

Planning for Palliative Care Delivery during the COVID-19 Pandemic

Purpose:

Palliative care is an essential component in pandemic planning. The intent of this document is to:

- Outline some of the key issues in planning for palliative care delivery in the context of COVID-19
- Share some considerations and resources to guide planning at the local level.

Target Audience:

This document is for clinicians and administrators who are involved in palliative care service planning and/or palliative care delivery.

NOTE: The initial content for this document was based on information available as of March 24, 2020. The links in this document have been reviewed and updated as of January 14, 2022.

This document is intended as additional guidance specific to the safe delivery of palliative care during the COVID-19 pandemic; it is not intended to replace or supersede government directives or public health measures. Adapted approaches may be required to address unique, organizational or other exceptional circumstances and conditions. Further updates may be released as the COVID-19 pandemic evolves and clinical evidence develops.

It is imperative that all planning is done in alignment and collaboration with regional and institutional bodies to ensure approaches are consistent with emerging provincial and regional planning and directives. It is also important to consult with providers who have expertise in palliative care when developing systems, pathways, care plans, and/or other resources that include a palliative approach.

The Ontario Palliative Care Network's (OPCN)¹ Regional Palliative Care Network (RPCN) directors and clinical co-leads can be a valuable resource for guidance and access to clinical tools. **Please reach out to Info@ontariopalliativecarenetwork.ca for contact information for your local RPCN leadership team.**

Prioritizing Palliative Care Delivery

During a pandemic, palliative care delivery planning needs to consider two populations:

1. Individuals with progressive, life-limiting conditions (individuals who would traditionally be identified as having palliative care needs where palliative care is the primary focus of their care or where palliative care is part of their overall care plan).
2. Individuals who become rapidly and terminally ill as a result of COVID-19.

If resources become constrained, it may become important to prioritize patients; identifying those who are most in need of care and those for whom some care provision can be deferred or delayed. Modeling Ontario Health's (Cancer Care Ontario) approach in establishing three priority levels for cancer care during a pandemic, including those receiving palliative care and end-of-life care, the following priority groups have been refined to be disease-agnostic. These priorities can be considered for any diagnosis

¹ The Ontario Palliative Care Network is a partnership of community stakeholders, health service providers and health systems planners who are developing a coordinated and standardized approach for delivering hospice palliative care services in the province. We are funded by the Ministry of Health to help deliver on Ontario's commitment to palliative care.

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and/or care setting and can be used to support triaging new referrals to palliative care services. For each priority group, a patient may meet any of the criteria outlined.

a. Priority A

- I. Severe or uncontrolled symptoms
- II. Serious or life-threatening complications of illness that may be reversible² in individuals with a [Palliative Performance Scale](#) (PPS) $\geq 30\%$ but where rapid decline in PPS is expected, and goals of care that support intervention
- III. Transitioning to or at end-of-life (including those dying of COVID-19)

Priority A patients are more likely to require direct, in-person care regardless of setting. Screening for COVID-19 is imperative as the first step for all direct care. These individuals will require more urgent conversations about their goals and plan of care. If the patient's care needs become too complex to manage in their usual place of residence, they may require care in an alternative setting such as a hospital, palliative care unit (PCU), or hospice residence³.

b. Priority B

- I. Moderate severity symptoms
- II. Complications of illness that can be managed in the community
- III. Psychological distress for the patient, family or caregiver
- IV. Caregiving crisis due to illness in family, loss, burnout, or reduced access to frontline care providers (e.g. availability of Personal Support Workers)

Priority B patients usually can be managed in their current setting either by direct, in person care or virtually. These will be individuals for whom use of virtual care options – telephone, virtual visits, text messaging - will be most beneficial and efficient. Refer to the OPCN's [Leveraging Virtual Care to Support Palliative Care](#) for further information.

c. Priority C

- I. Stable or mild symptoms
- II. PPS $> 60\%$
- III. Planned for routine follow-up

Priority C patients may continue with their current care plan and have routine follow-up visits deferred. These individuals should have clear information about what changes in their health status they should be monitoring and how to access care should any of these changes occur. Virtual care options will be particularly valuable if contact with these individuals is required. Refer to the OPCN's [Leveraging Virtual Care to Support Palliative Care](#) for further information.

² When patients with palliative care needs are identified early in the course of illness, treatment of serious or life-threatening complications can be very appropriate. While palliative care providers may not be responsible for providing these treatments, they may receive calls from these patients and/or be involved in helping to make decisions about care and providing direction to patients/families or other health care providers.

³ Hospice residences and some Palliative Care Units may not be able to accommodate patients with COVID-19

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Human resources

During the pandemic, the demand for palliative care is likely to increase. An important consideration is the human health resources crisis currently being experienced as a result of the pandemic in all settings of care, including hospital and home and community. A key issue in managing human resources will be making the most efficient and effective use of palliative care specialists⁴. Importantly, frontline providers will need to be prepared, supported and empowered to deliver the necessary care to address the needs of their individuals. Some key considerations will be:

- Establishing a triage function within palliative care programs to identify individuals in most need of care (as per the priorities above) and for whom specialist care or consultation may be required. When triage is needed, this function should be communicated to likely referrals sources (eg family doctors, cancer centers, hospitals, etc.).
- Establishing a standardized and transparent decision-making process to ensure effective deployment of palliative care specialists to the highest priority patients.
- Conducting regular risk assessments to identify where clinician shortages are occurring due to clinician illness, burn-out or self-isolation.
- Developing clear processes to access palliative care supports, for timely availability
 - Identifying for each setting of care (e.g. hospital, Long-Term Care, community, etc.) which palliative care specialists are available to provide direct care, consultation or provider support.
 - Establishing clear, accessible linkages between palliative care specialist clinicians and programs with local primary care providers and long-term care homes.
 - Ensuring strong connections at the local level between Long-Term Care and Retirement Homes and Palliative Care Specialists. For facilities facing an outbreak, or locations where staffing may be overwhelmed, palliative care specialists may be requested to provide enhanced support and/or consultation.
 - RPCNs can be a valuable resource for facilitating these connections and enabling access.
 - Refer to the OPCN's [Strategies to Support Palliative Care in Long-Term Care during the COVID-19 Pandemic](#) for additional information and guidance.
- Planning and implementing virtual care resources (telephone, email/text, virtual visits) to support patient care. Refer to Ontario Health's [Adopting and Integrating Virtual Visits into Care: Draft Clinical Guidance](#) and the OPCN's [Leveraging Virtual Care to Support Palliative Care](#) for additional information and guidance.
- Ensuring that primary level/frontline providers have ready access to evidence-informed tools (e.g. symptom management guides, standard order sets, goals of care discussion guides, COVID-19 communication guides, etc.). Refer to the OPCN's [Online Palliative Care Toolkit](#) for best practice tools to support primary care providers with palliative care delivery.

⁴ Palliative care specialists include palliative care physicians, nurses, social workers, and other health care providers who have specialist level competencies in palliative care, as outlined in the [Ontario Palliative Care Competency Framework](#).

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- Planning for the use of telephone and digital approaches to support frontline providers, including access to specialists for consultation and mentorship (e.g. [eConsult](#), OTN, etc.). Refer to the OPCN's [Leveraging Virtual Care to Support Palliative Care](#) for further information.
- Ensuring providers have access to services and information to help support their own mental health and well-being.

Access to Palliative Care Services

Typical patterns of referral and occupancy in hospitals, Palliative Care Units (PCUs) and hospices may change as a result of COVID-19. For example, directives designed to prevent the spread of COVID-19, and limited access to resources in certain care settings, may lead to increased demands for home care. Planning should include establishing regional mechanisms to monitor local/system service use in various care settings to identify volume spikes. Palliative care teams may need to pivot to focus on increasing services in settings of need (i.e. Long-Term Care, ICU, Emergency Department, etc.). The Regional Palliative Care Networks can play an important role in this process. There will also be an ongoing need for palliative care beds. Planning for bed allocations should be done in close coordination with regional and institutional planning bodies. Some important elements to consider will be:

- Ensuring providers engage in proactive conversations with patients and their families and caregivers about the current context and the pressures on hospitals and emergency departments. These sensitive discussions should include clarifying how the current context may affect decisions regarding their care and exploring what their goals and preferences would be in this context. Refer to [Speak Up Ontario](#) for conversation guides specifically tailored to patients with COVID-19, in different care settings, or to Vital Talk's [COVID Ready Communication Playbook](#) for practical advice on how to talk about difficult topics related to COVID-19.
- Within hospitals, planning for how designated palliative care beds will be used during the pandemic and ensuring optimal utilization of these beds, as well as aligning consult services to support high needs areas.
- Planning for the accommodation of patients who have severe illness due to COVID-19 and are not receiving aggressive life support. Transfer of individuals who are COVID-19 positive to other care settings may be impacted, and they may need to receive care in place (i.e. in home, acute care, LTC) if unable to be transferred to a PCU/hospice.
- On a longer-term basis, consideration of establishing alternative beds for palliative care for individuals in the community. This might include expansion of hospice beds or conversion of other beds for palliative care.
- Planning for the possibility that individuals in existing beds, e.g. PCU, hospice or at home, become COVID-19 positive or under-investigation.

Access to medications and equipment

Over the course of the pandemic it will be important to plan for the possibility of constraints on the supply chain for medications and equipment. These may be most notable in community or hospice settings.

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Some important elements of a plan will be:

- In community, hospice and LTC settings, ensuring that individuals have adequate supplies of prescribed medications. Please refer to the Government of Canada’s [Relevant exemptions to the Controlled Drugs and Substances Act](#) for clarification on activities that are currently permitted.
- In these same settings, ensuring adequate supplies of “rescue medications” that might be needed to manage a symptom crisis or to provide end-of-life care. This may involve reviewing the protocols for “symptom management kits” in community settings, in combination with regional planning efforts to ensure a balanced approach to the supply of essential medications.
- In these same settings, establishing a list of critical equipment and supply needs and ensuring adequate supplies. This may require some level of prioritization of needs.
- In hospitals, ensuring adequate supplies of medications needed to manage end-of-life care symptoms. Ensuring frontline clinicians have ready access to standard protocols for end-of-life care and guidelines for managing symptoms of those dying due to COVID-19 infection will be important (For example, refer to the OPCN’s [Symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside of the ICU](#) for a summary of synthesized recommendations on addressing the unique needs at end-of life for individuals with COVID-19.).
- At the regional level, community palliative providers and home-delivering pharmacies should establish communication mechanisms to inform providers about shortages (and resolution of shortages) so they can modify prescribing practices accordingly.
 - Regional Palliative Care Networks can play an important role in monitoring and communicating medication and equipment shortages that may arise.
- Despite efforts to mitigate medication shortages, palliative providers should be prepared to adapt to changing availabilities, and be ready to order alternative medications for common symptoms. Please refer to the OPCN’s [Strategies for Potential Shortages in Medications Relevant to Palliative Care](#) for guidance.

Managing Visitors

Given the important role that family and caregivers play as members of the palliative care team, care settings must consider the safest ways to implement a compassionate and inclusive approach to visitation policies⁵. The impact of visiting restrictions may have significant negative impacts for the surviving family members. In reviewing and updating visitation protocols and policies, the following should be considered:

- Referring to MOH/OH guidance and Public Health directives on visitation for specific settings
- Facilitating contact between patients and families while at the same time ensuring appropriate infection control procedures.
- Adopting a compassionate protocol that allows those nearing death to say goodbye to their loved ones, and follows safety measures including personal protective equipment.

⁵ Refer to the Canadian Hospice Palliative Care Association (CHPCA) and the CHPCA Champion’s Council’s [“Saying Goodbye” campaign](#) for their recommendations on implementing a compassionate approach to end-of-life visitations across Canada during the COVID-19 pandemic.

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- Ensuring grief and bereavement supports are available for those who lose a family member or loved one, especially if family presence is limited.

Psychosocial, grief and bereavement support

It can be anticipated that the need for psychosocial support for patients, their families and caregivers will increase during the pandemic, and after, due to complicated grief. Along with the usual sources of psychosocial distress, there will be heightened distress due to:

- Changing access to health care resources due to the pandemic
- Strained family care systems as a result of acute illness
- Limitations on visitation and direct contact with patients/residents who are in hospital or long term care
- Significant financial risks due to changes in the economy
- Challenges to accessing food and other supplies in instances of self-isolation
- Changes in how support is delivered, for example face-to-face or group support may not be available, or may be switched to online formats due to physical distancing guidelines

Some of the key issues in planning will be:

- Establishing a regular triage function to identify patients and family in most need of psychosocial support and ensure optimal use of those with specialized skills.
- Identifying the key clinicians with expertise in providing psychosocial care and regularly review assignments to ensure most effective use of their expertise.
- Reviewing human resource plans with a view toward reallocating some care providers to those support activities that can be accomplished with primary level competency and/or brief additional training. Refer to the OPCN's [Palliative Care Competency Framework](#), which provides a comprehensive guide of the knowledge, attributes and skills providers need to deliver high-quality palliative care in Ontario.
- Reviewing and updating visitation policies, considering the importance of contact for both patients and family while also aligning with relevant orders and directives.
- Planning for alternative approaches to support families where direct contact is not possible. This may include leveraging digital technologies to support contact among family member and alternative approaches to providing information and support to family members who are not able to enter an institution. Refer to the OPCN's [Leveraging Virtual Care to Support Palliative Care](#) for further information.
- Reviewing practices and protocols for managing care once a patient has died especially if that has occurred due to COVID-19.

Clinician safety and support

This will be a stressful time for health care providers and administrators. The pressures and stresses will come from workload, caring for a population that will have heightened anxiety, the risk of infection, reduced access to clinical consultation, pressures at home around childcare and/or financial constraints

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and others. Palliative care and frontline clinicians may feel additional pressures to advocate for appropriate and quality care in a climate where a major focus is on managing acute illness due to COVID-19. Some of the key issues in planning will be:

- Ensuring in all settings that clinicians are knowledgeable about and practice the appropriate approaches to infection control and have access to personal protective equipment.
- Ensuring that clinicians have easy access to reliable and up-to-date information about the evolving pandemic.
- Ensuring that frontline clinicians have the best possible access to clinical advice and tools.
- Ensuring that clinicians are well-informed about regional, local and institutional planning and direction within their setting of practice.
- Establishing mechanisms for community providers to connect with local facilities to ensure those providers are adequately supported, and have access to backup if needed.
- Ensuring that redeployed staff receive rapid orientations to their new setting and are aware of local resources and key contacts available to support them.
- Establishing regular opportunities for clinicians to debrief and receive support. This may be as a group but, there will need to be opportunities for one-on-one support when needed.
- Providing clinicians with access to resources for self-care.

References

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2. A Guide to Pandemic Planning for Pediatric Palliative Care. Canadian Network of Palliative Care for Children; November 2015. https://www.chpca.ca/wp-content/uploads/2019/12/caring_for_children.pdf
3. Pandemic Planning Guideline for Patients with Cancer. Cancer Care Ontario; March 10, 2020.