

Q and A from HPCO and OMA Zoom Webinar April 16, 2020

Palliative Care and COVID-19 Forum: Approach to Goals of Care Conversations

1. Who will be substitute decision maker for someone who has no family available?

The automatic SDM is the Public Guardian and Trustee office:

<https://www.attorneygeneral.jus.gov.on.ca/english/family/pgt/>

However, someone can appoint a friend or trusted person to be their Attorney for Personal Care (which is another form of SDM).

For all SDM-related questions, see: the HCPO resource guide at <https://www.speakupontario.ca/resource-guide/part-2-substitute-decision-makers/>

The hierarchy can be found here: <https://www.speakupontario.ca/resource/the-substitute-decision-maker-hierarchy/>

2. Any specific tips for having these difficult conversations over the phone or virtually?

Follow the same steps and approach as you would for an in-person conversation with the following additions:

Even more than usual, speak slowly, wait for patient/SDM to respond...

Acknowledge that you wish you could do this in person

People really appreciate this contact, so it usually goes quite well

3. For patients with already diagnosed dementia, do you have these conversations with the SDM?

You cannot have an ACP discussion as this can only be with a capable adult. Remember, ACP is specifically for the PATIENT to prepare the SDM by discussing their wishes and values. If a patient lacks capacity, they cannot do this. If you have a patient who lacks capacity to participate in ACP, you should:

- Explore and Educate the SDMs about the person's illness (expected course, where the person is at on the disease trajectory) & management
- Educate about the role of the SDM in decision-making and consent
- Explore SDMs information needs
- Address expectations about the role of this conversation and the uncertainty of future health care needs

E.g.

For a patient with dementia and who lacks capacity, meet with the SDM. Teach them about dementia and likely trajectory – loss of function, loss of speech, loss of swallowing. Explain how their care needs will increase. Explain about likelihood of infections as they approach end of life. Explain about aspiration and why that happens.

That way, in the future, when these things happen, the SDM will be more prepared to make decisions. It is better if they don't have to learn about aspiration and the inability to eat safely when it is happening.

4. I find from HPCO module that code status should be revisited for each hospitalization for the patient. Is that right?

Yes, that is generally true – it doesn't have to be redone in a formal way, but just review it gently. It is good practice to make sure there hasn't been a significant change in circumstances. E.g. a patient during a previous admission may have had an acute, serious illness such as sepsis and wished to forego resuscitative efforts. They may have recovered and are in hospital for a less serious illness and would want a different treatment. In fact, hospitals might have their own policy on this specifically, so check with your hospital.

5. How do you think is some of the best way for an organization to implement GOC discussion for all patients? Especially around educating the healthcare providers.

Consider developing an implementation working group. Determine who needs to be involved from management to front line-providers to possible IT support. It is important to have “buy-in” from someone in a leadership role and to try to link it to existing priorities that the organization already values. Set achievable goals and agree to be accountable to those goals, whether it’s related to creating a place in the EMR or chart for documentation or training a certain number of health care providers in conversation skills.

For healthcare providers, setting expectations and accountabilities around documentation can be an important driver for change. For GOC, clinicians need to be motivated to improve and fully participate in skill development activities that effectively improve communication skills. For interprofessional providers, they need to be allowed time in their schedules to both prepare for and attend sessions. Engage with a local physician to determine the motivators for physicians within your organization. This is critical to successfully improving GOC.

HPCO has created the beginning of an implementation guide that may be helpful. <https://www.speakupontario.ca/wp-content/uploads/2019/08/PCDM-Implementation-Guide-1.pdf>

Future workshops will be dedicated to addressing implementation challenges and strategies.

6. With regards to the Ontario Health Critical Care Triage Protocol, are you discussing the possibility of limited care options in the event of a surge (e.g. no ICU beds or ventilators available) with patients who have significant comorbidities during goals of care discussions? If so, how are you broaching this topic?

At this time, we don’t think that that is necessary... however, it is probably best to individualize this. Some patients may want to discuss it, as they are worried about it from the news and watching what happened in other countries.

I would ask patients what they already know and if they have any worries or concerns. If they don’t bring it up, then I might not bring it up. If they do, or if you feel it would be important, I might say something like: “you might have heard about other countries having to limit certain treatments because they didn’t have enough for everyone who was sick...so far we do not have that situation in Ontario because people are doing a great job of social distancing...if we ever had a situation where we didn’t have enough equipment such as those used for life support, the government has a system for all hospitals to use to be fair and equal for everyone.”

7. If the patient has no family/friends to act as a SDM, can they request a Public guardian before they become terminally ill (ie have multiple co-morbidities but not imminently dying)? and can they meet/speak with their public guardian to discuss their wishes? If so, how would we get them a public guardian?

Yes, see answer to question 1 on how to contact the office of the PGT.

8. If CPR is not indicated and would put nurses’ lives at risk, what are the legal obligations to accede to demands from SDM for CPR (despite GOC discussions prior)?

All institutions should have a protected code blue protocol in place, which would minimize risks to all clinicians performing CPR for a person who potentially has an infectious disease. If the treating physician believes there is no chance CPR would be of medical benefit, then the physician is not obligated to offer or provide CPR. In a non-urgent scenario, the physician is obligated to communicate this medical decision to the patient or SDM if the patient is not capable. The CPSO policy recommends that a dispute resolution process be followed in cases where a patient or SDM does not agree with the recommendation for a ‘no-CPR’ order. See the CPSO policy:

<https://www.cpso.on.ca/Physicians/Policies-Guidance/Policies/Planning-for-and-Providing-Quality-End-of-Life-Care>

9. would you suggest discussing end of life care with ALL patients or only those that WE feel might be at risk of mortality from COVID-19?

To start, definitely those who are at higher risk of more serious illness or death. But ACP conversations should happen with everyone. COVID-19 is affecting individuals of all age groups, although the mortality rate is lower for younger, healthy people.

10. Who do you send the revised certificate of death?

Office of the Registrar General. 189 Red River Rd 3rd Floor, Thunder Bay, ON P7B 6L8

11. If we initially suspect covid and write this on the death certificate but then the swab comes back negative, how do we write this on the revised certificate?

Complete a revised death certificate form and send as above with accompanying explanation.

12. If a patient dies at home from COVID-19, who reports this to Public Health?

The physician or nurse practitioner who pronounces the death

13. If a competent patient decides to stop medications and stop eating but is not officially depressed can we put natural causes as the cause of death

Typically, a person stops medications and eating/drinking because they are experiencing suffering of some kind in the context of an underlying illness. This includes dementia, cancer and many other serious illnesses.

14. If the patient passed away in sleep, how can we list cardiac cause if suspected?

It's unclear what might be suspected in this question.

15. Given the recent CPSO statement (i.e. no consent needed now for withholding CPR), how does that fit into the GOC discussion for COVID and any practical tips if we need to apply this?

See resources on HPCO website

16. Question about death in the home; home based palliative patients. Can we pronounce virtually if it is an expected death in the home? Just trying to decrease exposure and use of PPE. Any changes from how we do things usually?

Not yet, watch for updates from OMA

17. For my patients who are really old but still not in a LTC facility should we have this conversation in case they get COVID-19? – for example a 95 yr old patient

Absolutely

18. Is there a document that needs to be completed for advance directives?

No – there is no document that needs to be completed. In fact, in Ontario, there is no document that is a legal form to direct physicians or gives consent to treatments. If your patient would like to write things down, then that is fine – but it is for the SDM to use in understanding the patient when making decisions. If the person remains capable, they will make their own decisions. If the person lacks capacity, their substitute decision-maker will use all the information

available to them at that time to make a decision. This may include things that the person wrote when they were capable, but it also may include things that the person said or values that they had. The SDM will rely on the most recent capable wish (either written or verbal) when making substituted decisions.

19. Should all clients with multiple comorbidities complete a DNR form? If so, where do you get the form? The local paramedics gave me a few blank forms.

DNRC forms should only be completed after having a conversation with the person or their SDM to determine that CPR is not consistent with their goals or wishes. Someone may have multiple comorbidities and remain quite functional whereas another may be very clinically frail. Probably of benefit from CPR cannot be generalized based on just number co-morbidities; rather clinicians should have individualized discussions based on the person's illnesses and functional status AND that persons' goals.

Info on obtaining forms is here:

https://www.mcscs.jus.gov.on.ca/english/FireMarshal/Forms/form_DoNotResuscitate.html

20. In a retirement home, can I email the death certificate to a funeral home?

You can arrange however you want to get it to them, but they must have the original as well.

21. How do you document the recently mentioned situation in which CPR is not appropriate but you do not have consent for 'no CPR' so the patient remains 'full code', but it could be a random physician on-call when the patient arrests, who may not realize that they should only provide CPR if it is medically indicated in that context?

If, after a medical assessment, CPR is not indicated, the clinician who makes this assessment must communicate this decision to the person or SDM. Every attempt should be made to explain to the person/SDM as to why CPR is likely to be of medical benefit and would only prolong the dying process. If the person/SDM disagrees with your recommendation for a "no-CPR" order, they must remain Full code while the dispute resolution process is underway. The clinician should document the conversation in as much detail as possible including the particulars about the person's underlying illness, the person or SDM's understanding of those illnesses and the rationale for suggesting "no-CPR" based on unlikely medical benefit. To help future colleagues continue the conversation, it is also helpful to document what is driving the request to remain Full Code.

For the physician responding to any code, they complete their own medical assessment based on the condition at the time of an arrest. Any documentation from related prior conversations will form an important part of their decision-making process to determine if they should start or continue CPR on the patient who has arrested.

22. In Toronto, are there resources for care at home for those that make the choice to stay home despite COVID-19 pneumonia? E.g. nurses to provide IV abx administration for example with proper PPE

Yes – refer to the LHIN as normal. Make sure to indicate the patient wants a palliative approach to care and wants EOL at home. That will trigger resources and PPE for nursing. Feel free as well to access palliative care physician support as needed.

23. What about our less frail residents of LTC? Can we suggest that acute care or ICU may be appropriate for them?

Yes. Medical benefit of each treatment should be assessed at the time a person becomes medically unwell. Patients in LTC who may benefit from treatment and wish to be transferred to pursue these options should be transferred. When they arrive in acute care, after assessment and tests, the treating physician will determine which treatments will be offered based on the situation.

24. If a family member calls to say that mum has died at home (EDITH) at 11:30 pm Friday and then you get to the house at 12:30 am Sat to do the "formal" pronouncement - what date would you certify the death for? Thanks.

Friday

25. For the revised death certificate do we have to mail it, or fax would be acceptable?

It must be mailed – they need the original.

26. How can I help ensure a patient will not be given CPR or intubated by EMS or in ER if she needs to go as she has twice told me that she does not want those things? She has no family at all, is competent, in assisted living, and is 89. I found a form for Toronto/Ontario but am not sure how to implement.

You complete a DNRC form and leave it with patient – some people put it on the refrigerator door.

27. General question about death certificates- for Part II of death certificates, does the interval between illness and death need to be put in for chronic conditions if they have been present for years (e.g. COPD, dementia)?

Yes, just best estimate

28. Cognitively I fully accept the need to have these conversations. Emotionally, I really don't want to do so. Any suggestions how to deal with my own resistance?

What a good question – so good you have the insight into your resistance. The first thing I would say is to think about what emotions this is raising for you. Often, we think that patient's will be distressed by these conversations, so we avoid them. In fact, most people appreciate the opportunity to have these discussions...they don't see them as challenging or sad...they appreciate having an expert to guide and support them. Also, remember, you only have to have these conversations with patients who want to have them...these conversations are voluntary. I would suggest you start slowly – find some language you feel comfortable with and “invite” a patient to have this conversation. Assume the role of guide or coach – you don't have to tell them what to do – you are there to explore their understanding and goals and help them achieve them as best as possible. Then see where this goes. I suspect you will find it more satisfying than you imagine and will start to look forward to them.