Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Palliative care in the emergency department during a COVID-19 pandemic

The COVID-19 pandemic is challenging the healthcare system [1]. It is crucial for physicians to provide an opportunity for shared decision making and ascertain, without prejudice, a patient's goals of treatment and advanced directives [2]. Palliative care support at the point of initial care has the potential to play a vital role in assisting in ascertaining the patient's wishes for treatment, especially in the setting of a busy emergency department (ED). Palliative care specialists provide individualized, compassionate care including symptom control for those choosing to forgo aggressive interventions like ventilator support [3].

As this pandemic progresses, the role of ED physicians has become ever more demanding with high acuity COVID-19 patients. With clear education concerning the impact and outcomes of proposed treatments, some patients' goals may be more aligned with aggressive interventions while others may choose a less aggressive palliative approach focused on ameliorating symptoms [4]. Despite this evolving role, there is limited existing literature available for ED physicians on how to provide system wide palliative care services to COVID-19 patients. As such, we set out to develop and report on a palliative program created to meet the needs of the ED/hospital networks and our patients, both in decision making and subsequent palliative care in the time sensitive, high pressure milieu of the ED.

Our goal was to build and align infrastructure to allow more in depth palliative care conversations with the help of specialized providers in the ED and to support the network's six individual hospitals. We set out to develop schematics for clinicians to guide them in how to provide brief conversations and establish palliative care consult services for COVID-19 patients (Fig. 1).

A stakeholder workgroup was created to focus on three areas: Education of providers; Developing the infrastructure to support the plan (involving telehealth, managing language barriers, evaluation for providing 24/7 care at all sites); and working with hospitalists and hospice teams to develop cohort housing.

The clinician's tool (Appendix 1) included an abbreviated shared decision tool from the National Hospice and Palliative Care Organization [5] and a list of medications that were appropriate for symptomatic treatment [6]. Additionally a flow diagram from the Center to Advance Palliative Care for relief of dyspnea [7] and a conversation guide from the ACEP COVID-19 Field Guide was provided [8].

Two EM physician champions (one with fellowship training in palliative medicine), oriented the palliative medicine team to the ED and provided 'at the elbow' support to clinicians in three of the ED sites about how to start conversations and utilize the palliative care team resource.

At the largest hospital, a palliative care nurse practitioner was stationed from 11 am–9 pm, 7 days a week. The remainder of the coverage was managed 'on call'. All 6 sites were set up with resources and a guideline for using tablet based technology for the palliative medicine consult. A series of guidelines for workflow were developed and distributed to the team from the IS department to help patients and providers understand how to use the tools to communicate and how to manage disinfecting devices (Appendix 2). After the consult was completed, the documentation in the electronic medical record provided immediate access to any existing Physician's Orders for Life-Sustaining Treatment, Advance Care Plans, and "Do not resuscitate" status in the patient record.

The urban hospitals aligned cohorts for inpatient hospice. This project allowed for earlier identification of patients appropriate for palliative care in the emergency department setting so that patients could be cohorted to the most suited inpatient floor. This also prevented movement across inpatient floors. Because there were different resources available at the more rural sites, the hospitalist service managed patients there with comfort measures.

Factors like lack of knowledge about palliative care management can prevent providers from initiating palliative care [9]. It has been reported that only 5% of palliative care consults done in the ED were initiated by ED providers and the consultation occurred days into the patient's hospital stay [10].

The unusual pattern of this disease to progress and unexpectedly worsen without any indication that the patient is deteriorating motivates earlier goals of treatment discussions [11,12]. Additionally, while transmission of COVID-19 is primarily through droplet and fomite spread [13], the World Health Organization believes that airborne transmission may be possible when performing interventions that generate aerosols, such as manual ventilation, endotracheal intubation, or CPR [14-16]. Therefore, if it is clear after early goals of care discussions that patients choose to forgo aggressive interventions, such as these, there is also added benefit for staff of avoiding potential unnecessary exposures.

Prior to this program initiative, it was common that a patient be admitted with the order, "Full Code by Default". Further data needs to be collected on how these conversations change the orders placed for code status, the resources that are necessary to manage patient care as well as evaluations of patient satisfaction of the program. ED providers' acceptance of palliative care specialist support in the ED environment was very positive and the prospect of continuing it after Covid-19, is already being entertained.

Authors' contribution

All authors provided substantial contributions to the manuscript.

Declaration of competing interest

The authors declare that there is no conflict of interest regarding the publication of this article. The authors have no outside support information, conflicts or financial interest to disclose and this work has not been published elsewhere.

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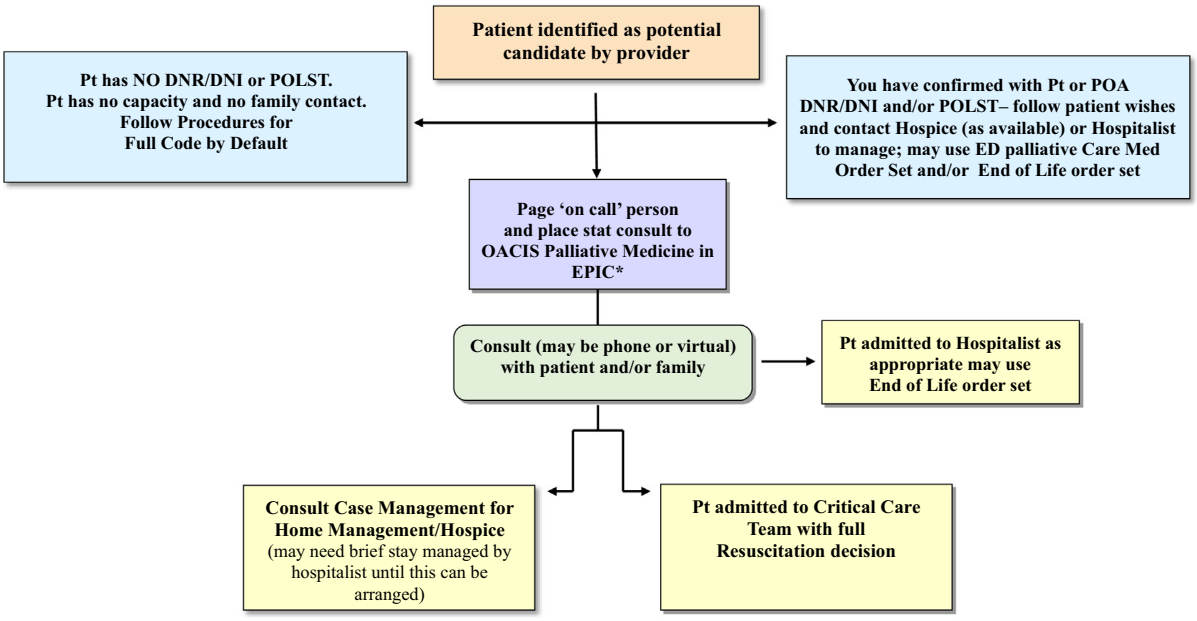

Fig. 1. COVID-19 palliative flow diagram. *Initiate consult even if there is discord between provider and patient/family expectations. Note: Ethics Committee can be consulted at any of these decision points if provider is uncomfortable with the plan.

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Appendix A. Supplementary data

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