WELCOME

The State of Palliative Care in Hospitals: Insights from the COVID Pandemic

Host: Dr. José Pereira MBChB, CFPC (PC), MSc, FCFP

Panelists:
Dr. Amane Abdul-Razzak MD, CCFP-PC, MSc
Dr. Tim Hiebert MD, FRCPC, MSc
Dr. Ebru Kaya MB BS, MRCP(UK), CCT (Palliative Medicine)

The webinar will begin soon (please note your microphone is muted).
Please use the Q&A function to submit questions.

Housekeeping

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Use the Q&A function at the bottom of your screen to submit questions. Please do not use the chat function for questions.

This session is being recorded and will be emailed to webinar registrants next week.

Presenters

Host and Moderator

Dr. José Pereira MBChB, CFPC (PC), MSc, FCFP
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Presenters

Panelists

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Palliative Consultant, Calgary Zone Palliative and End-of-Life Care program
Clinical Assistant Professor, Departments of Oncology and Family Medicine, University of Calgary

Dr. Tim Hiebert MD, FRCPC, MSc
Physician Consultant, Palliative care and internal medicine, WRHA
Undergraduate director, Palliative education, University of Manitoba

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Declaration of conflicts

Pallium Canada

- Non-profit
- Generates funds to support operations and R&D from course registration fees and sales of the Pallium Palliative Pocketbook
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Presenters

- Dr. José Pereira
- Dr. Amane Abdul-Razzak
- Dr. Tim Hiebert
- Dr. Ebru Kaya

Learning objectives

Upon completing this webinar, you should be able to:

Describe how the COVID-19 pandemic has impacted the delivery of palliative care in hospitals and the acute care sector;

Explain adaptations palliative care services in hospitals have had to make in response to the pandemic;

Start reorganizing hospital-based palliative care services to address the new emerging realities of a longer-term pandemic.

Hospital palliative care during a pandemic

Dr. Ebru Kaya

- University Health Network
  - Toronto General Hospital
  - Toronto Western Hospital
  - Princess Margaret Cancer Center
  - Toronto Rehabilitation Institute

- 281 COVID + cases

Kim et al, A Primer for Clinician Deployment to the Medicine Floors from an Epicenter of Covid-19, NEJM May 2020

Rapid changes

- Increased inpt bed capacity throughout
- Decanting of pts (IP/OP) to community
- Strict no visitor policy (Ipads/ smart phones)
- Virtual FMs
- On call schedule with back ups
- Separation into OP / IP teams
- Changes to PPE (conservation strategy)
- Teaching activities pivoted to building capacity
- Other academic activities held
- All research activities held

OP clinics

- 90 % virtual within 3 weeks except:
  - IHD
  - Urgent consults from on site Onc clinics
- OTN, phone calls
- Referral to community teams
- On stand by for IP services

IP consults model

- Triage tool to prioritize referrals
- Outbreaks
- Minimize staff on site
- Trainees
- Virtual rounds
- Drugs / delivery devices

IP consults

1. Initiate Triage Tool (Virtual / in person Consultations)

2. Initiate embedded model (ED, GIM, ICU)
   - Redeployment of MDs to PC
   - Redeployment of trainees
   - Redeployment of ambulatory CNS

3. MRP model (GIM)

Changes to PCU

- Revised admission policy
- Increased bed capacity
- Strict visitor policy
- Scaled back staffing
- Virtual rounds / huddles
- PCU staffing prioritized over consults and OP

Changes to PCU

- Rapid introduction of new order sets and revision of old
- Consolidation of existing partnerships (GIM, psych, APS)
- New partnerships (ICU, pharmacy)

Building capacity for primary palliative care

- Education materials and seminars (local/regional)
- Order sets (paper and EPR)
- Symptom Management Guidelines

Looking ahead

- Drug supply conservation strategy
- Local drug delivery systems strategy during a pandemic surge
- Leverage technology and existing infrastructure
- Document policy revisions / changes
- Coordination (local, regional, national)

Inpatient palliative care during a pandemic

Tim Hiebert
MD, MSc, FRCPC
Palliative Care and General Internal Medicine
University of Manitoba

The Winnipeg Context

- Regional Palliative Care Program
- Inpatient and outpatient service delivery by the same team
- 3 acute care, 3 subacute hospitals
- 2 palliative care units
  - Community (30 beds - Riverview)
  - Tertiary Care (15 beds – St Boniface)
  - Hospice (12 beds)
- Covid-19: 295 cases in province (as of June 2)
- 7 Covid-19 deaths
- 15 patients with critical illness – all recovered/resolved

Visitation restrictions and their impacts

- Visitors limited initially to pps 10% (on PCU's)
  - Only 2 visitors
- More recently pps 20%
  - 4 visitors
- Variable visitation policy elsewhere
  - Patients sometimes turned down transfer
- Patients at home not wanting to be admitted
- Palliative beds underutilized

Visitation restrictions and their impacts

- Very difficult to support families
- Patients in PCH being removed by families
  - Sometimes with no support
- Patients declining to end-of-life at home
  - not presenting/asking for care until very late.
- Presenting to ER at end-of-life
- After-hours calls to us when its too late to help

Impacts on Consultation

- Keeping same staff in same locations – not rotating
- Significant decline in consult requests April – late May from inpatient sources
  - Less admitted patients everywhere
  - No family presence – less advocacy
  - Desire to limit number of people moving between units
  - Increased telephone consultation - staff in isolation at times
- More recently:
  - Patients presenting late with illness
  - Dying during workup/acute assessment

Impact on inpatient palliative units

- Open beds
- Moral distress
- Challenging delirium
- Limited use of interventions that are considered AGMP
- Increased workload for nurses
- PPE a barrier to care at times

Impacts on patients/families

- Loneliness, hopelessness
- Increases in Anxiety and Depression
- Requests for MAiD
- Impaired Communication
- Families frustrated/angry
- Discharges with inadequate planning/support

Interventions

- Provided basic “palliative care during Covid-19” guidelines
- On PCU’s Virtual visits via tablets/phones, Solarium visits
- Modified visiting largely facilitated by social work
  - unable to perform some of usual duties.
- “Get to Know My Loved One” tool – in ICU’s and PCU’s
- In the ICU: Bundled intervention
  - Family liaison volunteers
  - Virtual family presence, including presence in rounds

Get To Know My Loved One

A tool to help healthcare professionals
Provide patient-centred care during COVID-19

Hi Team!

My name is _____ . *Please meet my* _____
(relationship to patient)

Some of the people who know _____ *best are:*
(patient name)

_____
(name and relationship to patient)

_____
(name and relationship to patient)

_____
(name and relationship to patient)

Her/His/Their preferred name is _____

Adapted from the UAB Center for Palliative and Supportive Care.

Her/His/Their favourite things are _____
(food, drinks, music, conversation topics)

_____

She/He/They do not like _____

Other important aspects I want you to know about my loved one:

_____

Tips to care for Her/Him/Them from a family/caregiver's standpoint:

Adapted from the UAB Center for Palliative and Supportive Care.

Moving forward

- Advocacy for inclusion in planning
- Inpatient Palliative care at all tertiary centers
- Working towards concomitant care models to move palliative care upstream

Upsides

- Recognition of the importance of compassionate, patient centered approach
- Increased collaboration with spiritual care and social work in acute settings
- Broad based support for palliative care approach from nursing and allied health
- We are learning that more stay-at-home deaths may be possible.

Implications for palliative care in the hospital setting
Dr. Amane Abdul-Razzak

- In Calgary Zone, not a lot of acute care palliative involvement in Covid-19 cases:
  - In Alberta LTC residents ~72% of covid-19 deaths1 (many not transferred to hospital)
  - We have been involved in small number of EoL situations, sometimes by phone to minimize exposure, preserve PPE

- Decreased volumes overall
  - Palliative consultation services at four adult hospital sites
  - Intensive Palliative Care Unit (IPCU) at the Foothills Medical Centre
  - (Colleagues in the community busier)

Implications for palliative care in the hospital setting

- Much less family presence in hospital
  - Challenges for healthcare providers, decision-making
  - Liaising with family (be their “eyes and ears” and complex communication)

- Complex Discharges:
  - Patients keen to get out/families keen to care for them at home
  - Limited supports in community
  - Families wishing to manage very complex cases at home

- Hospital versus Hospice
  - Hospital visitation policy sometimes more liberal than hospice
  - Patients/families wishing to stay in hospital to allow more family presence

The bad

- Communication and rapport building with PPE, physical distancing measures
- Family Centered Care & Visitation Policies
- “Reductionist” approach to palliative care
  - Phone consultations to minimize exposure for covid-19 + cases
  - Less interdisciplinary team involvement (e.g., on IPCU, recreational therapist, volunteers (bread!), music)
- Healthcare provider distress:
  - About hospital/public health policies
  - The uncertainty about covid-19; policies and changes
  - Concern about own health and family/loved ones

The good

- ACP is top of mind
  - Especially for those at higher risk of serious covid-19 infection (generally high priority group for ACP)
- Palliative care providers as leaders
  - Sharing knowledge
  - Lending support to our colleagues
- Highlights need for universal foundational palliative education
  - All healthcare providers should have fundamental palliative approach to care
  - Unique palliative care lens when looking at pandemic

The plans and changes

- Pandemic Surge Planning for acute care consult services and IPCU:
  - Pandemic palliative care: beyond ventilators and saving lives (CMAJ 2020 April 14;192:E400-4.doi: 10.1503/cmaj.200465) as a foundational reference
  - Adapted to local context
  - In anticipation of possible med shortages—alternative medication document

- Back-up planning for on-call shifts
  - Staff availability

- Resources for non-palliative care colleagues for example:
  - Symptom management, palliative sedation
  - Alberta Health Services Covid-adapted serious illness conversations guide (https://www.albertahealthservices.ca/assets/info/ppih/if-ppih-covid-planning-with-vulnerable-patients.pdf)

The plans and changes (continued)

- Palliative physician team meetings
- Multidisciplinary Rounds (acute care consultation services and IPCU)
- Grand Rounds, Journal Clubs and Resident teaching
- Video- or tele-conferencing between healthcare providers and family members
  - Including multidisciplinary family meetings

Thinking ahead

- Grief support
  - Isolation
  - Limited visitation, loved ones visiting on their own (burden)
  - Impact on traditional funeral services
  - Mourning alone
  - Potential for complicated grief[2]
- Healthcare provider distress[3]
- If future waves arise:
  - Cohesive group (Calgary Zone PEOLC)
  - Redeployment of acute care MDs and possibly clinical nurse specialists to other sites (e.g., LTC, community) as needed

Thinking ahead (continued)

Family-Centered Care

- High quality communication skills when delivering “bad news” about policies/restrictions
  - Recognition that these represent threats to family integrity and autonomy
- Develop a structured approach to maintaining communication with family:[4]
  - Healthcare provider with family
  - Patient with family
  - Family to family
- Progress, not regression in family-centered care[5]—pall care needs to lead the way

References

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THANK YOU

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