/or community rights clearly identified?

Decision Process Steps *(This is an Iterative Process)*	**Description and Guidelines**
	• In sum, are the patient's/client's, families' and/or communities right to choose being respected to the extent possible in ethics and law? **Quality of Life/Death** • What are the prospects, with or without treatment/intervention, for a return to the patient's/client's normal life? • Are there biases that might prejudice the provider's evaluation of the patient's/client's quality of life? • What physical, mental and social deficits are the patient/client likely to experience if treatment succeeds? • Is the patient's/client's present or future condition such that continued life might be judged undesirable by him/her? • Are there any plans and rationale to forego treatment? • What are the plans for comfort and palliative care? **Contextual Features** • What chapter is this in the patient's/client's life? • Are there provider (e.g. physician, nurse, social worker) issues that might influence treatment decisions? • Are there financial issues/implications that may impact the patient/client or go beyond the patient/client to set precedent? • Are there larger community health issues that go beyond the individual? **Ethical Issue/Problem Category, Scope and Scale** • What category of issue is this? Clinical; Social Services; Resource Allocation (Economic); Political; Policy or Research/Scientific Study. It is understood that the categories are not mutually exclusive and may involve more than one? • Is the issue at a local/regional scale with local implications or is there a potential for a broader health and social services system impact or precedent? • Which ethics committee or sub-committee(s) should address the issue (i.e., system wide or local/regional issue)?
Step 2: Identify Cultural Traditions or Beliefs that Impact the Ethical Issue or Resolution	**DESCRIPTION** Apply available cultural and religious practices to identify morally significant factors that may impact the ethical issue(s) identified. **OVERARCHING QUESTION(S)** • Have the relevant cultural or traditional beliefs been identified? • How might the cultural traditions or beliefs impact the ethical issue and resolution? • Are there larger social/community issues that go beyond the individual? **GUIDELINES** 2.1 Identify cultural or traditional beliefs that are relevant to the ethical issue and determine how these beliefs could impact the ethical issue. You may need to include the perspectives of relevant individuals. 2.2 Clarify any identified cultural practices and explore cultural options and alternatives for action. 2.3 Address any cultural competence and cultural safety dimensions.

Decision Process Steps *(This is an Iterative Process)*	**Description and Guidelines**
Step 3: Identify the Values and Principles in the Issue	**DESCRIPTION** Apply the available ethical resources (legislation, policies, professional codes of conduct) to identify morally significant factors and values. Decisions should be made on the basis of reasons (evidence, principles) that "fair-minded" people can agree are pertinent and important given the current context. Furthermore, it is important to provide clear explanations of potential ethical solutions and options. **OVERARCHING QUESTION(S)** ● Have the relevant ethical principles been identified, clarified and examined for potential conflicts? **GUIDELINES** 3.1 Use your ethical resources to identify morally significant factors. 3.2 Determine the relevant ethical principles: This step involves discussion about the dominant values and principles of the relevant parties (individuals and/or groups, as well as those of the organization). This is necessary to further clarify the ethical issue(s) at hand. This step requires an exploration of the nature and scope of the identified ethical principles and consideration of the *relative weights* to assign to each principle. Questions to guide the discussion include: What principles/values do stakeholders consider most relevant to this issue? And, which principles/values do the stakeholders agree are *most important*? The agreed upon set of prioritized principles (decision-making criteria) will be used to guide the decision-making process. The proposed NTHSSA Ethical Decision Making Framework includes a comprehensive list of principles intended to be robust enough to accommodate and inform a wide range of ethical issues in a range of categories (see Table 1). These are 'core' principles that are widely accepted (and can serve as a starting point in determining the relevant ethical principles related to the issue under discussion) in one form or another in the common moralities of many communities and organizations. ***Respect for Autonomy:*** Respect people's right to self-determination or self-governance such that their views, decisions and actions are based on their personal values and beliefs. The vehicle for this principle in health care and research is generally the free and informed consent process. ***Non-maleficence:*** Act so as to do no harm**.** Avoid causing harm to individuals or groups, or risking harms of significant magnitude and probability. ***Beneficence:*** Act beneficently toward others**.** Contribute to the welfare of others, which may include preventing harm, removing harm, promoting well-being, or maximizing good. ***Justice:*** Promote justice and fairness**.** Treat people and groups fairly by treating morally relevant cases alike, by promoting fair relations among individuals and social groups, and by ensuring fair and equitable access to resources and opportunities, including fair distribution of benefits and burdens. 3.3 Moral models: Sometimes you will receive moral insight from modeling your behaviour on a person of great moral integrity. 3.4 Use ethically informed sources**:** Policies and other source materials, professional norms such as institutional policies, legal precedents, and wisdom from your religious or cultural traditions.

Decision Process Steps *(This is an Iterative Process)*	**Description and Guidelines**
Step 4: Identify Alternative Courses of Action	**DESCRIPTION** In the context of legal rules and precedent, identify, explore and clearly explain potential solution options, while considering their absolute and relative strengths and weaknesses. Identify and assess the potential feasible alternative solutions in the context of the ethical and cultural issue(s) identified in earlier steps and the existing and emerging operating context. There may be times that require you to return to previous steps and seek additional information to inform the development of alternative solutions. **OVERARCHING QUESTION(S)** ● What is the most ethically justifiable option? ● Have the relevant individuals (stakeholders) been identified? ● Have the perspectives of relevant individuals been sought and obtained? ● Have the feasible solution alternatives been identified, clearly stated at a level that all stakeholders can understand and competently assessed? **GUIDELINES** 4.1 Specify feasible alternative solutions or courses of action by clearly identifying and describing them in a manner that all decision makers and stakeholders can understand them. 4.2 Clarify the context, identify and test possible solutions. 4.3 Clarify the legal rules and explore legal options that may have implications on possible solutions. 4.4 Evaluate options in relation to the relevant ethical principles. 4.5 The selected option is not necessarily the one with the highest number of positive considerations and/or the lowest number of negative considerations. Each option needs to be based on the magnitude of its advantages and disadvantages. Is there a sound explanation to each of the criticisms that can be brought to bear on the potential solution/recommended course of action? 4.6 You then should ask what the likely consequences are of various decisions. Here, you should remember to take into account good or bad consequences not just for yourself, your profession, organization or patients/client's, but also for all affected persons including families and the community. Be honest about your own stake in particular outcomes and encourage others to do the same.

Decision Process Steps *(This is an Iterative Process)*	**Description and Guidelines**
Step 5: Make a Decision and Identify Next Steps	**DESCRIPTION** The decision process at this stage involves making a choice, acting to implement it, and evaluating and learning from it. **OVERARCHING QUESTION(S)** ● What are the implications if this decision where to be made a general rule and could we live with this? ● Can you defend the decision process and result? (If you cannot, then return to an earlier step and reexamine if there is another justifiable option). **GUIDELINES** 5.1 Make your choice, act to implement it, and evaluate the decision and its impacts (including all stakeholders). 5.2 Make your choice in the context of feeling comfortable with the decision. If you are not comfortable, you may need to return to Step 4 and/or 5 and re-evaluate if there is another ethically justifiable option. 5.3 Develop an action plan. Also decide how to communicate the plan to those involved. 5.4 Determine how the decision will be carried and in what timeframe. 5.5 Determine how communications regarding the decision will be done. 5.6 Evaluate the plan – were the intended results obtained? Are changes needed? Is additional follow-up and/or action required? 5.7 Self-evaluate the decision. These types of situations are often difficult for those involved. It is important to reflect on the decision-making process and outcomes achieved, it is also important to reflect on one's feeling with respect to the situation, including: What would you do differently next time? What have you learned about the decision making process?

References

- http://www.bcchildrens.ca/health-professionals/clinical-resources/clinical-ethics#About
- https://www.albertahealthservices.ca/info/Page6671.aspx
- https://www.nthssa.ca/en/our-mission-vision-and-values

Appendix A: NWT COVID-19 Scarce Resources Approach

Northwest Territories Health and Social Services Authority

Box 1320, Yellowknife, NT X1A 2L9

Introduction:

COVID-19 is the clinical illness caused by SARS-CoV-2 virus (severe acute respiratory syndrome coronavirus 2). In the majority of patients, it will cause a self-limited illness that does not necessitate hospitalization or higher levels of care. Approximately 15% of affected individuals will become sick enough to require hospitalization and supportive care, and up to 5% will require critical care support. Depending on the rapidity of spread in the community, there exists the potential for more patients to require resources than are readily available.

Within the Northwest Territories, two such limited resources include medical transfer flights (medevac) and critical care beds with associated life support, such as ventilators. It is also possible that there will be limited capacity within our Tertiary referral center (Edmonton and Northern Alberta) to accept critically ill patients. This created the need for a triage system to assist in the ethical allocation of limited resources. The Alberta Health Services Resources Critical Care Triage during Pandemic or Disaster in Alberta March 2020 was utilized to develop a process for critical resource triaging in the Northwest Territories.

Goals of Care during COVID-19:

Before considering allocation of scarce resources, the first consideration must be the wishes of the individual patient. Having clear discussions and documenting what values and directions patients have regarding their care in the event of a significant illness is paramount. It is important for health care practitioners to work with the patient and their family to identify their cultural beliefs and values around end of life care and ensure they align with the patient's goals of care.

In particular, patients who are elderly, frail or have significant medical comorbidities that would predict a poor outcome in the event of severe COVID-19 infection should have a frank discussion with their care providers and family to discuss Goals of Care (GoC) and end of life wishes. A library of resources to help frame, guide and document these discussions with patients prior to a diagnosis of COVID-19 are available on the internal OurNTHSSA website.

The outcomes of such discussions should be documented on an NTHSSA Goals of Care sheet and flagged in the EMR (form and documentation instructions also available on the internal OurNTHSSA website). There is room at the bottom of the GoC sheet to document additional useful information, such as who would act as a substitute decision maker, or specific directions regarding care.

Most Appropriate Care and Location:

If, after a discussion with the patient and/or family, they would desire access to a limited resource, there needs to be determination if they are eligible to access that resource. This discussion is important even before considering a "scarce resource triage" setting (i.e., *before* ICU beds and ventilators are at capacity). It is important to determine the most appropriate location for care based on both the patient's wishes and according to the patient's likelihood to benefit from particular interventions such as ventilator support. Additionally, the resources available in the patient's home community will also weigh into this decision. Please see NWT the Covid Response Patient Pathway (Appendix A1).

Triage of Scarce Resources:

When the need for ICU beds, ventilators, staff, medevacs, or other scarce resources outstrips available supply, these resources will need to be triaged in an equitable manner. Ethical principles that were considered for the determination of scarce resource allocations were developed from the NTHSSA Ethical Decision Making Framework and the AHS Critical Care Triage during Pandemic or Disaster framework (please see the supporting documents section for more information). These include capacity to benefit, emphasizing the greatest good for the greatest number, formal equality and first come, first served, followed by random selection.

Patients that may require critical care support will need to be assessed for the presence of inclusion and exclusion criteria. A full list of exclusion criteria can be found on page 9 of the AHS Critical Care Triage during Pandemic or Disaster framework (please see the supporting documents section for more information) and include the presence of advanced cardiac, respiratory, hepatic and neurologic conditions including dementia, metastatic cancer and severe trauma. If there is any uncertainty regarding whether a patient would qualify for critical care and ventilator support, Internal Medicine will be consulted to review the patient with the referring practitioner. If uncertainty still remains after discussion between practitioners, the matter will then be referred to the NWT Scare Resource Triage Committee to assist with the adjudication of the limited resource.

Non-ICU Care:

Should it be determined that a patient does not qualify for intensive care, the resources under the OurNTHSSA website can assist in having the discussion with a patient and their family. It may still be appropriate for such a patient to be transferred from their original location to another location, depending on local resources and patient preference. This will occur according to the NWT Covid Response Patient Pathway (Appendix A1), depending on the Territorial Pandemic Response Stage. Full medical management and supportive care will still be offered to these patients. If end of life symptom management is required, resources are available to guide management.

Scarce Resource Triage Committee

The NWT Scarce Resource Triage Committee was established to assist with making the difficult decisions regarding the allocation of critical resources during the COVID pandemic. To access this team, Practitioners are able to contact the Territorial Medical Director or the Chair of the NWT Scarce Resource Committee. The Committee consists of a physician (and alternate), a Senior Nurse Leader (and alternate), the NWT Ethicist (based in Alberta) and an NWT Indigenous elder.

Activation of Scarce Resource Triage process:

The NWT Territorial Pandemic Stages have been aligned with Alberta's "Stages of Surge during pandemic or disaster" and are defined as follows:

Stage 1	**Minor**: Isolated cases, initial hospital admissions to Stanton Territorial Hospital (STH). Existing resources are insufficient requiring reallocation and reduction of non-essential services.
Stage 2:	**Moderate:** Sustained community transmission requiring active management of system resources to respond to increasing needs. Expect delays of critical patient transfers
Stage 3:	**Major:** Increasing admissions at STH, requires Inuvik Hospital for admissions of moderate COVID patients.
Stage 4:	**Critical**: Some or all critical system resources exceed maximum capacity. **Scarce resource allocation decisions required.** The Executive Leads of the Authorities COVID Response Team are responsible for activating each Stage of the pandemic response plan. When Stage 4 is activated, the Scarce Resource Triage approach will be utilized, both for internal decision making and for communication with AHS regarding support and transfer. At Stage 4, the triage document and tool will be distributed to all Acute Care services as well as MedResponse, and the NWT Scare Resource Triage Committee will be activated. The committee will prepare with a review of the current resources, be ready to guide healthcare providers through the triage tool, and to review cases as required by utilizing the scarce resource decision making document (please see the supporting document section for more information).

Processes Utilized by the Scarce Resource Triage Committee:

The Chair of the Scarce Resource Triage Committee intakes the concern from the Medical Practitioner or the Territorial Medical Director on the Scarce Resource Triage Committee Decision Making Form (Appendix A2)

The Chair will arrange an appropriate and expeditious meeting time for the Committee to review the case and determine the allocation of the Scarce Resource. The team will work through the form identifying the principles that were applicable and determining a final decision on the allocation of the resource.

Scarce Resource Triage Committee Guiding Principles:

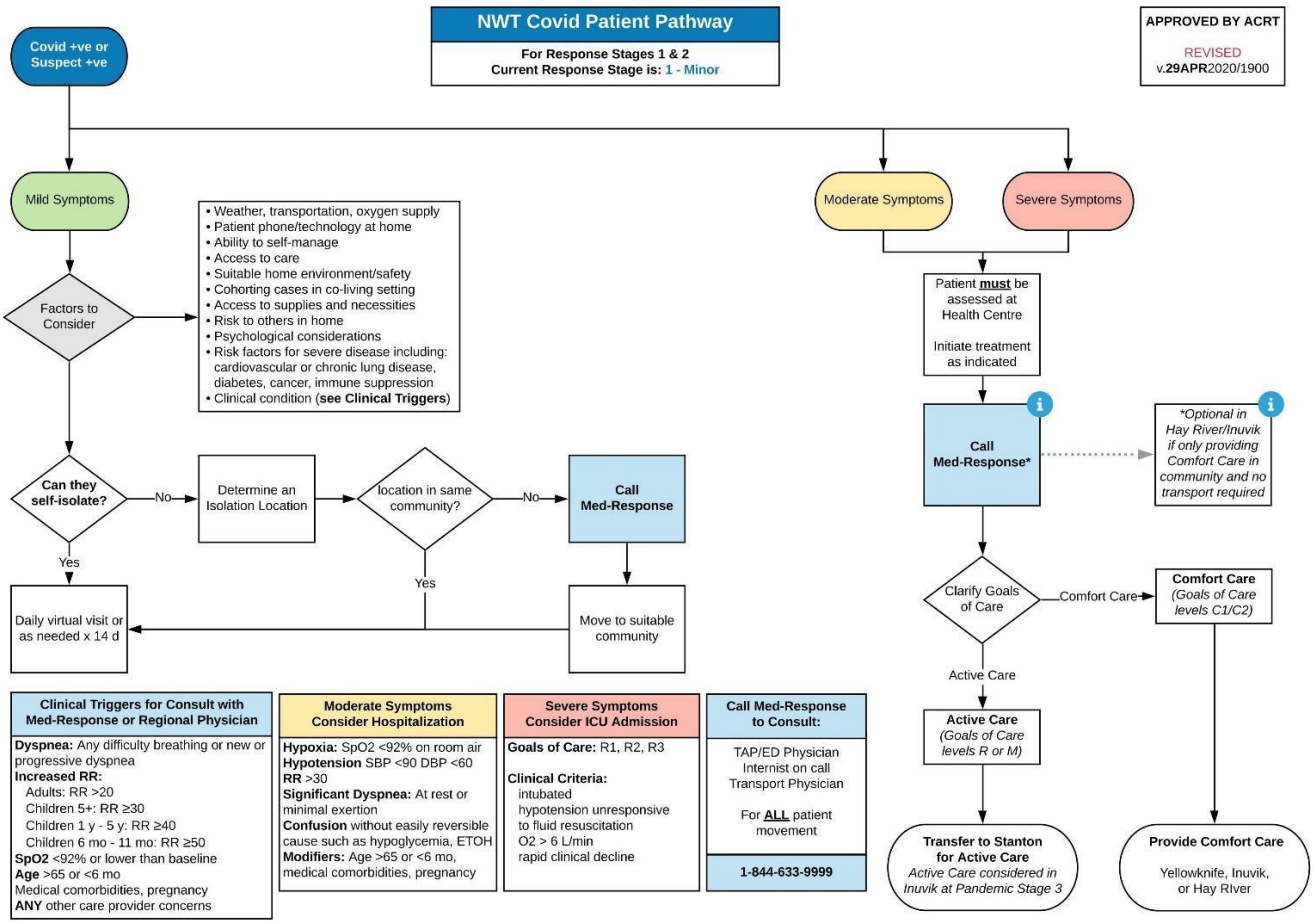
Guiding Principle	Ethical principles	Ethical considerations
Primary Principle	Capacity to Benefit	Triage patients based on improved incremental survival rather than on a first-come, first-served basis when a substantial incremental survival difference favors the allocation of resources to another patient.
Supplementary Principle	Formal Equality	All clinical considerations being equal, patients with equal likelihood to benefit and to survive should have the same access to needed healthcare resources.
Supplementary Criteria	First come, first served	If time of presentation is the same between patients or cannot be determined, random selection.
Supplementary Criteria	Fair innings or life-cycle	Prioritizing resources to those who are at an earlier stage in the life-cycle in comparison to those at a later stage of the life-cycle.
Supplementary Criteria	Multiplier effect	The multiplier effect is the idea that certain persons have the skills and knowledge necessary to save others in a given situation; saving a “multiplier’s” life could (down the road) enable that person to save the lives of others, multiplying the net benefit to society by reducing mortality and morbidity within a population

Rejected Supplementary Criteria	Reciprocity and Equity to Health care professionals/ Essential service workplace exposure	It is rejected because of the inability to manage the perceived conflict of interest of giving priority access to healthcare providers, and the ethically ambiguous task of defining 'essential' versus 'non-essential' workers.

Supporting Documents:

- NTHSSA Ethical Decision Making Framework
- AHS Critical Care Triage during Pandemic or Disaster in Alberta
- NWT Covid Response Patient Pathway (Appendix A1)
- Goals of Care Tools and Resources available on the internal OurNTHSSA website

Appendix A1: NWT COVID Patient Pathway



Appendix B: Authorities COVID-19 Operations Ethical Decision Making Framework

Northwest Territories Health and Social Services Authority

Box 1320, Yellowknife, NT X1A 2L9

Introduction to the Authorities COVID-19 Operations Ethical Decision Making Framework

Balancing the numerous competing moral obligations during a pandemic at a societal and/or organizational level can be extremely difficult. Because of this unique context, it is critical that decisions are made carefully and expeditiously: based on the best information available, and rooted within a shared understanding of what is important.

The values that make up the ethics decision-making tool below are commonly recognized in pandemic planning and familiar to previously developed pandemic ethics frameworks from the 2009 Pandemic Influenza Ethics Framework (Alberta Health Services & Covenant Health, 2009), Alberta's Ethical Framework for Responding to Pandemic Influenza (AH & AHS, 2016), Provincial Ebola Task Force (BC Provincial Health Office), and Stand on Guard for Thee (Joint Center for Bioethics, 2005).

This operational Ethical Decision-Making Framework is intended for use by decision-making groups within the Health Authorities of the Northwest Territories (NWT) and is based on the NWT Territorial Ethics Decision Making Framework. The Territorial Ethics Committee and the Ethicist from Alberta Health Services (AHS) are available to provide support for working through the framework, as required.

While using the Framework cannot guarantee an ethical decision, its goal is to ensure that decisions have been made based on a shared and accurate understanding of the relevant information, that the appropriate values have been thoughtfully considered and weighed against each other, and that decisions of such magnitude made by healthcare decision-makers in the public interest rest on ethically and publicly defensible considerations rather than on arbitrary criteria or unchecked biases.

The Framework:

- Establishes a set of key values to clarify, justify, and support pandemic-related organizational level decisions;
- Provides a template Decision-Making Form with a values checklist that will ensure consistency and transparency in ethical decision making across the organization; and
- Enables a process for tracking and retention of decisions receiving ethics review and reflection.

Who should use and what is the intent?

This Ethical Decision-Making Framework is intended for use by organizational level decision-making groups throughout the Health Authorities within the NWT – ideally with support of the Territorial Ethics Committee or the AHS ethicist, but can be used without the direct support of either.

It can be used to guide and review prioritization decisions, or other organizational level decisions.

How to use

A template form and checklist (Appendix B1) is included to support users to ensure their decisions fulfill the organizations' value commitments.

Initially when looking at the issue, it is important to rate the impact of the decision as compared to the values of the organization. The graph below identifies the importance of the value to the organization and what value it relates to.

Tier	Specific criteria Does this decision….?	Value Theme
1	Minimize the net harm to the public (including through the spread of disease, disruption to healthcare system)	Non-maleficence
1	Maximize good outcomes for patients with highest acuity needs(life-saving, long-term impacts of disease, and/or reducing suffering)	Beneficence
1	Provide healthcare providers with the supports and safety equipment they require in order to discharge their professional obligations and minimize their risk of being exposed to COVID-19. And recognize the additional risks or hardships they may be taking on to provide care in this higher risk context.	Safety
1	Ensure the policy decision does not create additional access barriers for, or disproportionately impact, those the most vulnerable or already face additional barriers (i.e. lower socio-economic status, homeless populations, some cultural minorities, etc.)	Justice
1	When possible, consult with those groups who will be impacted by the decision (e.g. patients, healthcare workers), and where not possible, strive to pull from pre-existing consultations.	Transparency, Autonomy, Cultural
1	Reflect the best available evidence, and ensures any assumptions made are well grounded and defensible	Safety
1	Where there is an absence of clear information or evidence, any decision made strives to minimize the risks of harm	Non-maleficence
2	Ensure less critically ill patients also continue to receive appropriate care	Beneficence, Justice, Solidarity, Culture
2	Minimize restrictions for staff/patients/public as much as possible, commensurate with the level of risk to public health	Autonomy
2	Respect the confidentiality of medical information of patients and their families	Confidentiality
2	Prevent patients from experiencing avoidable harm while waiting for a diagnosis of their illness (e.g. patient presenting to ED with co-morbidities that include the screening questions and so does	Non-Maleficence

	not receive their cardiac care because a COVID-19 test is pending)	
2	Reflect patient values and beliefs as much as possible in healthcare decisions, granting that choices may be limited in a pandemic	Dignity
2	Provide someone (patient, family, staff, member of public) who is impacted by a decision the rationale and, if possible within the constraints of the pandemic response, the ability to discuss and challenge the decision through the appropriate channels	Disclosure, Transparency
2	Set clear expectations about what interventions will and will not be provided under which circumstances and the rationale for these decisions	Disclosure, Transparency
3	Ensure all patients who present with COVID-19 symptoms receive a consistent level of care within the available resources	Justice, patient/family centred
3	Provide the public with timely, clear and consistent information	Disclosure, Transparency
3	Foster trust between the NWT Health and Social Services System and our workforces	Inclusiveness
3	Foster trust of the health and social services system by the public	Transparency
3	Align with approach taken across organizations DHSS, NTHSSA, TCSA & HRHSSA	Solidarity
4	Allow those closest to clinical decisions to exercise clinical judgement (based on professional knowledge, codes of conduct, college guidelines, etc.) in the difficult decisions they make	Integrity, patient/family centred
4	Align with and/or is supported by decisions in other provinces, territories and federally	Solidarity

Process for Operational Ethical Decision Making

For ethics support, make a request via the Director Quality Risk and Client Experience. An ethicist is available to walk you through the process. If not, you have the option of asking the Territorial Ethics team or the ethicist to review your decision after completing the checklist.

Step 1	Confirm question
Step 2	Identify who should be involved in the decision (and/or consultation)
Step 3	Develop a draft decision
Step 4	Use the checklist to rate the decision by: • Completing the checklist and ensuring the decision lives up to highest tier values/criteria • Ideally, a decision should fulfill all values, but as the context changes during

	an outbreak, it may not be possible to fulfill lower tier values/criteria • Include rationale in 'notes' column if a Tier 1 value *cannot be achieved*, and any other values most central to your decision
Step 5	Finalize the COVID-19 Operations Ethical Decision Making Form and submit to the Director of Quality Risk and Client Experience.