Recommendations of the COVIPAL group (CME) on the organisation of palliative care in COVID units
Proposals to be rejected, adapted or supplemented by hospital sites, according to field realities (20 March 2020)

1. Identifying patients early and recording the decisions made and the palliative care plan

→ Each hospital must define:
- How patients who are refused admission to intensive care or whose condition deteriorates while hospitalised in the COVID unit are to be identified early;
- How information will be disseminated and recorded:
  - ORBIS IT system, or
  - Other means: telephone number for the hospital, pre-completed paper documents, colour-coded for quick identification (design proposed by the College of Palliative Care)

2. Construct an organisational plan

a) COPIVAL working group of the Greater Paris Public Hospital Authority (AP-HP):

→ Collect and collate tools and documents and place them at the disposal of COVID units
→ An email address has been set up for this purpose: covipal@aphp.fr and a set of tools is being developed to gather these tools and documents and make them widely available;
→ Gather field initiatives in order to disseminate them and the difficulties of helping to find solutions

b) Mobile palliative care teams (EMSPs):

→ If possible, part of the EMSPs should be dedicated to COVID-19+ patients.
→ The EMSP (supported by care for the elderly and general medicine doctors):
- Coordinates palliative care in the hospital;
- Forms the day and night teams, in collaboration with a point of contact in each department;
- Will continue to provide non-COVID patients with palliative care;
- Can intervene as an independent party in pre-intensive care situations where treatment is to be limited or withdrawn;
- Participates in ethical support groups, whose objectives must be defined.

→ EMSPs benefit from additional resources (e.g. increased shifts and assistance from paediatric EMSPs).
→ An on-call number has been set up for weekends and public holidays.

c) COVID units

→ Two contacts (one medical and one paramedical) are named in each COVID unit, who will receive brief training on the main points of palliative care.
→ The contacts:
- Will support and train medical and paramedical staff (including healthcare assistants) in their unit to deliver palliative care;
- Will be in direct contact with the EMSP to receive support and expert knowledge;
- Will not be confined to working with palliative patients in the unit.

→ A particular focus will be placed on night staff (in the form of training and support), who will have access to individual palliative care resources for complex situations.
→ Psychological support has been organised for teams.

d) Other players involved with palliative patients

→ Each hospital:
- Will draw up a list of requirements for each COVID unit, in terms of psychologists, physiotherapists and other professions necessary for patient wellbeing;
- Will deploy these players and define the means of their intervention;
- Will organise the support of psychologists from the hospital and mobile palliative care teams;
- Will deploy hospital psychiatrists and medical liaison teams;
- Will organise the intervention and safety of religious representatives;

e) COVID-palliative care-specific units

→ These are anticipated in the recommendations of the French palliative care society (SFAP) in situations where "the ability of COVID units to provide curative care is compromised, due to the huge influx of patients".
→ The relevance of such units should be discussed by each hospital, on a case-by-case basis.
→ If such units are required:
- Explore the possibility of enlisting trained, competent voluntary staff;
- Consider how these professionals will be trained and supported effectively;
- Provide a place to receive families.

f) COVID hospital unit support to consider

→ Define a procedure for patients returning home for the end of life if the patient and his/her family so wishes, ensuring home-based care is technically possible;
→ Where it is conceivable for the patient to return home or to a nursing home (subject to agreement by the relevant hospital), put in place support from a specialist team (home care team and/or health network).

3. Developing recommendations, protocols and practical tools for teams dealing with palliative

→ Collate and disseminate treatment and evaluation tools indexed in the past by teams from AP-HP, the French high authority of health, the regional health authority and the academic societies. You can email your contributions to covipal@aphp.fr;
→ Make a checklist to aid decision-making, of palliative treatment protocols and of the guidelines on which treatments to continue or suspend;
→ Provide teams with a brief, basic and practical training module.

4. Prioritise access to medicines and essential devices for palliative care

→ Each hospital:
- Will check the availability of the stocks of medicines necessary for palliative care or sedation for hypoxaemic respiratory failure, in particular:
  - Paracetamol administered via IV, PO or suppository, used for relief from pain and fever
  - Fast-acting morphine PO and morphine (10 mg/1 ml), used for polypnoea and pain
  - Midazolam (5 mg/5 ml) used to induce anxiolysis (where PO administration is impossible) or sedation
  - Scopolamine (0.50 mg/2 ml - 3-6 vials/24 hours) used for end-of-life airway obstruction
  - Largactil (25 mg/5 ml) vials and Haldol (2 mg/ml) PO, used for opioid-induced hallucinations and for nausea and vomiting
  - Mouth treatments
- Will define which other medicines may be necessary and check their availability locally;
- Along with executive staff, assisted by logisticians and in conjunction with a designated pharmacist, will organise:
  - The collection of resources;
  - Monitoring of the availability of sufficient quantities of medicines in departments, 24 hours per day, seven days per week;

→ **Route of administration:**

- According to the needs and usual practices of the department, the subcutaneous administration of these medicines will take precedence if oral administration is impossible and the patient has not previously received an IV infusion. A simple infusion set could be considered in case of a shortage of syringe pumps (ensure an adequate supply);
- Pain relief patches, although seemingly practical to use, will not be considered as a first-line option, due to the long time they take to act and difficulties adjusting dosages, particularly in older patients.

5. Supporting the patient's relatives

a) End-of-life visits

→ Consider alternatives to restricting visits during the end of life;
→ Rely on the expertise of medical staff to determine visiting times;
→ Restrict patient visits to those closest to the patient or those specified by the patient;
→ Limit the maximum number of visitors to two (with the possibility of a rotation) and the duration of the visit;
→ Strictly adhere to rules on barrier measures;
→ Consider expanding the offer of Avicenne to include the engagement of non-resident medical students in helping families to get dressed;
→ Create an information sheet to help families prepare themselves, containing the contact details of hospital contacts.

b) Information for relatives on the patient's condition

→ Each unit will determine how to liaise with relatives, where possible securing the patient's agreement, in accordance with patient confidentiality; for example: regular calls to relatives from a specialist, junior doctor or nurse responsible for the patient, or by a trained non-resident medical students supervised by psychologists or transplant coordinators (i.e. those with extensive experience of liaising with relatives);
→ Consider making contact with relatives on a tablet, using applications such as Skype or *Whatsapp*.

c) Supporting relatives with restricted mobility

→ Consider psychological support for families, with a particular focus on children and aftercare for grieving families, in the form of systematic contact by a psychologist, remote consultations, freephone numbers, etc.
→ Ask the State to redeploy psychologists currently confined to their homes;
→ Determine how each unit will inform the family of the patient's death, i,e, who will do it, what if it occurs at night, etc.
→ Be aware of and record the conditions surrounding the patient's death, so as to be able to inform any relatives who would like to know about them for the grieving process;
→ Work with mortuaries to help them receive families and provide the deceased with the relevant care in this unique situation;
→ Consider what means can be made available to enable families to perform the minimum funeral rites, including symbolic rites.

6. Supporting medical staff

→ Financial bonuses and recognition of their work and commitment;
→ Group and individual supervision and other measures, and making medical staff aware of these provisions;
→ Identify colleagues suffering from emotional exhaustion and provide them with specialist help and treatment suited to their needs (work with psychiatric teams of the AP-HP).