



## BRIEF TO THE STANDING COMMITTEE ON HEALTH

### Immediate Issues and Recommendations Regarding Provision of Palliative Care During the COVID-19 Pandemic

Submitted by the Canadian Society of Palliative Care Physicians

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#### Context and reasons for urgency

The purpose of palliative care is to improve quality of life by relieving suffering of patients and their families through management of pain and other symptoms: physical, psychological, social, and spiritual.

In the context of the COVID-19 pandemic, palliative care delivery requires additional considerations due to the need for physical distancing, severity and rapid change of symptoms, varied responses to medications used for palliative care, and visitor bans/restrictions. While this is true for all people who are suffering and dying at this time, we are seeing that some people with COVID-19 can suffer immensely with shortness of breath, pain and delirium; and they may decline and die very rapidly. Symptoms from the virus do not respond predictably to usual palliative care treatments, which means physicians need to be ready for almost anything – with expertise, rapid response, alternate medications, and alternate medication delivery mechanisms.

#### Urgent Needs

- 1. More dedicated community resources for palliative care in community settings**, to provide humane, dignified care for people who do not need or want to be in the hospital. Settings include peoples' homes, long term care (LTC) and assisted living facilities, hospices, prisons, reserves, homes for adults with disabilities, and "street" services to people experiencing homelessness. Specifically:

- a. Sufficient supply of and expertise for personal protective equipment (PPE)**

Federal oversight of supply and distribution of PPE to ensure that supply is equitably distributed and that community-based settings like people's homes, LTC centres, and hospices are included.

- b. Sufficient supply of drugs and delivery mechanisms**

1. Federal monitoring of available supply of injectable drugs, management of shortages of medications needed for end of life care such as midazolam, lorazepam, methotrimeprazine, phenobarbital, fentanyl, hydromorphone, and morphine; equitable distribution including community.
2. Extend medication coverage to include a broader array of drugs than are normally used at end of life due to shortages (e.g., loxapine, phenobarbital).
3. Obtain and distribute more infusion pumps and/or syringe drivers and the associated lines and subcutaneous medication sets. Needed because higher doses and continuous infusions of medications are required to manage the symptoms of COVID-19.

## **2. Staffing to support primary and specialist palliative care for COVID-19 patients in all settings.**

Focus has been on acute management of COVID-19; however, not everyone can be saved. The need to provide humane, person-centered care is more important than ever for reducing suffering. Some healthcare providers are fearful (e.g., staff not showing up at LTC sites), which may lead to a gap in providing this care. Physicians from other disciplines have expressed they do not know how to have the difficult conversations with people about their wishes and choices. In the short term, we recommend:

- a. Expert palliative support for LTC: Ideally direct consultative support, or at minimum a regional or provincial call system for physician-to-physician advice. Not all regions have this. Those that do not will have worse problems than usual, because many primary care physicians in Canada have limited palliative care training and the symptoms of COVID-19 can be very severe, with rapid onset, rapid decline, and sometimes atypical response to treatment.
- b. Nurse navigators (or equivalent) to support patients at home and help with transfer from hospital to home.

## **3. Access to appropriate medications for management of severe symptoms in all settings.**

- a. Some medications are available in the hospital (e.g. injectable methotrimeprazine) but not in other settings.
- b. Some medications, such as midazolam and fentanyl, are being reserved only for ICU and not available in other units and settings despite being required to care for patients with palliative needs outside of the ICU.
- c. Some medications required to manage symptoms in ICU for withdrawal of life sustaining measures such as propofol, midazolam, fentanyl.
- d. Guidance for clinicians in all care settings is needed to ensure equitable access for all, as well as ways to reduce waste when medications are used.
- e. Guidelines are needed to permit reuse of unopened injectable medication vials so medications in short supply are not needlessly wasted.
- f. Ensure all nurses are trained in subcutaneous medication delivery.

## **4. National clinical standards and guidelines across all settings as well as clarity around accountability measures for organisations in all settings – for COVID-19 right now, and more broadly over time.**

- a. Healthcare professionals feel ill equipped to have goals of care or advance care planning discussions. They feel inadequately trained in their palliative and end of life care education and ability to manage symptoms at end of life. The crisis is showing that palliative care should be a standard part of training, education and care.
- b. The crisis shows need for improvements in advance care planning and the need to move palliative care upstream, so that these conversations are occurring earlier on in the illness trajectory i.e. family physicians and other specialists have these conversations for patients with advanced chronic lung diseases (such as COPD) or chronic kidney disease.
- c. There are gaps in availability and consistency of care for those who are structurally vulnerably housed.
- d. Ensure consistencies in care are provided in LTC and other community sectors.

### **About the Canadian Society of Palliative Care Physicians**

The Canadian Society of Palliative Care Physicians promotes access to palliative care for all Canadians, through advocacy, partnerships, research, and physician education. Our membership consists of over 575 palliative care physicians and physicians with a special interest in palliative care — including regional and local program leaders, educators, residency directors, clinicians, and palliative care residents.

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