End of Life Care Considerations during the COVID-19 Pandemic

Presented by:

Dr. Erin Gorman Corsten and Dr. Stephanie Connidis

Presenter Disclosure

Dr. Erin Gorman Corsten, MD, MEd, CCFP (PC)
Palliative Medicine Physician, Department of Medicine Central Zone
Palliative Medicine Residency Program Director
erin.gormancorsten@nshealth.ca

Conflict of Interest Information:

No conflicts of interest to declare, no honoraria, or industry sponsorship

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Presenter Disclosure

Dr. Stephanie Connidis MD, CCFP (COE)(PC), RACGP
Medical Director of Hospice Halifax
s.connidis@hospicehalifax.ca
Provincial Director, INSPIRED COPD Outreach Program
StephanieA.Connidis@nshealth.ca
Chair of Palliative Care Section of Doctors Nova Scotia

Conflict of Interest Declaration:

- Medical Director of Hospice Halifax- non-profit organization
- No other conflict of interest to declare, no honoraria, or industry sponsorship

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Palliative Care Pandemic Planning

SYSTEMS	• Challenges and Supports, Equity
STUFF	• What do we need?
SPACE	• Where can care occur?
STAFF	• Who can and who needs to provide palliative care?
SYMPTOMS	• Physical and existential suffering

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Downar J, Seccareccia D. Palliating a pandemic: "All patients must be care for". Journal of Pain and Symptom Management 2010;39:291-5

Arya A, Buchman S, Gagon D, Downar J. Pandemic palliative care: beyond ventilators and saving lives. Canadian Medical Association Journal (April 14, 2020 192 (15) E400-E404 (early release March 31, 2020)

Palliative Approach to Care

Provided by physicians, nurses and other health care providers who work together to provide the best quality of life possible when patients are facing a life limiting illness.

It is appropriate at any age and at any stage in a serious illness, and it can be provided along with curative treatment.

Specialized Palliative Care teams can offer an extra layer of support to this approach to care for complex symptom management.

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Equity: A Palliative Approach To Care in a Pandemic

- Although a palliative approach to care is recommended for anyone expected to die from a life limiting illness, a pandemic outbreak presents additional impetus to ensure all patients and their families receive high quality palliative care **when** and **where** it is required.
- Protocols for critical care triage may be implemented. Patients who cannot (or should not) receive critical care interventions should be the top priority for palliative care. **All patients must be cared for**.
- Inequities worsen in strained systems. Attention to marginalized and disenfranchised groups needed.

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Pandemic Palliative Care Challenges Expected

- **Surge:** Patients with ARDS and severe symptoms
- **Risk of death increases**: Comorbid illness, frailty
- **Advance Care Planning/Personal Directives**: Unexpected illness, not an imbedded practice.
- **Ventilation:** Outcome determination, resource limitations
- **Human Resources:** Palliative Approach to Care across settings and specialties
- **Pre-COVID:** close to 4500 referrals/yr requiring palliative care support

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SYSTEMS

- **Triage systems:** Ensures complex cases can be seen by Palliative Care Team
- **Community On Call**: A call rota is being established in each zone to support providers by phone with EOL care questions. *In Central Zone and Sydney, a palliative MD is available on call 24/7 via locating as usual.* In other zones, call schedule will be made available.
- **Leveraging Telemedicine/Virtual Care**: Reduce transmission, support care efficiently. Equity issues
- **Standard palliative processes and order set: Working together!**
  - **Reference COVID-19 HUB for:** Guiding Principles for a Palliative Approach to Care, End of Life Symptom Management Flowchart and PPO (soon to be approved), Assessment and Management of Delirium, Goals of Care discussions for LTC

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STUFF

- **Medication:** Conserve and monitor commonly used meds (morphine, haloperidol, midazolam, methotrimeprazine, and glycopyrrolate).
- **Pharmacy Association of Nova Scotia** (PANS): Change in practice.
- **Supplies for administration**: Access and availability.
- **PPE:** Availability for non-hospital settings is evolving. Important for high risk situations. (Health Canada guideline: How to care for a person with COVID-19 at home)

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SPACE

Inpatient Settings: Maximally utilize traditional palliative care spaces.

- In Central zone- have increased max inpatient census by 50% when beds available.
- Establish inpatient COVID cohort on wards to match Goals of Care (GOC).

Outpatient Settings: LTC, Hospice, Home.

- Care in place that aligns with GOC.
- Use of EHS Special Patient Program

Homeless: Explore options for vulnerably housed

- Example: hotel secured for vulnerably housed (North End Clinic/MOSH)

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STAFF

- Identify ALL clinicians with palliative care experience .
- **Front-line providers:** Provide education for symptom management for acute respiratory illness (eg Pallium, NSHA COVID-19 HUB, BC Centre PC Guidelines), **emphasizing the safety of symptom-targeted opioids as an early option.**
- **Allied health**: Explore online resources to provide emotional support to patients, and grief and bereavement support to family members.

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Good news!

- There are 1500 health care providers in Nova Scotia who have received primary level palliative care training through LEAP (Learning Essential Approaches to Palliative and End of Life Care).
- This training provides the basic competencies required for palliative care. Identify individuals within your team, program or site who have received this training.
- Six of these modules are currently available online free of charge from Pallium Canada **https://www.pallium.ca/course/covid-19-response-free-online-modules/**

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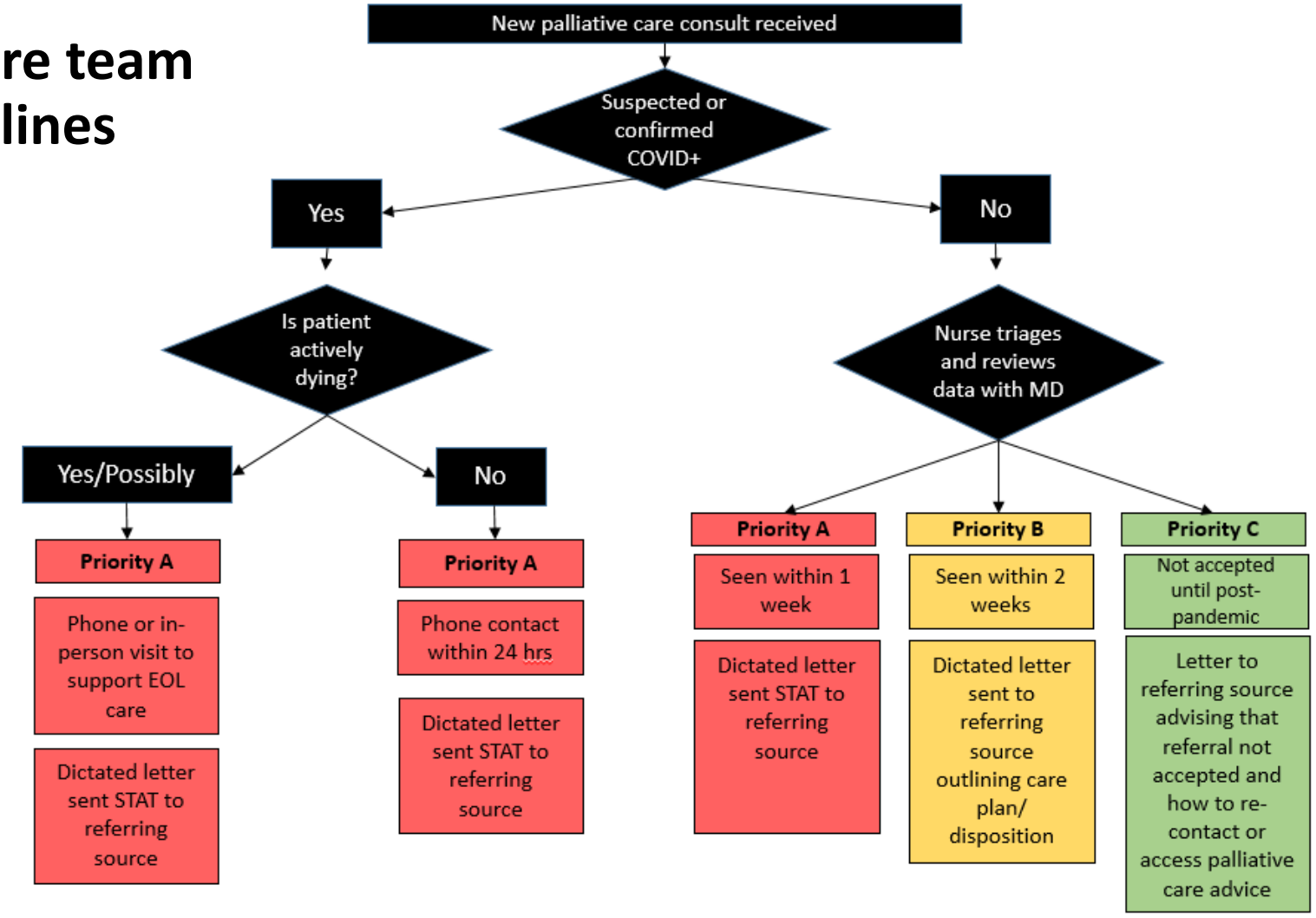
Taking Ownership	Advance Care Planning	Decision Making
Managing Dyspnea	Palliative Sedation	Last Days and Hours

Palliative Care team Triage guidelines (draft)



Caring For Actively Dying Patients With Known or Suspected Covid-19 Not Receiving Intubation

- All patients require care, including those not expected to survive.
- These patients may experience deaths with significant respiratory distress, requiring increasing and proportionate sedation to need.
- Patients may be isolated with no or limited supports.
- Dying patients will require palliation by the teams caring for them.
- Expected deaths occurring in the home rather than hospital need to be planned for, with clear instructions to families, arrangements for medications.
- Primary Care Physicians caring for someone actively dying at home, consider how home care nursing can easily reach them.

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Symptom Management

- **Recommendations for EOL care:** Are references and do not supersede your clinical judgement.
- **Appropriate opioid doses do not hasten death**. In other conditions like advanced cancer or COPD evidence supports use for dyspnea/pain; dosing should be reassessed as patient's condition or goals of care change.
- **NSHA COVID-19 HUB:** Please refer to the HUB regularly as resources and protocols continue to be added and updated.

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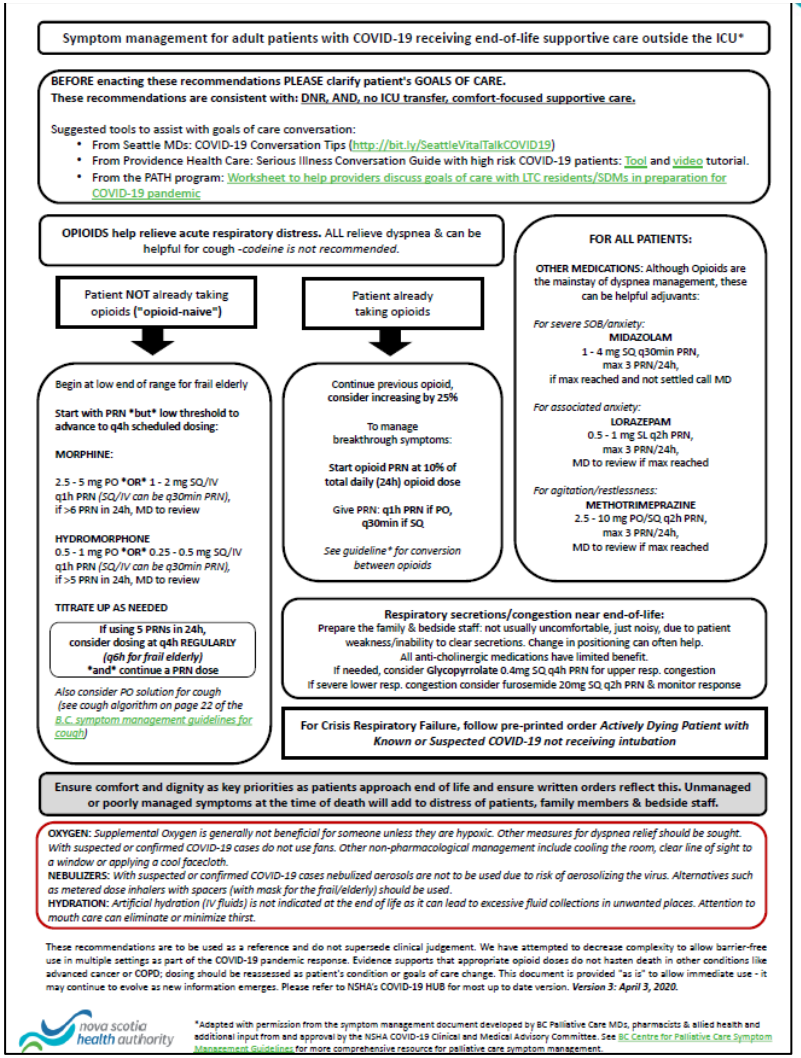
End of Life Care Symptom Management Flowchart for COVID-19:



Symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside the ICU*

BEFORE enacting these recommendations PLEASE clarify patient's GOALS OF CARE.
These recommendations are consistent with: DNR, AND, no ICU transfer, comfort-focused supportive care.

Suggested tools to assist with goals of care conversation:
- From Seattle MDs: COVID-19 Conversation Tips (http://bit.ly/SeattleVitalTalkCOVID19)
- From Providence Health Care: Serious Illness Conversation Guide with high risk COVID-19 patients: Tool and video tutorial.
- From the PATH program: Worksheet to help providers discuss goals of care with LTC residents/SDMs in preparation for COVID-19 pandemic

OPIOIDS help relieve acute respiratory distress. ALL relieve dyspnea & can be helpful for cough -*codeine is not recommended.*

Patient NOT already taking opioids ("opioid-naive")

Begin at low end of range for frail elderly

Start with PRN *but* low threshold to advance to q4h scheduled dosing:

MORPHINE:

2.5 - 5 mg PO ***OR*** 1 - 2 mg SQ/IV
q1h PRN *(SQ/IV can be q30min PRN),*
if >6 PRN in 24h, MD to review

HYDROMORPHONE
0.5 - 1 mg PO ***OR*** 0.25 - 0.5 mg SQ/IV
q1h PRN *(SQ/IV can be q30min PRN),*
if >5 PRN in 24h, MD to review

TITRATE UP AS NEEDED

If using 5 PRNs in 24h, consider dosing at q4h REGULARLY *(q6h for frail elderly)* *and* continue a PRN dose

Also consider PO solution for cough (see cough algorithm on page 22 of the B.C. symptom management guidelines for cough)

Patient already taking opioids

Continue previous opioid, **consider increasing by 25%**

To manage breakthrough symptoms:

Start opioid PRN at 10% of total daily (24h) opioid dose

Give PRN: **q1h PRN if PO, q30min if SQ**

See guideline for conversion between opioids*

FOR ALL PATIENTS:

OTHER MEDICATIONS: Although Opioids are the mainstay of dyspnea management, these can be helpful adjuvants:

For severe SOB/anxiety:
MIDAZOLAM
1 - 4 mg SQ q30min PRN,
max 3 PRN/24h,
if max reached and not settled call MD

For associated anxiety:
LORAZEPAM
0.5 - 1 mg SL q2h PRN,
max 3 PRN/24h,
MD to review if max reached

For agitation/restlessness:
METHOTRIMEPRAZINE
2.5 - 10 mg PO/SQ q2h PRN,
max 3 PRN/24h,
MD to review if max reached

Respiratory secretions/congestion near end-of-life:
Prepare the family & bedside staff: not usually uncomfortable, just noisy, due to patient weakness/inability to clear secretions. Change in positioning can often help.
All anti-cholinergic medications have limited benefit.
If needed, consider **Glycopyrrolate** 0.4mg SQ q4h PRN for upper resp. congestion
If severe lower resp. congestion consider furosemide 20mg SQ q2h PRN & monitor response

For Crisis Respiratory Failure, follow pre-printed order *Actively Dying Patient with Known or Suspected COVID-19 not receiving intubation*

Ensure comfort and dignity as key priorities as patients approach end of life and ensure written orders reflect this. Unmanaged or poorly managed symptoms at the time of death will add to distress of patients, family members & bedside staff.

OXYGEN: *Supplemental Oxygen is generally not beneficial for someone unless they are hypoxic. Other measures for dyspnea relief should be sought. With suspected or confirmed COVID-19 cases do not use fans. Other non-pharmacological management include cooling the room, clear line of sight to a window or applying a cool facecloth.*
NEBULIZERS: *With suspected or confirmed COVID-19 cases nebulized aerosols are not to be used due to risk of aerosolizing the virus. Alternatives such as metered dose inhalers with spacers (with mask for the frail/elderly) should be used.*
HYDRATION: *Artificial hydration (IV fluids) is not indicated at the end of life as it can lead to excessive fluid collections in unwanted places. Attention to mouth care can eliminate or minimize thirst.*

These recommendations are to be used as a reference and do not supersede clinical judgement. We have attempted to decrease complexity to allow barrier-free use in multiple settings as part of the COVID-19 pandemic response. Evidence supports that appropriate opioid doses do not hasten death in other conditions like advanced cancer or COPD; dosing should be reassessed as patient's condition or goals of care change. This document is provided "as is" to allow immediate use - it may continue to evolve as new information emerges. Please refer to NSHA's COVID-19 HUB for most up to date version. ***Version 3: April 3, 2020.***

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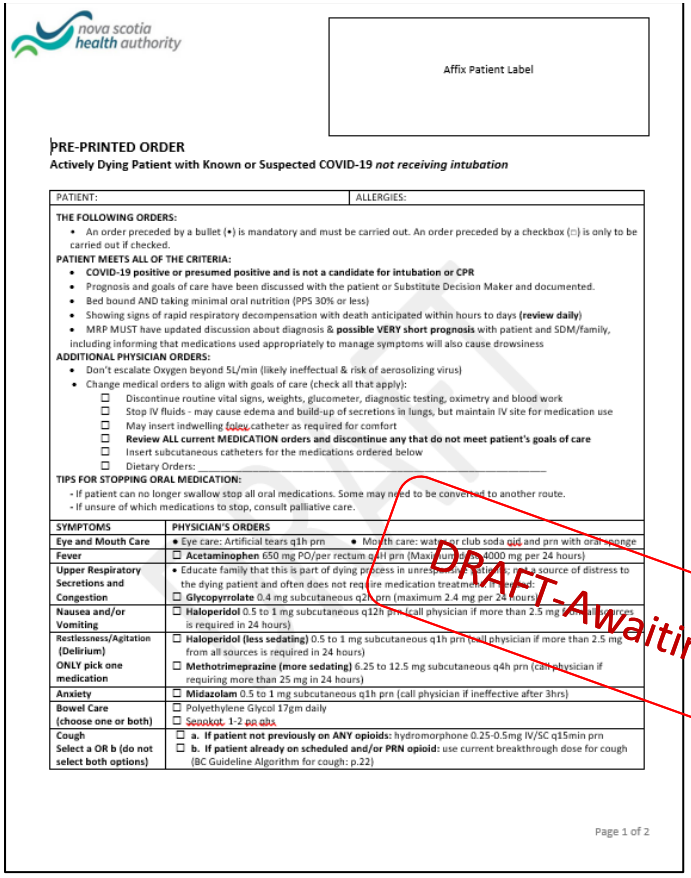
*Adapted with permission from the symptom management document developed by BC Palliative Care MDs, pharmacists & allied health and additional input from and approval by the NSHA COVID-19 Clinical and Medical Advisory Committee. See BC Centre for Palliative Care Symptom Management Guidelines for more comprehensive resource for palliative care symptom management.

Adapted with permission from the BC Symptom Management flowchart

Pre-Printed Order: Actively Dying Patient with Known or Suspected COVID-19 not receiving intubation



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Affix Patient Label

PRE-PRINTED ORDER

Actively Dying Patient with Known or Suspected COVID-19 *not receiving intubation*

PATIENT:	ALLERGIES:

THE FOLLOWING ORDERS:

- An order preceded by a bullet (•) is mandatory and must be carried out. An order preceded by a checkbox (☐) is only to be carried out if checked.

PATIENT MEETS ALL OF THE CRITERIA:

- **COVID-19 positive or presumed positive and is not a candidate for intubation or CPR**
- Prognosis and goals of care have been discussed with the patient or Substitute Decision Maker and documented.
- Bed bound AND taking minimal oral nutrition (PPS 30% or less)
- Showing signs of rapid respiratory decompensation with death anticipated within hours to days **(review daily)**
- MRP MUST have updated discussion about diagnosis & **possible VERY short prognosis** with patient and SDM/family, including informing that medications used appropriately to manage symptoms will also cause drowsiness

ADDITIONAL PHYSICIAN ORDERS:

- Don't escalate Oxygen beyond 5L/min (likely ineffectual & risk of aerosolizing virus)
- Change medical orders to align with goals of care (check all that apply):
  - ☐ Discontinue routine vital signs, weights, glucometer, diagnostic testing, oximetry and blood work
  - ☐ Stop IV fluids - may cause edema and build-up of secretions in lungs, but maintain IV site for medication use
  - ☐ May insert indwelling foley catheter as required for comfort
  - ☐ **Review ALL current MEDICATION orders and discontinue any that do not meet patient's goals of care**
  - ☐ Insert subcutaneous catheters for the medications ordered below
  - ☐ Dietary Orders: _____

TIPS FOR STOPPING ORAL MEDICATION:

- If patient can no longer swallow stop all oral medications. Some may need to be converted to another route.
- If unsure of which medications to stop, consult palliative care.

SYMPTOMS	PHYSICIAN'S ORDERS
Eye and Mouth Care	• Eye care: Artificial tears q1h prn • Mouth care: water or club soda qid and prn with oral sponge
Fever	☐ **Acetaminophen** 650 mg PO/per rectum q4H prn (Maximum dose 4000 mg per 24 hours)
Upper Respiratory Secretions and Congestion	• Educate family that this is part of dying process in unresponsive patient and not a source of distress to the dying patient and often does not require medication treatment if mild ☐ **Glycopyrrolate** 0.4 mg subcutaneous q2h prn (maximum 2.4 mg per 24 hours)
Nausea and/or Vomiting	☐ **Haloperidol** 0.5 to 1 mg subcutaneous q12h prn (call physician if more than 2.5 mg per 24 hours is required in 24 hours)
Restlessness/Agitation (Delirium) ONLY pick one medication	☐ **Haloperidol (less sedating)** 0.5 to 1 mg subcutaneous q1h prn (call physician if more than 2.5 mg from all sources is required in 24 hours) ☐ **Methotrimeprazine (more sedating)** 6.25 to 12.5 mg subcutaneous q4h prn (call physician if requiring more than 25 mg in 24 hours)
Anxiety	☐ **Midazolam** 0.5 to 1 mg subcutaneous q1h prn (call physician if ineffective after 3hrs)
Bowel Care (choose one or both)	☐ Polyethylene Glycol 17gm daily ☐ ~~Senokot~~ 1-2 ~~pp obs~~
Cough Select a OR b (do not select both options)	☐ **a. If patient not previously on ANY opioids:** hydromorphone 0.25-0.5mg IV/SC q15min prn ☐ **b. If patient already on scheduled and/or PRN opioid:** use current breakthrough dose for cough (BC Guideline Algorithm for cough: p.22)

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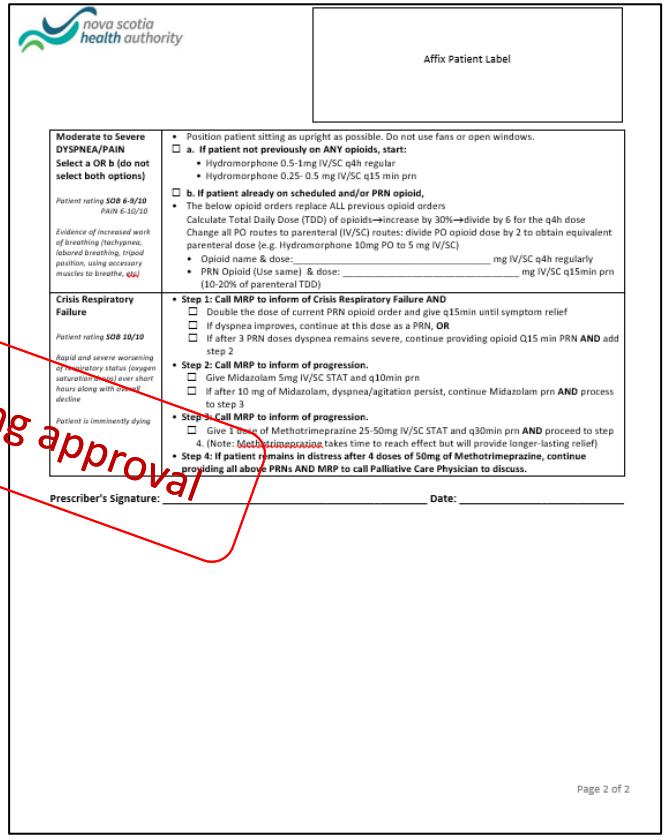

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Moderate to Severe DYSPNEA/PAIN Select a OR b (do not select both options) *Patient rating **SOB 6-9/10** **PAIN 6-10/10* *Evidence of increased work of breathing (tachypnea, labored breathing, tripod position, using accessory muscles to breathe, etc)*	• Position patient sitting as upright as possible. Do not use fans or open windows. ☐ **a. If patient not previously on ANY opioids, start:** • Hydromorphone 0.5-1mg IV/SC q4h regular • Hydromorphone 0.25- 0.5 mg IV/SC q15 min prn ☐ **b. If patient already on scheduled and/or PRN opioid,** • The below opioid orders replace ALL previous opioid orders Calculate Total Daily Dose (TDD) of opioids→increase by 30%→divide by 6 for the q4h dose Change all PO routes to parenteral (IV/SC) routes: divide PO opioid dose by 2 to obtain equivalent parenteral dose (e.g. Hydromorphone 10mg PO to 5 mg IV/SC) • Opioid name & dose:_____ mg IV/SC q4h regularly • PRN Opioid (Use same) & dose: _____ mg IV/SC q15min prn (10-20% of parenteral TDD)
Crisis Respiratory Failure *Patient rating **SOB 10/10*** *Rapid and severe worsening of respiratory status (oxygen saturations drop) over short hours along with clinical decline* *Patient is imminently dying*	• **Step 1: Call MRP to inform of Crisis Respiratory Failure AND** ☐ Double the dose of current PRN opioid order and give q15min until symptom relief ☐ If dyspnea improves, continue at this dose as a PRN, **OR** ☐ If after 3 PRN doses dyspnea remains severe, continue providing opioid Q15 min PRN **AND** add step 2 • **Step 2: Call MRP to inform of progression.** ☐ Give Midazolam 5mg IV/SC STAT and q10min prn ☐ If after 10 mg of Midazolam, dyspnea/agitation persist, continue Midazolam prn **AND** process to step 3 • **Step 3: Call MRP to inform of progression.** ☐ Give 1 dose of Methotrimeprazine 25-50mg IV/SC STAT and q30min prn **AND** proceed to step 4. (Note: Methotrimeprazine takes time to reach effect but will provide longer-lasting relief) • **Step 4: If patient remains in distress after 4 doses of 50mg of Methotrimeprazine, continue providing all above PRNs AND MRP to call Palliative Care Physician to discuss.**

Prescriber's Signature: _____ **Date:** _____

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“When is it appropriate to initiate medications or start using a PPO for EOL care for COVID-19 patients”?

- Patient with COVID-19 is not a candidate for intubation or CPR
- Prognosis and goals of care have been discussed with the patient or Delegate/Substitute Decision Maker and documented **AND**
- The patient is bed bound, functionally declining with no improvement anticipated AND taking minimal oral nutrition (PPS 30% or less)
- Showing signs of rapid respiratory decompensation with no reversibility with death anticipated within hours to days (review daily)

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First steps:

The most responsible physician MUST have updated discussion about diagnosis & **possible VERY short prognosis** with patient and/or Delegate/SDM (family if possible), including informing that medications used appropriately to manage symptoms will also cause drowsiness to allow death to occur with comfort.

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Other considerations:

- **Deprescribe:** Review ALL current MEDICATION orders and discontinue any that do not meet patient's goals of care (If unsure what to stop, consult palliative care).

- **Route:** Consider changing oral meds to subcut if likely the patient will be unable to swallow in the near future. **Remember the oral:subcut conversion is 2:1.**

- **Consider the benefit/harm of oxygen in COVID-19:** Oxygen beyond 5L/min is likely ineffectual & has a theoretical risk of aerosolizing virus.

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Focus your care on active symptom relief:

- Discontinue routine vital signs, weights, glucometer, diagnostic testing, oximetry and blood work
- Maintain IV access for medication. **NOTE: IF no IV in situ, SubCut lines can be used for symptom relieving medication**. IV fluids may contribute to edema and build-up of secretions in lungs - limit the use to small vol, if any!
- Insert indwelling foley catheter *as required for comfort*
- Avoid IM routes where possible (discomfort)

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Standard EOL Care Measures:

SYMPTOMS	PHYSICIAN'S ORDERS
Eye and Mouth Care	• Eye care: Artificial tears q1h prn • Mouth care: water or club soda qid and prn with oral sponge
Fever	☐ Acetaminophen 650 mg PO/per rectum q4H prn (Maximum dose 4000 mg per 24 hrs)
Upper Respiratory Secretions and Congestion*	• Educate family that this is part of dying process in unresponsive patients; not usually a source of distress to the dying patient and often does not require medication treatment. If needed: ☐ Glycopyrrolate 0.4 mg subcutaneous q2h prn (maximum 2.4 mg per 24 hours) *Can be given bucally as well but tastes terrible.*
Nausea and/or Vomiting	☐ Haloperidol 0.5 to 1 mg subcutaneous q12h prn (call physician if more than 2.5 mg from all sources is required in 24 hours)

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**Atropine eye drops 1%, used SUBLINGUALLY 2-4 drops q2H PRN (MORE readily available and does not require subcut route)*

Standard EOL Care Measures:

SYMPTOMS	PHYSICIAN'S ORDERS
Anxiety	☐ Midazolam 0.5 to 1 mg subcutaneous q1h prn (call physician if ineffective after 3hrs)
Bowel Care (choose one or both for patient taking PO meds)	☐ Polyethylene Glycol 17gm daily ☐ Senokot 1-2 tablets po qhs
Cough Select a OR b (do not select both options)	☐ a. If patient not previously on ANY opioids: hydromorphone 0.25-0.5mg IV/SC q15min prn ☐ b. If patient already on scheduled and/or PRN opioid: use current breakthrough dose for cough
Restlessness/ Agitation (End of Life Delirium) ONLY pick one medication	☐ Haloperidol (less sedating) 0.5 to 1 mg subcutaneous q1h prn (call physician if more than 2.5 mg from all sources is required in 24 hours) ☐ Methotrimeprazine "Nozinan" (more sedating) 6.25 to 12.5 mg subcutaneous q4h prn (call physician if requiring more than 25 mg in 24 hours).

Moderate to Severe DYSPNEA/PAIN

- *Patient rating **SOB 6-9/10** **or** PAIN 6-10/10*
- *Evidence of increased work of breathing (tachypnea, labored breathing, tripod position, using accessory muscles to breathe, etc)*

- Position patient sitting as upright as possible.
- **Do not use fans or open windows for COVID-19 patients.**

If patient not previously on ANY opioids, starting doses are:

- Hydromorphone 0.5-1mg IV or SC q4h regular
- Breakthrough dose: Hydromorphone 0.25- 0.5 mg IV/SC q15 min prn

If patient already on scheduled and/or PRN opioid

Calculate Total Daily Dose (TDD) of opioid:

- Increase by ~30%
- Take that total and divide by 6 for the q4h dose
- Change all PO routes to IV/SC routes. Divide PO opioid dose by 2 to obtain equivalent parenteral dose (e.g. Hydromorphone 10mg PO becomes 5 mg IV/SC)
- Ensure order PRN Opioid (Use the same opioid) & dose: " X" mg IV/SC q15min prn (10-20% of parenteral TDD)

Progressive and proportionate sedation may be needed as comfort measure: Crisis Respiratory Failure

- *Patient rating* ***dyspnea as 10/10, or objective distress not settling***
- *Rapid and severe worsening of respiratory status (oxygen saturation drops) over short hours along with overall decline*
- *Patient is imminently dying*

Step 1

- Double the dose of current PRN opioid order and give q15min until symptom relief
- If dyspnea improves, continue at this dose as a PRN, **OR**
- If after 3 PRN doses dyspnea remains severe, continue providing opioid Q15 min PRN **AND** add step 2

Step 2

- If distress continues despite opioid:
- Give Midazolam 5mg IV/SC STAT and repeat q10min prn
- If after 10 mg of Midazolam, dyspnea/agitation persist, continue Midazolam prn **AND**

Step 3

- Give 1 dose of Methotrimeprazine 25-50mg IV/SC STAT and q30min prn **AND** proceed to step 4.
- (Note: Methotrimeprazine takes time to reach effect but will provide longer-lasting relief)

Step 4

If patient remains in distress after 4 doses of 50mg of Methotrimeprazine, continue providing all above PRNs AND MRP to call Palliative Care Physician to discuss.

Communication and Difficult Conversations

Communication is essential to a palliative approach to care. Communication is important for:

- Identifying goals of care
- Ensuring patients and families understand and participate in decision-making regarding care

Resources for having difficult conversations can be helpful…

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Discussing Advance Care Plans

- More patients are willing to talk about their Advance Care Plans than you may think
- There are some great resources for you and your patients:
  - *SpeakUp!* *www.advancecareplanning.ca*
  - *Conversation tips and tools:* https://www.vitaltalk.org/guides/covid-19-communication-skills/

VITAL talk

Tip: *WISH - WORRY – WONDER*

- There is now a free app from the The Legal Information Society of Nova Scotia for completion of Personal Directives: *https://www.legalinfo.org/forms/personal-directive*

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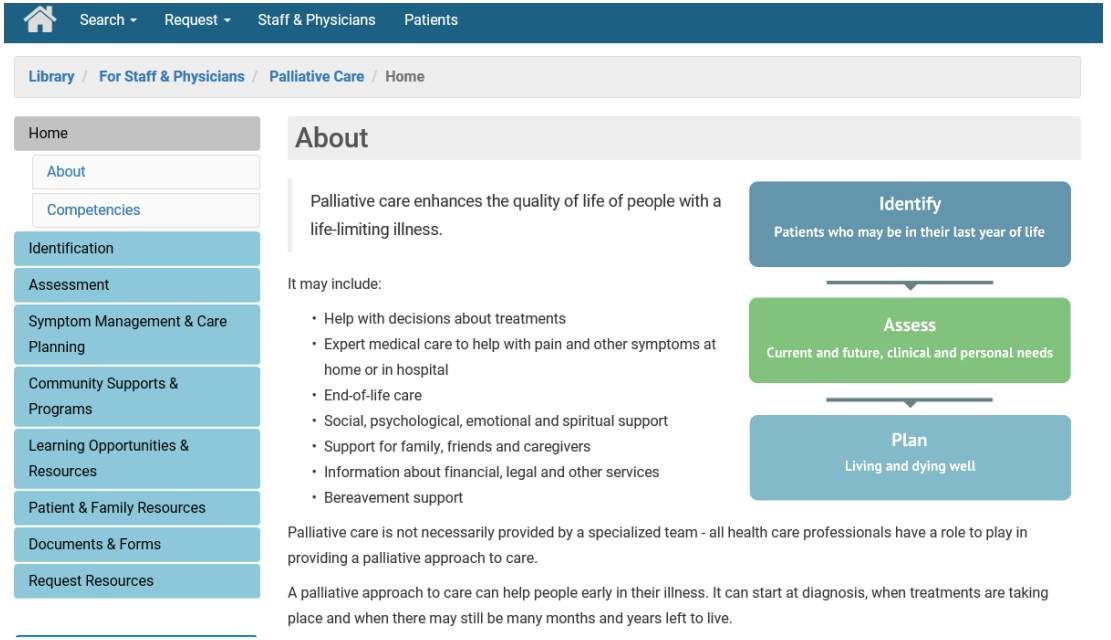
Planning for death

- There are many resources available at the NSHA Library Guide site: (https://library.nshealth.ca/PalliativeCare)

- Grief and Bereavement:
  - Virtual supports from Faith Based Groups, Social Work, Advance Care Planning Facilitators (INSPIRED)
  - Canadian Virtual Hospice



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Resources:

- NSHA COVID 19 Hub
- NSHA COVID 19 Hub: End of Life Care
- NSHA Palliative Care Library Guide
- BC Symptom management guidelines
  - BC Guideline Algorithm for cough: p.22
- Vital talk: COVID Ready Communication Playbook
- Pallium Canada: Free Online Learning Modules and Free recorded Webinars
- Canadian Virtual Hospice COVID-19 Resources

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References:

- *Arya A, Buchman S, Gagon D, Downar J. Pandemic palliative care: beyond ventilators and saving lives. Canadian Medical Association Journal (April 14, 2020 192 (15) E400-E404 (early release March 31, 2020)*
- *Downar J, Seccareccia D. Palliating a pandemic: "All patients must be care for". Journal of Pain and Symptom Management 2010;39:291-5*
- Etkind SN, Bone AE, Lovell N, Cripps RL, Harding R, Higginson IJ, Sleeman KE, 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, Journal of Pain and Symptom Management (2020), doi: https://doi.org/10.1016/j.jpainsymman.2020.03.029.
- Nova Scotia Health Authority: Symptom Management for adult patients with COVID-19 receiving end of life support outside the ICU (https://covid19hub.nshealth.ca/friendly.php?s=covid-19/care/ptpop_palliative)
- UBC Faculty of Medicine Division of Palliative Care symptom management guideline: https://med-fom-fpit.sites.olt.ubc.ca/files/2020/03/End-of-Life-Symptom-Management-COVID-19.pdf
- http://policy.nshealth.ca/Site_Published/covid19/document_render.aspx?documentRender.IdType=6&documentRender.GenericField=&documentRender.Id=77680
- Vital Talk COVID Ready Communication Playbook: https://www.vitaltalk.org/guides/covid-19-communication-skills/

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Questions?

Thank you for your time this evening.

Dr. Erin Gorman Corsten: erin.gormancorsten@nshealth.ca
Dr. Stephanie Connidis: StephanieA.Connidis@nshealth.ca

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