COVID-19 Palliative Care Team Response

Strategies to Support Staff Re-Entry to In-Person Palliative Care Delivery

As COVID-19 surges and ebbs in different areas of the country, some palliative care teams are working toward finding a new normal. This translates to the palliative care team moving from contingency mode of crisis planning back to conventional care. Staff who were working from home and providing telehealth may be returning to the hospital, clinic, or the home. Staff who were furloughed may be asked to return to the health setting. The palliative care team may need relief, and want to increase the use of their contract, locum, or per diem providers.

As these colleagues prepare to return to the health setting, it is important to consider how significantly conventional care has changed. Staff who are returning or reentering will need support and direction to provide optimal and consistent care.

1. Recognize that care delivery in the current environment is vastly different, and assess the changes caused by COVID-19.

- Make a short list of key changes to palliative care team processes and function. Is the list longer than you expected?
- Be sensitive to how returning team members experienced the crisis. COVID-19 presents a different fear/stress level based on individual backgrounds, underlying health conditions, family situation, and support at home.

  For example, consider how the coronavirus impacted the following team members differently:
  - 38 year-old palliative nurse practitioner, with history of cancer, with 2 small children at home, that meant they were unable to be on the frontline in the hospital but provided telehealth case management.
  - 67 year-old chaplain deployed to telehealth due to age-related COVID-19 risks.
  - 58 year-old palliative physician who provided telehealth home visits, with a history of bowel issues on chronic steroids, but was protected at home. Spouse now unemployed due to COVID-19.
  - 50 year-old palliative physician assistant worked part-time in the dialysis clinic and part-time in the neurology clinic, who was furloughed since the neurology clinic was closed.
  - 45 year-old palliative social worker on the oncology floor who was furloughed due to low census. Lives alone; was socially isolated during two months of furlough.

2. Recalibrate palliative care coverage boundaries and roles.

- Articulate the team mission and priorities in this moment for the re-entering team member. Have they changed during COVID-19, and if so, how?
- Review the COVID-19 era role and responsibilities of the palliative care team member who is re-entering, which may be different from that person's pre-COVID/ 'permanent' role.
- Re-establish team expectations for coverage (e.g. providing the best care possible in a new era, productivity or goal of number of encounters per shift, communication expectations).

3. Develop a re-entry process for palliative care staff.

Re-entry takes planning and is a collaborative team effort. It often works best if one person is assigned to managing the re-entry process, with the entire palliative care team working together to support person or people re-entering.

- The team member should not return without on-site support from someone on the team who is already fully oriented to the new processes, or who has been working in-person for a period of time (i.e. team member should not return on a weekend when no other team member is on-site).
- Ask/encourage the re-entering team member to submit a list of questions to the team.
- Consider having the team member review new policies or have a 'virtual reorientation' ahead of time (see below). This may depend on compensation (some organizations do not pay for any work done off-site for hourly or non-permanent staff).
- Have the team member meet staff on-site for an hour to go over the items listed below.
- Make sure there is adequate time for debrief all the information at the end of the day, perhaps during sign-out to another team member.
- Invite the team member to participate in any emotional and social support meetings provided to covering palliative care team members. These may occur off their shift.

4. Develop a reorientation checklist for palliative care staff re-entry, which includes a review of the clinical day from start to finish.

A. Preparation for Re-Entry

a. Notification to hospital/organization that the clinician will return to campus
b. COVID-19 testing prior to return, and clinician symptom monitoring process prior to each shift or between patients (supply your organization's policies and ensure that they are up to date)
c. New/changed rules about uniforms, scrubs, or street clothes
d. Changes in building/unit access or use of ID cards
e. Organizational policies (e.g. health care and financial coverage) if clinicians contract COVID-19, need to be quarantined, or other situations arise

B. PPE/Cleaning/Limiting Exposure

a. Ensuring proper fitting, use, and storage of personal protective equipment (PPE) – masks, eyewear, N95 respirators, etc.
b. Demonstration requirements for donning and doffing PPE
c. New policies and procedures for cleaning and care for patients with COVID-19
    i. Electronic surfaces
    ii. Stethoscope and blood pressure cuffs
    iii. Patient placement
d. Visitor policies (may vary for actively dying patients or pediatric patients)

C. Work Environment

a. Parking rules – these may have changed during the crisis so returning clinicians need this information
b. Ingress and egress of facility (many organization require that clinicians pass through one entrance for safety and monitoring checks)

c. Staggered work schedules and rules of social distancing within the facility

D. Palliative Care Team

a. Determine who is in charge of the reorientation for the palliative care team member.
b. Organization-specific treatment algorithms for COVID-19, based on availability and bandwidth of human resources, PPE, medical equipment, and formulary availability
c. Determination and triggers of patients to be seen by palliative care – particularly COVID-19 positive patients and patients under investigation (PUI).
d. Palliative care team meetings
    i. How do they occur? In-person, by video, or a mixture?
    ii. How often do team meetings occur?
    iii. What is the purpose of team meetings?
e. Telehealth for palliative care
    i. New use of telehealth within the facility for on-site visits or hospital visits
    ii. Determination of who is seen in-person vs. by telehealth
    iii. What does telehealth mean inside your organization during COVID-19? What equipment is used (tablets, smart phones, floor computers)? Are there new translation services?
f. Electronic Health Record (EHR) and Documentation
    i. Review of placement of pertinent information within the EHR for COVID-19 with specific details including:
        1. COVID-19 testing and results
        2. Delineation of COVID-19 status - positive or patient under investigation
        3. Advance care planning (ACP) information
        4. Code status
    ii. Use of any new EHR documentation templates for COVID-19, palliative care, or telehealth
    iii. Billing codes being used
    iv. New sign-out/handoff processes
g. Work Expectations for Palliative Care
    i. Volume of service (percentage of palliative care patients vs. COVID-19 patients)
    ii. New use of telehealth and number of visits per shift

5. What is different in the COVID-19 Era?

Overview of palliative care team issues/concerns pre-COVID and during COVID-19:

Issues	Pre-COVID-19	During COVID-19
Operational	I was familiar with how we took consults, rounded, charted, the key notes I used in my EHR, and team roles. Family members could visit loved ones in facilities.	What are the new operational processes? Do we chart differently? Round or take consults differently? Have team member roles changed and if so, how? What is the latest visitation policy in my facility? Is it different for COVID-19 and non-COVID-19 patients?
PPE	We only used to wear PPE for isolation patients.	What are the PPE protocols now? Do I need to wear a mask inside the facility all the time? What do I need to wear when caring for COVID-19 patients in my facility? Does my facility even want me to physically see and interact with COVID-19 patients?

	Individual: With universal precautions of care, I felt that physical and psychological safety were mostly assured.	Individual: Is there enough PPE for me and patients? What PPE is mandated that I wear? What if I expose my family/my next patient?
Financial	Palliative care was a standard part of the services our facility offered.	I'm hearing about layoffs at other health facilities. Is our palliative care service at risk? Is there a hiring freeze now?
Clinical	I knew how to handle most serious illnesses medically and/or psychosocially.	How is my organization caring for COVID-19 patients now? What are the medical or medication protocols being used? If COVID-19 patients in the ICU are often heavily sedated, how do we address symptom management?
Emotional and Physical Energy to Protect Ourselves	Our team knew our limits and how to manage the day. Individual: I knew my limits and how to manage the day.	Just donning and doffing PPE takes energy and attention to protect ourselves. How do we maintain our vigilance? Individual: There is so much to catch up on. Will I be able to attend to my safety? How do I juggle updates and new information to stay current with new procedures within a timely manner and my work shifts?
Anxiety	We always did the best we could with the resources we had. Individual: I worked to the extent I could, given my personal health limitations. I knew the resources and felt comfortable in my role.	Do we have the people and resources we need? Are we prepared, if some of our staff are exposed to or contract the virus and have to go into quarantine? Individual: What resources do I need? What happens if I am exposed/contract the virus and have to quarantine? Will my expenses be covered? What kind of testing is my facility offering staff and what are the criteria to get that testing?
Insecurity for non-Full-Time Staff	The full-time team has a better view of care and understands everyday needs. Should I offer my services more? Individual: I work to the extent I can, given my personal health limitations.	The permanent personnel had to deal with the frontline in the crisis. I am only providing relief and support to rest them. They were the heroes, not me. Individual: The virus is so unknown and I am not sure if I want to be there. What if I expose my family? I am really worried given my personal health, but I feel I need to pitch in.
Communication	We had a process for communication about patients.	We need a process for communication that includes patient information and COVID-19 information. Do we have a good template?

	Individual: I understood our communication processes.	Individual: I am not sure if I understand all the elements of information that are necessary now. Do I have the skills for telehealth including family meetings, goals of care, bad news, and death notification?
Debriefing	We had a formal process in place for debriefing with palliative care team staff.	Is the COVID-19 work different? What is the debriefing process for per diem staff who are unable to participate in debriefing times? Individual: This has been a more intense time with a lot of change - who will I be able to talk with so I am comfortable returning to assist again?
Scope of Mission	Boundary-setting and clear scope were needed to preserve our resources and protect our team	What are the new boundaries during COVID-19? What are the new priorities for the team?
Cognitive Framing	There were established service standards for palliative care access and quality (timely, high-quality consults).	What are the new priorities of care? Individual: What can I give up to accommodate new priorities?

Resources and References:

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