Palliative Care Guidelines for COVID - Part 3

Triage Decisions, Shared Decision Making and Advanced Care Planning for COVID-19 Situation: A Guidance Document for Levels 2 & 3 Hospitals

3 May 2020 (PROVISIONAL DRAFT)

Prepared by

Philippine Society of Hospice and Palliative Medicine (PSHPM)

and

Hospice Philippines

through the support of

The Ruth Foundation and Philippine Society of Public Health Physicians (PSPHP)

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Triage Decisions, Shared Decision Making and Advanced Care Planning during COVID-19 Pandemic:
A Guidance Document for Levels 2 & 3 Health Care Facilities

Background

With the unprecedented siege that COVID 19 has taken on our health care system, we are faced with a strain on both human and medical resources. This being, a rational and uniform process of communication regarding goals of care with both patient and family as well as a timely and sensitive triaging system has been seen as imperative. In the same manner, fundamental ethical principles are all the more crucial as we strive to maintain the best care possible patient-centered under the conditions of resource scarcity.

This document may serve as a provisional guidance for the process of shared decision making and triage for intensive-care treatment, the greater part of which has been adapted from existing international guidelines on the ethical framework of critical decision making, advanced care directives and palliative care in the context of this present pandemic. It has been prepared through the collaboration of the Philippines Society of Hospice and Palliative Medicine (PSHPM), the National Hospice and Palliative Care Council of the Philippines (Hospice Philippines Inc.), in consultation with the Philippine Society of Public Health Physicians (PSPHP) and Philippine Alliance of Patient Organization (PAPO) and reviewed by leaders in the Philippine Bioethics Community. As an interim guide, it may be useful to colleagues throughout the country, keeping in mind that it will be updated and expanded, in line with evolving national guidance and contributions from the medical community. The most current version of the guidance document will be available on the public-facing pages of PSHPM and Hospice Philippines.

Our present crisis requires everyone to work together to contribute towards the care of patients and families, especially those who are facing both the physical and psychological distress of COVID-19.

Who should use this Guidance Document?

This document aims to guide the process for Shared Decision Making and Advance Directives. It is for health professionals including doctors, nurses and hospital management especially those with COVID-19 and other patients facing life-threatening illness. It is most relevant in L2 and L3

hospitals where COVID patients may be referred. These include Provincial and Regional Government Hospitals as well as private hospitals of the same level.

This guidance material complements other existing guidance issued by hospitals, experts and medical societies

General Principles and Responsibility of Healthcare Providers

Fundamental ethical principles applied in this guidance document:

- **Equity**: Available resources are to be allocated without discrimination – The allocation procedure must be fair, objectively justified and transparent. [4,18]

- **Preserving as many lives as possible**: Under conditions of acute scarcity, all measures are guided by the aim of minimising the number of deaths. Decisions should be made in such a way as to ensure that as few people as possible become severely ill or die. [18]

- **Protection of the professionals involved**: Professionals involved in the care of patients during a pandemic are to be protected as far as possible against infection, but also against excessive physical and psychological stress. Professionals whose health is at greater risk in the event of infection with the coronavirus are to be especially protected and should not be deployed in the care of patients with COVID-19. [18]

- **Right to information on health status**: Health care providers must provide patient-tailored information, taking into account the religious, ethnic or linguistic specificities of the patient. A patient also has the right to refuse information about the health status

- **Right to informed consent**: The patient has the right to access all information that might enable him/her to actively participate in the decisions regarding health; this information is a prerequisite for any procedure and treatment. Health care providers must give the patient all information relative to a treatment, including the associated risks and discomforts, side-effects and alternatives. A patient has the right to refuse a medical treatment and to change his/her mind during the treatment, refusing its continuation

- **Patient autonomy**: The patient has the right to make decisions regarding medical care without the influence of their health care providers. Healthcare workers should respect patient's autonomy by presenting the information in a factual and unbiased manner, documenting patient's directives and regular communication between the healthcare provider, the patient and family to review the patient's advance care plan to stay up to date with the patient's wishes.[6]

Healthcare Challenges in the COVID-19 Response Scenario

The Duty to Plan: Managing Uncertainty[4]

Health care leaders have a duty to plan for the management of foreseeable ethical challenges during a public health emergency. Planning for foreseeable ethical challenges include identification of potential triage decisions, tools, and processes. Triage decisions may consist of :

a. Level of care (ICU vs. medical ward)

b. Initiation or cessation of life-sustaining treatment (including CPR and ventilation support)

c. Referral to palliative (comfort-focused) care

d. Concerns of shortages of staff, space, and supplies

The Duty to Safeguard: Supporting Workers and Protecting Vulnerable Populations[4]

Health care facilities have the duty to respond to public health emergencies by safeguarding the health care workforce, particularly in the face of a pandemic that well predicts deteriorating environmental conditions and heightened risk of occupational harms.

The Duty to Guide: Contingency Levels of Care and Crisis Standards of Care[4]

A hospital or health system's institutional ethics services, including clinical or bioethics consultation, should function as resources for clinicians experiencing uncertainty and distress under normal conditions.

Triage Decisions

General Advice for Triage Decisions

- As long as sufficient resources are available, patients requiring intensive care are to be admitted and treated in accordance with established criteria.

- Particularly resource-intensive interventions should only be undertaken in cases in which the benefits thereof have been unequivocally demonstrated.

- **It is important to discuss in advance, even before hospital admission, – with all patients capable of doing so – the patients' wishes in the event of possible complications (resuscitation status and extent of intensive care).** [7]

- If intensive-care interventions are withheld, comprehensive palliative care must be provided.

- A "Triage Committee" can work alongside the attending team in decision making, removing the weight of the decision making process from one individual. A "Triage Committee" is composed of people who have no clinical responsibilities in the care of the patient but who are respected leaders among their peers and in the medical community. Creating and use of triage committees, can help mitigate the enormous emotional, spiritual and existential burden to which caregivers may be exposed.

- In the context of resource and service rationing, the function of a Triage Committee may include:

  - application of criteria for ICU care
  - assessment of mortality risks using the Sequential Organ Failure assessment score (SOFA score)
  - repeating assessments over time for ventilated patients
  - communication of assessment to the family

- In the absence of a "Triage Committee" the decision-making process must be managed by experienced professionals. Whenever possible, decisions must be made within an interprofessional team. Ultimately, however, responsibility is borne by the most senior person present.

- Decision making phases are the following :

  - On admission: the extent and duration of treatment, determination of pathway (e.g. ICU treatment, intermediate care, palliative care).

- After 2–3 days: the continuation of treatment, limitation of treatment intensity or duration, modification of treatment goal and palliative care.[18]

- In triage decisions, confidence must be maintained under the most difficult conditions.
- Individual decisions must be amenable to examination: they must be documented in writing and include a statement of reasons and the name of the person responsible. Any deviation from the specified criteria must be similarly documented. In addition, mechanisms should be in place for subsequent review of conflicts.

Communication

- During communication of health workers with families and patients, maintain honesty and empathy. Use of key phrases can assist in conveying uncertainties and build understanding between the concerned groups. The Annexes provide some Communication guidance and tips.
- There should be sufficient time for effective communication planned.
- Avoid firm positive or negative predictions
- It is important that during communications, the opinions of the family regarding the best interests of the patient should be considered.
- Proper documentation is essential since this will aid future communication.
- If conflict occurs, mediation from within or outside the hospital may help in minimizing the conflict.

Adopted from the Faculty of Intensive Care Medicine (2019)

Shared Decision Making (SDM)

Definition

Shared decision making is a key component of patient-centered health care. It is a process in which clinicians, patients and their families work together to make decisions and select tests,

treatments and care plans based on clinical evidence that balances risks and expected outcomes with patient preferences and values.

Key concepts

- **Good communication is required**. Relationships between patients and health care providers are built on trust which would be developed through good conversation techniques. Health care providers should summarize to the patient their problems in a clear, concise and easily understandable manner, present the treatment options that the patient will choose from and provide objective medical opinions.
- **Patient autonomy should be preserved**. One of the main goals of shared decision making is to maximize patient autonomy. Oftentimes, medical decision making could be described as paternalistic where in the doctor is the one that decides what is good for the patient. In SDM, it is emphasized that the patient could exercise his/her right for self-determination and this will help the patient to accept the result of the decision making.
- **Patients should actively participate in the decision making process**. This is important since active participation of patients during the decision making process since this could increase patient's treatment satisfaction and compliance. To promote patient participation, the healthcare worker needs to provide relevant evidence when summarizing the patient problem and should make an effort in explaining the pros and cons of each option.
- **Decision making should be patient centered**. Medical decisions should correspond to individual patients' values and preferences.

Recommendations

- Necessary training and education to health workers regarding SDM should be made.
- Inter-professional collaboration for SDM should be required.
- It is important to increase the patients' capacity to do decision making. Developing guidelines and patient decision aids could help in decision making.

- Family presence and support, communication guides and specific consultations with ICU teams facilitate involvement in SDM. The Annexes have sample communication guides that can be used.
- Refer to Appendix A: Shared Decision Making Conversation Guide and Appendix B: Communication tips in COVID 19.
- **"Same Page Conversations",** upon admission and daily, regarding where the patient is in the disease trajectory at present and what psycho-social and spiritual needs may need attending to, helps facilitate continued SDM.
- Tools to evaluate if the patient correctly understands the information provided by the health worker and if the health worker accurately understands the patient's preference could be developed and applied.
- Shared Decision Making is used in the process of **Advanced Care Planning**

Advanced Care Planning (ACP)

Definition

Advanced Care Planning is making decisions about the healthcare a patient would want to receive if one is facing a medical crisis. These are the patient's decisions to make based on his/her personal values, preferences, and discussions with his/her loved ones. [8]

Advanced Care planning inclusions

- Assessing the patient's mental capacity to make informed decisions. Look for signs of losing the capacity to understand information, to retain information, to use and weigh information and to communicate information.[8,10]
- If the patient be incapable of attending advance directives, then a qualified relation or representative must be requested to become a substitute decision maker. [7]
- Giving the patient information on the types of life-sustaining treatments that are available.

- Helping the patient decide what types of treatment he/she would or would not want should he/she be diagnosed with a life-limiting illness.

- Encouraging the patient to share one's personal values with loved ones.

- **Completing Advance Directives** to put into writing what types of treatment the patient would or would not want – and who to speak to – should the patient be unable to speak for himself/herself. The written document may contain the following elements [7]:
  - The patient's (or the substitute decision maker's) awareness of the situation
  - Medical interventions that should not be administered
  - Medical treatments that should be considered
  - Consent (or non-consent) to participate in research that may or may not directly benefit the patient
  - Consent (or non-consent) to resuscitation measures
  - Instructions for palliative care.

- To ensure that the document reflects the current wishes of the patient, initiate a review of the advance planning decisions if the following happens[10]:

  - Change in the patient's place of residence
  - Change in the patient's perception of their quality of life
  - New therapeutic options
  - Change in the patient's values or aims as the condition progresses.

Recommendations

- All critical care teams should have a basic understanding of ACP and be able to answer patient's initial questions.[21]

- For patients that lack capacity, critical care teams should enquire about the presence of any ACP or advanced statements to better understand the beliefs of the individual[21]

- In a pandemic situation, advanced care planning at the onset of serious acute illness will be beneficial and should be given priority.

- In the process of ACP, the attending team may consult with the Palliative Care or Bioethics Consultation team, when appropriate.

Goals of Care Discussion

Conversations about goals of care and treatment escalation planning should be initiated as early as is practicable for any patient faced with a life threatening illness. It is important to also keep in mind that as the patient's situation changes , goals of care should be revisited by attending team and discussed with patient and family through timely and regular "same page conversations" or patient-family-physician conferences. (ANNEX D)

Given the context of COVID19 wherein the patient could rapidly deteriorate, families and those close to the person should be involved in the discussion of goals of care and remain in line with person's wishes.

The following general principles should be considered for the decision-making process on the potential escalation of medical interventions.:

1. The mandatory prerequisite for any medical intervention is the medical indication, which has to be provided by the responsible physician based on the actual situation and knowledge of comorbidities.
2. If a medical intervention cannot achieve a realistic and patient-centered treatment goal, the intervention is not indicated and should not be offered to the patient.
3. Identification of patient-centered treatment goals requires an evaluation of the preferences and priorities of the patient, either as the actual will of the patient, the mandated will (for example with an advance directive) or the presumed will of the patient.
4. Treatment limitations should be determined as early as possible and should be discussed with the patient if possible, or with the surrogate decision maker. Family members should be informed about the decisions as well.

For Further Assistance

Clinical Practice Guidelines, DOH Advisories and other Guidance Documents may be accessed at http://www.palliativecolab.com/

PSHPM, Hospice Philippines and The Ruth Foundation may be reached through the Palliative Collaborative hotline for inquiries and concerns:

09063141421 Globe

(02) 8938-0069 PLDT mobile landline

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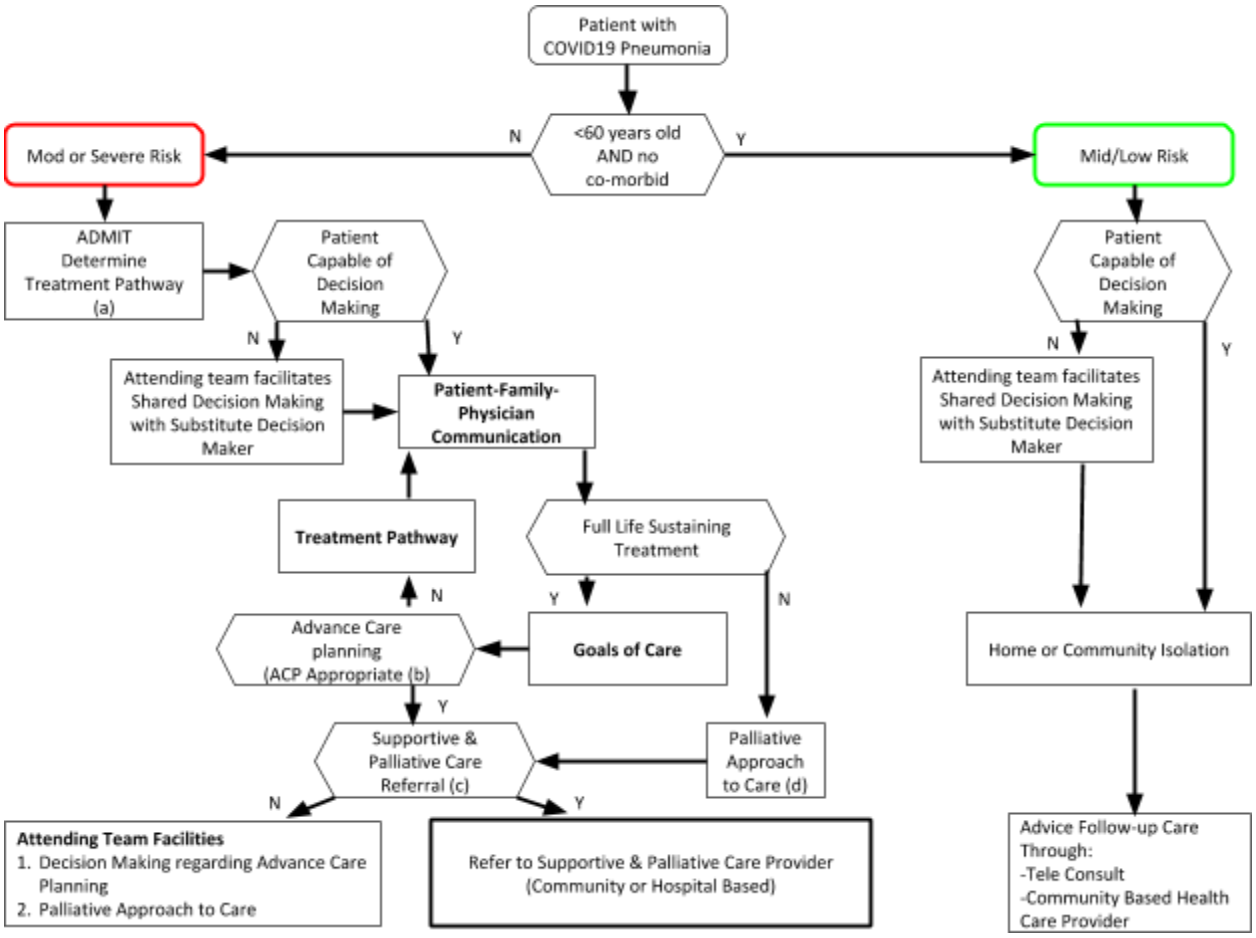
DISCLAIMER

This is a Provisional Guidance Document. In the context of COVID Emergency Response, this is being developed and disseminated among members of PSHPM, PAFP, PSPHP, AMHOP and other medical professionals as a guide/ reference to assist in decision-making, setting of local care systems and primary care. For more specific clinical or public health guidance, users are advised to refer to guidelines issued by DOH, hospitals and professional societies. For further concerns, questions and inquiries, you are advised to call PSHPM-Hospice Philippines Hotline at **09063141421 (Globe) or (02) 8938-0069 PLDT mobile landline**. This Provisional Guidance Document will be updated as new recommendations become available.

Annexes

Annex A. Decision algorithm for the Integration of Supportive and Palliative Care into the care of COVID-19 positive patients



FOOTNOTES

(a) Treatment Pathways

1. Intermediate Care
2. ICU Care
3. Palliative Care

(b) Advanced Care Planning (ACP)

1. Particularly important for the elderly, those who are frail or have other serious conditions.
2. ACP with or without DNAR form completion, must be made on an individual basis according to need.

(c) INDICATORS FOR SUPPORTIVE and PALLIATIVE CARE REFERRAL

1. Supportive Counselling for patients and/or family warranted
2. Advanced Care Planning
3. Comprehensive Palliative Care

(d) Palliative Care Approach

An approach that impress the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (WHO 2018)

References:

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University of the Philippine-Manila (4 April 2020). Ethics Guidelines on COVID19 Crisis-Level Hospital Care

Annex B. Shared Decision Making Conversation Guide

The following six steps will help providers with shared decision making:

1. Invite the patient to participate: Inviting patients to participate lets them know that they have options and that their goals and concerns are a key part of the decision making process.
2. Present options: Patients need to know the available options.
3. Provide information on benefits and risks: Provide balanced information based on the best available scientific evidence. Check back with patients to be sure they understand.
4. Assist patients in evaluating options based on their goals and concerns: To understand patients' preferences, ask them what is important to them and what they are concerned about.
5. Facilitate deliberation and decision making: Let patients know they have time to think things over, and ask them what else they need to know or do before they feel comfortable making a decision.
6. Assist patients to follow through on the decision:Lay out the next steps for patients, check for understanding, and discuss any possible challenges with carrying out the decision.

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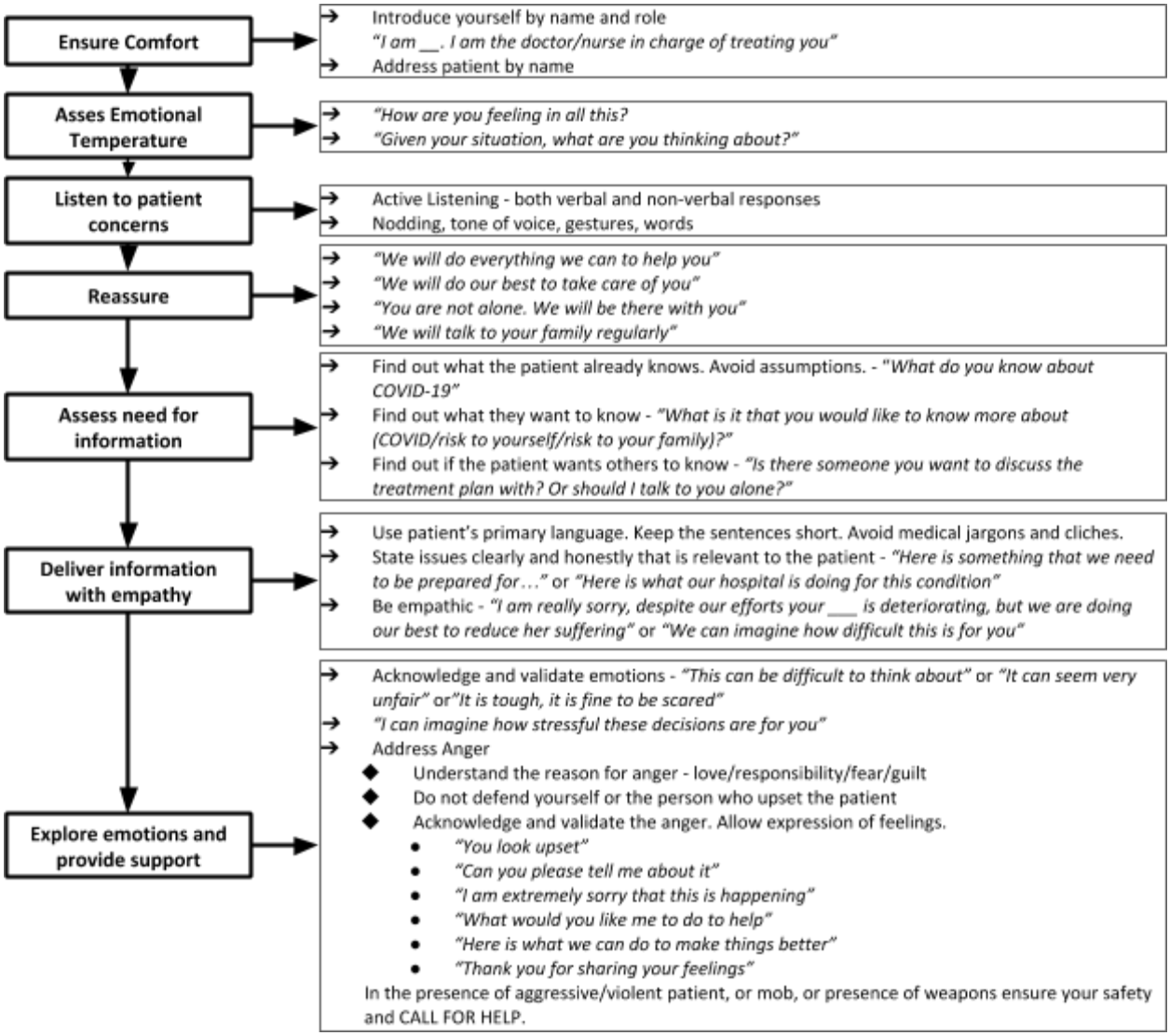
Reference:

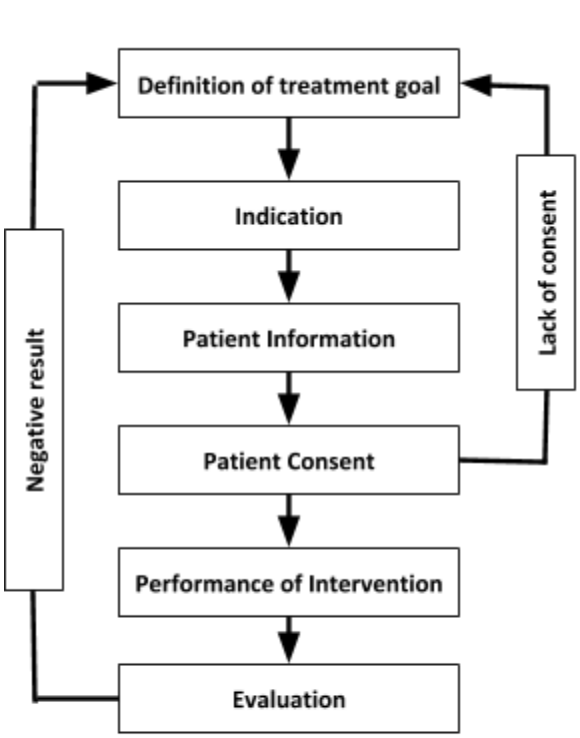
Six Steps of Shared Decision Making. Informed Medical Decisions Foundation 2012

Annex C. Patient-Family-Physician Communication Guide



Source:
"Communication Tips in COVID 19" by Dr. Seema Rao, Dr. Poornima Sunder and "Goals of Care Discussion Framework" by Dr. Seema Rao; e-BOOK ON PALLIATIVE CARE GUIDELINES FOR COVID-19 PANDEMIC Task Force in Palliative Care (PallicovidKerala) KERALA; April 2020

Annex D. Algorithm for Treatment Goals and Decision Guide



	Responsible[1]	To be involved[2]
Definition of treatment goal	Physician + patient	Team, family
Indication	Physician	Team
Patient Information	Physician	Team, family
Patient Consent	Patient	Team
Performance of Intervention	Physician + patient	Team, family
Evaluation	Physician + patient	Team, family

[1] The surrogate decision maker has to be involved, if there are reasonable doubts about the decision-making capacity of the patient. This person is tasked with supporting the patient in the decision-making process and, if necessary, represent him in this process.
[2] If medically advisable or requested by the patient.

Adapted from Guideline on palliative care for patients with incurable cancer, German Society for Palliative Medicine / German Society for Pneumology and Respiratory Medicine

Annex E. Advanced Directives Form

Adapted from University of the Philippine-Manila (4 April 2020). Ethics Guidelines on COVID19 Crisis-LevelHospital Care, with minor joint revisions by the Section of Supportive, Hospice and Palliative MedicineDepartment of Family and Community Medicine-Philippine General Hospital-University of thePhilippines and Philippine Society of Hospice and Palliative Medicine.

Advance Directive Template in COVID-19 Hospitalization

I, _____, of legal age from _____

[FULL NAME] *[ADDRESS]*

do hereby state that:

• **Awareness of the situation.** The health care team has explained to me the gravity of my medical condition and the possibility that this may worsen, despite their best efforts. I understand that a point may be reached wherein there is no reasonable expectation of a full recovery regardless of the use of aggressive medical interventions. While I am still of sound mind and have the capacity to decide for myself, I am now signifying my personal preferences on the medical interventions that may be undertaken for me. I understand that, while I am still able to communicate, and if I so desire, I can immediately express my wish to change any of these indicated preferences.

• **Substitute health care-related decisions.** Should I become unable to communicate, I wish _____, _____, to make health care-related decisions for me.
[NAME of KIN/. LEGALLY ACCEPTABLE REPRESENTATIVE/SUBSTITUTE DECISION-MAKER] [RELATION]

• **Part 1: Medical treatments / Interventions.** I wish to state my personal decision on the following medical treatments/interventions, should I show signs of rapid deterioration and my doctor and another healthcare professional determine that my illness is irreversible and my life is limited to a short period of time. My personal decisions on the following medical treatments/ interventions are as follows:

Life Prolonging Interventions	
Intubation and Mechanical Ventilation An intervention wherein a machine pumps air into my lungs and helps me breathe through an endotracheal tube placed in my mouth into my windpipe when I will have a hard time breathing.	
[ ] I am allowing the placement of the endotracheal tube and ventilator support. [ ] I allow only non-invasive ventilation	[ ] I **DO NOT** allow the placement of the endotracheal tube and ventilator on myself.
Vasopressor / Inotropic Support Medicines given to raise my low blood pressure and/or improve the contraction of my heart	
[ ] I am allowing the use of these medications	[ ] I **DO NOT** allow these medications.
Cardiopulmonary Resuscitation (CPR) • An emergency lifesaving procedure performed when the heart stops beating • Includes the following: manual or automated chest compressions and/or the application of electric shocks to jump start my heart in case of abnormal rhythms and cardiac arrest	
[ ] I am allowing CPR in case of cardiopulmonary arrest	[ ] I **DO NOT** allow CPR.

Dialysis This machine temporarily cleans my blood of poisonous substances if my kidneys stop working. In order for dialysis to be done, a small tube will be inserted through one of my large veins for connection to the machine.	
[ ] I am allowing this	[ ] I **DO NOT** allow dialysis.

dialysis.	
Blood transfusion This process will add blood in my veins.	
[ ] I am allowing blood transfusion.	[ ] I **DO NOT** allow blood transfusion

• **Part 2: Decisions about Life Prolonging Interventions.** I wish to state my preferences if Life Sustaining treatment has been started and my doctor and healthcare team determine that my illness is irreversible and my life is limited to a short period of time.

[ ] I wish to continue all Life Prolonging Interventions
[ ] I wish to **DISCONTINUE** all Life Prolonging Interventions after a thorough discussion with my loved ones and the authorized hospital representatives. I only wish for comfort measures to be administered during the whole process. I understand that I must stay in the hospital in isolation for the safety of my immediate family and the community where I belong to.
[ ] I wish to have my doctor and another healthcare provider determine when to discontinue Life Prolonging Interventions on the basis of medical futility. If am no longer able to communicate, I request that a thorough discussion should be facilitated with my substitute decision maker whenever there are changes in the goals of care.

●**Part 3:Palliative Care .** I wish to state my preference for comfort and supportive care measures throughout the course of my illness, with focused comfort measures during the terminal phase of illness.

[ ] I want to be kept as comfortable as possible through both appropriate pain and symptom management using pharmacologic and non-pharmacologic means.

[ ] I want full disclosure should there be changes in my medical situation especially if the goals of care has shifted. Apart from myself, I want my family to be counselled and fully informed as well.

[ ]I want spiritual and psycho-social care that is consistent with my personal beliefs, values cultures, and traditions. I understand that safety of the health care workers, my family and the community should be considered in all these aspects.

I understand that this directive can be revoked by me or any of my substitute health care decision makers at any time by any means, as my needs may change.

I grant permission for this document to be reviewed by all persons directly involved in my care & well-being.

I release the _____, the attending physician, and the staff from any liability
[NAME OF INSTITUTION]
related to my preferences indicated above.

Respectfully yours,

Patient's Printed Name and Signature
Date & time signed:

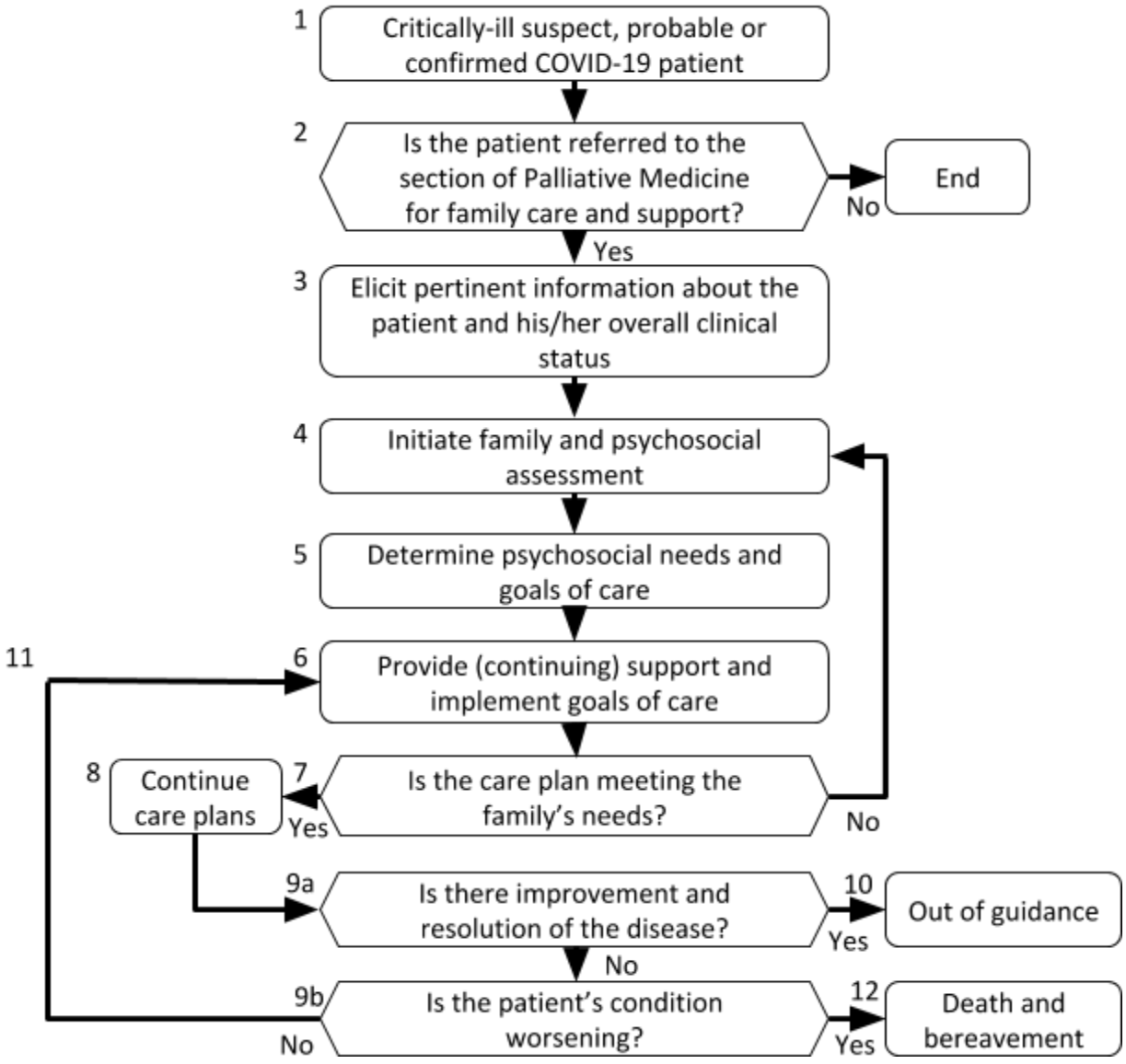
Explained by:

Printed Name and Signature of Attending Physician
Date & time signed:

Witnessed by:

Printed Name and Signature of Witness
Date & time signed:

Annex F. Decision algorithm for the Provision of Family Care and Psychosocial support for the critically ill suspect, probable and confirmed COVID-19 positive patients admitted in the Intensive Care Unit (ICU) of Southern Philippines Medical Center



Algorithm Annotations

1. This algorithm is for all critically ill patients that are suspected (patient with COVID-19 like symptoms and have exposure or travel history 14 days prior to symptom onset), probable

(patient that is suspected to have COVID 19 but have inconclusive COVID-19 test result or can not be tested) and confirmed (patients who have tested positive for COVID=10) cases of COVID-19.

2. The Section of Palliative Medicine is a subspecialty division of the Department of Family and Community Medicine of Southern Philippines Medical Center (SPMC) offering palliative and hospice care services. Family care and psychosocial support is an approach to health care that is respectful of and responsive to individual families' needs and values

3. It should be ensured that the palliative care fellow-in-charge have the following information and recorded appropriately:

- Complete name and contact details of the patient and of the immediate family member, next-of-kin or surrogate decision maker.
- Brief clinical background and status, including pertinent laboratory results and current plans and goals of care.
- Advanced directives as appropriate.

4. The palliative care physician-in-charge must introduce himself/herself as a member of the team caring for the person and then must identify to whom the physician is talking to. The family genogram assessment tool is used. Other family assessment tools may be used as appropriate.

5. It is important to include the patient's family into the conversation. It must be stressed to them the reason why it is important and the physician-in-charge should be able to elicit the family's communication preferences. level of health literacy and information needs. Also, in this time of crisis, the family should be made to understand that for the safety of everyone, the use of mobile devices and/or social media platform are the preferred modalities for exchange of communication.

6. Provide support by sharing medical information and updates, addressing the family's emotions with empathic and validating responses and exploratory questions, providing spiritual and psychological support, that is consistent with family's beliefs, cultures and traditions and culture, and counselling as appropriate.

7. Monitor if the family is satisfied with their current level of understanding immediately after the meeting and 24 hours after the initial contact has been made. The patient's condition and the family's needs should be regularly revisited to account for changes and a shared-decision making model should be used if appropriate.

8. Update and endorse to the primary service the details of the meeting and continue care plans if there are no gaps throughout the process.

9. Signs of improvement may include stabilization or improvement of oxygenation and ventilation, of underlying organ dysfunction and of hemodynamic function and the discharge from ICU or hospital. Signs of deterioration on the other hand may include, lack of improvement in the respiratory or hemodynamic status or in the underlying organ dysfunction, occurrence of cardiac arrest, presence of intractable multiple organ failure and the initiation of end-of-life care discussions.

10. Patient with COVID-19 infection are out of the guideline if they are discharged from the ICU or hospital, and they are able to reunite with their family members through whatever means possible. Patients at this time will have an improved general sense of well-being, activities of daily living, fully active and are capable of self-care.

11. Provide support and implement goals of care as stipulated in #6.

12. Physicians and health care workers in general play an important role in facilitating healthy grief and bereavement processes of the patient's surviving family members and significant others. Providing information and education on grief responses can assist them during the bereavement period. Practical support by completing death certificates in a timely manner, filling out necessary forms ,giving postmortem and funeral instructions in coordination with regulatory agencies as appropriate, or writing letters for the bereaved family. Palliative care physicians should be available to answer questions and offer support informally or through a formal debriefing to be scheduled at a later time when the public health emergency and strict quarantine measures are lifted.