



The Palliative Care and Covid-19 Pandemic

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Article History:

Received on: 07 May 2020
Revised on: 14 Jun 2020
Accepted on: 28 Jul 2020

Keywords:

COVID-19,
Pandemic,
Palliative care,
Treatment

ABSTRACT



During this phase of the COVID-19 pandemic, healthcare systems and healthcare personnel are overwhelmed and are already prepared to treat an influx of patients affected. The corona virus poses an uncertain period of intense acute care crisis where hundreds of thousands of people theoretically could get infected, some fatally, and ten thousands could die. This article addresses the normal palliative care issues — Life quality, comprehensive care planning, Patient discernment preferences, treatment of pain and symptoms, and encouragement for caregivers over prolonged trajectories — seem small and weak in contrast. The use of the particular Palliative care skills and abilities needs to be part of the programme. To agree that death is imminent for any human being should be right for the health system. Extending the dying process in days, weeks, or months against the person's wish is pointless; it will only prolong the physical and emotional agonies. Individual must be at peace at the end of the life and give as much dignity and comfort as possible, but intensive care units cannot give them the comfort or dignity they deserve. It basically means that all COVID- treating nurses will have expertise in the basics of palliative care, as well as access to opioids for symptoms management like breathlessness.

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ISSN: 0975-7538

DOI: <https://doi.org/10.26452/ijrps.v11iSPL1.2861>

Production and Hosted by

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INTRODUCTION

Palliative care services historically had been under supplied. For 2017, the Lancet Palliative Treatment and Pain Relief Board reported that the pervasive Lost links to the effective and reliable ser-

vices as a code of conduct for the courts. When health systems under COVID-19 are stressed, the provision of secure and appropriate Palliative treatment, and end-of-life diagnosis treatment, particularly gets important and extremely difficult. At least good- standard palliative treatment has to be given to non-surviving patients. But COVID-19 does make it easier. Time is scarce as patients quickly deteriorate, health care workers are super worked, isolation is needed and those families are cautioned not to contact and just live located in the same space as your dear mates. This situation would be faced more in countries with small and medium earnings where there is greatest shortage of both palliative and critical care facilities. Palliative treatment which is Community-based is also more difficult to do in a safe manner. Most of the patients needing care are at increased COVID-19 hazard, protective articles runs

short and the rate of deaths may prevail the Standard allowance of services ([The Lancet, 2020](#)).

World Health Organization has provided advice related to sustain services of critical health during the pandemic, highlighting, among others, immunization, and care during maternity, any emergency, and chronic illnesses, but palliative care was not listed. It has become a failure. Palliative care will in turn be an integral part of the COVID-19 response plans at national and international level. Practical measures can be introduced: maintaining access to medications (such as opioids) and protective devices, making as much as possible use of video assisted learning and telemedicine, reviewing advance care plans, offering improved health workforce training and readiness, and promoting the position of lay caregivers and the broader community. A pandemic is a source and strong amplification of misery by death and physical illness, stress and anxiety, and economical and social instability. The sufferings has to be alleviated to be a crucial part of the solution in all its forms ([The Lancet, 2020](#)).

COVID-19 fundamentally changed our environment, our systems of health care and our chains of supplies. Aged adults with heart disease suffer more particularly those who are above 80 years. This pandemic has highlighted the infrastructure of hospital capability, beds in ICU and ventilation support, and community care services, medical professionals, and personal protective equipment. Risk factors based on laboratory and clinical data can assist in the prognostication and decision making process. The triage of resources is important when governing authorities declare a crisis. Patients with COVID-19 and others who would usually be given life-sustaining medical care could be delayed or removed ([Palliative Care Considerations, 2020](#)).

Palliative care can direct, advise, support and assist in complicated medical decision-making before presentation of the disease and through clinical setbacks and at the end of life. This article explores opportunities to speed up palliative treatment during the COVID-19 outbreak to alleviate pain and provide relief to patients and families. In China, 80% of COVID-19 deaths occurred in older people of 60 years or above, about half of hospitalizations about ICU admissions in the United States, and 80% deaths occurred in those above 65 years. More than half of those injured at the Washington state's initial epicenter had heart failure. Multimorbidity, polypharmacy, and frailty adults with COVID-19 are at greater risk for morbidity and mortality. Aging is also associated with immune-senses, which results

in a decline in immune cells' ability to respond to a foreign particle. Relevant risks for COVID-19 include acute heart injury (7.2%), shock (8.7%), and arrhythmias (16.7%). For those suffering from COVID-19 disease, or documented diseases of cardiovascular system, palliative treatment should be combined with cardiovascular care ([Emanuel et al, 2020](#)).

ROLE OF PALLIATIVE CARE

Below some roles are given for palliative treatment in clinical settings of patients with COVID-19 and at risk. In light of this pandemic, decision-making related to health care and advance directives may need to be revisited. Advance treatment preparation by primary care professionals and outpatient cardiology services helps to determine what is more important, and to coordinate care in case of infection. Palliative treatment is often suggested when the person undergo end-stage heart failure or cardiogenic shock, consideration of eligibility for advanced therapies, transplant-related immune-suppression, and acute myocardial infarction particularly myocardial infarction with ST elevation. At the end stage of life, palliative care is very important, as the process of death and dying has changed due to COVID-19; sick patients are isolated and separated from family and friends, and thus are dying alone ([CDCMMWR, 2020](#)).

Pre-hospital Advance Care Planning

The aims of recording patient expectations and desires, maintaining approved health care decision-makers and reducing unnecessary hospitalizations can be accomplished by advance treatment preparation by cardiovascular clinicians. In addition to addressing hospitalization and treatment choices within the group, priorities for end-of-life care should be discussed in the light of COVID-19. Many of those discussions will occur through visits to telehealth. The debate about patients confirmed or suspected of COVID-19 will be revisited. In the light of this pandemic, previously implemented advance directive, orders of physician for life-sustaining treatments, medical orders for such situation and approval of medical-care from other states appropriate orders should be reviewed. Physician order for life sustaining treatment can be applied in any environment, as portable documents. POLST is voluntary and intended for high risk patients who die within 12 months. In the COVID-19 situation, POLST can be completed especially for patients who doesn't approve of hospitalization or who do not receive a resuscitation attempt. Patients can prefer to avoid hospitalization because of current needs to pre-

vent COVID-19 transmission, and because hospitalized means that the patient is separated from family, relatives and friends. POLST can be updated or rescinded at any time by the patient. Advance care planning should also help in decision-making about care and treatment. Hospitals are not able to perform any elective procedures for the future. Decisions on the optimum timing of care and treatment, as well as whether it will provide significant advantage in multiple chronic conditions, may include clinicians with a background on palliative care guidelines that determine whether or not this procedure can be performed. Patients with serious illness and their physicians and find themselves in challenging positions attempting to determine the cause of symptoms and distress that would otherwise be treated by medical tests and interventions which are delayed as hospital-specific protocols. Early goals of care discussions are critical as data from China suggest that patients can rapidly decompensate. Two percent of COVID-19 cases in the U.S. resulted in death, and 15 to 22 percent of age group above 80 years with suspected or confirmed infection died worldwide. Up to 10 percent of patients with COVID-19 are admitted in ICU. Also in the absence of COVID-19, just 19 percent of patients over the age of 66 at the ICU for 14 days or more on artificial ventilation were released from the hospital directly, with 40 percent of those dying within 12 months of ICU discharge, and those living with extreme functional dependency and cognitive disability. Palliative care programs can relieve the pain and can extend the lives of chronically ill patients. Patients and families can have different treatment choices for any acute illness, depending on the quality of the services in each healthcare environment ([Characteristics and Outcomes, 2020](#)).

Having taken into account the patient principles and the long period of hospitalization choices for the patient and the families can include,

1. Home with palliative treatment or a pain management hospice
2. Admission to a professional nursing center for symptom control and skilled care
3. Symptom treatment facility, where possible without ICU, cardiopulmonary resuscitation (CPR), or ventilator help
4. Clinic for all necessary steps to extend life

Such conversations allow physicians to consider the hospital infrastructure, and the facilities provided in the hospital environment of the patient, including

the facilities for expert nursing and recovery, health care at home and hospice. Despite the midst of the Medicare Centers and Medicaid Programs (CMS) crisis have relaxed the "three-midnight" requirement for the admission to eligible nursing facilities, but more and more visits by health care professionals to approved nursing facilities, and telehealth or emergency services can be given in the home and hospice. Personnel in social work or the hospice team can help identify resources ([Advice for public, 2020](#)).

CARE FOR INPATIENTS

Palliative care professionals May make provision interactive assistance (telehealth or telephone) in hospital and skilled nursing settings to the patients held strictly isolated, with no relatives members and with reduced visits by staff trying to maintain PPE. Palliative care professionals may have direct consultation with the main overseeing care clinician. Interdisciplinary teams in the palliative care sector will help family members not permitted to visit. Restrictions on visits add emotional stress to patients with severe cardiovascular disorder, which is referred to visiting their loved ones still in hospital and their loved ones. Audio and phone calls links for family or friends, or with comments or photographs can reduce isolation. Efforts to preserve PPE in the hospital and skilled nursing settings in the midst of this pandemic mean that only a single doctor treats and communicates with the infected patient. Such primary physicians may be medical professionals in the hospital setting but may be used more regularly to provide clinical treatment and procedures. Cardiovascular physicians will consider the overall clinical condition of each patient, and should play a major role in designing a patient care course. These may contribute to the objectives of treatment discussions and decision-making regarding interventions and the management of patients whose interventions are postponed. All physicians will know the symptom control, and should receive professional assistance with treatment from palliative care specialists. The first step is to ensure that effective treatments have been maximized for the underlying cardiovascular issue. It's really necessary to Note that morphine is not the favored opiate for cardiovascular or renal patients with dysfunction because of metabolites that are really excreted and cause delirium, myoclonus and other adverse effects ([Nikolich-Žugich, 2018](#)).

Caring for the Dead

Interdisciplinary care to patients and families alike, the end of life is significant. Patients with COVID-19 attested or suspected are will die alone and impos-

sible alongside their loved ones, unless they are at home. Telephone and video should be available via tablets and smart phones used to allow the patient to meet with family and friends and to say goodbye. Video and telephone are psychosocial and spiritual aids, too. Simple treatments like playing music that the patient likes too will support. When patients near the end of their lives, and track equipment may be removed with symptom management as its main focus. Opioids are the most effective dyspnea treatment, and can be given regularly and at around the time. All physicians should have guidelines for removing intrusive assistance and for treating terminal dyspnea or other symptoms. A limited number of caregivers can attend death at home. CMS requires hospices to provide disaster care and most hospice staff face to face visits. Death at home requires that the family or care provider inform the overseeing care physician or the death mortuary. In response to the increase in deaths in most countries, mortuary response systems are being coordinated. Support and acknowledgment of both our loss as physicians and the loss of the family after death should be normal ([Coronavirus, 2020](#)).

Offering strength

The cardiovascular care team is engaged in the front lines that plan for the COVID-19 patient surge or are already deeply involved depending on the venue. Novel adversaries have superseded normal stress and long hours. Clinicians operate in a modern world without PPE, with threats of COVID-19 disease yet death to their relatives and to themselves. The triage complex and the long hours are both physically and mentally exhausting. When these pressures add to the current burnout of medical professionals, our providers' mental and physical wellbeing is clearly at risk. We also need to collaborate with employers and healthcare programs to provide mental wellbeing and medical resources for both ourselves and the family at home ([A COVID-19 palliative care, 2020](#)).

Patients have a fundamental right to palliative treatment. "The current pandemic COVID-19 is likely to strain our palliative services beyond capacity," Dr James Downar, Head of the Palliative Care Division at the University of Ottawa and Palliative Care Physician at the Ottawa Hospital and Bruyère Continuing Care, says. "We advise you to store medicines and supplies used in palliative care now, train staff to meet palliative care needs, optimize our space, refine our systems, alleviate the effects of separation, engage in critical conversations and focus on marginalized populations to ensure that it is received by all patients requiring palliative care."

"Many people already have advance care plans that stipulate that comfort measures are to be used if they become seriously ill," writes with co-authors, Dr Downar. "Certain patients who are intubated and undergo artificial ventilation but who are not clinically improving will be extubated. Owing to lack of resource a third group of patients may be denied ventilation." The strategy is an extension of a system developed by the U.S. Mass Casualty Critical Care Task Force for incidents involving large numbers of casualties and fatalities, incorporating the last four components, sedation, isolation, coordination and equity.

Stuff

Medications should be kept to make patients more relaxed and longer than normal. The authors suggest the development of kits for treating palliative symptoms by workers in long-term, paramedical and other treatment facilities healthcare professionals.

Personnel

National pandemic preparations will include all palliative treatment practitioners, and include to train others provide palliative care. Space: it may be appropriate to change specific wards or nearby locations to accommodate large numbers of patients, and to maintain a quiet, comfortable atmosphere for dying patients.

Technology

New triage systems and models of virtual treatment can be used to delegate doctors and increase productivity, thus increasing the risk of infection.

Sedation

Palliative sedation may benefit people with irreversible effects of regular relief medicines.

Separation

Reducing the sense of separation due to isolation measures, using video calling and technology to interact with patients and their family members.

Communication

Open communication and consideration of a patient's needs are important, since many do not want to take lifelong action.

Equity

It is critical to ensure that vulnerable groups, including people with disabilities or traumas and those living in poverty, have access to palliative care during a pandemic.

"Any triage program that does not follow the values of palliative care is immoral. Patients not

expected to survive should not be discarded but should receive palliative care as a human right" ([The Role of Palliative Care, 2020](#)).

CONCLUSIONS

The COVID-19 pandemic has had big implications for patients needing complex medical decisions in a resource-scarce healthcare environment. Palliative care provides support to incorporate preparation and relaxation into treatment. In particular, telehealth may promote palliative care programs prior to hospitalization. By helping our most needy adult patients we can alleviate suffering and pain and foster dignity.

Funding Support

The authors declare that they have no funding support for this study.

Conflict of Interest

The authors declare that they have no conflict of interest.

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