Ontario Palliative Care Network

Strategies to Support Palliative Care in Long-Term Care during the COVID-19 Pandemic

Purpose:

The COVID-19 crisis in Long-Term Care homes has highlighted systemic issues, including the need to ensure access to palliative care. This document offers guidance to administrative and clinical leaders in Long-Term Care (LTC) during the COVID-19 Pandemic to support efforts to strengthen palliative and end-of-life care. This will also be valuable to hospital leaders who are involved with supporting LTC homes in their process of assessing clinical care needs and ability to manage palliative care delivery. Included are suggestions for maximizing the use of palliative care clinicians in supporting these efforts. Providers with palliative care expertise are uniquely equipped to address the suffering of residents with serious illnesses through expert symptom management, and meaningful communication that requires dedicated time. Through direct care, consultation, and mentorship, they can also provide an added layer of support to providers in LTC that are overwhelmed and working in busy settings. This information will ideally assist with guiding conversations to identify the most pressing needs within the home and opportunities to implement additional palliative care supports.

Background

Individuals in long-term care (LTC) who are nearing end-of-life will have increasing physical, emotional, social, psychological, and spiritual needs. The intent of palliative care is to improve quality of life and prevent and relieve suffering through early identification, assessment and treatment of pain and other issues across multiple domains, while also providing support to the family. For residents who wish to remain in the home, and forgo hospitalization, LTC staff can ideally manage these range of needs within the home.

Given the sudden onset of severe symptoms, and rapid deterioration that can occur with COVID-19 infection, early management is essential to reduce suffering. Care teams need to be able to respond by having Goals of Care discussions, determining treatment preferences and managing escalating symptoms. Clinicians may have significant challenges in managing symptoms and residents may require high doses of opioids, sedatives and anxiolytics. Additionally, residents' families require support and frequent communication and Substitute Decision Makers (SDMs) would need to be engaged in decision-making in most situations.

While addressing these needs is critically important, homes across the province are experiencing staff shortages, impacting the ability to provide palliative and end-of-life care to residents. In the context of the pandemic, LTC homes may need to consider innovative ways to access palliative care consultation and support. For homes in outbreak, consideration for increased staffing beyond the usual minimum requirements[1], and access to oxygen and symptom management medications will also be important to ensure residents' needs can be addressed.

What are the optimal supports to provide high quality palliative care in LTC?

Most residents have significant palliative care needs when they are admitted to LTC, and as such, a palliative approach to care should be integrated into the daily operations of all facilities. To support the

[1] For example, aligning with staffing levels at hospice residences.

provision of high-quality palliative care in the pandemic, it is especially important for homes to plan for access to the following[2]:

- 24-hour physician on-call for symptom management/crisis management
- Dedicated nursing staff with palliative care competencies, assigned to work with COVID+ residents with identified palliative care needs (e.g. symptom assessment and management skills, knowledge of when to administer PRN medications, butterfly insertions, management of infusion pumps etc.)
- Medications for symptom management available in contingency stock:
    - Opioids
    - Anxiolytics
    - Anti-emetics
    - Neuroleptics
- Parenteral medication administration supplies
- Availability of CADD Pump/Infusion pump (if required)
- Close connection to the pharmacy team to determine medication supports needed, particularly related to parenteral products
- Oxygen concentrators/tanks
- Technology with working/reliable Wi-Fi or cellular data connection (e.g. phones/tablets to connect residents and families, as well as staff, including for palliative care specialist support)
- Ensuring continued and safe access for essential caregivers
- Standardized symptom guidelines and resources
- Facility nursing staff/leadership with palliative care experience
- Specialist support for virtual guidance and consultation
- Options for virtual support for grief/bereavement for residents families and staff (referral to community resources)

Strategies to Support Long-Term Care Homes

Recognizing that many homes may not currently have access to the necessary supports that would enable high-quality palliative care, this document offers some strategies to strengthen existing supports. The intent of the document is to encourage close working relationships with palliative care providers in the local community who can be rapidly engaged in a coordinated response. It outlines models of palliative care and other key resources that can be leveraged to support these efforts. Availability of providers and access to resources will vary regionally. The Regional Palliative Care Network (RPCN) directors and clinical co-leads can help to support local connections by identifying providers with palliative care expertise. Please reach out to Info@ontariopalliativecarenetwork.ca for contact information for your local RPCN leadership team.

[2] Adapted from the *Guidelines for Palliation of COVID-19 Patients (positive and presumed positive) in Long-term Care (LTC) Facilities*

How can Palliative Care Clinicians Help?

Providers with palliative care expertise have the unique ability to augment the care being provided to residents with COVID-19, and other high acuity conditions in Long-Term Care homes. In particular, they can proactively identify and respond to needs across multiple domains including pain and symptom management support, psychosocial support to address high stress and isolation, and grief and bereavement support to help address the devastating losses occurring across homes. Equally important, they are skilled in compassionate communication, and can support LTC staff to clarify residents' Goals of Care early and ensure care is aligned with resident wishes and values. Finally, through just in time education, and mentorship, they can support clinicians in their practice, and continue to build capacity among staff in the home for high-quality palliative care.

Models of Palliative Care

Decisions about which model to apply will depend on various factors, including size of the LTC home, available staff resources, palliative care competencies of current LTC staff, and degree of impact by COVID-19. LTC administrative and clinical leadership should work together with existing local palliative care teams and/or providers with palliative care expertise to discuss the needs of the home, the supports that are available, and the model that may work best.

Integrated/Co-management Model

While LTC homes typically provide palliative and end of life care for residents, shifting to integrated or co-management models during the pandemic, can provide an added layer of support in caring for residents who are most symptomatic or likely to experience worsening condition. A palliative care team or a provider with palliative care expertise can help with the following:

- Screening residents to identify palliative care needs that require urgent interventions (e.g., uncontrolled physical symptoms, urgent needs for personal care services or social work services)
- Conducting comprehensive and holistic assessments to identify residents' health, social, linguistic, and emotional needs
- Engaging residents and their Substitute Decision Maker(s) in Goals of Care discussions
- Ensuring the resident and family receives high-quality care to address their identified needs in alignment with their identified preferences, values and goals
- Connecting the resident with additional specialized services as required (e.g., spiritual care, psychosocial support, etc.)
- Supporting transitions between care settings, including communication with the family
- Proactively developing and implementing a plan for expected death
- Providing grief and bereavement support to residents, their family/caregivers, and LTC staff
- Providing ongoing mentorship of LTC staff with the goal of building internal capacity using palliative care principles

For more details on the suggested role of the integrated palliative care team/provider with palliative care expertise in a LTC Home, as well as some examples of useful practices, please refer to the appendix.

Consult/Specialist Model

In some regions, palliative care teams and providers with palliative care expertise may have limited capacity and may not be able to participate in integrated models. LTC homes can work with their RPCN to identify local palliative care teams and/or providers with palliative care expertise who are available to provide direct care, consultation or provider support.

For LTC homes that are resource constrained and experiencing outbreak, it may be helpful to use the following tool to identify residents that are medically unwell and/or at risk of imminent death that would require palliative care consultation or referral (Adapted from *A COVID-19 Pandemic Assessment and Triage Tool for Resource Constrained Nursing Home Outbreak Settings*[3]).

1. Respiratory status:
    - Hypoxia: pulse oximeter saturation level <90-92% on room air
    - Tachypnea: respiratory rate >16-20 breaths per minute
2. Cardiovascular status:
    - Tachycardia: heart rate >100 beats per minute
    - Hypotension: systolic blood pressure <100-120 mmHg
3. Mental Status
    - Impaired level of consciousness
    - Delirium (abrupt and fluctuating change in cognition, inattention and either disorganized thinking or altered level of consciousness)
4. Decreased oral intake
5. Functional impairment
    - Deterioration in mobility
    - Deterioration in the performance of activities of daily living
6. Staff or family concern
    - Any concerning change in baseline status

Note: Recognizing that many residents have baseline cognitive and/or functional impairment, assessment should screen for new changes from a resident's baseline.

Rapid Response Team Model

For LTC facilities facing large outbreaks of COVID-19, the volume of illness may require formation of a Rapid Response Team (RRT) to enable a mass casualty approach. Some hospitals have been leveraging the RRT model to assist LTC homes in crisis[4]. A RRT is a multidisciplinary team of clinicians with acute care experience as well as training in palliative and end-of-life care along with the inclusion of

[3]Stall, N. M., Farquharson, C., Fan-Lun, C., Wiesenfeld, L., Loftus, C. A., Kain, D., ... & Mahtani, R. (2020). A hospital partnership with a nursing home experiencing a COVID-19 outbreak: description of a multiphase emergency response in Toronto, Canada. Journal of the American Geriatrics Society, 68(7), 1376-1381.

[4] More details about this model are described in the Ontario Hospital Association's webinar Long-Term Care Rapid Response Teams: A Palliative Care Focused Approach.

community paramedics[5]. Their role is to support mass triage, and address acute clinical issues, complementing existing care available in the home, rather than substituting it. The clinical team is typically equipped with cardiac monitoring, intravenous, fluid therapy, oxygen, and symptom relief medications. The team is also able to provide staffing, Infection Prevention and Control (IPAC), communication and administrative support as needed.

Building External Linkages

Building linkages with community partners can be another way to supplement LTC staff as well as creating more specialized knowledge and skills in LTC homes. Providers and organizations to engage include:

- **Palliative Pain and Symptom Management Consultants** can support care providers in long-term care homes by providing consultation, education, mentorship, and linkages to palliative care resources across the continuum of care.
- **Local Hospice Residences** can provide 24-hour support, referring staff to community experts, and written resources (e.g. books, brochures, directories), psychosocial/spiritual, grief & bereavement support, as well as education and mentoring to LTC staff.
- **Nurse Led Outreach Teams (NLOT)** can provide assistance to staff when residents are transitioning towards end-of-life (EOL) and support staff to provide EOL care. They help prevent unnecessary transfers to hospital at EOL. If the resident is transferred to hospital, the Nurse Led Outreach team can ensure smooth transitions during this period by sharing information with both the hospital and the LTC home.
- **Paramedics and Palliative Care Programs** train local paramedics to assess and treat palliative care needs. Community paramedics with palliative care competencies can provide hands-on experience in short-term medical management and have the capacity to initiate treatment on a range of clinical severity from mild symptoms to the actively dying[6].

Key Resources to Support Provision of Palliative Care

Each LTC home should ensure that LTC clinicians have ready access to evidence-informed tools to support palliative care delivery. Resources should include

- ☐ Palliative care/comfort care order sets[7].
- ☐ Symptom management guides (i.e. The OPCN's Symptom Management for Adult Patients with COVID-19 receiving End-of-Life Supportive Care Outside of the ICU).
- ☐ Resources to support serious illness conversations and Goals of Care discussions (i.e. Serious Illness Conversation Guide, SpeakUp Ontario Goals of Care Conversation guides, etc.).

[5] Downar, J., Arya, A., Lalumiere, G., Bercier, G., Leduc, S., and Charbonneau, V. Practice Innovations: Rapid Deployment of Palliative Care in Clinical Response Teams to Support Long-Term Care Facilities: The Community Paramedic Perspective. Canadian Paramedicine, December 2020/January 2021.

[6] Downar, J., Arya, A., Lalumiere, G., Bercier, G., Leduc, S., and Charbonneau, V. Practice Innovations: Rapid Deployment of Palliative Care in Clinical Response Teams to Support Long-Term Care Facilities: The Community Paramedic Perspective. Canadian Paramedicine, December 2020/January 2021.

[7] Typically these are facility specific, and established at the local level.

- Documentation template for Goals of Care discussions

In addition to this document, the Ontario Palliative Care Network[8] has also developed a toolkit for Providing Palliative and End-of-Life Care for Residents in Long-Term Care During the COVID-19 Pandemic which summarizes some of the readily available tools and resources to support LTC staff.

Each LTC home should also consider supplemental education on pain and symptom management (especially COVID-19 symptoms) and skills training to support Goals of Care discussions in order to help build capacity within the home long-term.

Additional references for more information:

Ankuda CK, Woodrell , CD, Meier , DE, et al.: A beacon for dark times: Palliative care support during the coronavirus pandemic. NEJM Catal Innov Care Deliv 2020; DOI: 10.1056/CAT.20.0204. Accessed at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7371325/

Blinderman, C. , Adelman, R., Kumaraiah, D., Cynthia X. Pan, C. , Palathra, B., Kaley, K., Trongone, N. and Spillane, K. . A Comprehensive Approach to Palliative Care during the Coronavirus Pandemic. Journal of Palliative Medicine. Online Ahead of Print: December 1, 2020. Accessed at: http://doi.org/10.1089/jpm.2020.0481

Froggatt, K. A., Moore, D. C., Van den Block, L., Ling, J., Payne, S. A., Arrue, B., ... & Vernooij-Dassen, M. (2020). Palliative care implementation in long-term care facilities: European Association for Palliative Care White Paper. Journal of the American Medical Directors Association, 21(8), 1051-1057.

Ministry of Long-Term Care. Long-Term Care Staffing Study. Accessed at: https://files.ontario.ca/mltc-long-term-care-staffing-study-en-2020-07-31.pdf

Quality Palliative Care in Long-Term Care Alliance. Long-term care homes: Hospices of the future. 2011. Accessed at: http://www.palliativealliance.ca/assets/files/OLTCA_final1.pdf

[8] 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.

Strategies to Support Palliative Care in Long-Term Care during the COVID-19 Pandemic

Appendix

The following provides examples of how a Palliative Care Team or a provider with palliative care expertise may work in an integrated or co-management model with providers in Long-Term Care homes.

Suggested Role of an integrated palliative care team/provider with palliative care expertise in LTC Home

- Provide "just in time" education, consultation, or shared care as appropriate
- Assist LTC clinicians with comprehensive and holistic assessments to identify resident's health, social, linguistic, cultural, and emotional needs
- Assist LTC clinicians to clarify residents' Goals of Care in a timely manner, and obtain informed consent for treatment decisions aligned with previous wishes, goals and values
- Provide high quality pain and symptom management for all residents
- Provide continuity and communication support during care transitions, to ensure providers are aware of identified Goals of Care across care settings (i.e. admission to hospital)
- Given that essential caregivers may not be able to be physically present, help to optimize communication with families, giving LTC clinicians more bandwidth to focus on caring for other residents
    - Provide families with updates on overall condition and prognosis
    - Facilitate virtual visits
- Work closely with the multidisciplinary team, especially social workers and chaplains, to ensure families have support to grieve
- Arrange spiritual care support and bereavement follow up

Useful practices may include:

- Dedicated provider with palliative care expertise with regular/scheduled in-person or virtual visits to the LTC home
- Palliative care clinician/team participation in rounds as a mechanism to integrate with LTC clinicians, and to support identifying:
    - Residents requiring Goals of Care clarification including where stated treatment preferences do not align with clinical prognosis
    - Residents with serious illness requiring symptom management.
    - Residents who can return home with supports or who can be transferred directly to a palliative care unit.
- Establishing access to a provider with palliative care expertise or a palliative care team/program that can provide after-hours consultation/support and coaching for LTC clinicians (e.g. extended hours beyond usual consult times, 24/7 access if feasible)