TriService Nursing Research Program

COVID-19 Palliative Care Toolkit

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Learning Objectives

At the end of the activity, the learners will be able to:

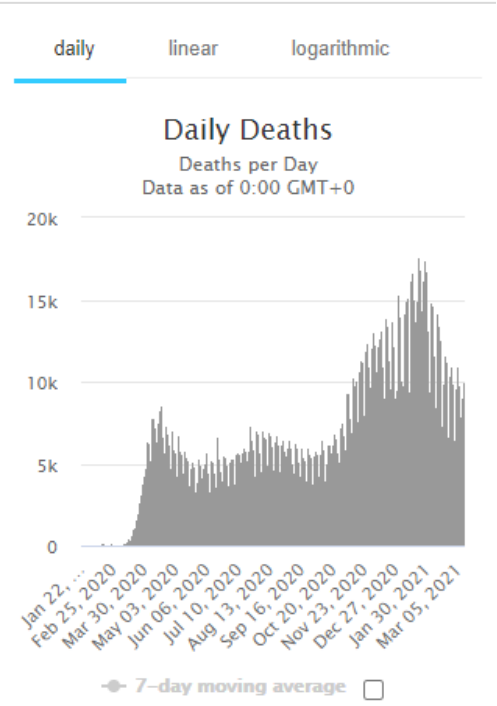
1. Define the need for and importance of basic palliative care for hospitalized inpatients during the COVID-19 pandemic.

2. List three central themes derived from the COVID-19 palliative care scientific literature synthesis.

3. Summarize the purpose for development and implementation of a COVID-19 palliative care toolkit.

COVID-19 Palliative Care Toolkit Background

- Early uncertainty of COVID-19 clinical impact on MTFs
- Travis AFB one of the earliest to be impacted mid March 2020
- Working on a rapid evidence-review for Crisis Standards of Care (CSC) the mortality rates in Italy were unprecedented
- FEMA DSCA COVID-19 military deployer feedback (NY)
  - Staff unprepared for volume of death/dying
  - Crisis standards of care



COVID-19 Palliative Care Toolkit Background

- Bridge gap with limited MHS resources
- MHS current Palliative Care Departments
  - Madigan Army Medical Center
  - Brooke Army Medical Center
  - Walter Reed National Military Medical Center
- TriService Nursing Research Program

  Evidence-based Practice (EBP) Mini-grant $9K
  - Toolkit development + 10 iPads/stands/cases

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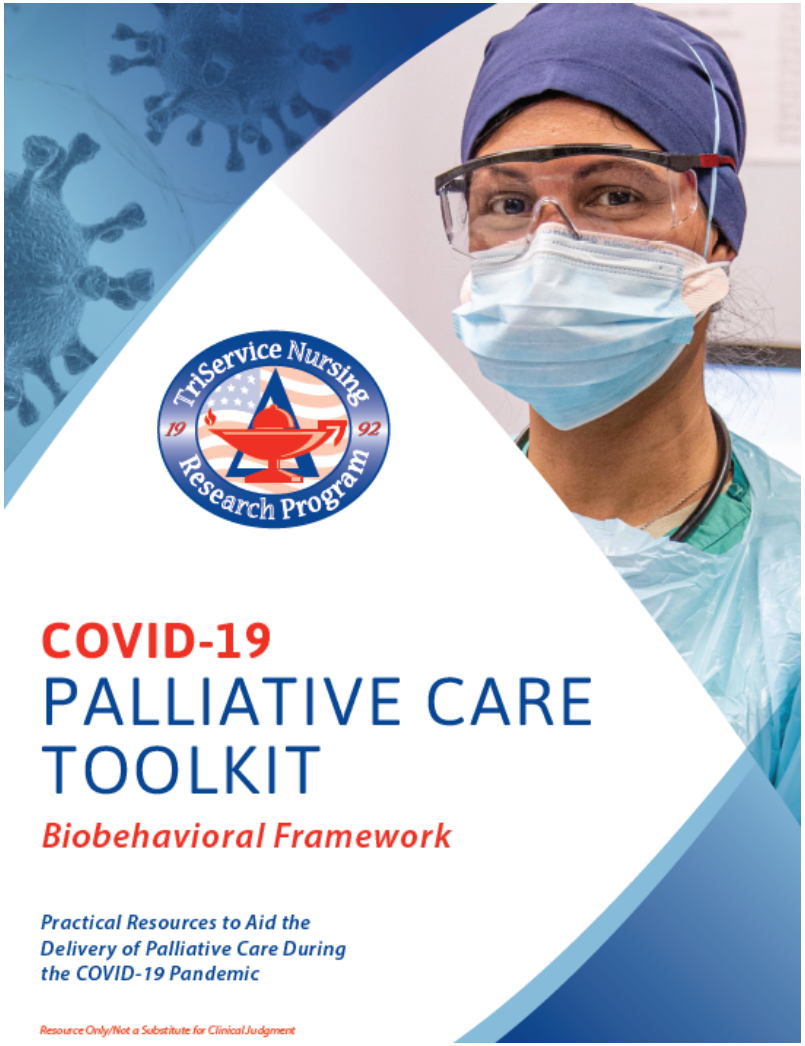
COVID-19 Palliative Care Toolkit Purpose

- Prepare/support frontline workers
- Unique COVID-19 palliative care challenges
  - Physical and social isolation
  - Limited access to in-person support (family, chaplains, social work, etc.)
  - Unpredictable rapid change of patient's clinical course
  - Complex decision-making conversations related to unanticipated death



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Literature Search: Show Me The Evidence!

PICOT

Population - Facilities caring for COVID-19 patients

Intervention - Palliative Care Team

Comparison - No Palliative Care Team

Outcomes - Management of COVID-specific care challenges

Time - During the COVID pandemic

In facilities caring for COVID-19 patients, how does having a palliative care team vs. having no palliative care team affect the management of COVID-specific care challenges?

Results: Evidence Review & Synthesis

- 17 publications were included for palliative care
- 9 publications included for iPad communication use
- Evidence ranged from Level V-VII
- 6 central themes and high demand, high priority, high impact education needs and resources were identified

6 Central Themes and Needs

1. Critical need for frontline/primary care staff to have rapid palliative care training

2. Use existing palliative care specialists as consultants and subject matter experts

3. Primary education and training focuses:

a) Immediate need to address goals of care

b) Hard conversations

c) Symptom management

d) Communication (clear, direct, transparent)

e) Mitigate social isolation through virtual/online/video calls

f) Holistic approach body, mind, spiritual, social needs

6 Central Themes and Needs

4. Support for caregivers (family members, staff)

5. Framework of stuff, staff, space, systems, separation

6. Need for quick use standardized resources (order sets, protocols, and guidelines)

COVID-19 Palliative Care Toolkit
Evidence Table

Defense Health Agency

EVIDENCE TABLE

Level of Evidence	Reference	Summary
VI	Arya, A., Buchman, S., Gagnon, B., & Downar, J. (2020). Pandemic palliative care: Beyond ventilators and saving lives. *CMAJ, 2020,* 1-5. doi: 10.1503/cmaj.299465	Reviews palliative care plan for equitable and compassionate care during a pandemic. **Requires**: -**Stuff**; medication "symptom management kit" -**Staff;** educate frontline staff on palliative care and have experts available -**Space**; identify designated spaces for palliative care -**Systems**; triage for palliative care/institute telemedicine, standardized order sets -**Sedation** -**Separation**; video calling, provide patients with laptop, phone to stay connected -**Communication**; review treatment plans based on wishes/likelihood of survival-example script provided -Equity
VII	Chidiac, C., Feuer, D., Naismith, J., Flatley, M., & Preston, N. (2020). Emergency palliative care planning and support in a COVID-*19* pandemic. *Journal of Palliative Medicine, 23 (*6), 1-2. doi: 10.1089/jpm.2020.0195	**London** ED expert opinion on required elements for COVID-19 management. Education to generalist staff on palliative care; how to have hard conversations, symptom management. Create system with expedited discharge process to get patients back into the community. Need frequent community communication and collaboration, especially regarding resources (medications). Develop and share guidance for COVID-19 symptom management. (**Sample community order set provided**). Supporting caregivers and assisting patients/family connections. Empower family to care for patient at home with supportive community palliative care resources, when possible.
VII	Curtis, J. R., Kross, E. K., & Stapleton, R. D. (2020). The importance of addressing advance care planning and decisions about do-not-resuscitate orders during novel coronavirus 2019 (COVID-19). *Jama*.	It is important to understand the patient's values and goals prior to discussing code status especially during a pandemic. 1. Patients can avoid intensive life-sustaining treatments unwanted by patients. 2. Avoiding nonbeneficial, or, unwanted, intensive care can save limited resources and eliminate burden on healthcare workers. 3. More patients and staff will be expose to COVID-19. To avoid this from happening the author recommends early discussion regarding patient's goals and values. Author also propose a framework for informed assent.
V	Etkind, S. N., Bone, A. E., Lovell, N., Cripps, R. L., Harding, R., Higginson, I. J., & Sleeman, K. E.	From multiple settings, acute care to community care. Across countries and pandemics. n=10 observational studies from 2004-2020. - **Systems**; hospice/palliative care protocols & training staff on symptom management, psychological support & bereavement counselling. Need for technology infrastructure for family support via phone.

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COVID-19 Palliative Care Toolkit Evidence Table

Level of Evidence	Reference	Summary
V	Etkind, S. N., Bone, A. E., Lovell, N., Cripps, R. L., Harding, R., Higginson, I. J., & Sleeman, K. E. (2020). The role and responses of palliative care and hospice services in epidemics and pandemics: A rapid review to inform practice during the COVID-19 pandemic. *Journal of Pain and Symptom Management*, S0885-3924 (20). doi:10.1016/jpainsymman.2020.03.029	From multiple settings, acute care to community care. Across countries and pandemics. n=10 observational studies from 2004-2020. - **Systems**; hospice/palliative care protocols & training staff on symptom management, psychological support & bereavement counselling. Need for technology infrastructure for family support via phone. -**Staff**; sufficient #, involving spiritual care/chaplain/palliative care experts. Implement measures to help healthcare worker stress. -**Space**; Consider shifting resources from inpatient to community, setup community centers -**Stuff;** PPE, medications for COVID-19 symptom management—cough, breathlessness, fever, pain, delirium, anxiety.
VI	Fausto, J., Hirano, L., Lam, D., Mehta, A., Mills, B., Owens, D., Curtis, J. R. (2020). Creating a Palliative Care Inpatient Response Plan for COVID-19—The UW Medicine Experience. *Journal of Pain and Symptom Management*. doi: 10.1016/j.jpainsymman.2020.03.025	The article shared their palliative care response plan for COVID-19 pandemic that incorporates conventional, contingency, and crisis capacity. There are multiple limitations on their strategy: 1.) This response plan hasn't been implemented. 2.) It may not be replicable since not all facilities have a palliative care team. 3.) It may not work for other facilities with no palliative care team and limited resources. Recommendations for Covid-19: • Palliative care specialist will serve as consultants and support for inpatient providers • Train and coach staffing for crucial conversations • Encourage phone / video consultation to conserve PPE and limit exposure to COVID-19
VII	Ferguson, L., & Barham, D. (2020). Palliative Care Pandemic Pack: a Specialist Palliative Care Service response to planning the COVID-19 pandemic. *Journal of Pain and Symptom Management*	New Zealand -The demand for palliative care will exceed availability of specialists -Primary care staff will need to provide palliative care to COVID patients -A **Palliative Care Pandemic Pack** was developed to guide nonpalliative care clinicians (7 documents) 1. Dyspnea management 2. Respiratory secretion management 3. Delirium management 4. Pre-existing renal failure management 5. Considerations for SNF/ALF residents 6. Primary Care Provider guide 7. Hospital wards/Regional Hospitals -There is limited information on the role of palliative care specialists in COVID crisis; the tool was a starting point to empower and enable primary care to develop similar resources in their own communities.

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COVID-19 Palliative Care Toolkit Evidence Table

Level of Evidence	Reference	Summary
VII	Fusi-Schmidhauser, T., Preston, N. J., Keller, N., & Gamondi, C. (2020). Conservative Management of COVID-19 Patients—Emergency Palliative Care in Action. *Journal of Pain and Symptom Management*	**Switzerland and UK** -Non palliative care healthcare personnel required to care for stable, unstable, and end-of-life patients triaged as not suitable for mechanical ventilation -A **COVID-19 specific assessment tool was developed** (3D-Ticino 2019-mCov Score) to quickly assess and identify key symptoms (i.e. dyspnea, distress, and pain) for use in emergency setting when time is limited due to number of patients and risk for infection (concise quick assessment guide) -Provides medication guidelines based on limited resources (competition with critical care for same types of drugs) -WHO early warning score used to determine unstable -Need for clear and concise treatment plan and rapid decision making at forefront (ED)
VII	Hendin, A., La Riviere, C. G., Williscroft, D. M., O'Connor, E., Hughes, J., & Fischer, L. M. (2020). End-of-life care in the Emergency Department for the patient imminently dying of a highly transmissible acute respiratory infection (such as COVID-19). *CJEM*, 2020 Mar 26, 1-4. doi:10.1017/cem.2020.352	Stress the importance of reviewing patients' goal of care (GOC) early in ED. Provides nonpharmacologic care considerations and pharmacologic symptom management order set taking into consideration COVID-19 risks, such as avoiding anything that aerosolizes. Debriefs should occur with ED staff with heighten risk of compassion fatigue/burnout.
VII	Koh, M. Y. (2020). Palliative Care in the time of COVID-19: Reflections from the frontline. *Journal of Pain and Symptom Management*	**Singapore** -Confirms COVID patient fears/questions similar to all other palliative care patients but under unique circumstances of isolation, no visitors, virtual social connection --Stressed negative impact on staff, decreased team supports, degradation to resilience, burnout, peer support -Although the hospital had a palliative care team it was dismantled and staff redirected to ICU and direct care roles outside of palliative care -Affirms the need for holistic care, symptom care, psychological support, comfort/encouragement --patients crying alone in rooms Experience in 1800 bed hospital with 13 acute palliative care beds -Palliative care staff was re-assigned to ICU, internal medicine, -Makes statement for need of holistic care as provided by palliative care specialist and difficulty during a pandemic to maintain palliative care

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COVID-19 Palliative Care Toolkit Evidence Table

Level of Evidence	Reference	Summary
VI	Lovell, N., Maddocks, M., Etkind, S. N., Taylor, K., Carey, I., Vora, V., ┼. & Sleeman, K. E. (2020). Characteristics, symptom management and outcomes of 101 patients with COVID-19 referred for hospital palliative care. *Journal of Pain and Symptom Management*	UK -Palliative Care is an essential part of COVID response -Research needed to characterize COVID symptoms and palliative management (community and ICU) -Most frequently referred for end-of-life and symptom control (most died within 3 days of referral to in hospital palliative care services) -Most common symptoms dyspnea, agitation, drowsiness, pain, and delirium -Approximately 50% prescribed SQ opioid infusions (deemed effective to treat dyspnea and pain) -Need SQ infusion pumps -Need international palliative care data set to evaluate best management and symptom frequency -Need proactive training and education for non-experts in palliative care (to meet need with COVID) -Social Workers, Chaplains, and Psychologists support deemed valuable
VII	Pattison, N. (2020). End-of-life decisions and care in the midst of a global coronavirus (COVID-19) pandemic. *Intensive & Critical Care Nursing*, *58*, 102862.	UK -References UK National COVID-19 Rapid Guidance for Critical Care (different standards than U.S.) -Discusses palliative pandemic plan 2010 w/four key focuses: **stuff** (meds, PPE); **staff** (maximizing palliative care education/protocols/guidelines); **space** (extending palliative care beyond ICU); **systems** (advanced directives, consultation support) -Special focus on bereavement support for staff and families
VII	Powell, V.D., & Silveira ,M.J. (2020). What Should Palliative Care's Response Be to the Covid-19 Pandemic? *Journal of Pain and Symptom Management.* doi.org/10.1016/j.jpainsymman.2020.03.013	The letter stated that there is a shortage of palliative team and their capacity is limited. In order to protect and preserve their limited resources, the author listed some recommendations. 1. Palliative care specialist will perform consults over the phone to avoid exposure to COVID. 2. Palliative care specialist will act as a support/coach for the primary physician and the palliative care specialist will only perform and face to face consult if the primary physician is inadequate. 3. Author also recommends, "having talking points at the ready for needs that are likely to arise in the care of COVID-19 patients; such as management of cough, secretions, and shortness of breath; communication of triaging decisions; and management of family grief. 4. Discourage existing palliative care and hospice patients from coming in the hospital. Strongly recommend that palliative care teams not participate in the crafting of guidelines to ration care or in clinical decision making about the value of life-sustaining therapies for individuals in order to remain neutral.

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COVID-19 Palliative Care Toolkit Evidence Table

Level of Evidence	Reference	Summary
VII	Radbruch, L., Knaul, F. M., de Lima, L., de Joncheere, C., & Bhadelia, A. (2020). The key role of palliative care in response to the COVID-19 tsunami of suffering. *The Lancet*	International focus -Immediate responsiveness to adapt to pandemic parameters -Panel strategies -Optimize cooperation and coordination -Preserve continuity of care: adequate PPE; supply of opioids; rapid COVID palliative care training for all personnel; telehealth; virtual family visits -Enhance social support; community and faith-based virtual connections -Assess emerging needs; epidemiologic surveillance - Long-term preparedness strategies that embed palliative care into the core of Medicine -Include core palliative care competencies in medical/nursing/social work/clergy curriculum -Establish standard and resource-stratified palliative care guidelines specific to phases of pandemic
VI	Ryan, P., Quinn, E., & Leen, B. Evidence summary: What are the palliative care considerations for COVID-19 patients at end-of-life? *Lenus*	Palliative care is an essential component of healthcare in pandemics, contributing to symptom control, psychological support, and supporting triage and complex decision making. The importance of delivering effective palliative care as the COVID-19 epidemic unfolds is becoming more and more recognized. While it is common to restrict the view of palliative care to the needs of patients who will not recover from the virus, palliative care also seeks to support the physical, social, psychological and spiritual needs of patients and their close ones, across the whole trajectory of illness. Concerns included scarcity of personal protective equipment, a lack of hospice-specific guidance on COVID-19, anxiety about needing to care for children and other relatives, and poor integration of palliative care in the acute setting. Clinicians have responsibilities to institute best practice palliative care for all patients. Severe illness with an uncertain outcome and end-of-life situations call for good palliative care for the patients concerned. The Association for Geriatric Palliative Medicine (FGPG) promotes the integration of a palliative care approach and skills into the care of elderly and very elderly people – both in the inpatient setting and at home.
VI	Sun, H., Lee, J., Meyer, B. J., Myers, E. L., & Blinderman, C. D. (2020). Characteristics and palliative care need of COVID-19 patients receiving comfort-directed care. *JAGS 00,* 1-3. doi: 10.1111/jgs.16507	8 bed palliative care unit developed at University Irving Medical Center/New York-Presbyterian Hospital. Data on deceased patients from 31Mar-10Apr 2020. n=30. Mean age 84.5 years, all with comorbidities prior to admission. All with ARDS. Dyspnea (100%), delirium (73%), pain (33%), and anxiety (33%) most common symptoms. 62 visits/calls from chaplain and social workers for spiritual, psychosocial support. Average LOS 1.4 days. Morphine, hydromorphone, and lorazepam most common medications utilized

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COVID-19 Palliative Care Toolkit Evidence Table

Level of Evidence	Reference	Summary
VI	Wallace, C. L., Wladkowski, S. P., Gibson, A., & White, P. (2020). Grief during the COVID-19 pandemic: considerations for palliative care providers. *Journal of Pain and Symptom Management*	United States -Review of grief associated with pandemic: anticipatory, disenfranchised, complicated -Identifies unique COVID circumstances --losses (financial, social, physical, autonomy, health, life) --patients have limited/no visitors, denied opportunities to say goodbye, funeral/rituals --social isolation/and lack of physical presence are associated with long term complicated grief -Mitigating grief through communication, advanced care planning, and self-care -Resources are listed for each mitigation strategy in **Table 1 (excellent table)**
VII	Wang, S., Teo, W., Teo, W., & Chai, Y. W. (2020). Virtual Reality as a Bridge Care during COVI *of palliative medic* 10.1089/jpm.2020. online publication. https://doi.org/10.1 0212	-Identify psychological impact of lack of closure/rapid deterioration: grief, depression, guilt for lack of presence -Virtual reality (VR) can simulate physical locations and allow bucket list experiences; record last lucid moments

EVIDENCE SYNTHESIS

Central themes and **high demand, high priority, high impact education needs and resources** were identified from our literature synthesis as noted below.

1. Critical need for frontline/primary care staff to have rapid palliative care training
2. Use existing palliative care specialists as consultants and subject matter experts
3. Primary education and training focuses:
    a) Immediate need to address goals of care
    b) Hard conversations
    c) Symptom management
    d) Communication ie clear, direct, transparent
    e) Mitigate social isolation through virtual/online/video calls
    f) Holistic approach body, mind, spiritual, social needs
4. Support for caregivers (family members, staff)
5. Framework of stuff, staff, space, systems, separation
6. Need for quick use standardized resources (order sets, protocols, and guidelines)

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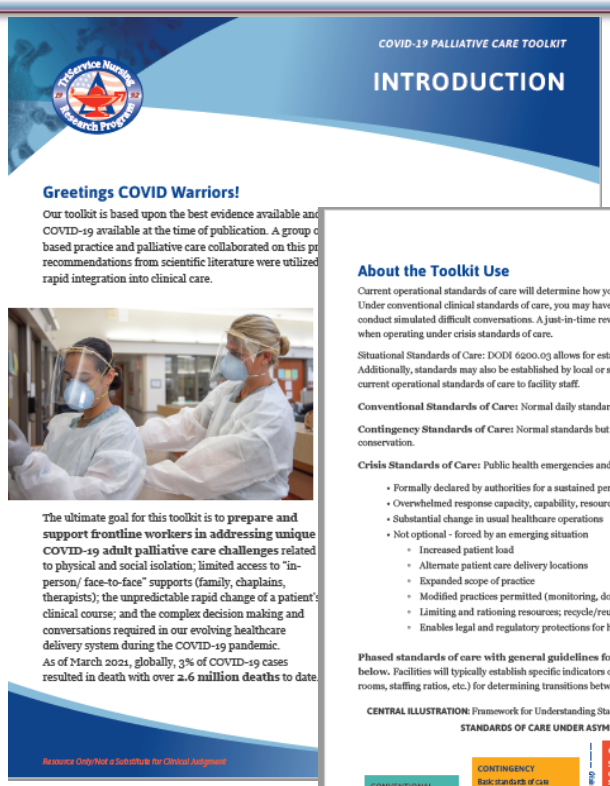
COVID-19 Palliative Care Toolkit Content

- Introduction
- About Toolkit Use
- Biobehavioral Framework
- Palliative Care 101
- Communication
- Pain & Symptom Management
- Support for Caregivers
- Mobile Apps
- Additional Resources



COVID-19 PALLIATIVE CARE TOOLKIT

INTRODUCTION

Greetings COVID Warriors!

Our toolkit is based upon the best evidence available and COVID-19 available at the time of publication. A group of based practice and palliative care collaborated on this pu recommendations from scientific literature were utilized rapid integration into clinical care.

The ultimate goal for this toolkit is to **prepare and support frontline workers in addressing unique COVID-19 adult palliative care challenges** related to physical and social isolation; limited access to "in-person/ face-to-face" supports (family, chaplains, therapists); the unpredictable rapid change of a patient's clinical course; and the complex decision making and conversations required in our evolving healthcare delivery system during the COVID-19 pandemic. As of March 2021, globally, 3% of COVID-19 cases resulted in death with over **2.6 million deaths** to date.

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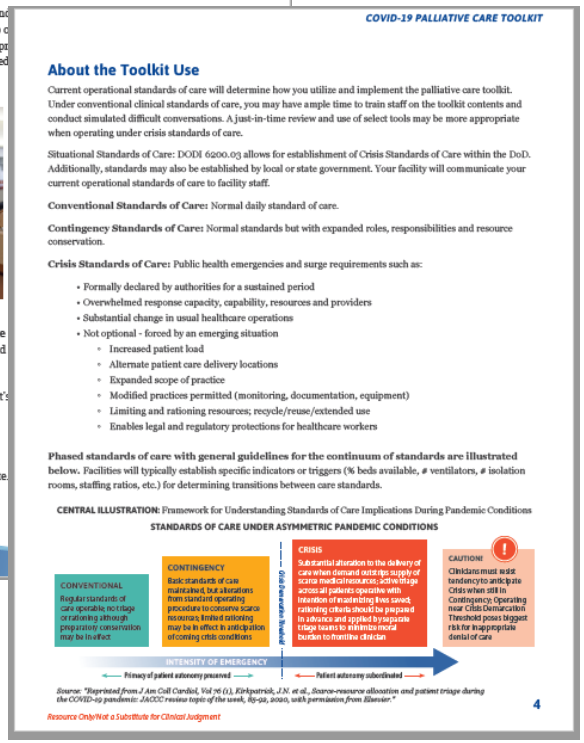

COVID-19 PALLIATIVE CARE TOOLKIT

About the Toolkit Use

Current operational standards of care will determine how you utilize and implement the palliative care toolkit. Under conventional clinical standards of care, you may have ample time to train staff on the toolkit contents and conduct simulated difficult conversations. A just-in-time review and use of select tools may be more appropriate when operating under crisis standards of care.

Situational Standards of Care: DODI 6200.03 allows for establishment of Crisis Standards of Care within the DoD. Additionally, standards may also be established by local or state government. Your facility will communicate your current operational standards of care to facility staff.

Conventional Standards of Care: Normal daily standard of care.

Contingency Standards of Care: Normal standards but with expanded roles, responsibilities and resource conservation.

Crisis Standards of Care: Public health emergencies and surge requirements such as:

- Formally declared by authorities for a sustained period
- Overwhelmed response capacity, capability, resources and providers
- Substantial change in usual healthcare operations
- Not optional - forced by an emerging situation
  - Increased patient load
  - Alternate patient care delivery locations
  - Expanded scope of practice
  - Modified practices permitted (monitoring, documentation, equipment)
  - Limiting and rationing resources; recycle/reuse/extended use
  - Enables legal and regulatory protections for healthcare workers

Phased standards of care with general guidelines for the continuum of standards are illustrated below. Facilities will typically establish specific indicators or triggers (% beds available, # ventilators, # isolation rooms, staffing ratios, etc.) for determining transitions between care standards.

CENTRAL ILLUSTRATION: Framework for Understanding Standards of Care Implications During Pandemic Conditions

STANDARDS OF CARE UNDER ASYMMETRIC PANDEMIC CONDITIONS

Source: "Reprinted from J Am Coll Cardiol, Vol 76 (1), Kirkpatrick, J.N. et al., Scarce-resource allocation and patient triage during the COVID-19 pandemic: JACCC review topic of the week, 65-92, 2020, with permission from Elsevier."

4

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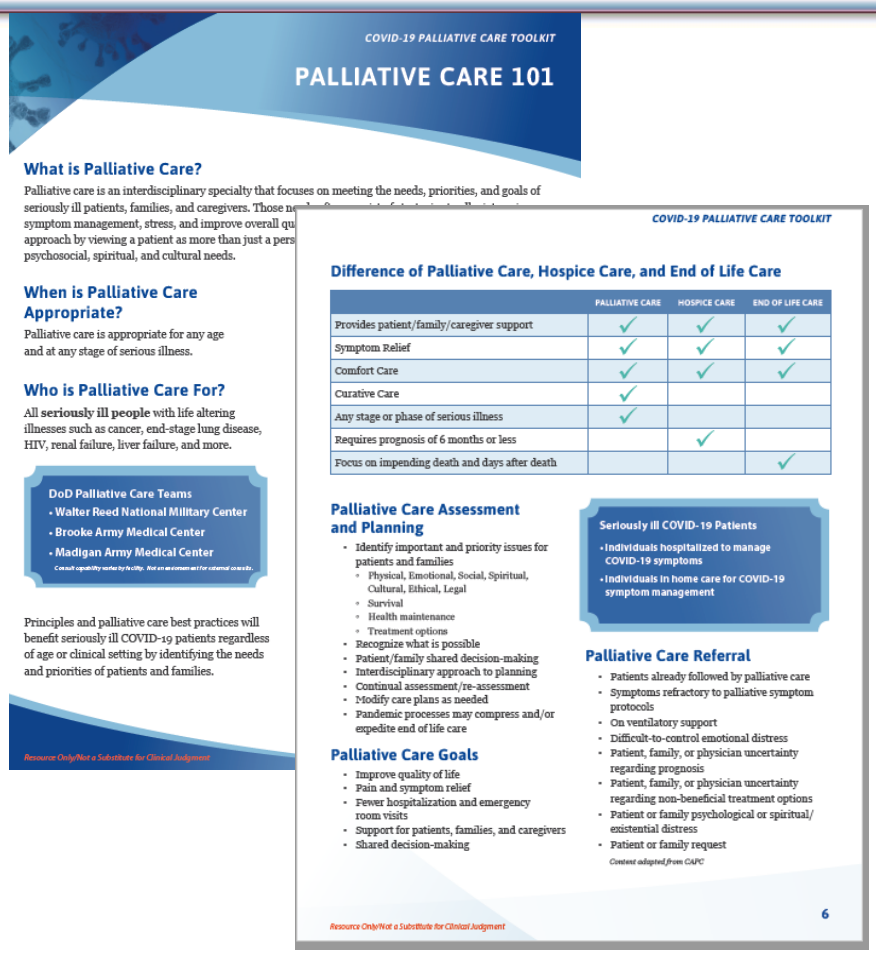
Biobehavioral Framework

- Integrates 7 Domains of Palliative Care into Point of Care Toolkit
  - Structure and process of care
  - Aspects of care
    - Physical
    - Psychological and psychiatric
    - Social
    - Spiritual, religious, existential
    - Cultural
    - Ethical and legal
  - Care of imminently dying patients

Palliative Care 101

- Who, what, when, where, why
- Care planning
- Goals
- Palliative Care vs Hospice vs End of Life care
- Referral considerations



COVID-19 PALLIATIVE CARE TOOLKIT

PALLIATIVE CARE 101

What is Palliative Care?

Palliative care is an interdisciplinary specialty that focuses on meeting the needs, priorities, and goals of seriously ill patients, families, and caregivers. Those ne… symptom management, stress, and improve overall qu… approach by viewing a patient as more than just a pers… psychosocial, spiritual, and cultural needs.

When is Palliative Care Appropriate?

Palliative care is appropriate for any age and at any stage of serious illness.

Who is Palliative Care For?

All **seriously ill people** with life altering illnesses such as cancer, end-stage lung disease, HIV, renal failure, liver failure, and more.

DoD Palliative Care Teams

- Walter Reed National Military Center
- Brooke Army Medical Center
- Madigan Army Medical Center

Consult capability varies by facility. Not an endorsement for external consults.

Principles and palliative care best practices will benefit seriously ill COVID-19 patients regardless of age or clinical setting by identifying the needs and priorities of patients and families.

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COVID-19 PALLIATIVE CARE TOOLKIT

Difference of Palliative Care, Hospice Care, and End of Life Care

	PALLIATIVE CARE	HOSPICE CARE	END OF LIFE CARE
Provides patient/family/caregiver support	✓	✓	✓
Symptom Relief	✓	✓	✓
Comfort Care	✓	✓	✓
Curative Care	✓		
Any stage or phase of serious illness	✓		
Requires prognosis of 6 months or less		✓	
Focus on impending death and days after death			✓

Palliative Care Assessment and Planning

- Identify important and priority issues for patients and families
  - Physical, Emotional, Social, Spiritual, Cultural, Ethical, Legal
  - Survival
  - Health maintenance
  - Treatment options
- Recognize what is possible
- Patient/family shared decision-making
- Interdisciplinary approach to planning
- Continual assessment/re-assessment
- Modify care plans as needed
- Pandemic processes may compress and/or expedite end of life care

Palliative Care Goals

- Improve quality of life
- Pain and symptom relief
- Fewer hospitalization and emergency room visits
- Support for patients, families, and caregivers
- Shared decision-making

Seriously ill COVID-19 Patients

- Individuals hospitalized to manage COVID-19 symptoms
- Individuals in home care for COVID-19 symptom management

Palliative Care Referral

- Patients already followed by palliative care
- Symptoms refractory to palliative symptom protocols
- On ventilatory support
- Difficult-to-control emotional distress
- Patient, family, or physician uncertainty regarding prognosis
- Patient, family, or physician uncertainty regarding non-beneficial treatment options
- Patient or family psychological or spiritual/existential distress
- Patient or family request

Content adapted from CAPC

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6

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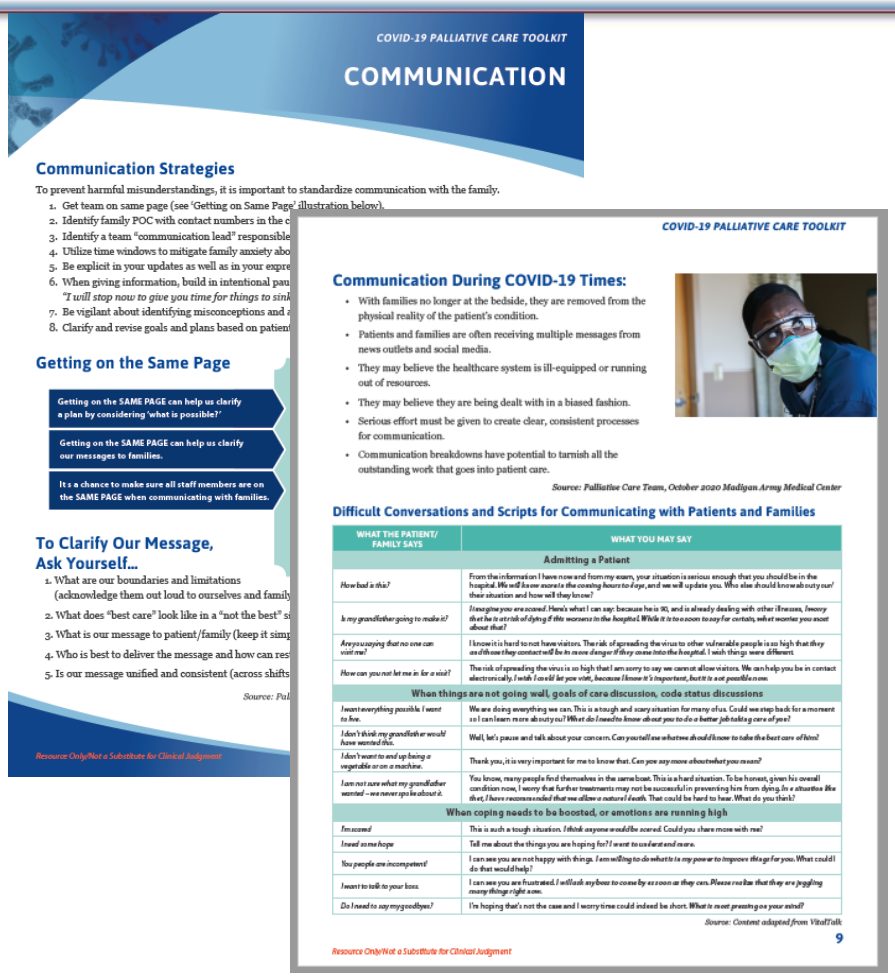
Communication

- Strategies
- Getting on the same page
- Scripts



COVID-19 PALLIATIVE CARE TOOLKIT

COMMUNICATION

Communication Strategies

To prevent harmful misunderstandings, it is important to standardize communication with the family.

1. Get team on same page (see 'Getting on Same Page' illustration below).
2. Identify family POC with contact numbers in the c
3. Identify a team "communication lead" responsible
4. Utilize time windows to mitigate family anxiety abo
5. Be explicit in your updates as well as in your expre
6. When giving information, build in intentional pau
   "I will stop now to give you time for things to sink
7. Be vigilant about identifying misconceptions and
8. Clarify and revise goals and plans based on patien

Getting on the Same Page

Getting on the SAME PAGE can help us clarify a plan by considering 'what is possible?'

Getting on the SAME PAGE can help us clarify our messages to families.

It s a chance to make sure all staff members are on the SAME PAGE when communicating with families.

To Clarify Our Message, Ask Yourself...

1. What are our boundaries and limitations (acknowledge them out loud to ourselves and family
2. What does "best care" look like in a "not the best" s
3. What is our message to patient/family (keep it simp
4. Who is best to deliver the message and how can res
5. Is our message unified and consistent (across shifts

Source: Pal

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COVID-19 PALLIATIVE CARE TOOLKIT

Communication During COVID-19 Times:

- With families no longer at the bedside, they are removed from the physical reality of the patient's condition.
- Patients and families are often receiving multiple messages from news outlets and social media.
- They may believe the healthcare system is ill-equipped or running out of resources.
- They may believe they are being dealt with in a biased fashion.
- Serious effort must be given to create clear, consistent processes for communication.
- Communication breakdowns have potential to tarnish all the outstanding work that goes into patient care.

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

Difficult Conversations and Scripts for Communicating with Patients and Families

WHAT THE PATIENT/ FAMILY SAYS	WHAT YOU MAY SAY
Admitting a Patient	
How bad is this?	From the information I have now and from my exam, your situation is serious enough that you should be in the hospital. *We will be examining the coming hours to days*, and we will update you. Who else should know about your their situation and how will they know?
Is my grandfather going to make it?	*I imagine you are scared.* Here's what I can say: because he is 90, and is already dealing with other illnesses, *I worry that he is at risk of dying if this worsens in the hospital. While it is too soon to say for certain, what worries you most about that?*
Are you saying that no one can visit me?	I know it is hard to not have visitors. The risk of spreading the virus to other vulnerable people is so high that *they as if those they contact will be in more danger if they come into the hospital.* I wish things were different.
How can you not let me in for a visit?	The risk of spreading the virus is so high that I am sorry to say we cannot allow visitors. We can help you be in contact electronically. *I wish I could let you visit, because I know it's important, but it is not possible now.*
When things are not going well, goals of care discussion, code status discussions	
I want everything possible. I want to live.	We are doing everything we can. This is a tough and scary situation for many of us. Could we step back for a moment so I can learn more about you? *What do I need to know about you to do a better job taking care of you?*
I don't think my grandfather would have wanted this.	Well, let's pause and talk about your concern. *Can you tell me what we should know to take the best care of him?*
I don't want to end up being a vegetable or on a machine.	Thank you, it is very important for me to know that. *Can you say more about what you mean?*
I am not sure what my grandfather wanted – we never spoke about it.	You know, many people find themselves in the same boat. This is a hard situation. To be honest, given his overall condition now, I worry that further treatments may not be successful in preventing him from dying. *In a situation like that, I have recommended that we allow a natural death.* That could be hard to hear. What do you think?
When coping needs to be boosted, or emotions are running high	
I'm scared	This is such a tough situation. *I think anyone would be scared.* Could you share more with me?
I need some hope	Tell me about the things you are hoping for? *I want to use it and more.*
You people are incompetent!	I can see you are not happy with things. *I am willing to do what is in my power to improve things for you.* What could I do that would help?
I want to talk to your boss.	I can see you are frustrated. *I will ask my boss to come by as soon as they can. Please realize that they are juggling many things right now.*
Do I need to say my goodbyes?	I'm hoping that's not the case and I worry time could indeed be short. *What is most pressing on your mind?*

Source: Content adapted from VitalTalk

9

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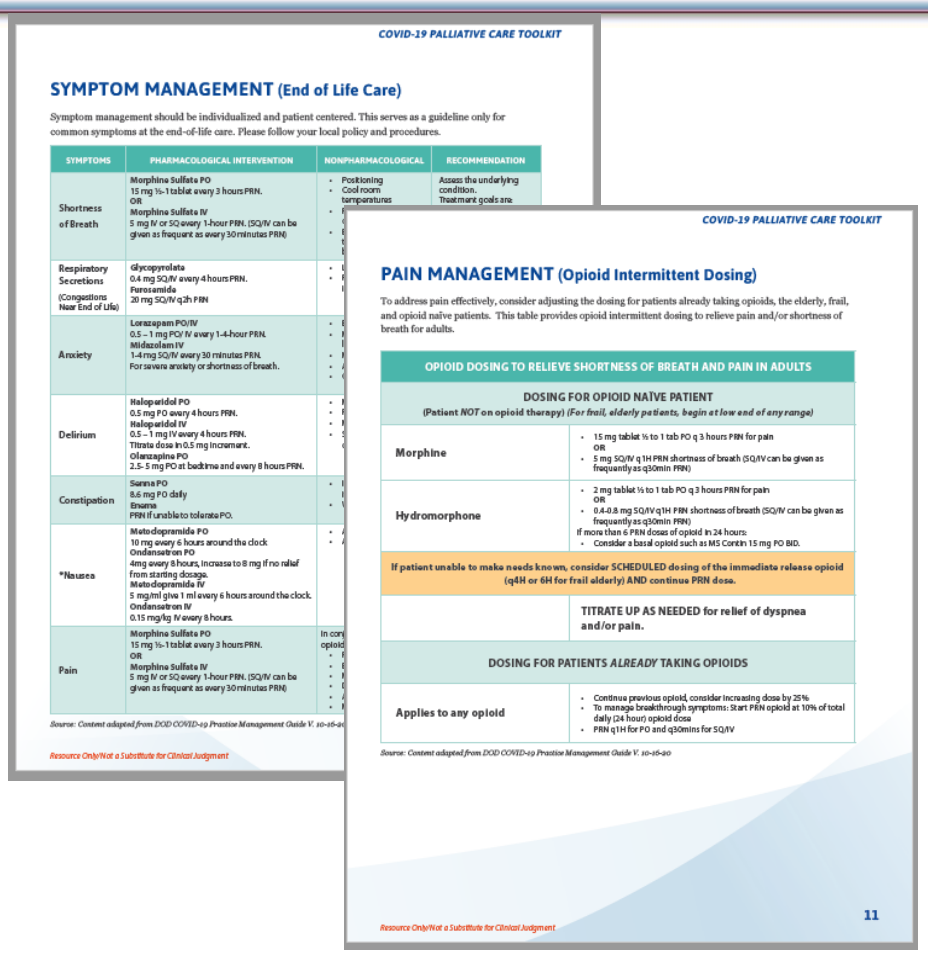
Pain & Symptom Management

- End of life medication dosages and indications from DoD COVID-19 Practice Management Guide
- Evidence-based nonpharmacological strategies



COVID-19 PALLIATIVE CARE TOOLKIT

SYMPTOM MANAGEMENT (End of Life Care)

Symptom management should be individualized and patient centered. This serves as a guideline only for common symptoms at the end-of-life care. Please follow your local policy and procedures.

SYMPTOMS	PHARMACOLOGICAL INTERVENTION	NONPHARMACOLOGICAL	RECOMMENDATION
Shortness of Breath	Morphine Sulfate PO 15 mg ½-1 tablet every 3 hours PRN. OR Morphine Sulfate IV 5 mg IV or SQ every 1-hour PRN. (SQ/IV can be given as frequent as every 30 minutes PRN)	• Positioning • Cool room temperatures	Assess the underlying condition. Treatment goals are
Respiratory Secretions (Congestions Near End of Life)	Glycopyrolate 0.4 mg SQ/IV every 4 hours PRN. Furosamide 20 mg SQ/IV q2h PRN		
Anxiety	Lorazapam PO/IV 0.5 – 1 mg PO/ IV every 1-4-hour PRN. Midazolam IV 1-4 mg SQ/IV every 30 minutes PRN. For severe anxiety or shortness of breath.		
Delirium	Haloperidol PO 0.5 mg PO every 4 hours PRN. Haloperidol IV 0.5 – 1 mg IV every 4 hours PRN. Titrate dose in 0.5 mg increment. Olanzapine PO 2.5- 5 mg PO at bedtime and every 8 hours PRN.		
Constipation	Senna PO 8.6 mg PO daily Enema PRN if unable to tolerate PO.		
*Nausea	Metoclopramide PO 10 mg every 6 hours around the clock Ondansetron PO 4mg every 8 hours, increase to 8 mg if no relief from starting dosage. Metoclopramide IV 5 mg/ml give 1 ml every 6 hours around the clock. Ondansetron IV 0.15 mg/kg IV every 8 hours.		
Pain	Morphine Sulfate PO 15 mg ½-1 tablet every 3 hours PRN. OR Morphine Sulfate IV 5 mg IV or SQ every 1-hour PRN. (SQ/IV can be given as frequent as every 30 minutes PRN)		

Source: Content adapted from DOD COVID-19 Practice Management Guide V. 10-16-20

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COVID-19 PALLIATIVE CARE TOOLKIT

PAIN MANAGEMENT (Opioid Intermittent Dosing)

To address pain effectively, consider adjusting the dosing for patients already taking opioids, the elderly, frail, and opioid naïve patients. This table provides opioid intermittent dosing to relieve pain and/or shortness of breath for adults.

OPIOID DOSING TO RELIEVE SHORTNESS OF BREATH AND PAIN IN ADULTS	
DOSING FOR OPIOID NAÏVE PATIENT (Patient *NOT* on opioid therapy) *(For frail, elderly patients, begin at low end of any range)*	
Morphine	• 15 mg tablet ½ to 1 tab PO q 3 hours PRN for pain OR • 5 mg SQ/IV q 1H PRN shortness of breath (SQ/IV can be given as frequently as q30min PRN)
Hydromorphone	• 2 mg tablet ½ to 1 tab PO q 3 hours PRN for pain OR • 0.4-0.8 mg SQ/IV q1H PRN shortness of breath (SQ/IV can be given as frequently as q30min PRN) If more than 6 PRN doses of opioid in 24 hours: • Consider a basal opioid such as MS Contin 15 mg PO BID.
If patient unable to make needs known, consider SCHEDULED dosing of the immediate release opioid (q4H or 6H for frail elderly) AND continue PRN dose.	
	TITRATE UP AS NEEDED for relief of dyspnea and/or pain.
DOSING FOR PATIENTS *ALREADY* TAKING OPIOIDS	
Applies to any opioid	• Continue previous opioid, consider increasing dose by 25% • To manage breakthrough symptoms: Start PRN opioid at 10% of total daily (24 hour) opioid dose • PRN q1H for PO and q30mins for SQ/IV

Source: Content adapted from DOD COVID-19 Practice Management Guide V. 10-16-20

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11

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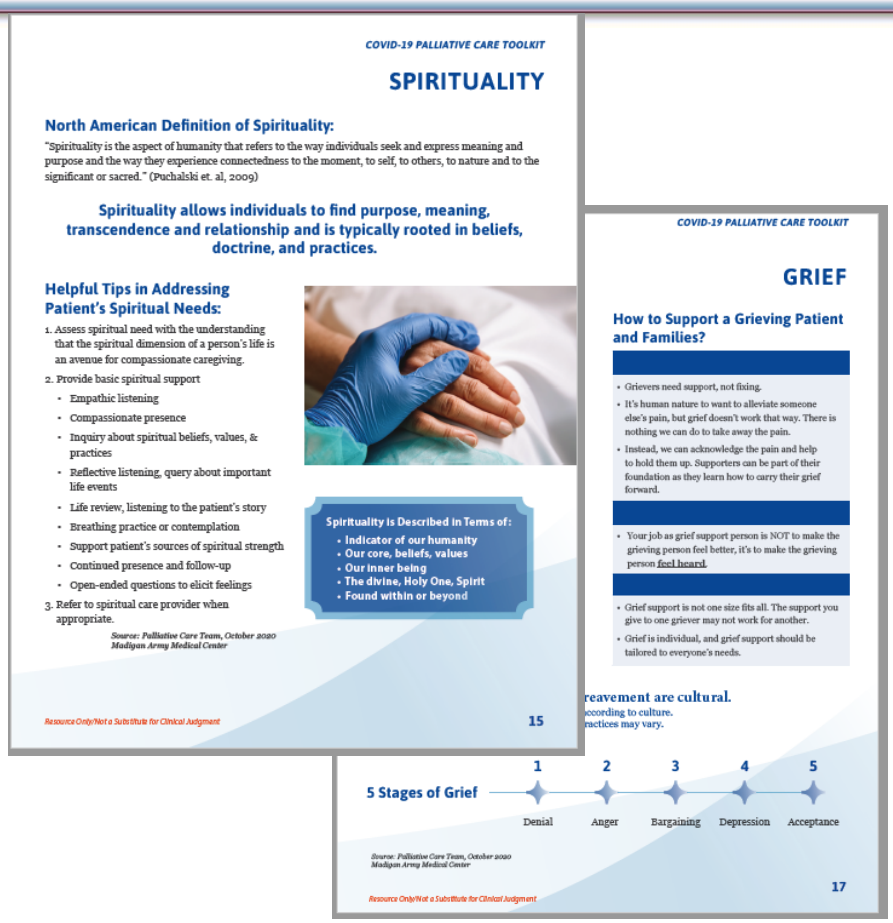
Spirituality

- Spirituality
- Faith and beliefs
- Grief
- Cultural considerations
- Bereavement



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SPIRITUALITY

North American Definition of Spirituality:

"Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience connectedness to the moment, to self, to others, to nature and to the significant or sacred." (Puchalski et. al, 2009)

Spirituality allows individuals to find purpose, meaning, transcendence and relationship and is typically rooted in beliefs, doctrine, and practices.

Helpful Tips in Addressing Patient's Spiritual Needs:

1. Assess spiritual need with the understanding that the spiritual dimension of a person's life is an avenue for compassionate caregiving.
2. Provide basic spiritual support
   - Empathic listening
   - Compassionate presence
   - Inquiry about spiritual beliefs, values, & practices
   - Reflective listening, query about important life events
   - Life review, listening to the patient's story
   - Breathing practice or contemplation
   - Support patient's sources of spiritual strength
   - Continued presence and follow-up
   - Open-ended questions to elicit feelings
3. Refer to spiritual care provider when appropriate.

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

Spirituality is Described in Terms of:
- Indicator of our humanity
- Our core, beliefs, values
- Our inner being
- The divine, Holy One, Spirit
- Found within or beyond

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15

COVID-19 PALLIATIVE CARE TOOLKIT

GRIEF

How to Support a Grieving Patient and Families?

- Grievers need support, not fixing.
- It's human nature to want to alleviate someone else's pain, but grief doesn't work that way. There is nothing we can do to take away the pain.
- Instead, we can acknowledge the pain and help to hold them up. Supporters can be part of their foundation as they learn how to carry their grief forward.
- Your job as grief support person is NOT to make the grieving person feel better, it's to make the grieving person feel heard.
- Grief support is not one size fits all. The support you give to one griever may not work for another.
- Grief is individual, and grief support should be tailored to everyone's needs.

reavement are cultural.
cording to culture.
actices may vary.

5 Stages of Grief

1 Denial, 2 Anger, 3 Bargaining, 4 Depression, 5 Acceptance

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

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17

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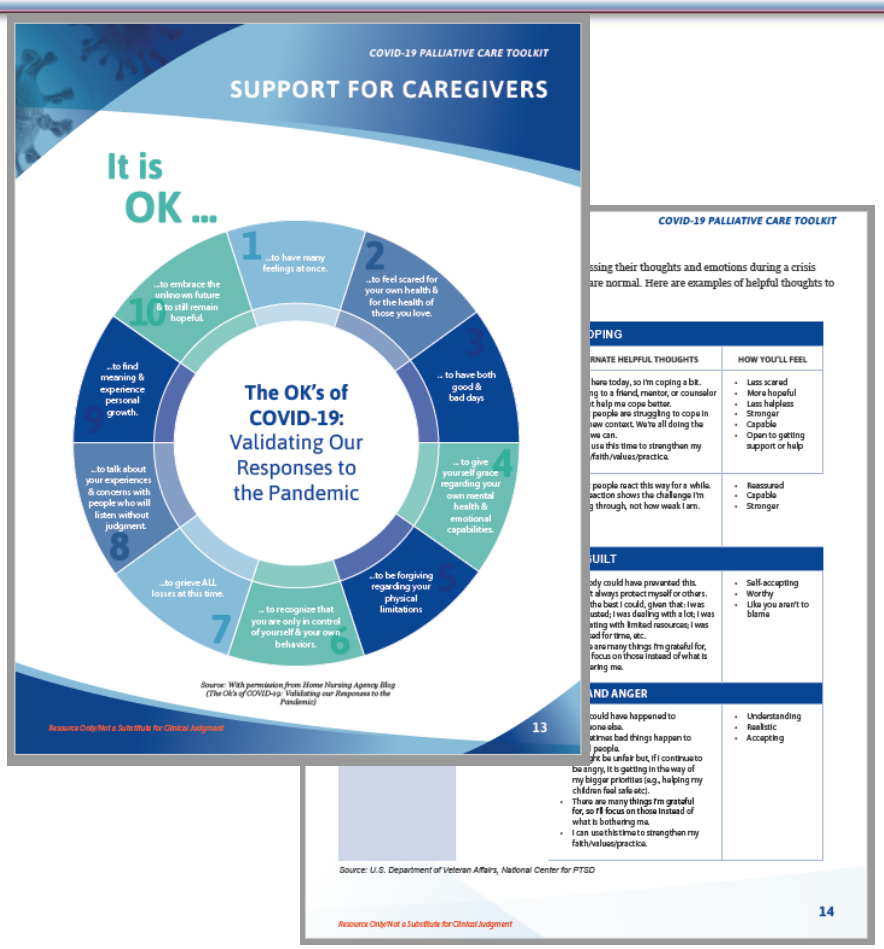
Support for Caregivers

- Validating responses
- Transforming unhelpful thoughts into helpful thoughts for
  - Coping
  - Guilt
  - Blame
  - Anger



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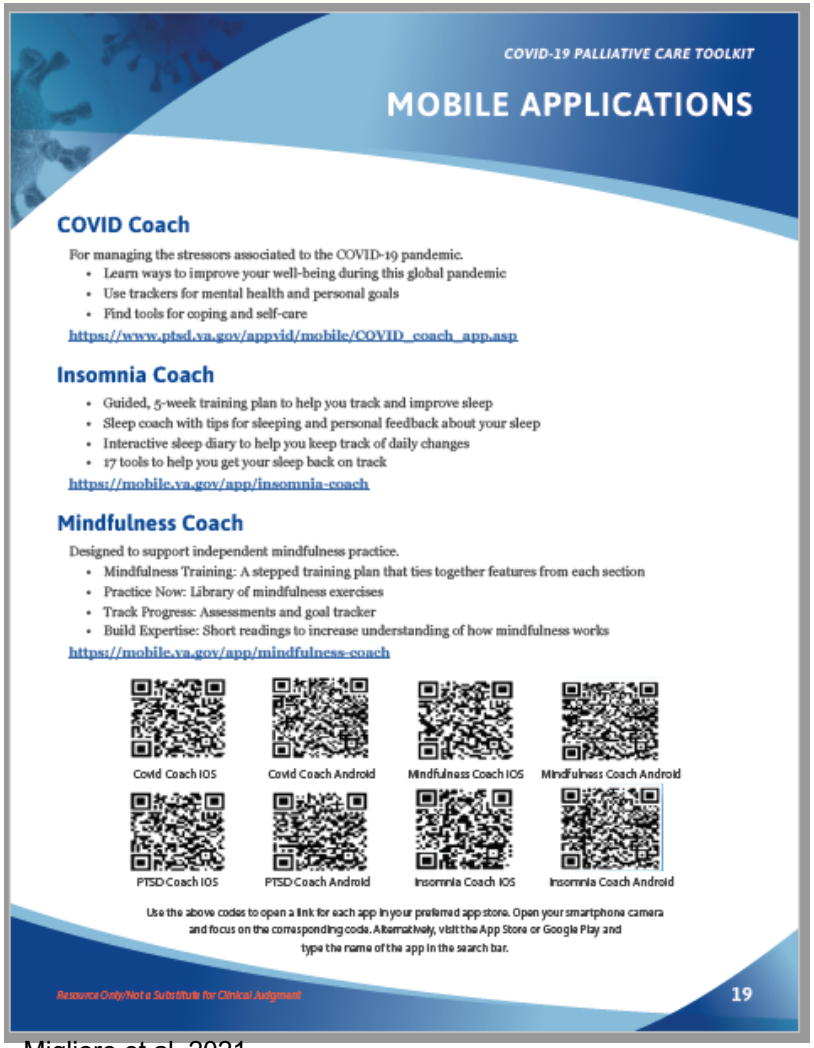
Mobile Apps

- DoD mobile IOS and Android apps
  - COVID Coach
  - Insomnia Coach
  - Mindfulness Coach
  - PTSD Coach



COVID-19 PALLIATIVE CARE TOOLKIT

MOBILE APPLICATIONS

COVID Coach

For managing the stressors associated to the COVID-19 pandemic.

- Learn ways to improve your well-being during this global pandemic
- Use trackers for mental health and personal goals
- Find tools for coping and self-care

https://www.ptsd.va.gov/appvid/mobile/COVID_coach_app.asp

Insomnia Coach

- Guided, 5-week training plan to help you track and improve sleep
- Sleep coach with tips for sleeping and personal feedback about your sleep
- Interactive sleep diary to help you keep track of daily changes
- 17 tools to help you get your sleep back on track

https://mobile.va.gov/app/insomnia-coach

Mindfulness Coach

Designed to support independent mindfulness practice.

- Mindfulness Training: A stepped training plan that ties together features from each section
- Practice Now: Library of mindfulness exercises
- Track Progress: Assessments and goal tracker
- Build Expertise: Short readings to increase understanding of how mindfulness works

https://mobile.va.gov/app/mindfulness-coach

Covid Coach IOS | Covid Coach Android | Mindfulness Coach IOS | Mindfulness Coach Android

PTSD Coach IOS | PTSD Coach Android | Insomnia Coach IOS | Insomnia Coach Android

Use the above codes to open a link for each app in your preferred app store. Open your smartphone camera and focus on the corresponding code. Alternatively, visit the App Store or Google Play and type the name of the app in the search bar.

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19

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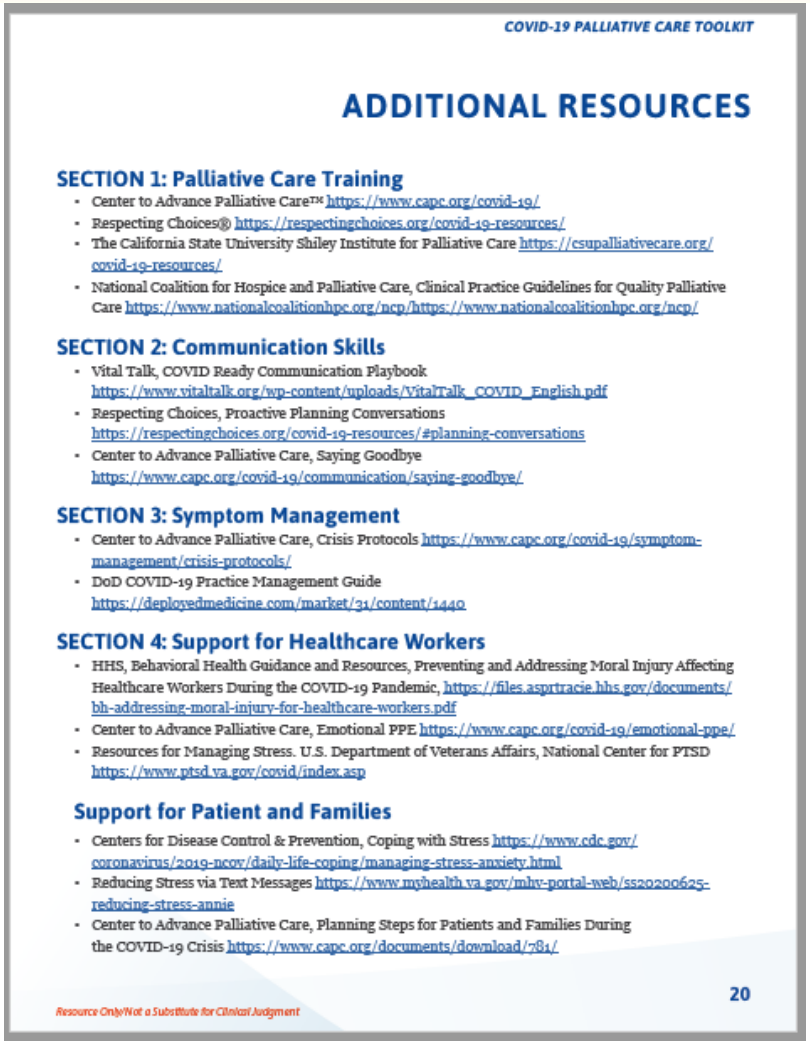
Additional Resources

- Helpful resources to provide more in-depth information and support



COVID-19 PALLIATIVE CARE TOOLKIT

ADDITIONAL RESOURCES

SECTION 1: Palliative Care Training

- Center to Advance Palliative Care™ https://www.capc.org/covid-19/
- Respecting Choices® https://respectingchoices.org/covid-19-resources/
- The California State University Shiley Institute for Palliative Care https://csupalliativecare.org/covid-19-resources/
- National Coalition for Hospice and Palliative Care, Clinical Practice Guidelines for Quality Palliative Care https://www.nationalcoalitionhpc.org/ncp/https://www.nationalcoalitionhpc.org/ncp/

SECTION 2: Communication Skills

- Vital Talk, COVID Ready Communication Playbook https://www.vitaltalk.org/wp-content/uploads/VitalTalk_COVID_English.pdf
- Respecting Choices, Proactive Planning Conversations https://respectingchoices.org/covid-19-resources/#planning-conversations
- Center to Advance Palliative Care, Saying Goodbye https://www.capc.org/covid-19/communication/saying-goodbye/

SECTION 3: Symptom Management

- Center to Advance Palliative Care, Crisis Protocols https://www.capc.org/covid-19/symptom-management/crisis-protocols/
- DoD COVID-19 Practice Management Guide https://deployedmedicine.com/market/31/content/1440

SECTION 4: Support for Healthcare Workers

- HHS, Behavioral Health Guidance and Resources, Preventing and Addressing Moral Injury Affecting Healthcare Workers During the COVID-19 Pandemic, https://files.asprtracie.hhs.gov/documents/bh-addressing-moral-injury-for-healthcare-workers.pdf
- Center to Advance Palliative Care, Emotional PPE https://www.capc.org/covid-19/emotional-ppe/
- Resources for Managing Stress. U.S. Department of Veterans Affairs, National Center for PTSD https://www.ptsd.va.gov/covid/index.asp

Support for Patient and Families

- Centers for Disease Control & Prevention, Coping with Stress https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html
- Reducing Stress via Text Messages https://www.myhealth.va.gov/mhv-portal-web/ss20200625-reducing-stress-annie
- Center to Advance Palliative Care, Planning Steps for Patients and Families During the COVID-19 Crisis https://www.capc.org/documents/download/781/

20

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Key Takeaways

- A literature review provided compelling evidence that there is a need for palliative care training and resources.

- A COVID-19 palliative care toolkit was developed to empower frontline workers and to bridge the gap in palliative care needs focusing on four components: palliative care, communication, symptom management during the end of life, and support for caregivers.

- iPads were utilized for communication using video calls to mitigate isolation and provide virtual support.

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How to Obtain CE/CME Credits

To receive CE/CME credit, you must complete the program posttest and evaluation before collecting your certificate. The posttest and evaluation will be available through 12 November at 2359 ET. Please complete the following steps to obtain CE/CME credit:

1. Go to URL https://www.dhaj7-cepo.com/
2. Search for your course using the **Catalog**, **Calendar**, or **Find a course** search tool.
3. Click on the REGISTER/TAKE COURSE tab.
   a. If you have previously used the CEPO CMS, click login.
   b. If you have not previously used the CEPO CMS click register to create a new account.
4. Follow the onscreen prompts to complete the post-activity assessments:
   a. Read the Accreditation Statement
   b. Complete the Evaluation
   c. Take the Posttest
5. After completing the posttest at 80% or above, your certificate will be available for print or download.
6. You can return to the site at any time in the future to print your certificate and transcripts at https://www.dhaj7-cepo.com/
7. If you require further support, please contact us at dha.ncr.j7.mbx.cepo-cms-support@mail.mil