

*What is the best use of our palliative care team in COVID-only inpatient units or other sites? Should we consult in the **emergency room**, before patients are admitted, or on these units?*

As the number of COVID-19 patients increase, hospitals are creating dedicated space to both protect from additional spread of the virus and ensure efficient use of PPE and staff.

Depending on the volume and organization’s goals, this could be in ICUs, through the conversion of existing, vacant, or new inpatient units, in the emergency room, or, in very extreme cases, the entire hospital.

Many hospitals are moving quickly on these decisions, while others are still considering. Decisions about dedicated units and space will vary based on organizational characteristics:

- Academic medical center
- Part of a larger health system or stand-alone
- Size of hospital
- Geography and degree of impact by COVID-19

Outlined below are several case examples and key actions palliative care teams should consider if asked to support or respond to a dedicated unit or space for COVID patients.

### Case Example #1: Closure of palliative care unit for conversion into COVID-only unit

There are not a lot of programs in this situation but some actions are relevant to any program asked to staff a dedicated unit.

- What will happen to those at-risk, seriously ill patients on the palliative care unit today? These patients need support if there are limited home supports. It may make more sense to retain the unit than convert unless there is a clear plan for existing patients.
- Ensure rooms will be redesigned to protect patients and staff and conserve PPE. (e.g. place IVs outside the room, video communication and video patient monitoring).
- Conduct a realistic assessment of staff availability (accounting for downtime, possible quarantines, or other conditions) and resources (PPE, palliative standing orders, access to other specialists) if asked to serve as attending. Ask for more resources if needed.
- If hospice is unable to come into the hospital, work with hospital leadership to develop a plan for those appropriate for hospice.

### Factors to consider when making choices about the best use of the palliative care team:

- **Size of your team** - accounting for downtime, quarantines, absences, etc.
- **Best use of palliative care skills** – e.g. support to ER before patients enter the hospital vs. providing comfort care
- **Organizational goals** – e.g. support faster discharges for non-COVID pulmonary or cardiac patients

## Case Example #2: Dedicated ICU or other unit, with palliative care as consult only

More common are units (or in some cases entire hospitals) that are being designated as COVID. Some of the same considerations from Case #1 apply, with the addition of the following:

- There may not be the ability to consult on every patient. Consider developing educational resources, standing orders, and other supports to equip fellow clinicians in managing the pain and symptoms or having goals of care conversations.
- Consider daily rounds with the attending staff to provide support and prioritize highest-need patients, achieved with respect to social distancing.
- Depending on staffing, consider 2 teams. One dedicated to the COVID patients and one covering other services and units.
- In situations where large numbers of non-COVID patients are being transitioned to regional or community hospitals, consideration must be given as to whether to cover the COVID hospital or shift resources to support patients at other sites or the emergency room.

## Case Example #3: Dedicated emergency room staff

Similar to inpatient units, palliative care teams may be asked to staff dedicated teams assigned to COVID patients coming to the emergency department. Actions specific to the emergency room setting:

- Develop community plans and resources for patients who are unable to be admitted due to capacity or who chose to go home.
- Partner with community hospices, identifying resources they need to support patients returning home. (e.g. will the hospital provide comfort packs and PPE if hospices are in short supply)
- 24/7 in person support is likely not feasible. Develop predictable staffing schedules that take into consideration the palliative care team's long term availability. (e.g. 12:30 – 8:30P 6 days per week)

## Other roles and actions for palliative care to support dedicated COVID units or sites

Palliative Care Support	Description
24/7 support line	Phone support for clinicians, families, or patients
Training	Just in time learning about communication and pain and symptom management
Comfort packs for home care	Work with pharmacy and hospices to have as part of discharge home from the hospital or emergency room
Standing order sets	Consistent pain or symptom management order sets accessible to all clinicians for use as indicated
Documentation template	Develop streamlined template for use with COVID patients
Partner with the community	Establish transition and referral processes for COVID patients. Where hospice is limited or unavailable, work with organizational leadership to create alternatives for patients and families.