COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care

Role of the specialty and guidance to aid care

22 March 2020

Collated for the Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland by:
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Please note

The COVID-19 outbreak currently being experienced around the world is unprecedented and requires everyone to work together to contribute to the health and well-being of populations as well as ensure that appropriate guidance and sharing of good practice occurs. This is essential in order to support the care of patients at the end of their lives or who are significantly unwell as the result of both COVID-19 or other possibly life-limiting illnesses.

This guidance, which is been prepared for secondary care initially and is not intended to be comprehensive, has been prepared and collated locally by the Northern Care Alliance NHS Group and the Association for Palliative Medicine of Great Britain and Ireland. While it is not nationally endorsed by the National Health Service, it may be useful to colleagues throughout the country when preparing their own guidance.

Please feel free to use, adapt and share this guidance appropriately, acknowledging where specific individuals have been identified as contributing to discrete parts of the guidance.

This will be a 'live' document that will be updated, expanded and adapted as further contributions are received and in line with changing national guidance. The most current version of the guidance document will be available on the public-facing pages of the Association for Palliative Medicine website (https://apmonline.org/). It is advised that you always check that you are referring to the most current version. **Please do not share the guidance on social media, as it contains some information that may be distressing to the public if not presented in a sensitive way with appropriate opportunity for discussion and explanation.**

Staff should be aware that this guidance is subject to change as developments occur. Every effort will be made to keep this guidance up to date. Additional information can be found at https://www.gov.uk/government/topical-events/coronavirus-covid-19-uk-government-response**. The Swan Bereavement team, site Bereavement Offices, mortuary teams and Coroners' Offices can be contacted for additional support and guidance.**

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times.

As far as is possible in such a short period of time, the information contained within this document has been checked by experts from across the palliative care profession. However, neither the Northern Care Alliance NHS Group nor the Association for Palliative Medicine of Great Britain and Ireland can accept any responsibility for errors or omissions in this document.

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Index

Background: COVID-19

Coronaviruses are mainly transmitted by large respiratory droplets and direct or indirect contact with infected secretions. They have also been detected in blood, faeces and urine and, under certain circumstances, airborne transmission is thought to have occurred from aerosolised respiratory secretions and faecal material.

As coronaviruses have a lipid envelope, a wide range of disinfectants are effective. PPE and good infection prevention and control precautions are effective at minimising risk but can never eliminate it.

As COVID-19 has only been recently identified, there is currently limited information about the precise routes of transmission. This guidance is based on knowledge gained from experience in responding to coronaviruses with significant epidemic potential such as Middle East Respiratory Syndrome Coronavirus (MERS-CoV) and Severe Acute Respiratory Syndrome Coronavirus (SARS-CoV).

COVID-19 is classified as an airborne, high consequence infectious disease (HCID) in the UK.

Emerging information from these experiences has highlighted factors that could increase the risk of nosocomial transmission, such as delayed implementation of appropriate infection prevention and control measures combined persistence of coronavirus in the clinical setting.

How long any respiratory virus survives in the environment will depend on a number of factors, for example:

- the surface the virus is on
- whether it is exposed to sunlight
- environmental conditions such as temperature and humidity
- exposure to cleaning products

Under most circumstances, the amount of infectious virus on any contaminated surfaces is likely to have decreased significantly by 72 hours.

In the absence of effective drugs or a vaccine, control of this disease relies on the prompt identification, appropriate risk assessment, management and isolation of possible cases, and the investigation and follow up of close contacts to minimise potential onward transmission.

Effective infection prevention and control measures, including transmission-based precautions (airborne, droplet and contact precautions) with the recommended PPE are essential to minimise these risks. Appropriate cleaning and decontamination of the environment is also essential in preventing the spread of this virus.

How Palliative, End of Life & Bereavement Care Services can contribute

Palliative, end of life and bereavement care (PEoLB), whose basis is one of effective symptom control, promotion of quality of life, complex decision-making and holistic care of physical, psychological, social and spiritual health is ideally placed to provide care and support to patients, those close to them and colleagues during the COVID-19 outbreak.

The sectors of the population most at risk at this time are those who are elderly, frail, have serious illness or co-morbidities and this is the population supported and managed by PEoLB professionals every day. In the context of COVID-19, its presence may exacerbate co-existing illness or lack of reserve and create a situation where the patient becomes sick enough that they might die and PEoLB skills of discussing and reviewing advance care plans, ensuring a comfortable and dignified death and supporting families and colleagues will be imperative.

Where healthcare resources and facilities some under so much pressure that difficult decision-making is required, the management of those patients not expected to survive then such decision-making can be complex both to undertake, but also to communicate to patients and those close to them. Again, this is where PEoLB professionals can help support their colleagues in the processes of triage and planning, difficult conversations and coordinating care.

Should travel or hospital visiting restrictions be put in place, conversations regarding decision-making, sharing clinical and prognostic information and supporting families may have to be carried out remotely. Again, this is an area where PEoLB professionals are already highly skilled and can be utilised effectively during the COVID-19 outbreak.

As one author has recently stated, "**In this time, palliative care is just as critically needed as fluids, fever reducers, and respirators.** We know the strength and extraordinary human kindness and caring that palliative care professionals live every day, in every interaction with patients, with families, with colleagues, and communities. Their role in the time of COVID-19 is to keep the "care" in healthcare, even as systems, patients, and providers are under siege." (Ballentine, 2020)

The guidance

As health care professionals, we all have general responsibilities in relation to COVID-19 and for these, we should seek and act on national and local guidelines. All professionals responsibility to provide palliative and end of life care symptom control in irreversible situations and also to support honest conversations about goals of care and treatment escalation planning should be initiated as early as is practicable so that a personalised care and support plan can be developed and documented. We also have a specific responsibility to ensure that essential palliative and end of life care is delivered, both for those who are likely to be in their last year of life because of a pre-existing health condition as well as those who may die as a consequence of infection with COVID-19.

It is important to remember that most people infected with COVID-19 virus have mild disease and recover. Of the laboratory confirmed patients, about:

- 80% have had mild to moderate disease
- 15% require admission to hospital for severe disease
- 5% require admission to an intensive care unit and are critically ill

This guidance is aimed at all professionals carers supporting patients with COVID-19, and their families, in the hospital setting – whether this is in critical care or elsewhere in the hospital.

All hospitals have access to specialist palliative care teams, whether as in-house Hospital Palliative Care Teams or as in-reach teams from the local palliative care services. These teams will be able to provide additional advice and guidance but it will not be possible for them to provide direct care to everybody who needs it, especially as the pandemic progresses.

How to use the symptom management flowcharts

These flowcharts relate to the relief of the common symptoms that may arise because of an infection with COVID-19, including how they should be managed if the patient is dying:

- breathlessness
- cough
- delirium
- fever

Local palliative care guidelines already exist for other symptoms commonly experienced by people with advanced disease, and should continue to be adhered to – this is not an attempt to replace normal symptom control guidelines or the local formulary.

They are described in terms of the severity of the disease and adopt the general approach of:

- correct the correctable
- non-drug approaches
- drug approaches

These guidelines assume that the patient is receiving all appropriate supportive treatments and that correctable causes of the symptoms have been considered and managed appropriately. Examples include:

- antibiotic treatment for a superadded bacterial infection may improve fever, cough, breathlessness and delirium
- optimising treatment of comorbidities (e.g. chronic obstructive airways disease, heart failure) may improve cough and breathlessness.

Generally, non-drug approaches are preferred, particularly in mild to moderate disease. Drug approaches may become necessary for severe distressing symptoms, particularly in severe disease.

Typical starting does of drugs are given. However, these may need to be adapted to specific patient circumstances, e.g. frail elderly (use even lower doses of morphine), or renal failure (use an alternative to morphine). Seek appropriate advice from the relevant specialists including specialist palliative care teams.

It is anticipated that critically ill patients with ARDS will be mechanically ventilated and be receiving some level of sedation ± strong opioids. Death may still ensue from overwhelming sepsis or organ failure. If endotracheal extubation is planned in a dying patient, teams should follow their own guidelines on withdrawal of ventilation.

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Management of breathlessness COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Breathlessness is the subjective sensation of discomfort with breathing and is a common cause of major suffering in people with acute, advanced and terminal disease. Treatment of underlying causes of dyspnoea should be considered and optimised where possible. Both COVID-19 and non-COVID-19 conditions (advanced lung cancer, lymphangitis carcinomatosis, SVCO, etc) ***may*** cause severe breathlessness / distress toward end of life.

Reversible causes

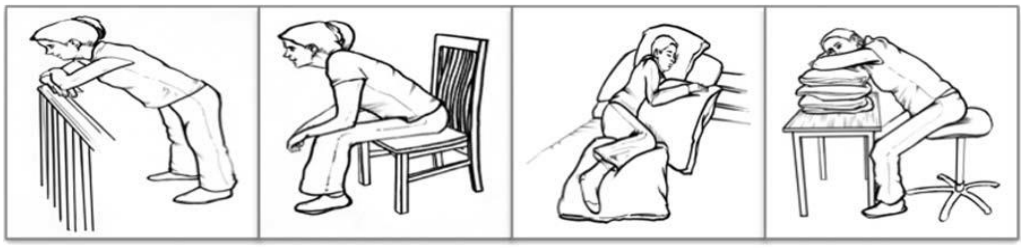
- both COVID-19 and non-COVID-19 conditions (advanced lung cancer, SVCO, lymphangitis carcinomatosis, , etc) ***may*** cause severe distress / breathlessness toward end of life
- check blood oxygen levels

Non-pharmacological measures

- positioning (various advice depending on position: sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward)
- relaxation techniques
- reduce room temperature
- cooling the face by using a cool flannel or cloth
- portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
- portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

Pharmacological measures

- humidified oxygen (no evidence of benefit in the absence of hypoxaemia)
- opioids may reduce the perception of breathlessness
  - morphine modified release 5mg bd (titrate up to maximum 30mg daily)
  - morphine 2.5-5mg PO prn (1-2mg SC if unable to swallow)
  - midazolam 2.5-5mg SC prn for associated agitation or distress
- anxiolytics for anxiety
  - lorazepam 0.5mg SL prn
- in the last days of life
  - morphine 2.5-5mg SC prn
  - midazolam 2.5mg SC prn
  - consider morphine 10mg and / or midazolam 10mg over 24 hours via syringe driver, increasing to morphine 30mg / midazolam 60mg step-wise as required



Forward lean 1 | Forward lean 2 | Adapted forward lean for lying | Adapted forward lean for sitting

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Management of cough COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Cough is a protective reflex response to airway irritation and is triggered by stimulation of airway cough receptors by either irritants or by conditions that cause airway distortion.

Cough hygiene

To minimise the risk of cross-transmission:

- cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping & blowing the nose
- dispose of used tissues promptly into clinical waste bin used for infectious or contaminated waste
- clean hands with soap and water, alcohol hand rub or hand wipes after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions

Non-pharmacological measures

- humidify room air
- oral fluids
- honey & lemon in warm water
- suck cough drops / hard sweets
- elevate the head when sleeping
- avoid smoking

Pharmacological measures

- simple linctus 5-10mg PO QDS
  if ineffective
- codeine linctus 30-60mg PO QDS
  or
- morphine sulphate immediate release solution 2.5mg PO 4 hourly

If all these measures fail, seek specialist advice, to discuss:

- use of sodium cromoglicate 10 mg inhaled 4 times a day (can improve cough in people with lung cancer within 36-48 hours)
- use of oral corticosteroids
- if severe / end of life: morphine sulphate injection 10mg CSCI over 24 hours and 2.5–5mg SC 4 hourly PRN

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Management of delirium COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Delirium is an acute confusional state that can happen when someone is ill. It is a SUDDEN change over a few hours or days, and tends to vary at different times of day. People may be confused at some times and then seem their normal selves at other times. People who become delirious may start behaving in ways that are unusual for them- they may become more agitated than normal or feel more sleepy and withdrawn.

Non-pharmaceutical measures

- identify and manage the possible underlying cause or combination of causes
- ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- consider involving family, friends and carers to help with this
- ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk
- avoid moving people within and between wards or rooms unless absolutely necessary
- ensure adequate lighting

Pharmacological measures: first line

- midazolam 2.5mg-5mg SC prn 1-2 hourly

or

lorazepam 500micrograms PO/SL prn 1-2 hourly

Pharmacological measures: second line

Option 1
midazolam 10mg-30mg/24hr via a syringe driver)

and

haloperidol 2.5mg-5mg SC prn 1-2 hourly (1-5mg in the elderly).

Option 2
midazolam 10mg-30mg/24hr via a syringe driver)

and

levomepromazine 12.5-25mg SC prn 2-4 hourly (12.5mg in the elderly)

Management of this symptom, which is distressing for both relatives and staff (patients are usually unaware of what they are doing at this time) can be troublesome. Through use of the medications below, titrated appropriately, this can usually be managed effectively.

- Prevention of delirium better than cure, so meticulous adherence to delirium prevention strategies (orientation, prevention of constipation, management of hypoxia, etc) is essential
- Adoption of daily screening, using Single Question in Delirium (SQiD) and / or 4AT rapid test for delirium (https://www.the4at.com/) to detect early and treat cause

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Management of fever COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Fever is when a human's body temperature goes above the normal range of 36–37° Centigrade (98–100° Fahrenheit). It is a common medical sign. Other terms for a fever include pyrexia and controlled hyperthermia. As the body temperature goes up, the person may feel cold until it levels off and stops rising.

Is it fever?

- significant fever is defined as a body temperature of:
  - 37.5°C or greater (oral)
  - 37.2°C or greater (axillary)
  - 37.8°C or greater (tympanic)
  - 38°C or greater (rectal)

- associated signs & symptoms:
  - shivering
  - shaking
  - chills
  - aching muscles and joints
  - other body aches

Non-pharmacological measures

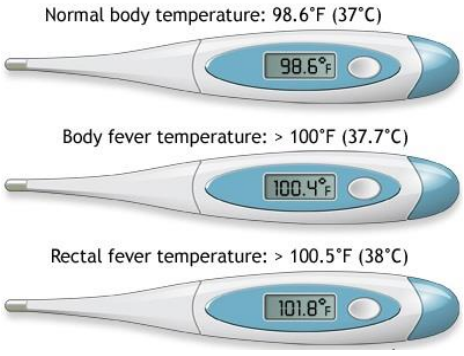
- reduce room temperature
- wear loose clothing
- cooling the face by using a cool flannel or cloth
- oral fluids
- avoid alcohol
- portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
- portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

Pharmacological measures

- paracetamol 1g PO / IV / PR QDS

****NSAIDS contraindicated in COVID-19**** (Day, 2020)

- if a patient is close to the end of life, it may be appropriate to consider use of NSAIDs (e.g. parecoxib 40mg SC OD-BD; maximum 80mg in 24 hours)



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Management of pain COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Patients may experience pain due to existing co-morbidities, but may also develop pain as a result of excessive coughing or immobility. Such symptoms should be addressed using existing approaches to pain management.

Patient on no analgesics - mild pain

- Step 1:
  - start **regular** paracetamol (usual dose 1g four times a day)
  - dose reduction is advisable in old age, renal impairment, weight <50kg, etc
- Step 2:
  - persistent or worsening pain: stop paracetamol if not helping pain
  - start codeine 30-60mg four times a day **regularly**
- Step 3:
  - maximum paracetamol and codeine, persistent or worsening pain: stop paracetamol if not helping pain
  - stop codeine
  - commence strong opioid (e.g. oral morphine)

****NSAIDS contraindicated in COVID-19**** (Day, 2020)

Commencing strong opioids

- start either an immediate-release (IR) or a modified-release (MR) preparation
- ALWAYS prescribe an immediate-release morphine preparation prn
- starting dose will depend on existing analgesia – calculate dose required
- monitor the patient closely for effectiveness and side effects
- always prescribe laxatives alongside strong opioids
- always prescribe an antiemetic regularly or prn

Suggested starting doses

- opioid-naïve/frail/elderly
  - morphine 2.5-5mg PO IR 4 hourly
- previously using regular weak opioid (e.g. codeine 240mg/24h)
  - morphine 5mg PO IR 4 hourly or MR 20-30mg BD
  - frail/elderly: use lower starting dose of 2.5mg PO IR 4 hourly or MR 10-15mg BD
- eGFR <30
  - seek advice

Titrating oral opioid dose

- if adjusting the dose of opioid, take prn doses into account
- check that the opioid is effective before increasing the dose
- increments should not exceed 33-50% every 24 hours
- titration of the dose of opioid should stop when either the pain is relieved or unacceptable side effects occur
- if pain control achieved on IR consider conversion to MR opioid (same 24-hour total dose)
- seek specialist advice if analgesia titrated 3 times without achieving pain control / 3 or more prn doses per day / total daily dose of oral morphine over 120mg / day unacceptable side effects

When the oral route is not available

- if analgesic requirements are stable - consider transdermal patches (e.g. buprenorphine, fentanyl)
- if analgesic requirements are unstable consider initiating subcutaneous opioids
- seek specialist advice if necessary
- morphine is recommended as the first line strong opioid for subcutaneous use for patients, except for patients who have been taking oral oxycodone or those with severe renal impairment
- if constant pain, prescribe morphine 4 hourly SC injections or as 24-hour continuous infusion via a syringe driver (McKinley T34)
- conversion from oral to SC morphine: oral morphine 5mg ≈ SC morphine 2.5mg
- wide inter-individual variation exists and each patient should be assessed on an individual basis
- prn doses of 1/10 to 1/6 of regular 24-hour opioid dose should be prescribed 2-4 hourly SC prn

Discussions about goals of care

(adapted from RCP, 2018)

The UK population is ageing and many more people are living with chronic illness and multiple comorbidities. A third of patients admitted unexpectedly to hospital (rising to 80% in those living in 24-hour care) are in the last year of their lives. (Clark *et al*, 2014) Despite such facts, few have ever had discussions about ceilings of treatment or resuscitation.

Timely honest conversations about the person's preferences and priorities, including advance decisions to refuse treatment, is part of advance care planning for anybody who has a progressive life-limiting illness. In the context of people who have severe COVID-19 disease, honest conversations about goals of care and treatment escalation planning should be initiated as early as is practicable so that a personalised care and support plan can be developed and documented. This will need to be revisited and revised as the situation changes. Families and those close to the person should be involved in these discussions as far as possible and in line with the person's wishes. This is standard good practice in palliative and end of life care.

However, in the context of COVID-19, the person is likely to have become ill and deteriorated quite quickly so the opportunity for discussion and involving them in decision making may be limited or lost. Families and those close to them may be shocked by the suddenness of these developments and may themselves be ill and / or required to self-isolate. There may be multiple members of the family ill at the same time. But as far as possible it remains important to offer these conversations. Being kept honestly informed helps to reduce anxiety, even if the health care professionals do not have all the answers and even if the conversations need to be conducted behind PPE or, in the case of families who are self-isolating, by telephone or by using other technology solutions.

It should be acknowledged that talking to patients and those close to them about prognosis, ceilings of treatment and possible end of life care is often challenging (Brighton & Bristowe, 2016) but, in the current COVID-19 outbreak, such conversations with the population described may become even more difficult, as health professionals may have to triage patients, often in emergency or urgent situations, and prioritise certain interventions and ceilings of treatment. This is not only to ensure that those with significant potential to recover receive appropriate care, but also that those who are very unlikely to survive also receive appropriate, end of life care.

Such decisions may have to be made when health professionals have not had the opportunity to get to know their patient as well as they would usually like, or may involve discussion with those close to the patient over the telephone or via internet-based communication facilities. While this is less than ideal (DoH, 2015; NPEoLCP, 2015), honest conversations are often what patients and those close to them actually want. (Choice, 2015)

<u>Key points to consider when discussing ceilings of treatment</u>

- don't make things more complicated than they need to be; use a framework such as SPIKES:
  - **S**etting / situation: read clinical records, ensure privacy, no interruptions
  - **P**erception: what do they know already?; no assumptions
  - **I**nvitation: how much do they want to know?
  - **K**nowledge: explain the situation; avoid jargon; take it slow
  - **E**mpathy: even if busy, show that you care
  - **S**ummary / strategy: summarise what you've said; explain next steps

- should ceilings of treatment conversations include ethical issues, for example where escalation to Level 3 care is thought not to be appropriate due to frailty, comorbidity or other reasons, health professionals should be prepared for anger / upset / questions

- these are usually not aimed directly at you, but you may have to absorb these emotions and react professionally, even if they are upsetting / difficult at the time
- patients or those close to them may request a ‘second opinion’ – this should be facilitated wherever possible

- be honest and clear
  - don’t use jargon; use words patients and those close to them will understand
  - sit down; take time; measured pace and tone; use silences to allow people to process information
  - avoid using phrases such as “very poorly” on their own – is the patient “sick enough that they may die”? If they are – say it

While palliative, end of life and bereavement care professionals cannot take over responsibility for this aspect of care and have the conversations for you, they should be able to support, advise and provide follow up care.

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Discussions about goals of care COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Talking to patients and those close to them about prognosis, ceilings of treatment and possible end of life care is often challenging but, in the current COVID-19 outbreak, such conversations with the population described may become even more difficult, as health professionals may have to triage patients, often in emergency or urgent situations, and prioritise certain interventions and ceilings of treatment.

Background

The UK population is ageing and many more people are living with chronic illness and multiple comorbidities. A third of patients admitted unexpectedly to hospital (rising to 80% in those living in 24-hour care) are in the last year of their lives. Despite such facts, few have ever had discussions about ceilings of treatment or resuscitation.

Such conversations, which constitute advance care planning, are useful during normal times, but even more so during the COVID-19 outbreak. Open, honest discussions regarding ceilings of treatment and overall goals of care are not only essential to ensure that those with significant potential to recover receive appropriate care, but also that those who are very unlikely to survive also receive appropriate, end of life care.

Such decisions may have to be made when health professionals have not had the opportunity to get to know their patient as well as they would usually like, or may involve discussion with those close to the patient over the telephone or via internet-based communication facilities. While this is less than ideal, honest conversations are often what patients and those close to them actually want.

While palliative, end of life and bereavement care professionals cannot take over responsibility for this aspect of care and have the conversations for you, they should be able to support, advise and provide follow up care.

Consider

- don't make things more complicated than they need to be; use a framework such as SPIKES:
  - **S**etting / situation
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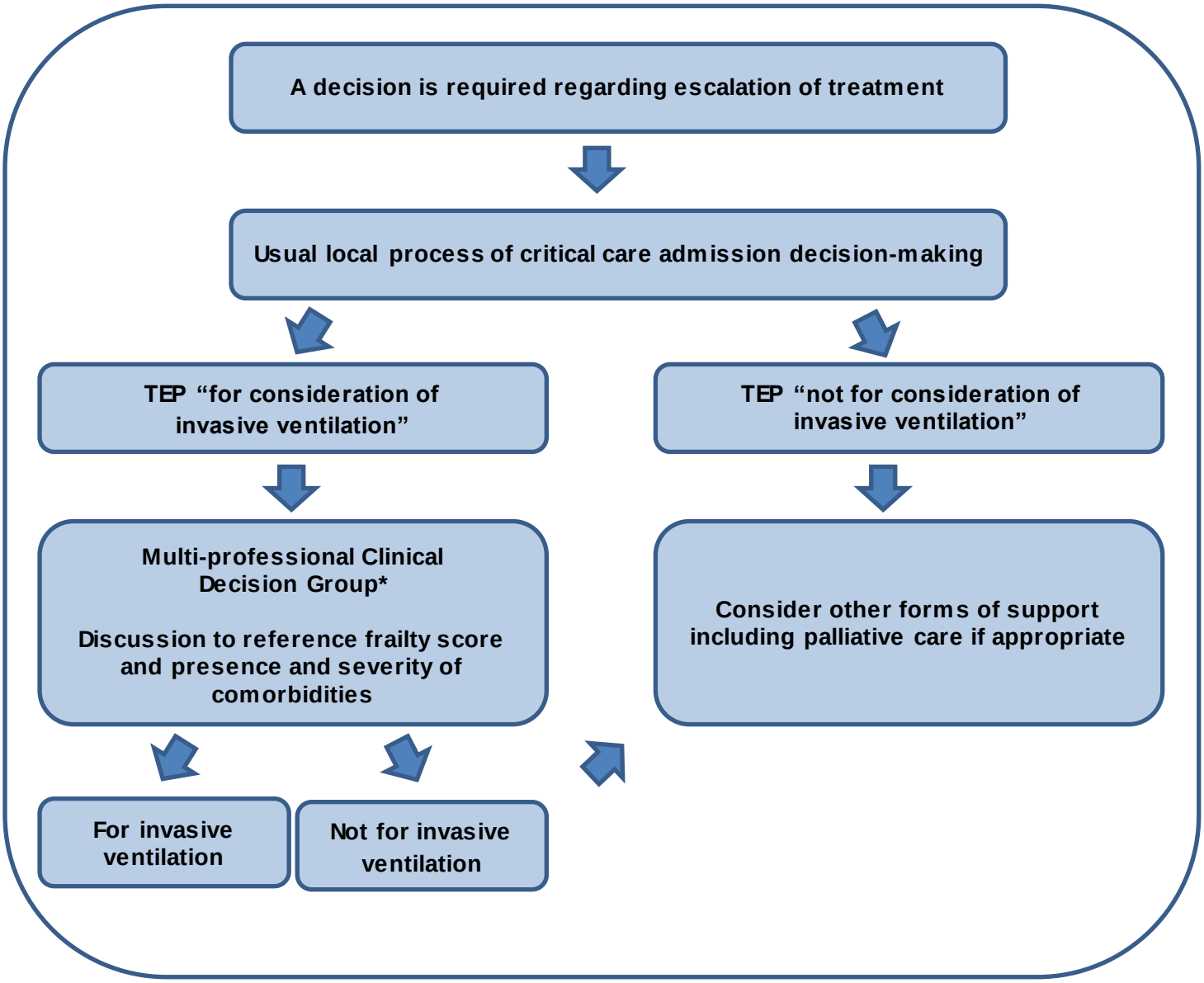
  - avoid using phrases such as "very poorly" on their own – is the patient "sick enough that they may die"? If they are – say it

Clinical decision-making in respiratory failure COVID-19 Outbreak

All emergency COVID positive and negative medical admissions to have Treatment Escalation Plan (TEP) including decision regarding invasive ventilation discussed and recorded.

Refer to Lasting Power of Attorney, Advance Decision to Refuse treatment, Statement of Wishes or Electronic Palliative Care Coordination system record if available and patient lacks capacity.



The National Institute for Health and Care Excellence (NICE) has produced a more comprehensive rapid guideline for critical care, published on 20 March 2020. It is available on their website at https://www.nice.org.uk/guidance/ng159.

Chaplaincy / Spiritual Care Teams

Spiritual care is a core element of palliative care (Weissman and Meier, 2009) and routinely provides emotional and spiritual support to patients and those close to them (Vanderwerker *et al*, 2008; Handzo *et al*, 2008; Flannelly *et al*, 2003; Fogg *et al*, 2004; Galek *et al*, 2009). Chaplains will regularly be involved in the support of patients' families pre-bereavement and in many instances will play a significant role in bereavement care, including the conduct of patients' funerals and the organisation and conduct of memorial services and related events. As members of the multi-disciplinary team chaplains will often be responsible for supporting staff, especially in difficult circumstances.

The individual needs of the patients, relatives, carers and members of staff should be fully assessed as part of a Spiritual Needs Assessment to take into consideration their religious, spiritual and cultural requirements. This will ensure that the safety of staff and patients is maintained and will enable a full risk assessment to be undertaken before each visit.

Chaplaincy teams should continue to work alongside relevant clinical staff, Specialist Bereavement Nurses, Equality and Inclusion Leads and to liaise with community partners to provide faith-related advice and resources around end of life issues, death and bereavement.

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Chaplaincy & Spiritual Care (Hospital Services) COVID-19 Outbreak

Space for local contact details:

All routine and intentional visits suspended

Religious, spiritual, cultural need identified response required from Chaplaincy Teams

Chaplaincy & Spiritual Care support accessed through normal routes
Urgent / out of hours – Switchboard ** Add local contact details
Non urgent – telephone or other local contact details

Chaplain to contact clinical staff to confirm COVID-19 status and response required

No COVID-19 suspected

New / Ongoing / Urgent Support

Triaged & reviewed in partnership with ward / unit / IC staff

Spiritual Needs Assessment completed

Consider appropriate and safe response:

- Is telephone / Skype response possible?
- What infection control measures are necessary?
- Is generic or faith specific response required?
- Is an urgent response required?

Urgent / EoL

Visit and respond as agreed with clinical staff

Non urgent

Arrange appropriate response and consider telephone contact

Confirmed/Suspected COVID-19

New / Ongoing / Urgent Support

Triaged, reviewed in partnership with ward / unit / IC staff

Spiritual Needs Assessment completed

Consider appropriate and safe response:

- Is telephone / Skype response possible?
- Discuss infection control measures and requirements?
- Is generic or faith specific response required?
- Is an urgent response required?

Urgent /EoL

If visit agreed as urgent and necessary, appropriately trained staff utilise PPE

Non urgent

Visit not appropriate unless urgent. Utilise remote support options

- The individual needs of the patients, relatives, carers and members of staff will be appropriately assessed as part of a Spiritual Needs Assessment to take into consideration their religious, spiritual and cultural wishes.
- An initial risk assessment will be undertaken with a review before each subsequent visit.
- Chaplaincy teams to work alongside relevant clinical staff, Specialist Bereavement Nurses, Equality and Inclusion Leads and to liaise with community partners to provide faith related advice and resources around end of life issues, death and bereavement.

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Visiting palliative care / end of life patients COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

The public should be asked to limit visiting patients in hospital and to consider other ways of keeping in touch with those close to them, through phone calls and using facilities such as FaceTime, WhatsApp and Skype.

Visitors in clinical areas must be immediate family members or carers.

General principles

Members of the public should not attend any health or care setting if they:

- are unwell, especially with a high temperature or a new persistent cough
- vulnerable as a result of medication, have a chronic illness or are over 70 years of age
- all visitors should be advised of, and adhere to, local and national guidance regarding handwashing and use of alcohol hand gel when visiting patients

COVID-19 patients: negative

- end of life visiting and care continues as normal practice, this includes the performance of mementos in care after death)
- consideration regarding the number of visitors at the bedside at any one time should be guided by the individual situation, the facility and appropriate risk assessments
- no children under the age of 12 should be visiting without the nurse in charge's prior permission, but considerate, informed decision-making should be the rule of thumb

COVID-19 patients: suspected or positive

- visitors will wear PPE in the same way as the staff caring for the patient
- there should be no time limit on how long visitors can stay with a patient and relatives can, if they wish to do so, be involved in providing care
- mementoes in care after death can be provided, on the ward
  - mementoes should be placed in a sealed bag and the relatives must not open these 7 days
  - for all other care after death guidance please refer to the appropriate flow chart

Visitors should be restricted to essential visitors only, such as parents or carers of a paediatric patient or an affected patient's main carer. Visiting should also be restricted to those assessed as able to wear PPE (see risk assessment below). Visitors should be permitted only after completion of a local risk assessment which includes safeguarding criteria as well as the infection risks.

Visitors should be advised not to go to any other departments or locations within the hospital or healthcare facility after visiting.

The risk assessment must assess the risk of onward infection from the visitor to healthcare staff, or from the patient to the visitors. The risk assessment should include whether it would be feasible for the visitor to learn the correct usage of PPE (donning and doffing under supervision) and should determine whether a visitor, even if asymptomatic, may themselves be a potential infection risk when entering or exiting the unit. This must be clear, documented and reviewed.

Northern Care Alliance NHS Group

Important considerations for care immediately before and after death COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

This advice is for cases where a COVID-19 is suspected or confirmed.

The utmost consideration and care must be given to the safety of other patients, visitors and staff by maintaining infection control procedures at all times. The Swan Bereavement team, site Bereavement Offices, mortuary teams and Coroners Offices can be contacted for additional support and guidance.

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family / significant others

Before death

Decisions regarding escalation of treatment made on a case by case basis

If death is imminent and family wish to stay with their loved one staff must advise them that they should wear full PPE

Faith deaths – AWAITING CLARIFICATION

At the time of death

Inform and support family and /or Next of Kin

Appropriately trained professional completes Verification of Death process wearing required PPE and maintaining infection control measures

Appropriate Doctor completes MCCD as soon as possible

- COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the Medical Certificate of Cause of Death
- COVID-19 is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009
- that COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status

If the deceased is to be cremated, doctors will not be able to physically see the deceased due to risk. AWAITING OF CONFIRMATION OF CREMATORIUM ACCEPTABLE RECOGNISED IDENTIFIERS

Where next of kin / possible informant are following self-isolation procedures, arrangements should be made for an alternative informant who has not been in contact with the patient to collect the MCCD and attend to give the information for the registration

If referral to HM Coroner is required **<u>for another reason</u>**, a telephone conversation should take place as soon as possible with HM Coroner's Office and guidelines within Care after Death policy should be followed alongside this guidance

Consideration of emotional/spiritual/religious needs of the deceased & their family/significant others

SWAN Model of Care

Northern Care Alliance NHS Group

Care after death
COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family / significant others

This advice is for cases where a COVID-19 is suspected or confirmed. If tested and no results, treat as high risk during care after death.

Mementoes / keepsakes (e.g. locks of hair, handprints, etc) should be offered and taken at the time of care after death. These cannot be offered or undertaken at a later date

- mementoes in care after death can be provided, on the ward
  - mementoes should be placed in a sealed bag and the relatives must not open these before 7 days

Full PPE should be worn for performing physical care after death.
PPE Guidance

Moving a recently deceased patient onto a hospital trolley for transportation to the mortuary might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk - a body bag should be used for transferring the body and those handling the body at this point should use full PPE (see above)

The outer surface of the body bag should be decontaminated immediately before the body bag leaves the anteroom area. This may require at least 2 individuals wearing PPE as above
decontamination guidance

Registered nurses on ward to complete Notification of Death forms fully including details of COVID-19 status and place in pocket on body bag along with body bag form, ID band with patient demographics placed through loops in body bag zip, body bag wiped over with, for example, Chlorclean & porters contacted to transfer to mortuary

- the deceased's property should be handled with care as per policy by staff using PPE and items that can be safely wiped down such as jewellery should be cleaned with, for example, Chlorclean
- clothing, blankets, etc., should ideally be disposed of. If they must be returned to families they should be double bagged and securely tied and families informed of the risks
- any hospital linen should be treated as Category B laundry

Property bags should still be used for property that has been properly cleaned / bagged

Refer all suspected / confirmed COVID-19 deaths to the Swan Bereavement team

Organ / tissue donation is highly unlikely to be an option as per any other active systemic viral infection

Consideration of emotional / spiritual / religious needs of the deceased and their family / significant others

SWAN Model of Care

Northern Care Alliance NHS Group

Mortuary transfer and care COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family / significant others

Porters, wearing full PPE, PPE collects patient from ward and transfers to Mortuary by way of the process in place for safe removal

- patient placed in the ambulance for Bury & Oldham Care Organisations and transported across to the Mortuary
- walked down to mortuary at North Manchester & Salford Care Organisations

Usual booking in procedures at the Mortuary

Trolley used to transfer the deceased to the mortuary and the electric trolley used in the mortuary must both be cleaned with, for example, Bioguard disinfectant on receipt of the deceased

If a pacemaker or defibrillator is in situ these patients will **need to be buried not cremated** due to unnecessary risk to mortuary staff to facilitate removal

No Visits to reduce any risk to staff and family
Skype / FaceTime / photos may be possible on a case by case basis if families wish – mortuary staff / Bereavement Nurses will advise

Families that do wish to visit their loved one should be advised that this may be pursued via their chosen Funeral Director

Mortuary Technicians to do checks on the name tags on body bag tag, body bag **NOT** to be opened

On release of the deceased, Funeral Director to bring coffin into Mortuary, deceased to be placed into coffin and coffin sealed and cleaned prior to being placed in Funeral Director's transport

The trolley and fridge tray that the deceased has been on must be cleaned after release to funeral directors with, for example, Bioguard disinfectant

If a post mortem examination is required, staff to follow Royal College of Pathologists guidelines (Osborn *et al*, 2020)

Consideration of emotional / spiritual / religious needs of the deceased and their family / significant others

SWAN Model of Care

Northern Care Alliance NHS Group

Registering a death COVID-19 Outbreak

Association for Palliative Medicine Of Great Britain and Ireland

All deaths must continue to be registered by an informant. This information has been provided by local Registry Offices in Greater Manchester.

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased's family / significant others

- where next of kin / or a possible informant are following self-isolation procedures, arrangements should be made for an alternative informant who has not been in contact with the patient to collect the MCCD and attend to give the information for the registration
- where there is no alternative informant available, a member of Bereavement Service staff can register the death as an "occupier".

Wherever possible, the following information is required to be given to the Registrar by whoever is registering the death:

- NHS number
- date of death
- full name at death
- details of any other names that the deceased has been known by
- maiden name if applicable
- date of birth
- place of birth
- occupation and if deceased retired
- marital status
- full Name of spouse / civil partner if applicable
- spouse / civil partner occupation and if retired
- full address and postcode of deceased
- for statistical information date of birth of spouse and the industry they work / worked in and if they supervised staff

Green "release" paperwork can be taken to chosen Funeral Director

- should a member of Bereavement Service staff need to register the death on behalf of the family, payment by card can be arranged via the General Office
- the member of staff registering the death can then request the cash from General Office
- a receipt must be obtained by the staff member from the Registry office to go with the petty cash slip as evidence of payment

Bereavement Offices

- Bereavement Service/General Office Manager: 0161-656-1125 (71125)
- Royal Oldham Hospital: 0161-627-8322 (78322)
- Fairfield General Hospital: 0161-778-3859 (83859)
- Rochdale Infirmary: 01706-517027 (57027)
- North Manchester General Hospital: 0161-720-2199 (42199)
- Salford Royal Infirmary: 0161-206-5175
- Swan Bereavement Nurse referral via Bereavement Offices or here

Spiritual Care Teams

- Royal Oldham Hospital: 78796
- Fairfield General Hospital / Rochdale Infirmary: 83568
- North Manchester General Hospital: 42990
- Salford Royal Infirmary: 0161 206 5167

Consideration of emotional/spiritual/religious needs of the deceased & their family/significant others

SWAN Model of Care

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