Template Policy on Palliative Care in a Disaster

Policy

It is the policy of (fill in name) Hospital/Home Care/Hospice/Residential Facility Palliative Care program to have in place procedures to provide palliative care in a disaster to a surge of patients/residents, who are in need of palliative care. In a disaster, the goal of the healthcare system is to save as many lives as possible. Scarce life-saving resources may need to be allocated to those most likely to survive. However, there will be those who are so severely ill or injured that their likelihood of survival is minimal. In addition, those already medically fragile may have their condition worsened by the disaster and thus their prognosis becomes even less tenable. Under normal circumstances, these patients/residents would be provided with necessary treatment, unless the patients/residents have advance directives\(^1\) or choose to forgo such treatment. In a disaster, with limited resources, the goal of the healthcare system is to provide, for those patients/residents that cannot be treated aggressively, comfort care to ease adverse symptoms, as much as possible, both for the patient/resident and for their care givers. Consultation and other services also may be available on a limited basis.

Definitions

Austere Care: In a mass casualty incident, it is likely that there will be a lack of sufficient resources, e.g. supplies, equipment, staff. Decisions to allocate these scarce resources will result in treatment for some and limited to no treatment for others whose survivability is determined to be low in comparison to other patients/residents.

BLACK Beds: Triage systems\(^2\) use colors to identify the severity of the victim. BLACK is used to identify victims that have died or have illness or injury that makes it likely that they will not survive. Hospitals in the State of Wisconsin have identified existing or surge beds that can be used for palliative care. These are referred to as BLACK beds.

Disaster: In this policy, a disaster refers to any incident that overwhelms the resources of the healthcare system, locally or regionally, and the effects of the disaster are expected to affect the healthcare system for more than 96 hours.

Disaster Ethics: A set of principles and values that serve to direct the duties, obligations and parameters of the delivery of healthcare in a disaster situation. Disaster Ethics is the study of what ought to be done in a disaster situation.

Hospice Program: This refers to agencies whose sole purpose is the care of the dying.

Palliative Care: The World Health Organization defines palliative care as “an approach which improves the quality of life of patients and family facing life-threatening illness, through the

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\(^1\) It is to be noted that the Power of Attorney becomes ineffective with the death of the principal.

\(^2\) The triage system currently used by many EMS and hospitals in the state of Wisconsin is called START (Simple Triage and Rapid Treatment).
prevention, assessment and treatment of pain and other physical, psychosocial and spiritual problems”3.

**Palliative Care Programs:** These are programs usually offered by the following: hospitals to their inpatients, Home Care to their outpatients, Hospice Organizations and residential facilities to their residents.

**Residential Facilities:** For the purpose of this policy, this means nursing homes, assisted living facilities and group homes that may provide palliative care for their residents.

**Surge Capacity:** This means the ability of any Palliative Care Program to increase the number of inpatients and/or outpatients that it can care for in a disaster.

**Procedures**

1. **Public Health Emergency**

   a. This policy is to be implemented only when there is a surge of patients/residents in need of palliative care and when a public health emergency has been declared.

   b. It is the responsibility of public health authorities, in collaboration with healthcare organizations, to have pre-scripted messages available for the public once a public health emergency is declared.

   c. It is the responsibility of public health authorities to inform and educate the public regarding the effects that a mass casualty incident such as pandemic influenza may have on the community.

      i. There needs to be education about austere care and how this may result in some patients/residents receiving limited or no healthcare services.

      ii. This education will include information that patients/residents will be assessed for the appropriate treatment, to the extent possible.

      iii. For some patients/residents, appropriate treatment may be palliative care.

   d. There are two types of patients/residents, who may require palliative care:

      i. those, who are directly affected by the incident

      ii. those, who had been previously ill (the chronically ill) and whose illness may be exacerbated by the disaster and/or by the fact that there may be limited or no treatment and/or medications available.

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3 Association for Healthcare Quality and Research, Chapter VII, Palliative Care, page 103.
2. Sites of Care

a. During inter-agency emergency planning meetings, all Palliative Care Programs should be informed that the hospital may not be able to admit palliative care residents from residential facilities and Home Care Palliative Care Programs.

i. Residential facilities should be responsible, in a disaster, for their own residents, who may be in need of palliative care.

ii. Residential facilities and other Home Care and Hospice Palliative Care programs are also to be asked to have plans to surge in place so that they can accept patients/residents in need of palliative care, who have no caregiver to provide for them.

b. The hospital Home Care, Hospice and Residential Facility Palliative Care programs are to have a tiered response for the management of patients/residents in need of palliative care:

i. Tier 1 (NORMAL OPERATIONS): Patients/residents will be admitted to established inpatient and outpatient hospital, Home Care, Inpatient Hospice and Residential Facility Palliative Care programs that have capacity to receive these patients/residents.

ii. Tier 2 (SURGE): The hospital, Hospice and Residential Facility Palliative Care programs will deploy their pre-identified BLACK (“expectant”) beds to manage a surge of inpatients/residents in need of palliative care. These BLACK beds should primarily be intended for patients/residents, who have no caregivers or those not likely to survive transfer to another facility.

iii. Tier 3 (REFERRAL): The hospital, Home Care, Hospice and Residential Facility Palliative Care programs will refer palliative care patients/residents to Surge Palliative Care programs, which have outpatient or inpatient capacity and which will need to be adapted to manage an increased number of patients/residents with fewer staff and other scarce resources.

iv. Tier 4 (HOME): The hospital, Home Care, Hospice and Residential Facility Palliative Care programs will provide limited direct and indirect support to patients/residents, who are dying at home, and cannot be admitted to a Surge Hospital, Home Care, Hospice or Residential Facility Palliative Care programs due to a lack of resources.

Note: It is to be recognized that medical services provided in Tiers 2, 3 and 4 may not be optimal palliative medical services.

3. Staffing
a. The hospital, Home Care, Hospice and Residential Facility Palliative Care programs are to assume that in Tiers 1 and 2, there will be fewer staff due to the fact that staff themselves may be ill or may be absent because they are attending to the needs of their own family members.

b. The hospital, Home Care, Hospice and Residential Facility Palliative Care programs are also to assume that there will be little to no staff available to assist patients in Tiers 3 and 4. These programs may be able to utilize its limited staff by providing assistance through telephone consultations.

4. Triage

a. The hospital, Home Care, Hospice and Residential Facility Palliative Care programs are to have a multi-disciplinary Clinical Review Committee or its equivalent to establish and oversee the application of allocation of scarce resources guidelines for the triage of patients/residents, including those that will be triaged to palliative care.

b. It is the responsibility of the hospital, Home Care, Hospice and Residential Facility Palliative Care programs to determine their internal procedures by which they will assign persons to the appropriate Tier of palliative care.

5. Patient Categorization

a. Because of the need to allocate scarce resources, the hospital, Home Care, Hospice and Residential Facility Palliative Care programs are to categorize patients/residents in need of palliative care so that resources can be allocated to these patients/residents, based on an assessment of the patient/residents, which will include survivability and acuity of symptoms. The abbreviated assessment should lead to the Patient Plan of Care.

b. There are three categories for patients/residents in palliative care:
   
   i. those expected to live for HOURS/DAYS
   
   ii. those expected to live for DAYS/WEEKS
   
   iii. those expected to live for WEEKS/MONTHS

6. Caring for a Seriously Ill Person at Home: Guidelines for the Caregiver (separate document) is intended to be a handout for care givers, especially those in Tier 4.

7. Medications for Palliative Care Patients

   a. Medications for pain and symptom control are to be obtained through the patient’s regular pharmacy.
b. Based on the nature of the incident, pharmaceuticals may not be available. Other comfort measures can be implemented per “Caring for a Seriously Ill Person at Home: Guidelines for the Caregiver” document.

8. Support for Caregivers

   a. The Hospital, Home Care, Hospice and Residential Facility Palliative Care programs, to the extent possible, are to work with community resources, prior to any incident, to determine how support can be provided to caregivers, e.g. food, errands, respite care, etc.

   b. The hospital, Home Care, Hospice and Residential Facility Palliative Care programs should have a Call-In Number that caregivers can access for information and assistance.

   c. The hospital, Home Care, Hospice and Residential Facility Palliative Care programs should train their volunteers and staff to assist with the handling of these calls, since this may be the only source of support and assistance available to some caregivers.

9. Patient Documentation: The hospital, Home Care, Hospice and Residential Facility Palliative Care programs are responsible for documenting the assessment, referral and disposition of all patients it has placed in any of the four Tiers.

10. Placement in a Residential Facility Palliative Care Program is to follow established regulations for admission.

11. Allocation of Scarce Resources:

   a. Hospitals, Home Care, Hospices and Residential Facilities are to:

      i. establish a Clinical Review Committee or its equivalent, whose purpose is to establish guidelines for the allocation of scarce resources in a public health emergency

      ii. build strong support for triage and standards of care in disasters by redefining public expectations (to the extent possible) and training of palliative care and other health professionals to the concepts and services of palliative care providers;

      iii. establish guidelines for “just-in-time” training for and service delivery by secondary providers

   b. Hospitals, Home Care, Hospices and Residential Facilities should make every effort to be “transparent” in all their communications with the community and their patients and families regarding the availability of resources for patients, who may be triaged to palliative care.
c. Hospitals, Home Care, Hospices and Residential Facilities should make every effort to plan for the needs of individuals chronically dependent on life-sustaining technology where transition to palliative care may be a necessity.

d. The “Caring for a Seriously Ill Person at Home: Guidelines for the Caregiver” provides suggestions on alternatives that can be employed if there is a lack of medications, oxygen, hygiene supplies, etc.

e. Hospitals, Home Care, Hospices and Residential Facilities should make every effort to stockpile palliative care medications in each community for disaster response and identify points of access to such stockpiles;

f. Hospitals, Home Care, Hospices and Residential Facilities should make every effort to incorporate palliative care training for first responders as an integral part of disaster preplanning and drills;

g. Hospitals, Home Care, Hospices and Residential Facilities should make every effort to develop, implement and be transparent to the community concerning competency-based evaluation and measurement of palliative care programs for disaster planning.