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# COVID-19 Palliative Care Toolkit

*Pandemic Use and Beyond*

TriService Nursing Research Program  
Biobehavioral Research Interest Group  
& Evidence-Based Practice Facilitators

# Presenters

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- TriService Nursing Research Program (TSNRP) Biobehavioral Research Interest Group Leader
- Directs TSNRP post-doctoral and AFMS Clinical Inquiry in Nursing Readiness fellowships
- Research focus: military identity, culture, psychological well-being, resilient mindset

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- AF Nurse Scientist leading biobehavioral and operational readiness research
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- TriService Nursing Research Program (TSNRP) Evidenced-Based Practice Facilitator providing consultative services and mentorship for Evidence-Based Practice initiatives
- AFMS Centers of Clinical Inquiry Executive Board Member
- Evidence-Based Practice focus: self-care, complementary and alternative medicine, mindfulness, palliative care, resiliency

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# LeAnne Lovett-Floom, DNP, MSN, PHN



- TriService Nursing Research Program (TSNRP)  
Evidence Based Practice Facilitator
- Leadership roles within numerous professional groups, disaster teams, and community organizations
- Cochrane peer and community reviewer
- Student mentor and coach at George Washington University, University of Arkansas for Medical Sciences, and others
- Research interests: operational readiness, deployment health, translational research, neurodegenerative diseases, complementary health modalities

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- The presenters have no relevant financial or non-financial relationships to disclose relating to the content of this activity.
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- Commercial support was not received for this activity.
- Funding for this project was awarded by the TriService Nursing Research Program (#N20-14 MEB).

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# Acknowledgements

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- **Funding:** TriService Nursing Research Program (#N20-14 MEB)
- **Professional Organizations:**
  - Center to Advance Palliative Care (CAPC)
  - Vital Talks
  - Respecting Choices
- **Subject Matter Experts:**
  - Col Stephen Hernandez, PhD, RN
  - Kristin Callaghan, MSN, APRN, FNP-C, MBA
  - Linda Gowenlock, MSN, MPH, ACNS-BC, CCNS, ACHPN
  - Dr. Diane A. Faran, MD, FAAHPM, Palliative Medicine Consultant

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# Learning Objectives

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At the conclusion of this activity, participants will be able to:

1. Define the need for and importance of basic palliative care for hospitalized inpatients during the COVID-19 pandemic.
2. List three common themes derived from the COVID-19 palliative care literature reviews.
3. Summarize two lessons learned from the pilot implementation of a COVID-19 palliative care toolkit.
4. Identify two recommendations for utilizing the COVID-19 palliative care toolkit in future operations.

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# Overview

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- Background
- Toolkit Development
- Toolkit Contents
- Pilot Implementation
- Evaluation: Lessons Learned
- Integration and Sustainment
- Military Relevance and Future Recommendations
- Key Takeaways

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# Background

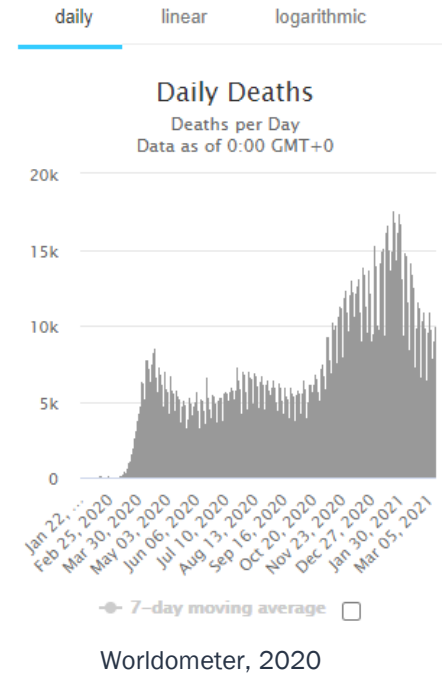
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# COVID-19 Palliative Care Toolkit Background

- Early uncertainty of COVID-19 clinical impact on MTFs
- Travis AFB one of the earliest to be impacted mid March 2020
- Working on a rapid evidence-review for Crisis Standards of Care (CSC) the mortality rates in Italy were unprecedented
- FEMA DSCA COVID-19 military deployer feedback (NY)
  - Staff unprepared for volume of death/dying
  - Crisis standards of care



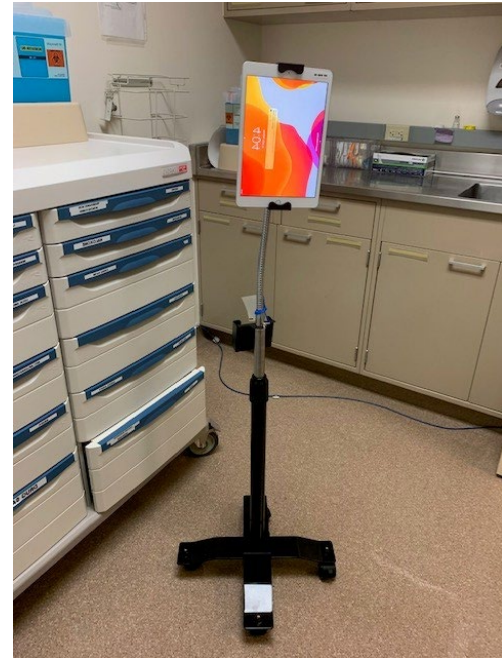
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# COVID-19 Palliative Care Toolkit Background

- Bridge gap with limited MHS resources
- MHS current Palliative Care Departments
  - Madigan Army Medical Center
  - Brooke Army Medical Center
  - Walter Reed National Military Medical Center
- TriService Nursing Research Program  
Evidence-based Practice (EBP) 2020 Mini-grant: \$9K
  - Toolkit development + 10 iPads/stands/cases



Migliore et al, 2021

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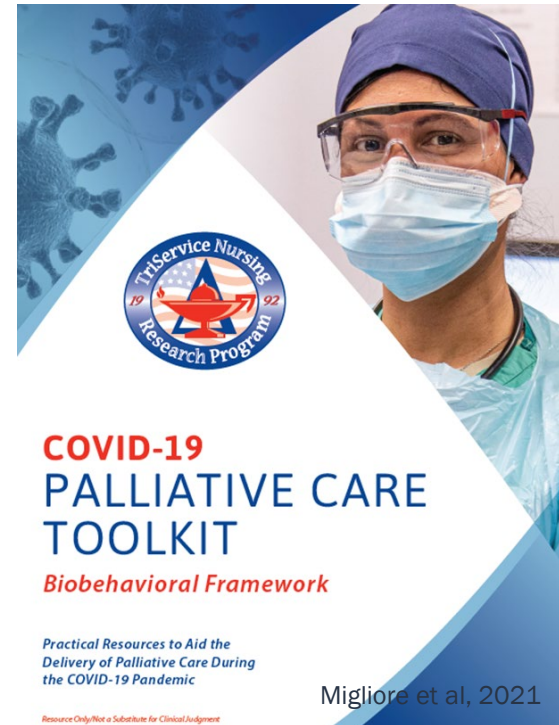
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# COVID-19 Palliative Care Toolkit Purpose

- Prepare/support frontline workers
- Unique COVID-19 palliative care challenges
  - Physical and social isolation
  - Limited access to in-person support (family, chaplains, social work, etc.)
  - Unpredictable rapid change of patient's clinical course
  - Complex decision-making conversations related to unanticipated death

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# Toolkit Development

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# Literature Search: Show Me The Evidence!

## PICOT Question

Population - Facilities caring for COVID-19 patients

Intervention - Palliative Care Team

Comparison - No Palliative Care Team

Outcomes - Management of COVID-specific care challenges

Time - During the COVID pandemic

*In facilities caring for COVID-19 patients, how does having a palliative care team vs. having no palliative care team affect the management of COVID-specific care challenges?*

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# Results: 2020 Rapid Review & Synthesis

- 17 publications were included for palliative care
- 9 publications included for iPad communication use
- Evidence ranged from Level V-VII
- 6 central themes and high demand, high priority, high impact education needs and resources were identified

Level of Evidence	Reference	Key Elements
VI	Arya et al. (2020). Pandemic palliative care: Beyond ventilators and saving lives. <i>CMAJ</i> , 2020, 1-5.	<ul style="list-style-type: none"> <li>- Symptom management and standard order sets</li> <li>- Staff education: palliative care principles, triage, telemedicine, critical communication regarding patient wishes and likelihood of survival</li> <li>- Leverage technology for patient/family communication</li> </ul>
VII	Chidiac et al. (2020). Emergency palliative care planning and support in a 19 pandemic. <i>Journal of Palliative Medicine</i> , 23 (6), 1-2.	<ul style="list-style-type: none"> <li>- Symptom management and standard order sets</li> <li>- Staff education: palliative care principles, critical communication</li> <li>- System for expedited discharge home with needed resources</li> <li>- Family/caregiver support for the provision of community-based palliative care</li> </ul>
VII	Curtis et al. (2020). The importance of addressing advance care planning and decisions about do-not-resuscitate orders during novel coronavirus 2019 (COVID-19). <i>JAMA</i> , 323(18), 1771-1772.	<ul style="list-style-type: none"> <li>- Importance of early discussion regarding patient's values, code status, goals for COVID-19 treatment</li> <li>- Avoiding non-beneficial or unwanted interventions to better allocate limited resources and reduce burden on healthcare workers</li> </ul>
V	Eckind et al. (2020). The role and responses of palliative care and hospice services in epidemics and pandemics: A rapid review to inform practice during the COVID-19 pandemic. <i>Journal of Pain and Symptom Management</i> , S0885-3924 (20).	<ul style="list-style-type: none"> <li>- Staff education: hospice/palliative care protocols, symptom management, psych support, bereavement counseling, personal protective equipment (PPE)</li> <li>- Need for palliative care and spiritual care experts, infrastructure for patient/family, support via phone</li> <li>- Shifting resources from inpatient to the community</li> </ul>
VI	Frausto et al. (2020). Creating a palliative care inpatient response plan for COVID-19—The UW Medicine Experience. <i>Journal of Pain and Symptom Management</i> . DOI: 10.1016/j.jpainsymman.2020.03.025	<ul style="list-style-type: none"> <li>- Inpatient response plan incorporates conventional, contingency, and crisis capacity.</li> <li>- Palliative care specialist consultation for inpatient providers</li> <li>- Train and coach staffing for crucial conversations</li> <li>- Encourage phone/video consultation to conserve PPE and limit exposure</li> </ul>
VII	Ferguson et al. (2020). Palliative care pandemic pack: a specialist palliative care service response to planning the COVID-19 pandemic. <i>Journal of Pain and Symptom Management</i> , 60(1), e18-e20.	<ul style="list-style-type: none"> <li>- "Palliative Care Pandemic Pack" guide for non-palliative staff in New Zealand</li> <li>- Includes symptom management and other primary care provider resources</li> <li>- Empowers primary care teams to develop similar tools for their own communities</li> </ul>
VII	Fuss-Schmidhauser et al. (2020). Conservative management of Covid-19 patients—emergency palliative care in action. <i>Journal of Pain and Symptom Management</i> , 60(1), e17-e19.	<ul style="list-style-type: none"> <li>- Discussion regarding need for clear/concise treatment plan, rapid decision making</li> <li>- Focus United Kingdom (UK) and Switzerland during the COVID-19 pandemic</li> <li>- Developed a COVID-19 specific assessment tool to assist with quick assessment</li> <li>- Identification of key symptoms in an emergency setting when time is limited</li> </ul>
VII	Hendin et al. (2020). End-of-life care in the emergency department for the patient imminently dying of a highly transmissible acute respiratory infection. <i>Canadian Journal of Emergency Medicine</i> , 22(4), 414-417.	<ul style="list-style-type: none"> <li>- Importance of reviewing patient's goals of care early in emergency department</li> <li>- Development of COVID-19 symptom management order sets</li> <li>- Importance of debriefing sessions for emergency department staff</li> <li>- Aid in decreasing risk of compassion fatigue/burnout</li> </ul>
VII	Wong et al. (2020). Palliative care in the emergency department during COVID-19.	<ul style="list-style-type: none"> <li>- Identification of palliative care and bereavement needs</li> </ul>

Snapshot of one section of Evidence Table, Migliore et al., 2020

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# Central Themes: 1 - 3

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1. Critical need for frontline/primary care staff to have rapid palliative care training
2. Use existing palliative care specialists as consultants and subject matter experts
3. Primary education and training focuses:
  - a) Immediate need to address goals of care
  - b) Hard conversations
  - c) Symptom management
  - d) Communication (clear, direct, transparent)
  - e) Mitigate social isolation through virtual/online/video calls
  - f) Holistic approach body, mind, spiritual, social needs

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# Central Themes: 4 - 6

4. Support for caregivers (family members, staff)
5. Framework of stuff, staff, space, systems, separation
6. Need for quick use standardized resources (order sets, protocols, and guidelines)



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# Toolkit Contents

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# COVID-19 Palliative Care Toolkit Content

- Introduction
- About Toolkit Use
- Biobehavioral Framework
- Palliative Care 101
- Communication
- Pain & Symptom Management
- Support for Caregivers
- Mobile Apps
- Additional Resources

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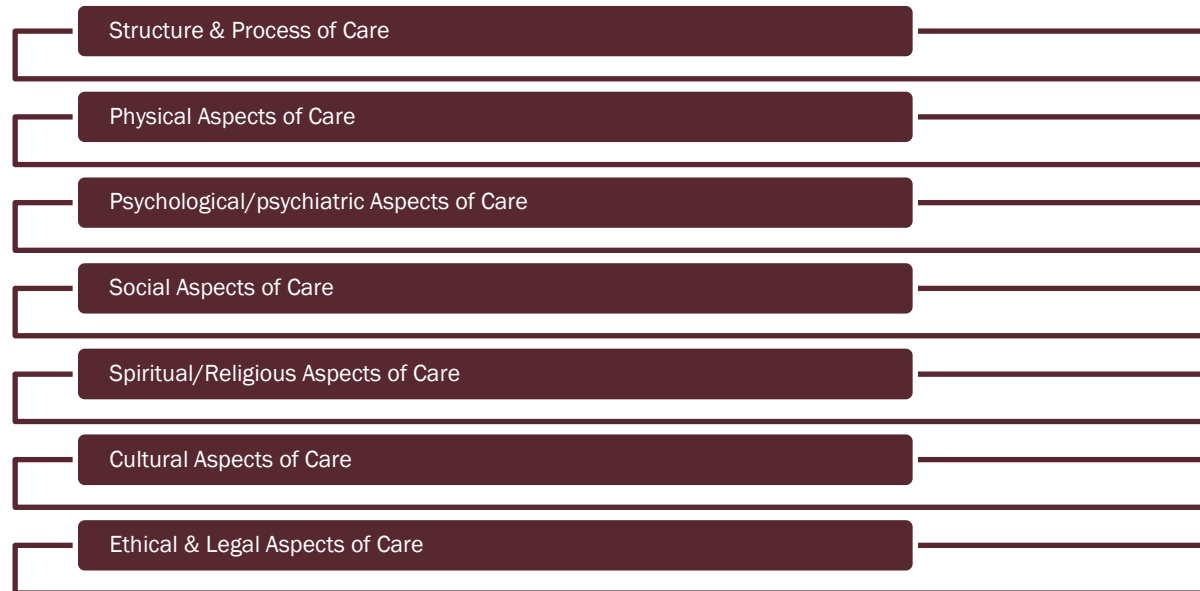
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# Biobehavioral Framework

- Integrates 7 Domains of Palliative Care into Point of Care Toolkit



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# Palliative Care 101

- Who, what, when, where, why
- Care planning
- Goals
- Palliative Care vs Hospice vs End of Life care
- Referral considerations

COVID-19 PALLIATIVE CARE TOOLKIT

## PALLIATIVE CARE 101

**What is Palliative Care?**  
Palliative care is an interdisciplinary specialty that focuses on meeting the needs, priorities, and goals of seriously ill patients, families, and caregivers. Those needs often consist of strategies to alleviate pain, symptom management, stress, and improve overall quality of life. Palliative care embraces a holistic approach by viewing a patient as more than just a person but a human being consisting of physical, psychosocial, spiritual, and cultural needs.

**When is Palliative Care Appropriate?**  
Palliative care is appropriate for any age and at any stage of serious illness.

**Who is Palliative Care For?**  
All seriously ill people with life altering illnesses such as cancer, end-stage lung disease, HIV, renal failure, liver failure, and more.

**Who Provides Palliative Care?**  
Interdisciplinary teams with palliative care certified professionals, doctors, nurses, social workers, chaplains, psychological specialists, and all healthcare workers caring for the seriously ill.

**Not all hospitals have palliative care departments and specialists, but all clinicians are called on to provide generalist palliative care.**

**Front-line staff (ER, ICU, COVID-19 units) will be the primary deliverers of palliative care.**

**Palliative care experts are available for just in time coaching and assisting with managing complex cases.**

**DoD Palliative Care Teams**

- Walter Reed National Military Center
- Brooke Army Medical Center
- Madigan Army Medical Center

Content updated 10/20/20 by Dr. M. H. Not an endorsement of any commercial product.

Principles and palliative care best practices will benefit seriously ill COVID-19 patients regardless of age or clinical setting by identifying the needs and priorities of patients and families.

Resource Only/Not a Substitute for Clinical Judgment

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COVID-19 PALLIATIVE CARE TOOLKIT

### Difference of Palliative Care, Hospice Care, and End of Life Care

	PALLIATIVE CARE	HOSPICE CARE	END OF LIFE CARE
Provides patient/family/caregiver support	✓	✓	✓
Symptom Relief	✓	✓	✓
Comfort Care	✓	✓	✓
Curative Care	✓		
Any stage or phase of serious illness	✓		
Requires prognosis of 6 months or less		✓	
Focus on impending death and days after death			✓

**Palliative Care Assessment and Planning**

- Identify important and priority issues for patients and families
  - Physical, Emotional, Social, Spiritual, Cultural, Ethical, Legal
  - Survival
  - Health maintenance
  - Treatment options
  - Recognize what is possible
- Patient/family shared decision-making
- Interdisciplinary approach to planning
- Continual assessment/re-assessment
- Modify care plans as needed
- Pandemic processes may compress and/or expedite end of life care.

**Palliative Care Goals**

- Improve quality of life
- Pain and symptom relief
- Fewer hospitalization and emergency room visits
- Support for patients, families, and caregivers
- Shared decision-making

**Seriously ill COVID-19 Patients**

- Individuals hospitalized to manage COVID-19 symptoms
- Individuals in home care for COVID-19 symptom management

**Palliative Care Referral**

- Patients already followed by palliative care
- Symptomatic refractory to palliative symptom protocols
- On ventilatory support
- Difficult-to-control emotional distress
- Patient, family, or physician uncertainty regarding prognosis
- Patient, family, or physician uncertainty regarding non-beneficial treatment options
- Patient or family psychological or spiritual/existential distress
- Patient or family request

Content updated 10/20/20 by Dr. M. H.

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# Communication

- Strategies
- Getting on the same page
- Scripts

COVID-19 PALLIATIVE CARE TOOLKIT

## COMMUNICATION

### Communication Strategies

To prevent harmful misunderstandings, it is important to standardize communication with the family.

1. Get team on same page (see "Getting on Same Page" illustration below).
2. Identify family POC with contact numbers in the chart and posted in the rooms.
3. Identify a team "communication lead" responsible for ensuring regular contact with family.
4. Utilize time windows to mitigate family anxiety about missed phone calls (i.e., call between 2-4 pm every day).
5. Be explicit in your updates as well as in your expressions of empathy and commitment to care.
6. When giving information, build in intentional pauses to allow for processing of information. For example, "I will stop now to give you time for things to sink in. Let me know when you are ready to continue."
7. Be vigilant about identifying misconceptions and address them directly.
8. Clarify and revise goals and plans based on patient preferences, values, and priorities.

### Getting on the Same Page

**BEFORE talking with families, consider:**

1. Where have we been?
  - Review updates regarding hospital course
  - Consider big picture of the admission as well as overall illness trajectory
2. Where are we now?
  - What's being done (monitoring, testing, therapies, consults, etc.)
  - Consider short term prognosis for survival, as well as quality of life, prognosis, needs, etc.
  - Use all of this to inform possibilities for ongoing care here and other discharge
3. Where are we going?
  - Consider patient/family values, preferences, and priorities to inform clinical goals
  - Consider patient/family expectations and stresses
  - Consider staff expectations and stresses
  - Establish level of faculty and uncertainty

**Getting on the SAME PAGE can help us clarify a plan by considering "what is possible?"**

**Getting on the SAME PAGE can help us clarify our messages for families.**

**It is a chance to make sure all staff members are on the SAME PAGE when communicating with families.**

### To Clarify Our Message, Ask Yourself...

1. What are our boundaries and limitations (acknowledge them out loud to ourselves and family)?
2. What does "best care" look like in a "not the best" situation (be specific and speak simply)?
3. What is our message to patient/family (keep it simple)?
4. Who is best to deliver the message and how can rest of team best reinforce it?
5. Is our message unified and consistent (across shifts, team changes, consultants, etc.)?

Source: Palliative Care Team, October 2020 Madigan Army Medical Center

Source: Original Not a Substitute for Clinical Judgment


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COVID-19 PALLIATIVE CARE TOOLKIT

### Communication During COVID-19 Times:

- With families no longer at the bedside, they are removed from the physical reality of the patient's condition.
- Patients and families are often receiving multiple messages from news outlets and social media.
- They may believe the healthcare system is ill-equipped or running out of resources.
- They may believe they are being dealt with in a biased fashion.
- Serious effort must be given to create clear, consistent processes for communication.
- Communication breakdowns have potential to tarnish all the outstanding work that goes into patient care.

Source: Palliative Care Team, October 2020 Madigan Army Medical Center



### Difficult Conversations and Scripts for Communicating with Patients and Families

WHAT THE PATIENT/FAMILY SAYS	WHAT YOU MAY SAY
	<b>Admitting a Patient</b>
How bad is it?	From the moment I have seen and there were signs, your situation is serious enough that you should be in the hospital. But of course, none of us wants the wrong location for, and we will update you. We also should have done your situation and how all this looks.
Is my grandfather going to make it?	Things are uncertain. Even when I see my patients here, I'm not already talking with other families, I never do because I'm not sure of the outcome or the trajectory. What is an outcome to you? I mean, what do you want about that?
Anyone says there are no more ventilators!	There isn't a ventilator here, but that's not the issue. The risk of spreading the virus to other vulnerable people is so high that they just wouldn't be used here. It's a very difficult situation. I wish things were different.
How can you not be in a room?	The goal of spreading the virus is so high that we have to try to prevent other visitors. We can help you be in contact with your loved one, but we can't be in the room. I'm sorry that's not what you want.
	<b>When things are not going well, goals of care discussion, code status discussions</b>
I want everything possible, I want to live.	We are doing everything we can. This is a tough and scary situation for many of us. Can I ask you to look for a moment at what we can do for you? What do families have about you to be home with you or go?
I don't think my grandfather would live another day.	What, let's pause and talk about your concerns. Can you tell me what you don't want to do? What do you want?
I don't want to end up being a burden on a machine.	Thank you, it is very important for me to know that. Can you say more about what you want?
I am certain when my grandfather wakes up, we cannot get out of here.	We know, many people feel that way in the moment. This is a hard situation. To be honest, given the overall condition, even if the further treatments may not be successful, preventing him from doing it is a situation that we think we cannot hold that off for another day. That could be hard to hear. What do you think?
	<b>When coping needs to be boosted, or emotions are running high</b>
I've never seen anything like this.	This is such a tough situation. I think anyone would be overwhelmed. Can you share more with me?
I don't want to die.	I'll be there with you every step of the way. I'll be there with you every step of the way.
No people are incompetent.	I can see you are not happy with things. I'm willing to do what it takes to improve things for you. What could I do for you right now?
No people are to blame.	I can see you are frustrated. I would like to know by whom or what. Please tell me that by you saying things like that, you are saying things like that.
Do I need any more tests?	The things that we can do and we're trying to do, but I'm not sure if that's what you want.

Source: Content adapted from VitalTalk

Source: Original Not a Substitute for Clinical Judgment

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# Pain & Symptom Management

- End of life medication dosages and indications from DoD COVID-19 Practice Management Guide
- Evidence-based nonpharmacological strategies

**COVID-19 PALLIATIVE CARE TOOLKIT**

**SYMPTOM MANAGEMENT (End of Life Care)**

Symptom management should be individualized and patient centered. This serves as a guideline only for common symptoms at the end-of-life care. Please follow your local policy and procedures.

SYMPTOMS	PHARMACOLOGICAL INTERVENTION	NONPHARMACOLOGICAL	RECOMMENDATION
Shortness of Breath	Morphine Sulfate PO 15 mg to 1 tablet every 3 hours PRN OR Morphine Sulfate IV 1 mg IV or SQ/IV every 1 hour PRN. SQ/IV can be given as frequently as every 30 minutes PRN	<ul style="list-style-type: none"> <li>Positioning</li> <li>Cool room temperature</li> <li>Remove restrictive clothing</li> <li>Bedside relaxation techniques such as breathing exercises</li> </ul>	<p>Assess the underlying condition. Treatment goals are:</p> <ul style="list-style-type: none"> <li>Maximize use of accessory muscle, nasal flaring, and retractions</li> <li>Patient comfort</li> </ul>
Respiratory Secretions (Gurgling/Noisy Fluids)	4/6 morphine 0.4 mg SQ/IV every 4 hours PRN. Fentanyl 20 mg SQ/IV q4h PRN	<ul style="list-style-type: none"> <li>Lean position</li> <li>Reduce or stop saline infusions</li> </ul>	<ul style="list-style-type: none"> <li>Timing and of the pharyngeal secretions occurred.</li> </ul>
Anxiety	Lorazepam PO/IV 0.5 - 1 mg PO/IV every 1-4 hours PRN Midazolam IV 1-4 mg SQ/IV every 30 minutes PRN. For severe anxiety or shortness of breath.	<ul style="list-style-type: none"> <li>Breathing exercises</li> <li>Minimize noise and light</li> <li>Music therapy</li> <li>Acupressure and cool rooms</li> </ul>	<p>Dyspnea often induces anxiety. Treat dyspnea with opioids as first-line of treatment.</p> <ul style="list-style-type: none"> <li>Lorazepam and midazolam can be helpful as adjuncts</li> </ul>
Delirium	Risperidone PO 0.2 mg PO every 8 hours PRN. Haloperidol IV 0.5 - 1 mg IV every 4 hours PRN. Thioridazine 150.5 mg increase. Olanzapine PO 2.5 - 5 mg PO at bedtime and every 8 hours PRN.	<ul style="list-style-type: none"> <li>Music therapy</li> <li>Reorientation</li> <li>Massage</li> <li>Shout and direct communication</li> </ul>	<p>These underlying causes for delirium.</p> <ul style="list-style-type: none"> <li>Avoid benzodiazepines</li> </ul>
Constipation	Senna PO 6-8 mg PO daily Bisacodyl PRN if Laxative tolerance PO.	<ul style="list-style-type: none"> <li>Increase fluid intake if tolerated</li> <li>Warm prune juice</li> </ul>	<p>Constipation is a common side effect of opioid use.</p> <ul style="list-style-type: none"> <li>Establish bowel regimen</li> </ul>
*Nausea	Metoprolol PO 10 mg every 3 hours around the clock Ondansetron PO 4mg every 3 hours, increase to 8 mg if no relief from starting dosage Metoprolol IV 5 mg/ml give 1 ml every 4 hours around the clock. Ondansetron IV 0.15 mg/kg IV every 8 hours.	<ul style="list-style-type: none"> <li>Acupressure</li> <li>Acupressure</li> </ul>	<p>Treat underlying cause.</p> <ul style="list-style-type: none"> <li>Effective medication</li> <li>nasal, give anti-nausea medication 30 minutes before opioids</li> </ul>
Pain	Morphine Sulfate PO 15 mg to 1 tablet every 3 hours PRN OR Morphine Sulfate IV 1 mg IV or SQ/IV every 1 hour PRN. SQ/IV can be given as frequently as every 30 minutes PRN	<p>In conjunction with opioid therapy</p> <ul style="list-style-type: none"> <li>Relaxation techniques</li> <li>Breathing exercises</li> <li>Massage</li> <li>Distraction</li> <li>Acupressure</li> <li>Acupressure</li> <li>Acupressure</li> </ul>	<p>Pain is subjective.</p> <ul style="list-style-type: none"> <li>Re-assess pain after every intervention.</li> <li>The goal is to make the patient comfortable.</li> </ul>

Source: Content adapted from DoD COVID-19 Practice Management Guide V. 10-01-20 | \*Nausea: CMAP

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Revised 03/16/21 & Updated for Clinical Alignment

**COVID-19 PALLIATIVE CARE TOOLKIT**

**PAIN MANAGEMENT (Opioid Intermittent Dosing)**

To address pain effectively, consider adjusting the dosing for patients already taking opioids, the elderly, frail, and opioid naïve patients. This table provides opioid intermittent dosing to relieve pain and/or shortness of breath for adults.

OPIOID DOSING TO RELIEVE SHORTNESS OF BREATH AND PAIN IN ADULTS	
<b>DOSING FOR OPIOID NAÏVE PATIENT</b> (Patient NOT on opioid therapy) (For frail, elderly patients, begin at low end of any range)	
<b>Morphine</b>	<ul style="list-style-type: none"> <li>15 mg tablet to 1 tab PO q 3 hours PRN for pain OR</li> <li>2 mg SQ/IV to PRN shortness of breath. SQ/IV can be given as frequently as q10min PRN</li> </ul>
<b>Hydromorphone</b>	<ul style="list-style-type: none"> <li>2 mg tablet to 1 tab PO q 3 hours PRN for pain OR</li> <li>0.4-0.8 mg SQ/IV q10 PRN shortness of breath. SQ/IV can be given as frequently as q10min PRN</li> <li>If more than 4 PRN doses of opioid in 24 hours</li> <li>Consider a basal opioid such as MTC Cover 15 mg PO bid.</li> </ul>
If patient unable to make needs known, consider SCHEDULED dosing of the immediate release opioid (q4R or q4H for frail elderly) AND continue PRN doses.	
<b>TITRATE UP AS NEEDED for relief of dyspnea and/or pain.</b>	
<b>DOSING FOR PATIENTS ALREADY TAKING OPIOIDS</b>	
<b>Applies to any opioid</b>	<ul style="list-style-type: none"> <li>Continue previous opioid, consider increasing dose by 25%</li> <li>To manage breakthrough symptoms, start PRN opioid at 10% of total daily 24 hour opioid dose</li> <li>PRN can be PO and SQ/IV for SQ/IV</li> </ul>

Source: Content adapted from DoD COVID-19 Practice Management Guide V. 10-01-20

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Revised 03/16/21 & Updated for Clinical Alignment

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# Spirituality

- Spirituality
- Faith and beliefs
- Grief
- Cultural considerations
- Bereavement

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## SPIRITUALITY

**North American Definition of Spirituality:**  
 "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience connectedness to the moment, to self, to others, to nature and to the significant or sacred." (Puchalski et al, 2009)

**Spirituality allows individuals to find purpose, meaning, transcendence and relationship and is typically rooted in beliefs, doctrine, and practices.**


**Helpful Tips in Addressing Patient's Spiritual Needs:**

- Assess spiritual need with the understanding that the spiritual dimension of a person's life is an avenue for compassionate caregiving.
- Provide basic spiritual support
  - Empathetic listening
  - Compassionate presence
  - Inquiry about spiritual beliefs, values, & practices
  - Reflective listening, query about important life events
  - Life review, listening to the patient's story
    - Breathling practice or contemplation
  - Support patient's sources of spiritual strength
  - Continued presence and follow-up
  - Open-ended questions to elicit feelings
- Refer to spiritual care provider when appropriate.

Source: Palliative Care Team, October 2020  
 Madigan Army Medical Center

Assess Chaplain's Suitability for Clinical Judgment

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**Spirituality is Described in Terms of:**

- Indicator of our humanity
- Our core, beliefs, values
- Our inner being
- The Divine, Holy One, Spirit
- Found within or beyond

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## GRIEF

**What is Grief?**  
 Grief is an experience not a process. Grief is not a single emotion. Grief symptoms can manifest physically, emotionally, and mentally.

**Helpful Tips in Addressing Patient's Spiritual Needs:**  
 Our individual grief experience is shaped by a myriad of factors:

- The relationship we had with the person who died
- The cause of death
- Our society and cultural background
- Our personality and coping style
- Our past experiences with loss
- Our support networks
- Our religious or spiritual beliefs and customs


**How to Support a Grieving Patient and Families?**

- Grievers need support, not fixing.
  - It's human nature to want to alleviate someone else's pain, but grief doesn't work that way. There is nothing we can do to take away the pain.
  - Instead, we can acknowledge the pain and help to hold them up. Supporters can be part of their foundation as they learn how to carry their grief forward.
- Your job as grief support person is NOT to make the grieving person feel better, it's to make the grieving person feel heard.
- Grief support is not one-size-fits-all. The support you give to one griever may not work for another.
- Grief is individual, and grief support should be tailored to everyone's needs.

**Grief and bereavement are cultural.**

- Practices, traditions, and beliefs vary according to cultures.
- There is no right or wrong and local practices may vary.

**5 Stages of Grief**



Source: Palliative Care Team, October 2020  
 Madigan Army Medical Center

Assess Chaplain's Suitability for Clinical Judgment

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# Support for Caregivers

- Validating responses
- Transforming unhelpful thoughts into helpful thoughts for
  - Coping
  - Guilt
  - Blame
  - Anger



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Clinicians and families experience challenges in processing their thoughts and emotions during a crisis and difficult situations. These emotions and thoughts are normal. Here are examples of helpful thoughts to use during those situations.

TOPIC: COPING			
COMMON UNHELPFUL THOUGHTS	HOW YOU MAY FEEL	ALTERNATE HELPFUL THOUGHTS	HOW YOU'LL FEEL
<ul style="list-style-type: none"> <li>I should be coping better.</li> </ul>	<ul style="list-style-type: none"> <li>Helpless</li> <li>Useless</li> <li>Scared</li> </ul>	<ul style="list-style-type: none"> <li>I got here today, so I'm coping a bit.</li> <li>Thinking in a kind, patient, or considerate way might help me cope better.</li> <li>Most people are struggling to cope in this new context. We're all doing the best we can.</li> <li>I can use the time to strengthen my skills with new practices.</li> </ul>	<ul style="list-style-type: none"> <li>Less scared</li> <li>More hopeful</li> <li>Less helpless</li> <li>Stronger</li> <li>Capable</li> <li>Open to getting support or help</li> </ul>
<ul style="list-style-type: none"> <li>Other people deal with this better than I do, so what is wrong with me?</li> <li>Only weak people react the way I do.</li> </ul>	<ul style="list-style-type: none"> <li>Worthless</li> </ul>	<ul style="list-style-type: none"> <li>Most people react this way for a while. My reaction shows the challenge I'm going through, not how weak I am.</li> </ul>	<ul style="list-style-type: none"> <li>Reassured</li> <li>Capable</li> <li>Stronger</li> </ul>
TOPIC: GUILT			
<ul style="list-style-type: none"> <li>I should have prepared this.</li> <li>I should have done something differently.</li> <li>I am disappointed in myself.</li> </ul>	<ul style="list-style-type: none"> <li>Gulky</li> <li>Worthless or blameworthy</li> <li>Frustrated</li> <li>Upset</li> </ul>	<ul style="list-style-type: none"> <li>Nobody could have prepared this.</li> <li>I can't always protect myself or others, and I did the best I could, given that I was operating with limited resources I was prepared for then.</li> <li>There are many things I'm grateful for, so I'll focus on those instead of what is bothering me.</li> </ul>	<ul style="list-style-type: none"> <li>Self-accepting</li> <li>Worthy</li> <li>Like you want to blame</li> </ul>
TOPIC: BLAME AND ANGER			
<ul style="list-style-type: none"> <li>It's not fair.</li> </ul>	<ul style="list-style-type: none"> <li>Angry</li> <li>Vengeful</li> </ul>	<ul style="list-style-type: none"> <li>This could have happened to someone else.</li> <li>Sometimes bad things happen to good people.</li> <li>It might be a bad day, or someone may be angry, it is getting in the way of my higher purpose (eg., helping my children feel safe, etc.).</li> <li>There are many things I'm grateful for, so I'll focus on those instead of what is bothering me.</li> <li>I can use this time to strengthen my faith with new practices.</li> </ul>	<ul style="list-style-type: none"> <li>Understanding</li> <li>Realistic</li> <li>Accepting</li> </ul>

Source: U.S. Department of Veterans Affairs, National Center for PTSD

Source: OIG/MH's Subtitle for Clinical Judgment

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# Mobile Apps

- DoD mobile IOS and Android apps
  - COVID Coach
  - Insomnia Coach
  - Mindfulness Coach
  - PTSD Coach

COVID-19 PALLIATIVE CARE TOOLKIT

## MOBILE APPLICATIONS

**COVID Coach**

For managing the stressors associated to the COVID-19 pandemic.

- Learn ways to improve your well-being during this global pandemic
- Use trackers for mental health and personal goals
- Find tools for coping and self-care

[https://www.pbod.va.gov/apps/mobile/COVID\\_coach\\_app.asp](https://www.pbod.va.gov/apps/mobile/COVID_coach_app.asp)

**Insomnia Coach**

- Guided, 6-week training plan to help you track and improve sleep
- Sleep coach with tips for sleeping and personal feedback about your sleep
- Interactive sleep diary to help you keep track of daily changes
- 17 tools to help you get your sleep back on track

<https://mobile.va.gov/apps/insomnia-coach>

**Mindfulness Coach**

Designed to support independent mindfulness practice.

- Mindfulness Training: A stepped training plan that ties together features from each section
- Practice Now: Library of mindfulness exercises
- Track Progress: Assessments and goal tracker
- Build Expertise: Short readings to increase understanding of how mindfulness works

<https://mobile.va.gov/apps/mindfulness-coach>

  
 Covid Coach iOS

  
 Covid Coach Android

  
 Mindfulness Coach iOS

  
 Mindfulness Coach Android

  
 PTSD Coach iOS

  
 PTSD Coach Android

  
 Insomnia Coach iOS

  
 Insomnia Coach Android

Use the above codes to open a link for each app in your preferred app store. Open your smartphone camera and focus on the corresponding code. Alternatively, visit the App Store or Google Play and type the name of the app in the search bar.

Resource Catalog is a contribution by OIGAS/IGAS/IGAS

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# Additional Resources

- Helpful resources to provide more in-depth information and support

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## ADDITIONAL RESOURCES

**SECTION 1: Palliative Care Training**

- Center to Advance Palliative Care® <https://www.ccapc.org/covid-19/>
- Respecting Choices® <https://respectingchoices.org/covid-19-resources/>
- The California State University Shiley Institute for Palliative Care <https://csupalliativecare.org/covid-19-resources/>
- National Coalition for Hospice and Palliative Care, Clinical Practice Guidelines for Quality Palliative Care <https://www.nationalcoalitionhpc.org/nhcp/>

**SECTION 2: Communication Skills**

- Vital Talk, COVID Ready Communication Playbook [https://www.vitaltalk.org/wp-content/uploads/VitalTalk\\_COVID\\_English.pdf](https://www.vitaltalk.org/wp-content/uploads/VitalTalk_COVID_English.pdf)
- Respecting Choices, Proactive Planning Conversations <https://respectingchoices.org/covid-19-resources/#planning-conversations>
- Center to Advance Palliative Care, Saying Goodbye <https://www.ccapc.org/covid-19/communication/saying-goodbye/>

**SECTION 3: Symptom Management**

- Center to Advance Palliative Care, Crisis Protocols <https://www.ccapc.org/covid-19/symptom-management/crisis-protocols/>
- DoD COVID-19 Practice Management Guide <https://deployedmedicine.com/market/51/content/1440>

**SECTION 4: Support for Healthcare Workers**

- HHS, Behavioral Health Guidance and Resources, Preventing and Addressing Moral Injury Affecting Healthcare Workers During the COVID-19 Pandemic, <https://files.asprtracie.hhs.gov/documents/bh-addressing-moral-injury-for-healthcare-workers.pdf>
- Center to Advance Palliative Care, Emotional PPE <https://www.ccapc.org/covid-19/emotional-ppe/>
- Resources for Managing Stress, U.S. Department of Veterans Affairs, National Center for PTSD <https://www.ptsd.va.gov/covid/index.asp>

**Support for Patient and Families**

- Centers for Disease Control & Prevention, Coping with Stress <https://www.cdc.gov/coronavirus/2019-ncov/daily-life-coping/managing-stress-anxiety.html>
- Reducing Stress via Text Messages <https://www.mphhealth.va.gov/mhr-portal-web/ss20200625-reducing-stress-annie>
- Center to Advance Palliative Care, Planning Steps for Patients and Families During the COVID-19 Crisis <https://www.ccapc.org/documents/download/281/>

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Resource Only/Not a Substitute for Clinical Judgment

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# Toolkit Pilot Implementation

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# Pilot Implementation

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- Toolkit development Jun-Dec 2020
- 60 MDG, David Grant USAF Medical Center, Travis AFB, CA
- Pilot rollout on Med/Surg unit, COVID unit, ICU
- Incorporated 10 iPads for patient communication
  - Loaded with self-care apps (COVID/Insomnia/Mindfulness Coach)

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# Implementation Phases

**Phase I:** Develop the toolkit content and format; engage palliative care consultants; identify stakeholders; recruit unit Implementation Champions; assess Systems capability for supporting iPads

**Phase II:** Educate Implementation Champions using draft toolkit; test iPads on pilot unit; consultant review and revisions of draft toolkit; brief implementation efforts locally; feedback from patient and staff end-users

**Phase III:** Final draft of toolkit for PAO review; re-educate Implementation Champions; troubleshoot IT issues with iPads; provide final toolkit for sustained implementation; feedback from patient and staff end-users



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# Evaluation: Lessons Learned

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# Lessons Learned: Implementation Phase

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- Assess environmental challenges PRIOR to and CONTINUALLY during implementation (IT, staffing, room configuration, ed needs)
- When possible, have Systems Department purchase, maintain, and sustain devices (iPad/tablets) to ensure consistent management, integration, and sustainment
- Anticipate delays and disaster impacts
- Develop a contingency plan--triple redundancy for all Implementation Champions (DSCA FEMA deployments, illness, quarantines)
- Know bed expansion/surge plans to prep for staffing/structural changes (consolidated units; dedicated COVID unit; expanded unit)
- Implementation teams for palliative care, when possible, should include multidisciplinary representation and engagement

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# Lessons Learned: Sustainment Phase

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- Implementation of any toolkit requires stakeholder engagement, dedicated Champions, firm commitment from Systems Department (iPad/tablet integration) and inpatient clinical and administrative leaders
- Establish sustainment Champions (facility and unit level) to own toolkit maintenance, sustainment (new staff a refresher training)
- Engage consultants and SME's early and continuously in processes
- Pre-determine targeted/intentional dissemination plan
- Secure permission on variety of platforms for toolkit implementation education (Virtual Grand Rounds, DHA Toolkit site, DHA KX, link to CPG, NTP, MTF Newcomers orientation, ProStaff)

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# Integration & Sustainment

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# Results: 2021 Rapid Review & Synthesis

- 10 COVID-19 publications
- Evidence ranged from Level I-VII
- 4 central themes consistent w/initial 2020 Rapid Review
  - Critical need for staff to have rapid palliative care training
  - Palliative care delivery methods
  - Symptom management
  - Support for caregivers (family members, staff)

Level of Evidence	Reference	Key Elements
VI	DeLima et al. (2020). Development of a palliative care toolkit for the COVID-19 pandemic. <i>Journal of Pain and Symptom Management</i> , 60(2), e22–e25.	<ul style="list-style-type: none"> <li>- Products included: online resources, mobile and desktop web applications, one-page guides, pocket cards, and communication skills training videos.</li> <li>- Education resources: expert and evidence-based guidance regarding symptom management, conversations about goals of care, code status, and end of life.</li> <li>- Established nurse hotline and virtual palliative consult service.</li> </ul>
VI	Fadul et al. (2021). Integration of palliative care into COVID-19 pandemic planning. <i>BMJ Supportive &amp; Palliative Care</i> , 11(1), 40-44.	<ul style="list-style-type: none"> <li>- Primary planning considerations for palliative care during the pandemic.</li> <li>- Decision algorithms for rationing care.</li> <li>- Training on effective symptoms management.</li> <li>- Alternative delivery methods of palliative care services.</li> <li>- Death and bereavement support for surviving family members.</li> </ul>
IV	Hernandez, S. (2021). A case report of Air Force Reserve nurses deployed to New York City for COVID-19 support. <i>Military Medicine</i> , 186 (12 Suppl 2), 56–60.	<ul style="list-style-type: none"> <li>- Improve competency with Crisis Standards of Care.</li> <li>- Focused training on providing effective nursing care during the surge of COVID-19-positive patients.</li> <li>- Need to develop a higher level of resilience &amp; mitigate moral distress.</li> </ul>
VI	Janssen, D. J. (2021). Palliative care in COVID-19. <i>Current Opinion in Supportive and Palliative Care</i> , 15(4), 199-204.	<ul style="list-style-type: none"> <li>- Highlighted the needs, challenges, and development of COVID-19 palliative care.</li> </ul>
I	Lieneck et al. (2021). Provision of palliative care during the COVID-19 Pandemic: A Systematic review of Ambulatory Care Organizations in the United States. <i>Medicine</i> , 57(10).	<ul style="list-style-type: none"> <li>- Barriers and Facilitators identified.</li> <li>- Need for additional resources, training, and policy development within palliative care planning and outcomes.</li> </ul>
VI	Mitchell et al. (2020). The role and responsibilities of primary healthcare services in delivering palliative care in epidemics and pandemics: A rapid review to inform practice and service delivery during the COVID-19 pandemic. <i>Palliative Medicine</i> , 34(9), 1182-1192.	<ul style="list-style-type: none"> <li>- Key factors for successful primary healthcare palliative care response.</li> <li>- Communication between policymakers and healthcare providers.</li> <li>- Education, training, and debriefing the workforce.</li> <li>- Support for family/caregivers.</li> <li>- Continued delivery of equipment and access to support services.</li> </ul>
VI	Mitchinson et al. (2021). Missing the human connection: A rapid appraisal of healthcare workers' perceptions and experiences of providing palliative care during the COVID-19 pandemic. <i>Palliative Medicine</i> , 35(5), 852-861.	<ul style="list-style-type: none"> <li>- Healthcare workers struggle to connect with patients due to increased work pressures and limited opportunities for human interaction.</li> <li>- Designated teams and processes for communication should be established early.</li> <li>- Policies on care delivery should support forming human connections with patients and retain the fundamentals of palliative care.</li> </ul>

Snapshot of one section of Evidence Table, Migliore et al., 2021

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# Dissemination Efforts

DHA

- Chief Medical & Nursing Officers brief May 2021
- J-7 CEPO Nurse Week Recording May-Nov 2021

JTS

- Link added Joint Trauma System COVID Resources Oct 2021
- <https://www.triservicenurse.org/resources>

TSNRP

- Link added to TSNRP website Jun 2021
- Plenary brief to TSNRP audience Sep 2021
- Manuscript submitted for TSNRP Supplement: Nursing Outlook Journal Mar 2022

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# Integration & Sustainment: A Call to Action

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- Identify Enterprise Key Personnel and Stakeholders
  - Strategic Planning
  - Target appropriate working groups, clinical communities, clinical champions
- Education and Training
  - Stakeholder focused vs. Key Personnel
  - Decision-maker/Policy-maker
  - Clinical skills training; new staff orientation, residency programs, nurse transition program
  - Deployment training platforms
- Clinical Integration
  - Bedded facilities
  - Exercise scenarios

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# Next Steps

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- Consider TriService implementation science grant
  - Clear implementation plan
  - Documented stakeholder support (letters of support required for grant submission)
  - Controlled, systematic implementation
  - Standardized outcomes, tracking, reporting
  - Funding for program manager, support staff
- Target roll-out at Joint MTFs/DHA Large Markets
- Partner with/consult experts
  - Joint Trauma System Process Improvement
  - Implementation Science consultant
  - Marketing & strategic communications

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# Military Relevance & Future Recommendations

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# Military Relevance

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- Standardized enterprise-level DHA palliative care resources such as the COVID-19 Palliative Care Toolkit may benefit DHA inpatient settings without palliative care departments **BEYOND THE PANDEMIC** for broad implementation in garrison Military Treatment Facilities (MTF) and in austere battlefields experiencing prolonged field care.
  
- **Toolkit link: <https://www.triservicenurse.org/resources>**


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# Recommendation: Universal Palliative Care Strategy

 American Academy of Nursing on Policy

**International consensus-based policy recommendations to advance universal palliative care access from the American Academy of Nursing Expert Panels**

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<sup>a</sup> Palliative Care & End-of-Life Expert Panel

<sup>b</sup> Global Nursing & Health Expert Panel

<sup>c</sup> Expert Panel on Aging

<sup>d</sup> Bioethics Expert Panel

- Fundamental competency
- Generalist palliative care
- Consistent with nursing philosophy: whole person
- Vital for all disciplines
- Aligns with American Academy of Nursing 2021 international policy recommendations

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# Recommendation: Disaster Preparedness Resource



- Future pandemics
- Disaster response
- Humanitarian crises

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# Recommendation: Prolonged Field Care Resource



- Think: stuff, staff, space, systems, separation
- Environment
  - Limited resources
  - Contested, Aerial denial
- Clinical
  - Lack of specialty care, medications, supplies, equipment, manpower
  - Ruthless prioritization & triage
  - Focus: **alleviate suffering, manage symptoms, have tough conversations**

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# Key Takeaways

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- Literature reviews in 2020 & 2021 provided compelling evidence of the need for universal palliative care basic training and resources.
- A COVID-19 palliative care toolkit was developed to empower frontline workers and to bridge the gap in palliative care needs focusing on four components: palliative care, communication, symptom management during the end of life, and support for caregivers.
- Palliative care is a fundamental clinical competency, is consistent with nursing's whole person philosophy, and has practical utility for all disciplines beyond the pandemic.
- The COVID-19 Palliative Care Toolkit is a point of care nursing resource for pandemic care, basic palliative care, humanitarian and disaster care, and military prolonged field care.

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