

Invited letter: Integrated palliative care in a geriatric mental health setting during the COVID-19 pandemic

Since December 2019, coronavirus disease 2019 (COVID-19) has spread worldwide, with over 230 million cases and 4.7 million deaths confirmed as of 28 September 2021.¹ The impact of the virus has been devastating internationally in long-term care (LTC), mental health hospitals and retirement homes, given an elevated risk of infection, morbidity and mortality.² Increased risk of infection arises in the congregate setting from overcrowding,³ inadequate availability or use of personal protective equipment, and the inability of some residents to follow public health guidelines due to cognitive impairment.⁴ The demographic and clinical characteristics of LTC residents, including advanced age, frailty and medical comorbidities, contribute to high morbidity and mortality.⁵

In Canada, like other jurisdictions, the majority of residents in LTC have major neurocognitive disorder, or dementia, a progressive, disabling, irreversible and ultimately fatal disease.⁶ Reported 6-month mortality rate among people with advanced dementia is 25%. There have been longstanding calls to expand palliative care to include advanced dementia.⁷

The culture in some Canadian LTC and inpatient geriatric psychiatric settings is to defer management of acute medical issues and palliation.^{8–10} Patients with dementia may have challenges expressing their wishes. As a result, patients are often sent to medical hospitals, at times against their best interests, with increased risk of nosocomial infection and functional decline, and at a high cost to the medical system.⁹

The COVID-19 pandemic has challenged healthcare systems internationally due to threatened and actual resource scarcity. Faced with the potential need to ration critical care resources, clear advance directives with respect to life-sustaining care are necessary. Defaulting to intensive life-sustaining therapy (e.g., CPR) to all patients without their truly informed consent may be harmful. The ethical principle of non-maleficence demands that we protect such vulnerable people from dying in this uncomfortable way.⁵

Given these considerations, along with changes in the risk-benefit ratio during this pandemic, many institutions have had to pivot to be able to provide dignified death within their walls.

1 | OUR EXPERIENCE

Here we report our local experience in hopes that it will be useful for others in international settings, given the global context of the pandemic and universal ethical principles involved. Our setting is the

48-bed geriatric mental health unit at the Centre for Addiction and Mental Health, an academic mental health hospital in Toronto, Canada. Our patient population resembles LTC homes, with approximately half of patients admitted for behavioural symptoms of dementia, many being residents of LTC or retirement homes. Lengths of stay are months to years, mirroring LTC homes rather than general psychiatry inpatient units.

As of September 2021, we have had 111 COVID-19-positive cases within the hospital. Six of these occurred on our unit in April 2020. Of these six, one required ICU admission. Another was provided comfort-based care on site consistent with the substitute decision-maker's (SDM) decisions and died within 3 weeks of symptom onset.

At the time, there were concerns about lack of medical hospital space. This led to a broader acceptance of the idea that patients may die at our facility, accelerating our efforts upskill capacity to integrate palliative care in our setting. We integrated a clinical frailty scale in goals of care discussions to assist families in deciding between life-prolonging treatments and comfort-based approaches.^{11,12}

Using elements of the palliative care pandemic framework set out by Arya et al.¹³ we developed a plan to address 'stuff, staff, space and systems', the need for sedation and communication, with minimal additional expenses.

2 | STUFF AND SEDATION

We developed an electronic order set to standardize the provision of palliative care for those not frequently using those skills (Table 1). We reviewed local hospital palliative order sets and elicited interdisciplinary feedback. We collaborated with our pharmacists to ensure an adequate supply of medications and obtained specialized equipment such as butterflies for subcutaneous medication administration.

2.1 | Staff

We developed a collaborative, working relationship with a local palliative care team for virtual support to our front-line physicians. A medical mobile team of two nurses with palliative care expertise provided nursing staff with bedside support. Palliative care staff training was provided by nurse educators.

2.2 | Systems

Our hospital's Resuscitation Status for Inpatients Policy helped guide our clinicians in addressing relevant clinical, legal and ethical issues whereby different levels of medical care could be clearly requested by the patient or, if incapable, the SDM.

2.3 | Communication

Discussions about goals of care were held with patients, family and SDMs following the principles of shared decision-making. We set up the conversation and shared information and prognosis. We explored goals, fears, and strengths and provided a summary. We documented the conversation and resuscitation status in the electronic medical record.

We increased communication among the clinical team through daily 'huddles' to discuss concerns and ensure proper provision of palliation. During hospital-wide grand rounds, we shared our experiences to promote a more palliative-friendly culture.

Key points

- The COVID-19 pandemic has disproportionately impacted the elderly residents of congregate settings with respect to morbidity and mortality. The high rate of severe illness in this population necessitates timely and quality access to palliative care.
- There are a number of challenges facing teams working in geriatric mental health settings during the COVID-19 pandemic with respect to palliative care.
- We outline our experience as an example of changes made to improve the provision of pandemic palliative care on site in a geriatric mental health inpatient unit.
- Improving palliative care can help to increase the quality of care for patients beyond the pandemic, can increase the skill set of staff members, and help to prevent staff burnout.

TABLE 1 COVID-19 palliative care order set

Order categories	Order options
Patient care	Resuscitation status Subcutaneous line insertion, monitoring, discontinuation Urinary catheterizations (intermittent, indwelling, topical antiseptic)
Assessment and monitoring, laboratory, and diagnostics	Prompt to consider reassessing need and frequency of vital sign monitoring, need for laboratory services and diagnostic services
Medications	Hydromorphone (dyspnoea/pain/cough) Lorazepam (anxiety/dyspnoea) Midazolam (refractory anxiety/dyspnoea, seizures) Haloperidol, methotrimeprazine (agitation/restlessness) Glycopyrrolate (respiratory secretions) Bisacodyl (constipation) Ocular lubricant, saliva substitutes (mouth/eye care) Acetaminophen (pain, fever)
Consultations	Palliative care physician (with after-hours number listed) Hospitalist Mobile medical team Pharmacist Occupational therapist Spiritual care

Note: An electronic order set was implemented and integrated into the electronic medical record to facilitate access to medical and non-medical palliative care interventions for patients who require provision of palliative care for COVID-19 on site at our mental health hospital. This table outlines the items on the order set. The actual order set includes further details about indication, dose range and each item can be selected or not selected by the ordering physician.

3 | CONCLUDING REMARKS

The COVID-19 pandemic brought to the forefront institutional gaps in palliative care, such as insufficient goals of care discussions and lack of skill to provide palliative care on site. The acute need threatened by the pandemic served as a 'burning platform' to accelerate change in hospital culture.

We realized that the risk of sending some patients to medical hospital may outweigh benefits. We acknowledged that death on the unit may be a preferred outcome by some patients and families. We adapted quickly to increase our comfort in managing end-of-life treatment. The issues facing our LTC homes and psychiatric hospitals in Canada were similar internationally.²

As the COVID-19 pandemic continues to impact residents in our inpatient setting, as in LTC and other congregate settings in which people with dementia reside, integrated palliative care services will be needed. Failing to properly address patients' goals of care and to provide effective palliation will compound the tragedy of this pandemic. By upskilling and adapting, we will be better prepared for future pandemics or new cycles of the present one. Our experience attests to the feasibility of rising to this mission.

KEYWORDS

advanced directives, code status, COVID-19, dementia, inpatient psychiatry, palliative care

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CONFLICT OF INTEREST

The authors declare no conflict of interests.

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DATA AVAILABILITY STATEMENT

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

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