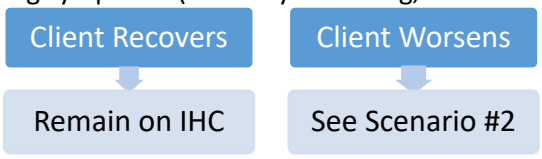
Palliative Care Support for COVID-19+ Clients Receiving Home Care in the Community

Purpose: This document outlines three (3) scenarios, recommendations, and supporting resources for providing Palliative care support to clients with COVID19 who are currently on Integrated Home Care.

Supporting Documents: Please see "*Palliative Care Toolkit for Integrated Home Care Teams during COVID-19 Pandemic*" for resources to support community care of clients with COVID19

Scenario 1: COVID 19+ client with mild flu-like symptoms

IHC Client Description:	Mild flu-like symptoms include: cough, sore throat, muscle aches, fatigue, runny nose, low grade fever
Primary Recommendation(s):	Client remains on Integrated Home Care (IHC) team
Guidance:	In light of the COVID-19 pandemic, there are a number of important conversations regarding Goals of Care Designations, which should be revisited by clinicians. AHS Clinical Ethics has created the Goals of Care Designations during Pandemic Conditions guidance document, intended to support decision-making during COVID-19. **1.** Refer to Palliative Care Consult Service for support with Serious Illness Conversations and ACP and GCD discussions, especially if GCD is M1 or M2. **2.** IHC Case Manager, in collaboration with MRHP, and with support from Palliative Care Consult Service, to monitor client DAILY for worsening symptoms (difficulty breathing, increased SOB). 

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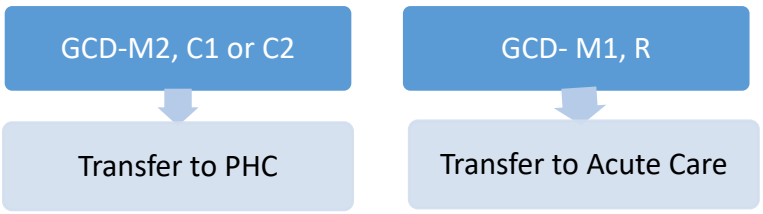
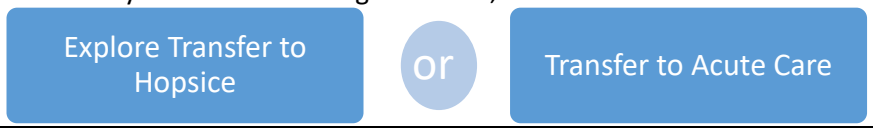
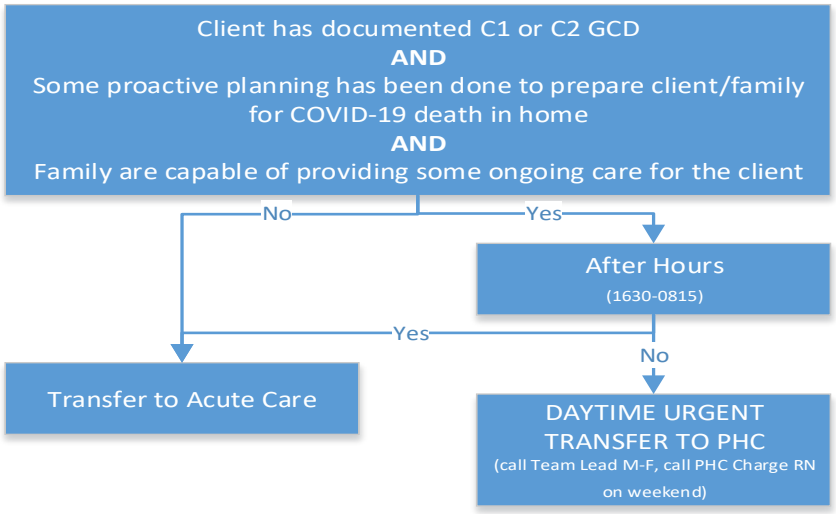
Scenario 2: COVID 19+ client with worsening symptoms

IHC Client Description:	Worsening symptoms include: difficulty breathing, increased SOB
Primary Recommendation(s):	IHC to have discussion with client and family re: GCD and wishes for care and proceed as appropriate (guidance).
Guidance:	1. Refer to Palliative Care Consult Service for support with Serious Illness Conversations and ACP and GCD discussions, especially if GCD is M1 or M2.  2. PHC Transfer processes: Call PHC Team Lead M-F, call PHC Charge RN on weekend. **AFTER HOURS 1630-0815**, consider transfer to acute care, or initiation of EMS –ATR 3. PHC Case Manager (CM) will have follow up discussions to confirm GCD, client and family wishes, available informal support system, and explain expected death in the home (EDITH) in context of COVID- 19. 4. Client to remain on PHC and be seen daily for ongoing assessment of symptoms and plan of care. 5. PHC CM to discuss with MRHP/Palliative Consultant MD regarding the initiation of medications for symptom management. 6. PHC CM to get medications in home proactively, if desire is to remain at home. • Oxygen if required. No benefit in absence of hypoxemia, deeply unconscious patients are unaware of dyspnea, others may feel adequate relief with opioids and benzodiazepines. • Palliative sedation may be needed more often for patients with COVID 19 related dyspnea 7. If family is unable to manage at home, or do NOT desire a home death: 

Scenario 3: Presumed COVID 19+ client with sudden respiratory decline

IHC Client Description:	Presumed COVID19+ client with sudden respiratory decline with the following profile: first symptoms to death within 24-48 hrs.
Primary Recommendation(s):	Urgent transfer to PHC or Acute Care as per process: 
Guidance:	1. Daytime Urgent Transfer to PHC: • Activate EMS – ATR, only if C1 or C2, for symptom management, and expected death in the home. 2. PHC RN to be deployed to clients' home for EDITH. • PHC to Support EMS as needed, collaborate with Palliative MD regarding plan of care and the initiation of medications for symptom management 3. PHC will administer & titrate medications as per palliative sedation protocol. Take CADD Solis pump to home and SC medication initiation supply kit. Palliative sedation may be needed more often for patients with COVID-19 related dyspnea 4. PHC to arrange oxygen if required. Note: No benefit in absence of hypoxemia, deeply unconscious patients are unaware of dyspnea, others may feel adequate relief with opioids and benzodiazepines. 5. PHC to coordinate ongoing plan of care for shift RN and ensure orders in the home (if Shift RN not available, PHC leadership to develop plan to deploy PHC RN to home for ongoing care) 6. PHC to provide daily visits to support Shift RN and assess ongoing symptom management and family coping/support 7. Support patient, family during and after death

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