# **Decision-making framework**

# Inter- and Intra-Health Authority Relocation

# **Scope**

The below content is focused on the establishment of common decision-making processes associated with the evacuation and repatriation of patient/client/residents of long-term care (LTC) facilities, assisted living (AL) facilities, and independent living (IL) facilities, in support of health authority emergency operations/coordination structures. This framework acknowledges its limited scope and possibly interim nature, due to an awareness of evolving provincial health system emergency management structures and governance.

**Activation process**

* Health authority Emergency Operations Center (EOC) Director(s) to apply whenever conducting community-level evacuations and repatriations of healthcare facilities. Utilizing this framework and associated tools would apply to both sending and receiving health authorities if inter-health authority movement is required.
* This is not intended to replace Code Green protocols/plans/processes.

**Evacuation/repatriation principles and values**

* **Health and well-being.** The health and wellbeing of patient/client/residents is a paramount priority.The need for patient/client/resident movement is regularly evaluated in consultation with key administrative, emergency management, and clinical stakeholders. Risks associated with an evacuation should be weighed against the risks posed by patient/client/resident frailty, natural hazard activity, road closures, etc.
* **Minimizing harm.** All attempts should be made in relocation to avoid injury to patient/client/residents and/or exacerbating illness. To minimize physical and/or psychological harm, patient/client/residents should be moved as little as possible and in keeping with their preferences wherever possible. While the overarching goal should be to minimize burdens and saving lives, consideration should be given to unique circumstances such as sustainability of a community and ameliorating systemic inequities.
* **Proportionality.** Measures implemented should be proportionate to and commensurate with the level of threat and risk.
* **Least coercive and restrictive means.** Any infringements on individual autonomy and choice must be carefully considered, and the least restrictive or coercive but effective means must be sought.
* **Flexibility.** Any plan must be iterative and adapted to new knowledge and circumstances that arise.
* **Working together.** Cooperation is essential between individuals, health authorities, province, and all other relevant stakeholders. This includes collective commitment to providing advance notice or engaging in pre-planning efforts, whenever feasible, to support partner and system readiness.
* **Equity.** Those with greatest need and who can derive the greatest benefit should be prioritized. Where social inequities have resulted in a greater burden on some populations or groups, then decisions should seek to lessen the impact of these inequities.
* **Respect**. Measures should be put in place to promote dignity of patient/client/residents and prevent placing them in a vulnerable situation. For those who are already in a vulnerable situation, avoid violating their rights and dignity through decisions made. This is particularly important when considering the rights of Indigenous people of BC as underscored in the [United Nations Declaration on the Rights of Indigenous Peoples](https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf) and the [BC Declaration on the Rights of Indigenous Peoples Act](https://www2.gov.bc.ca/gov/content/governments/indigenous-people/new-relationship/united-nations-declaration-on-the-rights-of-indigenous-peoples).
* **Cultural safety**. Moving patient/client/residents should be done in a trauma-informed, culturally-safe manner with particular attention paid to unique populations and individuals (e.g. Indigenous people, refugees) who may face significant trauma related to forced relocation. Decisions must not be made on the basis of ethically irrelevant, non-defensible and/or discriminatory criteria. Attempts should be made to ensure that individuals are respected, supported and will not be judged for their identity including their beliefs, values or way of being (e.g., race, colour, ancestry, place of origin, religion, marital status, family status, physical or mental disability, sex, sexual orientation, gender identity or expression, age, socioeconomic status, pre-existing health conditions, perceived obstacles to treatment, past use of resources and/or presumptions about quality of life, etc.) Particular attention should be paid to Indigenous patients/clients/ residents who may be significantly impacted by evacuation and being away from their land and community due to both their connection to their lands, as well as potential for re-traumatization related to colonial practices and systemic racism in Canada.
* **Procedural justice.** There should be accountability and a transparent process throughout the planning and implementation of moving and repatriation of patient/client/residents. As much as possible, decisions should be reasonable, inclusive, efficient and effective and consistent. When making decisions, attention should be given to promoting trust of stakeholders.
* **Informed decision-making.** Decision-makers should operate with the best clinical, administrative, and contextual information possible including information about sending and receiving health facilities.

**Ethical decision-making process**

**Situation**

The increasing frequency and ferocity of natural hazards, such as fire and flood, have led to recognition of the need to put in place mechanisms to determine whether and when to evacuate LTC, AL, and IL facilities, as well as when to repatriate patient/client/residents back to these facilities once risks from the natural hazard have diminished.

These decisions include consideration of both substantive and procedural ethical principles and values to ensure that decisions are made in a manner that both protects and respects the health and well-being of patient/client/residents living in LTC, AL, and IL and also supports decision-makers to make well thought-out, transparent, and accountable decisions.

In this context there are two separate but overlapping issues:

1. The ethical considerations that should be used to determine when and which LTC/AL/IL facilities are **evacuated**?
2. The ethical considerations that should be used to determine when and which LTC/ AL/IL patient/client/residents are **repatriated**?

**Background**

Key facts relevant to both evacuation and repatriation include:

* Natural hazard impacts have increased in frequency and intensity in the last number of years. This trend is expected to continue as climate change is rapidly changing the hazardscape.
* Natural hazards such as wildfires and floods create threats to the health and well-being of local populations, including but not limited to: destruction of buildings and facilities, disruption of transportation routes, disruption of supplies including fuel, medications, food and other basic necessities.
* LTC, AL, and IL facilities vary in size and typically serve elderly clients with physical and/or cognitive health and behavioural challenges.
* Both evacuation and shelter-in-place practices carry risks and benefits to patient/client/residents. Lengthy and uncomfortable transport and disruptions to routine and living situation have both short and long-term consequences on physical and mental health and well-being of patient/client/residents.
* Community-level hazard impacts are dynamic and may evolve rapidly, thus decisions need to be made quickly and sometimes with incomplete information.
* Due to the rapidity of evolution of community-level hazard impacts, assessment of risk must be done at the level of a particular LTC, AL, or IL facility rather than the unique needs of individuals.

**Analysis**

While each of the values and principles identified above (health and well-being, minimizing harm, proportionality, least coercive and restrictive means, flexibility, working together, equity, respect, cultural safety, procedural justice, and informed decision-making) have import in evacuation and repatriation decisions, there are times that not all of these values can be equally upheld, thus ethically justifiable trade-offs between these values need to be considered. In this context there are several key trade-offs that needs to be considered:

* The context of patient/client/residents who have chosen (whether themselves or via their substitute decision-maker) to reside LTC, AL, or IL facilities means there is a duty to protect health and well-being and minimize harm, as well as an implicit assumption that those who reside in LTC/ AL/IL facilities would consent to mechanisms taken to protect them. As such, considerations related to individual consent and individual choice to live at risk may be given less weight than duty to protect.
* The duty to protect health and well-being and minimize harm should be given more weight when considering whether and when to *evacuate* (rather than repatriate) a particular facility, as the risk or harm is more immediate. However, when *repatriation* of individuals is being considered, considerations of equity, respect and cultural safety should be given more weight as immediate risks to health and well-being are likely to be diminished.

## **Recommendations**

* The fact that patients/clients/residents (or their substitute decision makers) reside in an LTC, AL, or IL facility means there is an appropriately founded implicit assumption that those patients/clients/residents would likely consent to mechanisms taken to protect them. There is a duty to protect the individuals who have chosen to reside in such facilities.
* In the context of evacuation, the greatest weight should be given to health, well-being, and minimizing harm of patients/ clients/ residents. To do this, decision-makers should consider both the risks of relocation (including transit, disruption of routine, being moved from home/community/loved ones) vs. risks of shelter-in-place in the short, medium, and long term. Any relocation should be done in a manner that avoids injury and/or trauma to patient/client/residents and/or exacerbating illness.
	1. To decrease chance of physical and/or psychological harm, patient/client/residents movement should be minimized and in keeping with their preferences wherever appropriate, i.e. to the nearest safe geographic location, when possible. Particular attention should be paid to ‘unbefriended’ individuals (individuals with no family who are in the guardianship of the Province) who are unable to advocate for themselves and lack family to advocate for them.
* While the overarching goal should be to minimize harms and save lives, consideration should be given to unique circumstances such as sustainability of a community and ameliorating systemic inequities. This is of particular importance in repatriation decisions, where considerations related to equity (e.g. length of time of evacuation, distance from home community), cultural safety, and respect should be given more weight.
	1. Particular attention should be paid to Indigenous patients/clients/ residents who may be significantly impacted by evacuation and being away from their land and community due to both their connection to their lands, as well as potential for re-traumatization related to colonial practices and systemic racism in Canada.
* Recognition and attention should also be given to the considerable moral weight on those making decisions, and measures to alleviate this weight, including clear decision-making criteria and shared decision making, as well as debrief support, should be in place where possible.
* Proactive measures should be put in place to ensure patient/client/residents, families, and staff are aware of how and when decisions to evacuate, shelter-in-place, and repatriate are made. Communication should be transparent and timely and seek to foster trust in those making decisions. This may be of particular importance in relation to shelter-in-place orders as, on the surface, people may feel abandoned and may not understand that this is be the preferred options after weighing risks and benefits of available options.

**Assumptions and risk mitigation**

This section outlines a non-exhaustive list of assumptions that should be collectively approved and assumed. They require common understanding and/or may require pre-approved mitigation measures from leadership to allow for timely decision-making within the EOCs.

* **Fundamental risk**. Assumption that an evidence-informed assessment has been made that the fundamental risk to the facility sending patient/client/residents is significantly greater than the risks and consequences of transport and the state of readiness of the receiving site.
* **Dynamic situation.** Assumption is that the situation is constantly dynamic, and if/when context changes, patient/client/resident acuity/care will be prioritized over sunk costs associated with less favorable transport options/movement timelines that were sourced in the original context.
* **Selection of transport method.** Assumption is that selection of transport method is driven by patient/client/resident acuity, environmental situation, timelines, and number of individuals requiring repatriation, and would be aligned with the above principles.
* **Change management documentation.** Assumption is that if/when the relocation plan requires a fundamental change in direction/approach, the role designated as final approving authority (see RACI) will communicate in writing the change to the core Operational Patient Movement Team as confirmed point of reference and updated source of truth for broader relocation planning.
* **Support for decision-makers**. Assumption is decision-makers operate with the best available information at the time of evacuation or repatriation. Therefore, the consequences are the result of the framework and not the individual decision-maker.
* **Resource maximization.** Assumption is Ambulance service have an important role during community-level evacuations/repatriations of healthcare facilities and inter-health authority movement, and will participate in collaborative efforts, in all phases from planning to support system readiness, to implementation.

**Stop checks**

* Prior to entering into the next phase of planning, a designated member of the Operational Patient Movement Team (e.g. a Section Chief) will be tasked with asking “Is the patient/client/resident movement still required?” and completing a quick SBAR to support movement based on preparation team discussion. This would then be provided to the final approving authority and health authority leadership. For example:
	+ *Situation:* Wildfire is no longer posing a threat based on current situational awareness and ground transport is still viable due to road conditions.
	+ *Background:* See initial SBAR documentation for repatriation.
	+ *Assessment:* Conditions are improving. Ground transport is still an option based on available information. Patient/client/resident population is stable and healthy to make the move home.
	+ *Recommendation:* Preparation team will continue planning repatriation for ground transport for all of the patient/client/resident population.

**Roles and responsibilities**

* **In scope:** Activation of the patient/client/resident movement tools, if a community-level evacuation/repatriation takes place, and what facilities it applies to.
* **Out of scope:** The clinical decision-making process for appropriateness to move individual patient/client/residents and specific transport options to be used. These decisions would utilized the principles, decision-making process, risk assumptions and stop checks outlined, but a different RACI would apply. This RACI chart may not apply in all exceptional circumstances and actions may be taken outside of these outlined roles and responsibilities in the interest of preserving safety and life of patient/client/residents, staff, and members of the public.

**Responsibility Assignment Matrix**

In various geographies, different emergency response agencies are involved in responses, so an environmental scan is recommended, and a responsibility matrix is developed to ensure clear roles are defined prior to an event. Ensure all stakeholders, rightsholders, partners and agencies that operate in this space are accurately reflected in the matrix and included as required.