Mississauga Halton Palliative Care Network

Recommendations for Palliative Care Services in Hospitals, Palliative Care Units, Residential Hospice, Long Term Care, Retirement Homes and the Community

May 4, 2020

Purpose of this document
This document provides guidance to Mississauga Halton palliative care service providers (hospital, hospice, long-term care (LTC), retirement homes, community) who have been or will be called on to support the increase in patient care demands due to COVID-19. This document also describes guidelines for managing patients with suspected or confirmed COVID-19 who would benefit from palliative care services.

Background
Over the past two months, Mississauga Halton’s health care system has been managing an influx of patients affected by COVID-19. Recently, COVID-19 outbreaks in congregate settings including long-term care homes and retirement homes have been a significant concern. In this context, the usual concerns of palliative care - quality of life, support of patient goals, advance care planning, pain and symptom management, and support for caregivers over the illness trajectory have never been more important. Utilizing the unique skills and expertise of palliative care providers continues to be a critical part of Mississauga Halton’s COVID-19 response.

Guiding Principles
- Patients with palliative care needs will continue to receive quality care, despite the limitations imposed by COVID-19.
- The safety and wellbeing of patients, their families and health care workers is paramount; ensuring adequate and appropriate personal protective equipment (PPE) is essential.
- It is an ethical imperative to provide high-quality palliative care for all patients who are likely to die from COVID-19, especially given their high symptom burden (dyspnea, anxiety, etc.).
- All organizations (i.e. hospital, LTC, home care) should include plans for palliative care in their current capacity and surge planning in response to COVID-19.
- Triage discussions can be averted by clarifying goals of care with patients and substitute decision makers in advance of significant clinical deterioration.
- Reasonable efforts will be made to support patients’ wishes regarding location of care/death.
- Caregivers play a vital role in their loved ones care. A caregiver’s health and well-being must also be a priority during this time and it is important to ensure that they are supported.
- Psychosocial care for patients, families and healthcare workers is of paramount importance. To access visiting hospice support for the emotional needs of individuals, families and professionals who are facing serious illness, grief and end of life, please call the Hospice Palliative Helpline 905-667-1865 (See Appendix A)
- Professional Practice Tools and Guidelines will be used to support primary providers (i.e., ED, GIM, primary care, etc.) in the delivery of quality palliative care and transitions in care. Palliative care specialists will be engaged in the development of structures and processes to support operationalizing these tools.

RECOMMENDATIONS
Capacity Management
- System-wide capacity management will be required to support optimal patient care and flow.
- Patients with COVID-19 may move on a continuum of care that includes critical care, acute medical care and comfort care pathways. Where possible, keeping these care pathways aligned will support seamless patient flow and flexibility in care models. Note: There are potential COVID positive patients who are unable to go home and could be considered for transfer to inpatient palliation which may include a COVID-19 unit, palliative care unit, complex continuing care unit or other destinations of care.
• All regional palliative care services (hospital, palliative care unit, hospice, community) will be expected to support regional capacity and resource planning.

**Advance Care Planning and Goals of Care Conversations**

• Patients being admitted to a health care facility (hospital, residential hospice, LTC) should have a substitute decision maker (SDM) established and goals of care conversations with care plans clearly outlined and documented. If arriving without plans documented, patients will be engaged to talk about their wishes, values and goals — especially patients that are particularly vulnerable (i.e., long-term care clients, vulnerably housed, patients with significant co-morbid disease, etc.).

• Before transfers to hospital from the LTC home, retirement home or complex continuing care (CCC) sector, conversations should occur to ensure that patients or their substitute decision-makers understand COVID-19 management in these populations is supportive care. They are unlikely candidates for aggressive care, that visitors may not be allowed, and that despite understanding this, a transfer remains in line with patients’ goals of care.

• Goals of Care Conversation Guides (example provided in Appendix B) will be used in facilities to help support conversations with patients and their caregivers. This should be considered a priority in LTC, retirement home and CCC settings.

**Locations of Care**

• Hospitals will identify patients in need of palliative care, with special attention to those patients with COVID-19 and those patients under the care of general internal medicine (GIM)/hospitalists, emergency medicine (EM) and critical care services.

• Where patients are transitioning from one care setting to another, notification will be issued by the referring team about suspected, pending under investigation or confirmed COVID-19 status.

• Patients should be engaged regarding their wishes with respect to location of care/death and providers must make reasonable efforts to support these requests, while also considering the safety of patients, their families, health care providers and the public.

• Strategies and resources should be developed to connect patients with their loved ones virtually if in-person visits are restricted, and to provide psychosocial and spiritual support to patients and their loved ones, including for grief and bereavement (See Appendix A & E).

1. **Hospital Palliative Care Services (Inpatient and Ambulatory Consultatory models)**

   o Hospitals should develop a strategy to support and integrate palliative care approaches into the GIM, ED and critical care models developed as part of their institutional COVID-19 planning

   o Hospital teams should regularly review patient lists to identify those that should be transitioned to a palliative care unit, residential hospice, or home with support.

   o Each hospital should decide on an approach to support patients with COVID-19 who require palliative and end of life care. If feasible, patients requiring palliative care should be located on designated wards or areas within wards to better utilize palliative care expertise and facilitate education and upskilling of clinicians. Palliative care support should be integrated within these designated areas, while still being available to other areas of the hospital.

   o Hospitals will identify all clinicians with palliative care expertise who can be leveraged to provide support and facilitate redeployment and training of additional clinicians who could provide further manpower in case of a surge of patients in need of palliative care.

   o Hospital based palliative care services that do not already support continuity of care in the community will support their discharged and ambulatory clinic patients at home in partnership with Home and Community Palliative Care (as required) unless an appropriate transfer of care to another provider can be facilitated (i.e. primary care, palliative care specialist, home visiting team, etc.). If in line with patient goals and wishes, this may require the management of clinical deterioration and possible death in the home.

   o Palliative care education and training for staff caring for dying patients is available via online resources (Appendix D).
2. Palliative Care Units (PCU) and Residential Hospice
   o Current PCU and residential hospice patient rosters and future admissions should be reviewed to determine whether patients could be supported at home, if this is the desired location of care for the patient/family. Discharges should be facilitated in partnership with home and community palliative care services.
   o PCUs and retirement homes should plan for the likelihood that they will have to manage the care of a patients that is/becomes suspected or confirmed COVID-19 positive, and develop appropriate procedures and protocols to protect patients, their families, health care workers and the public.
   o Designated palliative care (PCU, CCC, etc.) bed placement should be prioritized to those acutely dying or those requiring acute or complex symptom management. If system demands and waitlist dictates, PCU beds may be allocated to best ameliorate system stresses. This would be done via a centralized bed review process to ensure timely PCU bed admissions and apply core principles such as equity to bed offers.
   o Negative swab for COVID-19 is recommended prior to admission to residential hospice.

3. Long-term Care (LTC)
   o LTC homes should document and outline residents’ wishes and care plans and have these documents readily available should a transfer be required (see example Appendix B).
   o Residents with decision-making capacity or their substitute decision-makers should be informed of the risk of a COVID-19 infection, that current treatment of COVID-19 is supportive, and that their prognosis would be very poor even with aggressive treatment. Considering this, all residents or their substitute decision-makers should be asked about their care preferences to inform a care plan that should be documented in the patient chart.
   o Residents, families, and substitute decision makers should be informed that, even if they express a wish for hospitalization and intensive care in the case of COVID-19 infection, this wish may not ultimately be put into practice if there is a lack of medical indication, or if triaging of care occurs, particularly in a situation of rationing of scarce resources.
   o LTC homes should support patients with appropriate symptom management and end of life care. For educational and symptom management resources, see Appendix B and C.
   o Virtual access to palliative care expertise should be a priority and may be achieved via existing mechanisms, partnerships and structures in development such as the Virtual in the LTC program.
   o All sectors should support psychosocial and grief and bereavement services for those families that have a loved one who is seriously ill or dies due to COVID-19 within LTC.

4. Palliative Care in the Home
   o All providers should discuss advance care plans with their patients who may be particularly vulnerable to infection with and adverse outcomes from COVID-19 (e.g. older patients or those with multiple comorbidities), and should make reasonable efforts to organize and/or provide care for patients with COVID-19 who require palliative care in the community.
   o Providers should document and outline patients’ wishes and care plans and have these documents readily available should a transfer be required (see example Appendix B).
   o If it is in line with their wishes, patient with palliative care needs should be supported at home in partnership with Home and Community Palliative Care (as required). This may require the management of clinical deterioration and possible death in the home.
   o Primary providers should have virtual access to education resources and consultative palliative care expertise to support patients who require palliative care at home.

Home and Community Palliative Care (H&CC) and Visiting Hospice Care
   - H&CC will maximize the use of virtual visits and improve integration within the care team.
   - H&CC will advance communication pathways with homebound visiting primary care physicians and palliative care physicians in community to ensure rapid identification of patients in need of integrated care and support to remain at home.
Where appropriate, H&CC will support patients and caregivers with education and teaching for established procedures to minimize the need for nursing, rehabilitation therapies and personal support worker (PSW) visits in the home and ensuring adequate equipment and supplies in the home.

H&CC will continue to monitor supply of palliative care medications, equipment and supplies and health human resource capacity issues, communicate significant risks with partners and collaborate on mitigation strategies.

Visiting hospice responds to the emotional needs of people who are facing serious illness and end of life through support for community partners, support for individuals living with palliative illnesses (including COVID-19) and support for bereaved family members.

Health Care Providers/Non-specialist Palliative Care Providers:

- Healthcare facilities will identify all clinicians with palliative care expertise who can be leveraged to provide support and will facilitate redeployment and training of additional clinicians who could provide further manpower in case of a surge of patients in need of palliative care.
- Front line care providers will be required to support symptom management and end of life care for patients with COVID-19. See Appendix C and D for an education resources and symptom management order sets for non-palliative care clinicians.
- Health care providers will help facilitate virtual access to spiritual care supports, where needed.

Supplies, equipment and medications:

- All pharmacological measures must be adapted to the possibilities of the care setting in question.
- Prescriptions should be made in advance for the problems expected to arise and documented in an emergency plan.
- Drugs and the equipment required for their administration must be available at the site where care is to be provided.
- Order sets should be used to enable optimal care. See Appendix C.
- Effort should be made to ensure ready access to all medications used in regional symptom management kits and algorithms (i.e. iv/sc preparations of morphine and hydromorphone for dyspnea management, antipsychotics such as methotrimeprazine for sedation). This will include the equipment needed to provide these medications such as supplies, and CADD pumps. **NOTE: Methotrimeprazine is currently on back order in the community.**
- Health care organizations will ensure appropriate PPE is available to health care workers providing palliative care. PPE conservation strategies should be deployed to ensure sustainability of PPE supplies.

Approved by: Co-Chairs:
Mississauga Halton Palliative Care Network Operational Leadership Katherine Davison Dr. Laura Harild Committee

N.B. Please note that this document is only providing guidance and/or recommendations to support individual planning for hospitals and other sectors within Mississauga-Halton. This document does not constitute provincial decisions, directions or guidance.

NOTE: This document has been adapted from the Toronto Region COVID-19 Hospital Operations Table Recommendations for Palliative Care Services in Hospitals, Palliative Care Units, Residential Hospice, Long Term Care and the Community.
Resources
Tools and additional resources around conversation guides, symptom management and system planning during COVID-19 are available at: http://www.mhpcn.net/
Appendix A: Hospice Palliative Helpline

Hospice Palliative Helpline  905-667-1865

**Who Should Call:**
- Front line staff supporting residents who are palliative or diagnosed with COVID-19
- Residents living with a palliative illness or diagnosed with COVID-19
- Family members of a loved one who is palliative or diagnosed with COVID-19
- Family members/friends who have experienced the death of a loved one

**How We Can Help:**
- Confidential counselling and emotional support by phone or video conference
- Listen, answer questions, and provide/share resources
- Facilitate conversations about the goals and plan of care for end of life
- Address challenges and support emotional well being
- Support, information and education about grief, and spiritual distress

**When You Call:**
- You will be connected with a person/answering service
- You will be asked to provide your name, phone number and the city where you/your loved one reside
- A hospice counsellor will call you back within the arranged time

Hospice is here to support the emotional needs of individuals, families and professionals who are facing serious illness, grief and end of life. We are here to support, listen and care for you. Please reach out. 905-667-1865
## Person-Centred Decision-Making: Documenting Goals of Care Discussions

**Goals of Care** (GOC) discussions occur in the context of a serious illness and there are treatment or care decisions that need to be made. The aim is to align available treatment and care options with the patient’s goals and values. If there are no current decisions, please see Advance Care Planning resources on the back of this document.

### 1. Reason for the GOC Discussion?

- Treatment or care decisions to make
- Admission/Transfer to a new facility
- Code status discussion
- Follow up from previous GOC discussions
- Information sharing
- Other ___________

### 2. Any concerns about patient’s ability to participate in the discussion?

- Yes ☐  No ☐

  **If Yes:**
  - Document concerns if patient is mentally incapable to make decision
    - Engage SDM (patient may still be involved in discussion)
    - For specific treatments, obtain consent from capable patient or SDM
    - See below for SDM Hierarchy and resources
    - Address language or communication barriers

### 3. Document the GOC Discussion

<table>
<thead>
<tr>
<th>Assess understanding:</th>
<th>Explore and listen</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Tell me in your own words what is happening with your health?”</td>
<td></td>
</tr>
<tr>
<td>“What is your understanding of where things are with your illness”</td>
<td></td>
</tr>
</tbody>
</table>

**Inform:**  Ask permission

- “I need to give you some information that is important to the decisions you need to make, is that ok?”
- “What other information would be helpful to you?”

**Goals & Values:**  Ask gently:

- “What are you hoping to achieve?”
- “What are your most important goals?”
- “What are your biggest fears and worries about the future?”
- “How much does your family know about your goals and priorities?”

**Make a Plan:**  Based on goals and values

- Recommend treatments based on patient goals (or, explain why goals are not achievable)
- Acquire further input from specialists?
- Organize further meeting?

**Document answers in patient’s/SDM’s words**

- (e.g. “I know my heart is weak, but I get better each time I come to hospital...”)
- (e.g. “I don’t know what is wrong...”)
- (e.g. “I know I am sick, and I don’t know what to expect”)

**Document information you provided to patient/SDM**

- (e.g. patient wishes to hear all information. We discussed the benefits and risks of further treatment – he understands that treatment may prolong his life for weeks to months and that the risks are...)

**Document next steps**

- (e.g. we will arrange a team meeting with all specialists to discuss possible next steps, we will obtain consent to do a trial of antibiotics and reassess in 3 days; “determined no sole for dialysis”)
Person-Centred Decision-Making:
Documenting Goals of Care Discussions

4. Specific Treatment and Care Preferences

Attempts at Resuscitation in the event of cardio-pulmonary arrest:

Many institutions have specific CPR order sets for documentation. Please use those to document orders. This list is a guide for discussion of preferences and may be used by institutions without specific order sets to create orders.

☐ Full Cardiopulmonary Resuscitation (CPR/Intubation/ICU transfer)
☐ Modified resuscitation for respiratory distress: Intubation and mechanical ventilation only NO CPR
☐ Allow natural death

For Long Term Care, Complex Continuing Care or Rehabilitation:
Prefer to remain in current facility or for transfer to acute care

☐ Transfer to Acute Care
☐ No transfer to Acute Care

*Use this to start a discussion about treatment options available at each facility. Every situation will be different, and a discussion is required before transfer.

Preferred place of death (if known and appropriate):

Not all options are available in every location (preference is not always possible and decisions may change as illness progresses)

☐ Home
☐ Hospice / Palliative Care Unit
☐ Long Term Care (includes nursing and residential facilities and Complex Continuing Care)
☐ Hospital – acute care facility

Discussion occurred with:

☐ Patient:

☐ SDM(s) [specify name(s) & relationship]: ...........................................................................................................................................................................

- Attach power of attorney document if applicable
- Others present for discussion: .............................................................................................................................................................................

Signed by: (Health Care Provider)

Print Name: ........................................................................................................

Signature: ................................................................................................................

Professional designation: ......................................................................................

Date: .....................................................................................................................

[Diagram showing SDMs and their relationships, including Legally Appointed SDMs, Automatically Appointed SDMs, and Public Guardian and Trustee]

Ontario’s Health Care Consent Act, 1996
### Appendix C: Symptom Management

To access more examples of symptom management kits or order sets for specific sectors and patient populations go to:  
[http://www.mhcpn.net/](http://www.mhcpn.net/)

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain</strong></td>
<td>If opioid naïve&lt;br&gt;&lt;br&gt;<code>Start with oral tabs if able to swallow:&lt;br&gt;HM 0.25-0.5mg po q1-2hrs PRN or Morphine 2.5-5mg po q 1-2hrs PRN. Consider scheduled dosing and PRN dosing. Oral liquid formulation also available for Morphine and HM in 1mg/ml concentration. If not able to swallow:&lt;br&gt;Hydromorphone 0.2mg - 0.5mg SC q1h PRN or Morphine 1-2.5 mg SC q 1hr PRN (if renal function normal).</code></td>
</tr>
<tr>
<td><strong>Dyspnea</strong></td>
<td>Opioid as above – 1st line to manage dyspnea&lt;br&gt;&lt;br&gt;If pt able to swallow start with oral dose of HM 0.25-0.5mg po q1-2hrs PRN or Morphine 2.5-5mg po q 1-2hrs PRN. Consider scheduled dosing and PRN dosing. Oral liquid formulation also available for Morphine and HM in 1mg/ml concentration. Can titrate to long acting formulation if able to swallow based on 24 hr use.&lt;br&gt;&lt;br&gt;If dyspnea moderate to severe switch to subq formation Hydromorphone 0.2mg - 0.5mg SC q1h PRN or Morphine 1-2.5 mg SC q 1hr PRN . Based on 24-48 use could consider a PCA pump.&lt;br&gt;&lt;br&gt;For refractory dyspnea not managed with opioids then consider:&lt;br&gt;&lt;br&gt;Midazolam 1-2 mg SC q1h PRN – when goal is temporary sedation. If after 3-4 doses not effective, reassess.&lt;br&gt;&lt;br&gt;Nozinan as 4th line can be considered. Starting dose of 12.5-25mg subq q4-6hrs PRN. <strong>(Consider only if patient does not have meaningful awake time; these medication are typically sedating)</strong></td>
</tr>
<tr>
<td><strong>Fever/Headache/Pain</strong></td>
<td>Acetaminophen 500-1000mg PO q4h PRN (max 4g per 24hrs) OR 650mg PR q4h PRN (max 4g per 24hrs)</td>
</tr>
<tr>
<td><strong>TERMINAL Secretions</strong></td>
<td>Glycopyrrolate 0.4 SC q4h PRN&lt;br&gt;Or Scopolamine 0.4 mg. sc q4h prn</td>
</tr>
<tr>
<td><strong>Advise family &amp; bedside staff:</strong></td>
<td>not usually uncomfortable,</td>
</tr>
</tbody>
</table>
just noisy, due to patient weakness / not able to clear secretions.  
scopolamine patches also available OTC if subq doses not available.  
Buscopan 10-20 mg sub cut Q 4 hr prn.

| Nausea / Vomiting | Haloperidol 0.5-1mg PO/SC q4h prn OR  
| | Metoclopramide 5mg - 10mg PO/SC q6h PRN  
| | * If able to swallow start with orals to conserve and save subq doses unless needed.  
| | OR  
| | Olanzapine Zydis 2.5mg- 5mg PO/SL q6h PRN  
| | Other option available but does not have coverage:  
| | Zofran 4-8mg po/SL q 6-8hrs PRN |

| Delirium (Restlessness/Agitation/Restlessness/Calling Out) | Haldol:  
| Mild Delirium: 0.5mg – 1 mg. sc q 4hr PRN  
| Moderate/Severe Delirium/Agitation: 2 mg sc q1hr PRN to a max of 3 doses for control, then 2mg sc q 4hr PRN for maintenance.  
| Methotrimeprazine:  
| (Nozinan) 6.25-12.5mg SC q4h standing until controlled then (consider if patient does not have meaningful awake time; this medication is typically sedating) then  
| Methotrimeprazine 6.25-12.5mg SC q4-6h PRN  
| Moderate/Severe Delirium/Agitation:  
| Methotrimeprazine 12.5-25mg SC q4-6h PRN  
| Olanzapine 2.5-5mg SL/SC q12h PRN  
| Midazolam 2 – 5 mg SC q1h PRN 3rd line or severe acute distress – when goal is temporary sedation |

| Mouth and Eye care | Isopto tears 1% 1-2 drops each eye q4h PRN  
| | Moistir spray/gel BID to mouth + q4h PRN  
| | Biotene Oral spray/gel/mouthwash available OTC |

| Bowel Regimen | Bisacodyl 10mg PR daily PRN (give if no BM x3 days) OR  
| | Senna 1-2 tabs po BID PRN OR  
| | Lactulose 30cc po od PRN |

| Pulmonary Edema | Lasix 20mg sc q 2-4hr PRN for SOB. Only for symptoms of Congestive heart failure (pulmonary edema) – must have some preserved renal function to be effective |
Appendix D: Educational Resources

To access more educational resources, including A Primer in Palliative Care go to:
http://www.mhpcn.net/

Free online access to essential education on palliative care for all health care professionals at Pallium:
https://www.pallium.ca/

Free access to Hospice Palliative Care Ontario’s Health Care Consent Advance Care Planning and Goals of Care E-Learning modules.

Mississauga Halton Palliative Care Network’s Academic Detailing: The Palliative Approach to Care in the Mississauga Halton LHIN. - http://www.mhpcn.net/

Southwestern Ontario Hospice Palliative Care Education Program: The Fundamentals of Hospice Palliative Care Modules
http://www.palliativecareswo-fundamentals.ca/

RNAO End-of-life Care During the Last Days and Hours – Best Practice Guideline
https://rnao.ca/sites/rnao-ca/files/End-of-Life_Care_During_the_Last_Days_and_Hours_0.pdf

Appendix E: Psychosocial & Bereavement Supports

The Dorothy Ley Hospice (Etobicoke) - https://www.dlhospice.org/ - 416-626-0116 x233
Heart House Hospice (Mississauga) - https://hearthousehospice.com/ - 905-712-8119 x241
Acclaim Health (Halton Hills, Milton or Oakville) - https://acclaimhealth.ca/ - 905-827-8800 x2312
Mygrief.ca - Canadian Virtual Hospice.

Supports people in understanding and working through grief.
- Confidential
- Access in the privacy of your own home
- Developed by families and grief experts
- Stories from people who have "been there"
- A resource for professionals

Searchable list of regional mental health services: https://www.ementalhealth.ca/