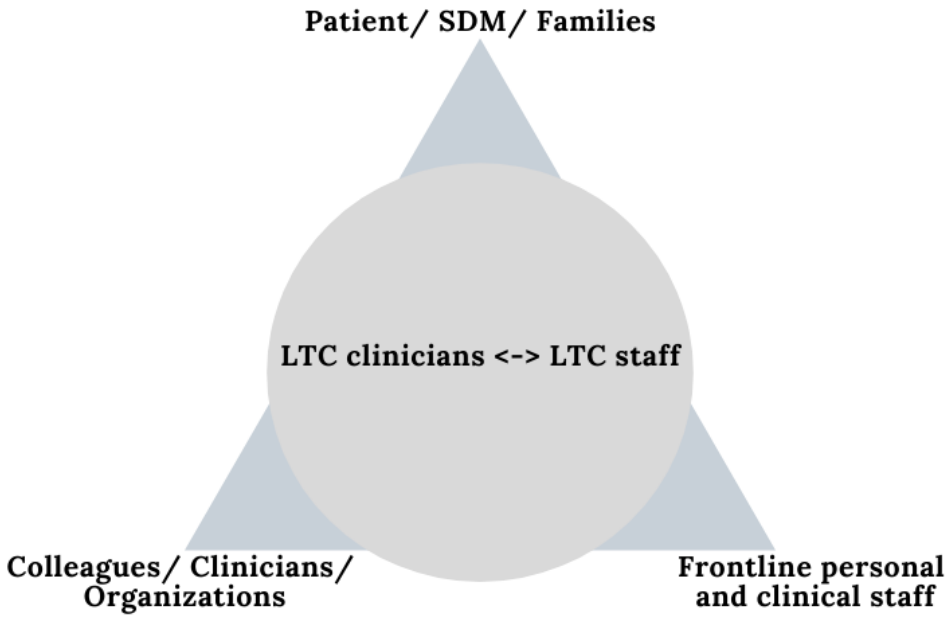
An approach to end-of-life care in LTC during COVID-19 outbreaks

This document includes a summary of what we learned so far about the process, barriers, and resources pertaining to palliative approach to care in LTC that could help current homes with COVID-19 outbreaks.

COVID-19 outbreaks in long-term care can overwhelm even the most prepared homes. Given the known high mortality rate in this vulnerable population, readiness at the time of the outbreak should involve not only serious efforts to contain the transmission of the virus but also preparedness for the inevitable high mortality in COVID-19 infected patients. Preparedness to provide high quality palliative approach to care can ensure comfortable end-of-life journey for patients and their families in spite of strained resources. The following is an approach to be considered from a group of palliative care providers who work in long-term-care and have experience with longstanding challenges in this setting. For convenience, consider using the **3Cs of communication** intended to encapsulate and address all involved in the process of providing good end-of-life care during this pandemic. This is further illustrated through the infographic below.



A COMMUNICATION MODEL TO ENHANCE APPROACH TO PALLIATIVE CARE IN LTC HOMES DURING COVID-19 OUTBREAKS

C1- Communication with RNS/RPNs/PSWs

Communicate with frontline nursing and support staff. Some LTC homes have PSW's and nurses who have taken the LEAP palliative care course for LTC. They can be identified as palliative care champions. They can educate and increase the awareness of their colleagues to be on the lookout for signs of discomfort and report to the attending clinician immediately. As this highly valuable resource **VitalTalk** put it, *" these are unprecedented times. There's no roadmap. We're facing conversations that we never expected—or wanted—to have"*. The website offers helpful language for communicating with patients and families about serious illness and end-of-life decisions.

The clinician can have ongoing check-in rounds with nurses on all floors/ units in the home to ensure that not only acute or new medical concerns are addressed but that comfort care is reviewed as its own topic during rounds, whether in person or virtually. As we continue to develop the provincial palliative care strategy with leading organizations such as OPCN and HPCO, it is worth remembering that palliative end-of-care involves every layer of care, including personal, recreational, clinical, etc.

This continues to evolve and improve provincially. Various LHINs have placed efforts into offering training to frontline long-term care workers (including PSWs, nurses, management staff, etc) on Advance Care Planning and having difficult conversations about serious illness and death. With efforts made to reduce visitors to LTC homes forcing some clinicians to choose one working place or conduct virtual rounds, perhaps ordering end-of-life medications is the most obvious step in the practice of palliative care. Recognition and shared understanding of goals need to happen as early as possible and this requires an intentional interdisciplinary effort that begins well before order sets. HPCO published an excellent education video on management of respiratory distress in LTC that is useful for all frontline healthcare works **here.**

C2-Communicate with the patient/ SDM/ families

Given the physical distancing within the community and clinical settings, communicating with patients and families through alternative means is critical. Virtual rounds and phone rounds became necessary. Pallium Canada is offering a webinar on Providing Virtual Palliative Care on May 8th. Participants can register **here**. Many of these webinars are recorded for future viewing. Some homes have chosen to send a letter from the medical director to the families of residents in LTC.

Sample letters can be found on the OLTCC website from April 3rd COVID-19 report **here** and on **speakupontario.ca** **here** This kind of communication is helpful and assures the families that the staff in the nursing home are working as a team where medical leadership is engaged. Once a resident is confirmed to have COVID-19, the SDM (Substitute Decision Maker) should be contacted as soon as possible to discuss Goals of Care (GOC) if they were never discussed. If they were, they can be updated and documents and a Serious Illness Conversation (SIC) can be had. Templates for GOC and SIC have been published previously by OLTCC **here**. This allows families to be involved in shared decision-making and end-of-life care immediately which alleviates their anxiety and grief.

OLTCC has also created a summary of resources from **speakupontario.ca** in the COVID-19 Report from April 6th **here**. It can be accessed directly **here** as well. The family should be prepared and informed that while their loved one could recover from the viral illness there is also a higher chance of mortality. Permission can be obtained to initiate comfort care without delay if the patient deteriorates rapidly. This permission and availability to act and initiate comfort measures early is key to ensure that patients do not suffer unnecessarily and for families to know that their loved one will be treated according to their wishes and be peaceful and comfortable about the process to the end.

Order sets for end-of-life care have been made available by **Baycrest**/ UoT, McMaster University Division of Palliative Care, and HPCO and can be utilized for convenience. A sample from HPCO is also available **here**. Finally, an evidence-based palliative sedation protocol developed by Waterloo Region Hospice Palliative Care can be accessed **here**. The guide provides not only clinical guidelines but also definitions and context which is helpful when having discussions with patients and their SDMs.

C3-Communicate with other colleagues/ clinicians/ organizations

Clinicians who work in long-term care tend to be well-versed in end-of-life care. Many OLTCC members have had the advantage of attending full-day workshops and lectures by renown palliative care experts during the annual OLTCC conference Pearls in LTC, which usually takes place in October. Various LHINs and OHTs have created working groups to engage long-term care clinicians. Some through virtual meetings, others through WhatsApp chat groups.

Organizations and associations such as OCPN, HPCO, OCFP, CCFP and OMA have engaged their members and clinicians making available plenty of resources and access to webinars with Q&A opportunities for long-term-care clinicians. Clinicians working in LTC can reach out to OTCC via email to inquire about resources if needed at office@oltcc.ca. Connecting with other colleagues who work in homes that have outbreaks can be helpful with sharing clinical experience and creating a community of practice given the unique context of LTC homes.

Through engagement with various groups and organizations, clinicians have been able to access resources pertaining to clinical practice and also resource to help support their interdisciplinary teams and families, including grieve and bereavement resources which are most critical through these difficult times. An example is a resource through **Wellbeing Waterloo**. HPCO will be offering 10 seminars on Complicated Grief and Trauma beginning May 6th. Clinicians can register **here**. While we recognize that there is no centralized location or pathway to access resources, it is evident that there is an abundance of knowledge and willingness to share expertise and create collaborative networks amongst clinicians.

This is a critical time for building such bridges to enhance the quality and standards of end-of-life care delivered in various primary care settings and in particular LTC where COVID-19 has hit the hardest.

To close the circle of communication, clinicians can share resources and skills back with frontline and interdisciplinary team in their LTC homes, including frontline personal and clinical staff as well as social workers,

BSO support staff, recreational therapists and the chaplain or spiritual support staff when appropriate.

We suggest that this is the time for intimate communication amongst interdisciplinary staff in long-term-care homes wether directly or via an organized mechanism with support from administrative and clinical management. Through the harvesting of such collective power, end-of-life care can be maximized and optimized as we endure this crisis and look forward to long term solutions to to enhance high quality resident care and safety in long-term-care.

It is also worth mentioning that tremendous collaborative efforts have been made by OTCC and various other organizations to work with Ontario Health and the Ministry of LTC to address barriers to high standards in end-of-life care in LTC. This includes, but is not limited to making available emergency response teams during this unprecedented crisis and ensuring that clinicians can bill fairly for such critical medical services wether delivered in person or virtually. Continuing to collaborate to strengthen the infrastructure for end-of-life care in LTC is something that OLTCC will continue to take seriously during this pandemic and beyond.

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