

## Pandemic-Context Palliative Care triage: a response to COVID-19

### INTRODUCTION

This summary document considers triage relevant to palliative care provision in the context of the COVID-19 pandemic. Our approach aims to consider the specific circumstances related to COVID-19, but also remain applicable to any other future pandemic (see ANZSPM Guidance document – Palliative Care in the COVID context preamble). It also serves as an overview of issues relating to clinical practice, rather than a comprehensive exploration or a clinical guide. All elements within this summary should be considered as general perspectives and may not directly pertain to specific regions or contexts.

The knowledge base relating to these issues is expanding rapidly. Key publicly available references at the time of this document's development are included at the end of this document.

### UNDERLYING CONSIDERATIONS

- A palliative approach to care is goal-focused, holistic, compassionate and induces comfort and quality for patients and their families. Limitations of resources, and the uncertainties associated with providing care within a pandemic should not limit a steadfast focus on quality palliative care provision.
- Knowledge of a person's care preferences is fundamental to quality palliative care practice. Advanced care planning, advance care directives and the conversations that inform them are key instruments to provide the best palliative care.
- Many people with severe cases of COVID-19 are likely to require palliative care, mostly from healthcare professionals who are not palliative care specialists. This is particularly true for older people and those with other co-morbidities.
- If the number of people who are severely affected by COVID-19 exceeds the capacity of local healthcare systems, the impact on care delivery to our communities will be significant. The provision of palliative care will be limited by numerous "resources". These include, but are not limited to:<sup>1</sup>
  - **Stuff:** such as ventilators, syringe drivers, and medicines
  - **Space:** such as acute or ICU care beds, palliative care unit beds
  - **Staff:** such as palliative care specialist doctors, nurses, and allied health professionals.
  - **Systems:** such as care models including approaches to triage and resource allocation
- Some resources, such as equipment, are tangible and easily quantifiable. Many resources which contribute to palliative care, such as time spent with patients and their families, are more difficult to quantify and categorise, but are nonetheless critical. The intangible nature of palliative care may lead to the supposition that it is less essential. We consider access to palliative and comfort elements of care an "essential" aspect of care generally, especially during pandemic.
- Within the COVID-19 pandemic, usual and critical healthcare resources risk inaccessibility despite their urgent need. Therefore, a thoughtful approach to decisions relating to resource allocation will be required if limitations force changes to usual healthcare practices.
- If decisions to allocate limited healthcare resources are required due to the pandemic, these decisions should be informed by ethical considerations:

**NOTICE:** This ANZSPM guidance document has been prepared for healthcare professionals by the ANZSPM COVID-19 SIG. It is subject to regular review and revision in response to the changing COVID-19 environment. Check [anzspm.org.au](http://anzspm.org.au) for updates and speak to your local Palliative Care Team.

- The processes that support these decisions should be rigorous, systematic, and transparent. These processes should enable care which is compassionate and demonstrate solidarity.
- These processes should be instituted when they are required (when resources are scarce) rather than beforehand. That is, crisis decision-making to allocate scarce resources should only be made in a crisis when resources are scarce.
- That these processes should enable an equitable access to resources, where everyone has the same right to what is available.
- Decision-making processes should be just, with access to care based on clinical needs and the anticipation of who will benefit from resources, rather than on discriminatory or unjust determinations of the value of people and their experiences.
- Numerous jurisdictions and institutions in our region are developing frameworks which identify recommended approaches. An updated list of available resources is available on the Australasian Association of Bioethics and Health Law [website](#).
- Thoughtful consideration of these ethical concerns needs to be translated into useful, pragmatic guidance for those people who are involved in making these decisions, and for those who are affected by them.
  - An increasing number of documents which provide practical guidance are available or are being compiled. These include the ANZICS guidelines<sup>3</sup>, the [NICE guidelines](#), and key publications exploring the role of palliative triage internationally within the COVID-19 pandemic.

## PALLIATIVE TRIAGE ELEMENTS DURING THE COVID-19 PANDEMIC

The following section briefly highlights key areas that require consideration in palliative triage within the COVID-19 pandemic. This table is intended as a prompt to thinking through palliative triage in our region during the COVID-19 pandemic.

Key concept	Element to consider
Palliative triage decisions are not just about access to escalated acute care	<ol style="list-style-type: none"> <li>1. Think through the “stuff”, space, staff and systems that are required to provide palliative care.</li> <li>2. What changes will be needed to provide care to those who need it as the pandemic progresses?</li> </ol>
Specialist palliative care should be available for those who need it	<ol style="list-style-type: none"> <li>1. Palliative care should be available for everyone.</li> <li>2. Specialist palliative care should be provided to those whose needs won't be adequately met without that care.</li> <li>3. How will you determine this for your service?</li> </ol>
Local approaches should be informed by their context	<ol style="list-style-type: none"> <li>1. Key points and considerations are generalisable.</li> <li>2. Local responses need to be based on their own context.</li> <li>3. How should these considerations be managed in your context?</li> </ol>
The experience of people cannot be forgotten	<ol style="list-style-type: none"> <li>1. Utilising “objective” clinical tools to triage care is appropriate</li> <li>2. The experience and comfort of people is important and needs to be considered.</li> <li>3. How will your service balance these priorities?</li> </ol>
Care must be for all	<ol style="list-style-type: none"> <li>1. Vulnerable populations are at particular risk from COVID-19 and healthcare changes in response to the pandemic</li> <li>2. How will your service respond to this challenge?</li> </ol>
The safety of the healthcare workforce is a priority	<ol style="list-style-type: none"> <li>1. Healthcare providers are at risk due to their roles</li> <li>2. Providing care for everyone entails keeping healthcare providers safe and well.</li> <li>3. Healthcare providers do not have a greater right to healthcare than any other community member</li> <li>4. How will you provide for your healthcare providers safety?</li> </ol>
Proportionate response to the crisis	<ol style="list-style-type: none"> <li>1. Planning for the crisis is critical</li> <li>2. How will you ensure that you implement changes based on current (rather than possible future) needs?</li> </ol>
Treating clinicians should not be tasked with making resource limitation decisions	<ol style="list-style-type: none"> <li>1. Triage in clinical practice is routine, but allocating limited critical resources is not.</li> <li>2. How can these decisions be made by someone other than the treating clinicians in your context?</li> </ol>

## Palliative triage decisions are not just about access to escalated acute care

While there has been a necessary focus on the *space, stuff and staff* of escalated acute care (such as ICU) due to the challenges of COVID-19, palliative triage issues include broader considerations. Additional elements of palliative triage may include consideration of:

- **Stuff:** Who will be provided with equipment such as syringe drivers, or physical aids, or injectable medicines if resources are short? What implications will access to protective personal equipment (PPE) have for the roles that staff are asked to fulfil?
- **Space:** Will people with COVID-19 be admitted to palliative care units if that type of care should be required? Will people at home, or in aged care facilities with COVID-19 will be supported to be cared for in their abode or transferred to hospitals or palliative care units? What physical spaces can be used to accommodate the palliative needs of patients with COVID-19 in institutions such as aged care facilities, hospitals or palliative care units?
- **Staff:** Which clinicians are available to provide palliative care for their patients? What training or support do they need to do this? What direct palliative care support will be provided to people who are COVID-19 positive? What measures are in place to maintain care if key staff are unavailable or unwell?
- **Systems:** Who will be seen first by palliative care teams, and for what reasons? How will approaches be changed to maintain palliative care support during the COVID-19 pandemic?

The focus on the availability of escalated acute care, and the processes to determine who has access to these supports, entails the concomitant consideration of palliative support. Palliative goals of care are not inconsistent with a goal of survival or being cared for in ICU. On the other hand, palliative care will be required if a request for ICU-type care is determined to be clinically inappropriate, or if resources to provide such care are unavailable. Services will need to consider how integrated approaches to palliative care will be described, triaged and provided during a pandemic.

Whenever possible these palliative triage decisions should be considered before they arise. A transparent, systematic and well communicated approach, which considers the ethical issues raised above, to respond to these questions will likely be very useful for clinicians, services, patients and their families. Wherever possible, it would be useful to use evidenced-based tools to quantify and describe clinical needs. The following tools may be useful to achieve this though the evidence to support their use varies:

- [PCOC scoring](#)
- [Gold Standards Framework \(including the SPICT and surprise questions\)](#)
- [Amber-Care Bundle](#)
- [Clinical Frailty Scale](#)
- [RUN-PC score](#)

## Specialist palliative care should be available to those with need it

Determining who will receive specialist palliative care during the COVID-19 pandemic is a key element of palliative care triage that should be deliberated, discussed and communicated. All patients who have palliative needs require palliative care, but these needs do not always initially require specialist palliative care input.

Decisions which determine which patients and families get initial access to specialist palliative care should be based on the **complexity** of their needs, the difficulty in resolving those needs (their **refractoriness**), or the **specialised nature of the interventions** that might be required.

This approach described by Arya et al<sup>4</sup> suggests a way of describing this for clinical services:

- *All clinicians providing palliative care should address physical, social, financial and spiritual concerns*
- *Clinicians who are not palliative care specialists (hospitalists, family physicians, internists, ICU physicians, nurse practitioners, nurses and paramedics) support the following:*

- Identification and management of pain, dyspnoea, agitated delirium and respiratory congestion
- Management of caregiver grief
- Discussions about prognosis, goals of treatment, suffering and resuscitation status
- *Palliative care specialist clinicians* support the following:
  - Patients with complex or refractory symptoms
  - Patients who are denied access to critical care owing to a triage protocol, despite wanting aggressive care
  - Management of complex depression, anxiety, grief and existential distress
  - Requirement for palliative sedation therapy
  - Pre-existing opioid use disorder
  - Patients with young children
  - Patients belonging to marginalized populations, including the homeless, incarcerated persons and Indigenous Peoples, who are at risk of being underserved by the health care system

### Local approaches should be informed by their context

An agreed national (or regional) approach to the issues related to palliative triage during COVID-19 is valuable, however this cannot be a replacement for local approaches.

Different services and localities will have different access to resources, and different experiences of the pandemic. It is also likely that communities will have different senses of how to engage with the challenges that palliative triage entails. Local approaches that are relevant to the experience of those regions, communities and institutions should be developed but be under-pinned by broader national guidelines.

### The experience of people cannot be forgotten

While clinical (and on some level “objective”) measures to inform decision-making are of value, the importance of being attuned to the experience of individual patients and their families cannot be overstated. Quality palliative care and ethical triage within a pandemic continues to recognise that comfort occurs with the minimising of suffering. Key elements of holistic palliative care, such as the benefit of contact with friends and family during dying, will be challenging to respond to, but retain their importance.

- Palliative triage measures and palliative care should seek to maximise the comfort of people. Assessment of comfort should be routine and should drive practice.
- The impact of spatial distancing, isolation and quarantine on patient care will be significant. The limited additional support and advocacy from family, available to people with palliative needs, means that routine assessments of comfort are additionally critical during the pandemic, particularly in institutional settings.
- Creative adaptations to the challenges of caring for someone who is isolated from our usual connections will be required. The use of technology will be important to allow clinicians, families and patients to be virtually connected while physically distant.

### Care must be for all

Palliative care plays an important part in supporting, educating and informing all healthcare workers about end-of-life care. The unique challenges placed on healthcare systems and communities by COVID-19 will highlight the importance of our work. Furthermore, it will also place already vulnerable groups of people at further risk of disadvantage and discrimination, and this may affect the palliative care support that is provided to them. Decisions to offer resources should not be discriminatory or based upon the assumed value of the experiences of those people.

Examples of populations at risk of disadvantage include, but are not limited to, the following:

- Older people in aged care

- Prisoners
- The homeless
- People of diminished socioeconomic means
- People from a culturally and linguistically diverse background
- Indigenous peoples
- People who live in remote populations
- People who are receiving palliative care in their home setting.

Community interventions to prevent the spread of COVID-19, such as spatial distancing and limiting the contact to vulnerable populations, may negatively impact the access to palliative care services to these groups.

Local palliative triage plans should take these challenges into consideration and mitigate them with creative solutions as much as possible. Possible examples include:

- Adopting shared care and indirect or remote care models, in collaboration with groups directly in contact with vulnerable populations
- Using IT solutions to overcome spatial distancing and extend the palliative support that is available.

Additionally, there is a risk that the healthcare focus on COVID-19 and the care needs of the population directly affected by the pandemic may mean that those with other healthcare problems receive less than usual care. Services must balance care provision as much as possible to ensure that all people with palliative needs are cared for to the best degree that this is possible.

### The safety of the healthcare workforce is a priority

All healthcare workers require a safe work environment. This is deserved and enables more sustainable quality care for the whole community. The risks of providing care for people during the COVID-19 pandemic need to be minimised for healthcare workers as much as possible. While healthcare workers are a resource that needs to be protected, PPE is also a resource that needs judicious and sensible use.

- Local guidelines based on national strategy need to be developed for palliative care workers to balance these needs and issues.
  - Specific consideration of issues for palliative care providers in home, aged care and community settings is necessary. Limiting the provision of community and home-based care protects staff at the potential expense of increasing the unmet palliative needs of patients in those settings. Impacts on patient care need to be considered when making decisions to prioritise the safety of healthcare providers (See “**Care Must be for All**”).
- The priority of safety of the healthcare workforce should not be translated into prioritisation over other community members. Any decisions made within the context of limited resources (such as approaches to allocating ICU resources) should apply universally and healthcare providers should not be an exception to these rules.

### Proportionate responses to the crisis

The COVID-19 pandemic requires urgent healthcare planning to meet the palliative needs of our communities. Any changes that are instituted should be staged and proportionate to the current challenges that the pandemic is raising, rather than wholesale and anticipatory to the need. Utilising a staged and proportionate response to healthcare change will minimise unnecessary disruption, disadvantage and confusion. It may also allow adequate communication and dynamic planning for the uncertainty of future situations as they arise.

Like the responses to surges in the pandemic, consideration will also be required for triggers that may signal a return to more usual circumstances. Once again, a proportionate and staged response will be needed and should be part of the palliative triage strategy.

## Treating clinicians should not be tasked with making resource limitation decisions

While clinicians are routinely tasked with determining which patients are provided resources, the situation in this pandemic is different. It is likely that Australia and New Zealand will encounter more comprehensive and sustained resource limitations than normal, with associated complex ethical decision-making. Due to these factors, all services, institutions, collaboratives and regions should engage in considering these challenges and determining plans prior to being required. In this way, clinicians can be guided in making these decisions. For the most difficult decisions (such as the provision of life-saving resources like ICU ventilators) explicit development of approaches which support teams or groups to make resource allocation decisions will be helpful. A collaborative approach with stakeholders to develop these plans and open communication of what is intended is recommended.

## RESOURCES

1. Downar J, Seccareccia D, Associated Medical Services Inc. Educational Fellows in Care at the End of Life. Palliating a pandemic: "all patients must be cared for". Journal of pain and symptom management. 2010 Feb 1;39(2):291-5.
2. [Sydney Health Ethics: An Ethics Framework for Making Resource Allocation Decisions within Clinical Care: Responding to COVID-19](#)
3. [ANZICS COVID-19 Guidelines](#)
4. Arya, A., Buchman, S., Gagnon, B., & Downar, J. (2020). Pandemic palliative care: beyond ventilators and saving lives. CMAJ, 1–5. <https://doi.org/10.1503/cmaj.200465>
5. [COVID-19 Rapid guideline: critical care in adults NICE guideline \[NG159\]](#)
6. [Allocating Scarce Healthcare Resources During The COVID-19 Pandemic, Australasian Association of Bioethics and Health Law](#)
7. [BMA COVID-19- ethical issues a guidance note](#)

THIS INFORMATION IS OF A GENERAL NATURE AND SHOULD BE ADAPTED DEPENDING ON LOCAL PROTOCOLS. For further assistance, please contact THE PALLIATIVE CARE TEAM on

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