COVID-19 Critical Intelligence Unit

Evidence check

updated 12 April 2020

Rapid evidence checks are based on a simplified review method and may not be entirely exhaustive, but aim to provide a balanced assessment of what is already known about a specific problem or issue. This brief has not been peer-reviewed and should not be a substitute for individual clinical judgement, nor is it an endorsed position of NSW Health.

Palliative care and COVID-19

Rapid review question

What evidence is available on the organisation of palliative care services during COVID-19 (or previous pandemics)?

In brief

Published guidance varies in the use of stepped approaches to palliative care as demand increases in the course of the COVID-19 outbreak:

- Guidelines from Switzerland emphasise the importance of providing access to palliative care, clarifying goals in advance, interdisciplinary team decisions and psychosocial and spiritual needs
- A rapid review of previous pandemics and insights from experts in the field both acknowledge the need to respond rapidly and flexibly to changing circumstances, to train non-specialists in palliative care, deploy volunteers, and use technology to support communication with patients and carers
- A case report of a staged model for providing palliative care outlines what comprises 'conventional', 'contingency' and 'crisis' models of care
- A narrative article outlines a pandemic plan with four key themes; 'stuff' (stockpile medications for common symptoms), staff (identify all clinicians with palliative care expertise), space (identify wards that could accommodate large numbers of people) and systems (create a triage system).

Background

Older, often frail, people are at highest risk for severe and fatal COVID-19 infections. Severe illness with an uncertain outcome call for good palliative care of patients. (1) This review aims to synthesis the evidence available of palliative care services during COVID-19 or previous pandemics.

Limitations

New evidence on this topic is emerging rapidly. The evidence is generally based on case studies and expert opinion. Health systems differ in the models of palliative care provided pre-COVID-19.

Methods (Appendix 1)

Google and PubMed were searched on 28 March using terms palliative care and COVID-19, and was updated on 12 April.

Results (Table 1)

Table One: COVID - 19		
Source Title and Organisation	**Advice**	**Source Link**
Creating a palliative care inpatient response plan for COVID-19 – the UW Medicine Experience (University of Washington, Seattle, USA) Fausto et al, 2020 (2)	Developed a strategy to implement a palliative care response for a multi-hospital healthcare system that incorporates conventional capacity, contingency capacity, and crisis capacity • focuses on the ED, ICU, and acute care services. • key content areas including identifying and addressing goals of care, addressing moderate and severe symptoms, and supporting family members.	https://www.sciencedirect.com/science/article/pii/S0885392420301767?via%3Dihub
Palliative Care Pandemic Pack: a Specialist Palliative Care Service response to planning the COVID-19 pandemic (New Zealand) Ferguson and Barham, 2020 (3)	Describes the Waikato Palliative Care Pandemic Pack which was developed to disseminate information, guidance, and resources to enable rapid up-skilling of non-specialist clinicians needing to provide palliative care. Includes: • guidance for organisations and clinicians • management of dyspnoea • management of respiratory secretions • management of delirium • patients with pre-existing renal failure	https://www.sciencedirect.com/science/article/pii/S0885392420301779?via%3Dihub
The Role and Response of Palliative Care and Hospice Services in Epidemics and Pandemics: A Rapid Review to Inform Practice During the COVID-19 Pandemic (UK) Etkind et al, 2020 (4)	Hospice and palliative services have an essential role in the response to COVID-19 by: • responding rapidly and flexibly; • ensuring protocols for symptom management are available, and training non-specialists in their use; • being involved in triage; • considering shifting resources into the community; • considering redeploying volunteers to provide psychosocial and bereavement care; • facilitating camaraderie among staff and adopt measures to deal with stress; • using technology to communicate with patients and carers; • adopting standardised data collection systems to inform operational changes and improve care.	https://pubmed.ncbi.nlm.nih.gov/32278097/

"COVID-19, decision making, and palliative care Kunz et al, 2020 (1)	Principles for palliative care triage include: • All dying COVID19 patients should have access to palliative care. All triage policies should underline the pivotal role of palliative care for all patients who are likely to die from COVID-19 especially given their high symptom burden • Prevent triage discussions by clarifying goals of care with the patients in advance • Involve a palliative care specialist in complex triage decisions. Decisions should involve an interdisciplinary team, e.g. with an intensive care physician, an internist, and a palliative care specialist, and should never rest on a single person alone • Psychosocial and spiritual care of patients, relatives and health care professionals are of utmost importance. The availability of qualified psychosocial and spiritual support, including in particular bereavement services, is essential. **Clinical options of palliative care during COVID-19** If the medical decision is to offer palliative care, the decision whether this should take place in a hospital setting or in the nursing home depends on: ○ The severity and complexity of symptoms and additional care needs ○ The nursing home/ambulatory care capacity of delivering quality palliative care ○ The availability of hospital/palliative care unit beds ○ The patients wish	https://pubmed.ncbi.nlm.nih.gov/32208497/
COVID-19 Pandemic: Palliative Care for Elderly and Frail Patients at Home and in Residential and Nursing Homes - Swiss Medical Weekly Borasio et al, 2020 (5)	Advanced care planning is crucial early, as most people would prefer to die, not in an intensive-care unit, but in their familiar environment. Explaining the serious nature of the infection and the poor prognosis and the possibilities of palliative care allows the patient to make an autonomous decision. The decision should be discussed with the relatives caring for the patient and appropriately documented, able to be accessed at all times. If the patient decides against	https://pubmed.ncbi.nlm.nih.gov/32208494/

	hospital treatment, plans should be made for palliative care in the (nursing) home setting.	

Statement on Coronavirus Disease 2019 (COVID-19), Palliative Care Australia	• Key principles; This includes understanding people's preferences and wishes, developing clear goals of care and helping patients undertake advance care planning.
	• The group have put together immediate issues that warrant consideration:
	  ○ Access to - and stock of - the appropriate prescription medicines
	  ○ Optimising telehealth for reduced face to face consultations
	  ○ Protecting healthcare workers (e.g. PPE)
	  ○ Advanced care planning
		https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2020/03/Palliative-Care-Australia-statement-FINALupdated-2603.pdf

Palliative care network framework in response to COVID-19 emergency – Bologna Italy	• Patients are management by phone where possible • Video calls are encouraged where possible to improve clinical assessments • Suitability of any current non-lifesaving treatment be reviewed and the use of diagnostic tests reduced to a minimum • Seek the advice of specialist colleagues regarding the potential adjustment of treatment that requires continuous clinical and laboratory monitoring, for patients in the advanced stages of disease • The home delivery of drugs will be organised for delivery without any direct contact if resources allow or a family member could collect • Regarding home care, patient visits are possible, but only after a telephone consultation and where care cannot be organised in another way • The medical history questionnaire was completed first (which shows if suspected COVID-19) • If not suspected COVID-19, home visit takes place with standard PPE • If indicates COVID-19, a home visit may not take place	https://www.eapcnet.eu/Portals/0/adam/Content/9mJL4s6J4k2llSSDO-dEEQ/Text/Example%20operational%20guidelines-LPCN-Bologna_17-Mar-20%20ENG%20PLUS%20questionnaire.pdf

Table Two: Pandemics		
Source Title and Organisation	**Advice**	**Source Link**
World Health Organisation - Integrating palliative care and symptom relief into the response to humanitarian emergencies and crises: a WHO guide 2018	Outlines broad principles of palliative care during and epidemic including: • Put in place policies • Train and equip staff • Include essential palliative care medicines in emergency health kits • Seek partnerships • Recruit volunteers • Support staff • Provide information	https://apps.who.int/iris/bitstream/handle/10665/274565/9789241514460-eng.pdf?sequence=1&isAllowed=y
Oxford university press - Palliative Care Needs of People Affected by Natural Hazards, Political or Ethnic Conflict, Epidemics of Life-threatening Infections, and Other Humanitarian Crises 2019	Regardless of the types of humanitarian crisis or the types of suffering it causes, several principles apply to the triage process: 1. Palliative care and life-saving treatment should not be regarded as distinct. Palliative care should be integrated as much as possible with life-saving treatment for patients with acute life-threatening conditions (triaged red). 2. Palliative care must be provided for all patients deemed expectant (triaged blue) and should commence immediately. 3. Palliative care should commence immediately, as needed, for patients with non-life-threatening conditions whose injury- or disease-specific treatment may be delayed (triaged yellow). 4. Repeat triage should be practiced, especially for patients triaged blue and yellow, to make sure that important changes in the patient's condition that should result in a change in triage category are not missed.	https://oxfordmedicine.com/view/10.1093/med/9780190066529.001.0001/med-9780190066529-chapter-2?print=pdf

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Table 2.3. Recommended Triage Categories in Humanitarian Emergencies and Crises
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<tr><th>Category</th><th>Color Code</th><th>Description</th></tr>
<tr><td>1. Immediate</td><td>Red</td><td>Survival possible with immediate treatment.
Palliative care should be integrated with life-sustaining treatment as much as possible.</td></tr>
<tr><td>2. Expectant</td><td>Blue</td><td>Survival not possible given the care that is available.
Palliative care is required.</td></tr>
<tr><td>3. Delayed</td><td>Yellow</td><td>Not in immediate danger of death, but treatment needed soon.
Palliative care and/or symptom relief may be needed immediately.</td></tr>
<tr><td>4. Minimal</td><td>Green</td><td>Will need medical care at some point after patients with more critical conditions have been treated.
Symptom relief may be needed.</td></tr>
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Source: WHO (2018).[3]
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<td>Systematic review (descriptive)

Nouvet et al, 2018</td>
<td>Palliative care needs and interventions provided in crises, challenges of care provision particularly due to inadequate pain relief resources and guidelines, a lack of consensus on the ethics of providing or limiting palliative care as part of humanitarian healthcare response, and the importance of contextually appropriate care. Four main themes were found: the complexity of defining palliative care needs, characteristics of palliative care provision, ethical rationales and potential objections to providing palliative care and recommendations for best practices of palliative care</td>
<td>https://jhumanitarianaction.springeropen.com/articles/10.1186/s41018-018-0033-8</td>
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~~Journal of pain and symptom management~~ – review article 2009 Downar et al, 2010	**Table 1** Summary of Palliative Care Pandemic Plan	https://www.jpsmjournal.com/article/S0885-3924(09)01143-9/pdf

"Stuff"	Staff	Space	Systems
Stockpile medications for common symptoms: • Opioids for dyspnea and pain • Haloperidol or methotrimeprazine for nausea and delirium • Scopolamine for secretions Stockpile equipment to deliver medications: • Subcutaneous butterflies • Continuous drug delivery pumps Prepare kits including medications and equipment to deliver medications for long-term care facilities and home care services.	Identify all clinicians with palliative care expertise: • Physicians • Nurse specialists Provide focused education sessions to frontline staff for symptom management and end-of-life care for H1N1 patients. Develop standardized order sheets and protocols for symptom management and end-of-life care for H1N1 patients. Involve specialist allied health care workers to provide psychosocial support and grief and bereavement counseling. • Social workers • Spiritual care staff	Identify wards and nonclinical areas in allhealth care facilities that would be appropriate to accommodate large numbers of patients expected to die. Maximize the use of identified palliative care unit, hospice, and ward beds.	Create a triage system to identify patients in need of specialist palliative care management (see text). Create a triaging system for intrafacility, interfacility, and community transfers to dedicated palliative care units, hospices and wards. Create a system for direct consultation support for staff in hospitals, long-term care facilities, and the community by telephone or telemedicine. Ensure that all patients currently admitted to health care facilities have clear and updated advance care plans.

References

1. Kunz R, Minder M. COVID-19 pandemic: palliative care for elderly and frail patients at home and in residential and nursing homes. Swiss Med Wkly. 2020;150:w20235.
2. Fausto J, Hirano L, Lam D, Mehta A, Mills B, Owens D, et al. Creating a Palliative Care Inpatient Response Plan for COVID19 - The UW Medicine Experience. J Pain Symptom Manage. 2020.
3. Ferguson L, Barham D. Palliative Care Pandemic Pack: a Specialist Palliative Care Service response to planning the COVID-19 pandemic. J Pain Symptom Manage. 2020.
4. Etkind SN, Bone AE, Lovell N, Cripps RL, Harding R, Higginson IJ, et al. The role and response of palliative care and hospice services in epidemics and pandemics: a rapid review to inform practice during the COVID-19 pandemic. J Pain Symptom Manage. 2020.
5. Borasio GD, Gamondi C, Obrist M, Jox R, For The Covid-Task Force Of Palliative C. COVID-19: decision making and palliative care. Swiss Med Wkly. 2020;150:w20233.

Appendix 1:

PubMed search terms: ((palliative care[MeSH Terms] OR palliat*[title/abstract] OR hospices[MeSH Terms] OR “terminal care”[title/abstract] OR "terminally ill"[title/abstract])) AND ((2019-nCoV[title/abstract] or nCoV[title/abstract] or covid-19[title/abstract] or covid19[title/abstract] or "covid 19"[title/abstract] OR "coronavirus"[MeSH Terms] OR "coronavirus"[title/abstract]))

PubMed search terms: ((palliative care[MeSH Terms] OR palliat*[title/abstract] OR hospices[MeSH Terms] OR “terminal care”[title/abstract] OR "terminally ill"[title/abstract])) AND ("pandemics"[MeSH Terms] OR "pandemic*"[title/abstract])

Document History

Original search **28 March 2020**	
Review 12 April 2020	• Four new publications included (Fausto et al, Ferguson and Barham; Etkind et al; Borasio et al) • Key messages changed to reflect the variation in guidance and the move toward a stepped approach to palliative care services as demand increases in the course of the COVID-19 outbreak. • Removed results text as new format is to use in brief and tabulated results only. • Added a limitations section