

Video hospice consultation in COVID-19: professional and patient evaluations

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ABSTRACT

Background Providing care for our patients during the COVID-19 pandemic required a rapid shift to video consultations (VCs). A service evaluation was performed to capture hospice professionals' (HPs) and patients' experiences of VC.

Methods Online or postal surveys were sent to HPs and patients, who had participated in VC between March and July 2020, focusing on their experience and satisfaction with the service.

Results 31 responses from HPs were received. 19 (61.3%) rated their experience of VC as good, despite 29 (93.5%) having no prior VC experience. One-third of HPs had undertaken potentially sensitive consultations, including resuscitation discussions. 23 (74.2%) undertook a VC that included a family member and 18 (58.1%) had included an external healthcare professional. 25 (80.6%) wanted to offer VC as an option going forward. Well-being staff successfully provided multiple group support sessions via video. 26 responses from patients (23) and carers (3) were received. 22 (84.6%) had access to a smartphone. 8 (30.8%) included a family member in their consultation. All patients/carers reported satisfaction with their VC, although 10 (38.5%) expressed a preference for face-to-face consultations. 22 (84.6%) patients would be happy to receive care via VC going forward and 21 (80.8%) stated they would recommend the use of VC to others.

Conclusion Patients reported VC to be an acceptable way to receive support from a hospice service and HPs would like to continue to offer VC in the future. VC can be offered as an alternative to face-to-face consultations with the potential to continue and improve access to a wide range of hospice services.

INTRODUCTION

Background

Due to the COVID-19 pandemic, video consultations (VCs) have been encouraged throughout the National Health Service and have played an important role

Key messages

What is already known?

- ▶ Video consultations have helped to maintain patient and carer support during the COVID-19 pandemic however feedback from patients and hospice professionals about their experiences of video consultations in hospice care is lacking.

What are the main findings?

- ▶ Patients and carers reported overall satisfaction with consulting with hospice professionals during the COVID-19 pandemic using videoconferencing technology. Hospice professionals were able to quickly adapt to providing support this way and are keen to be able to continue to offer video consultations in the future when appropriate.

What is their significance?

- ▶ Clinical: Video conferencing technology can be used in creative ways to widen access to a range of palliative care services with the potential to reach more people.
- ▶ Research: Further research across more hospices should be planned to address the limitations of this service evaluation and to assess post-pandemic views of accessing and providing hospice care using videoconferencing technology.

in maintaining the delivery of hospice support. VC guidance was created for healthcare professionals (HCPs)¹⁻⁴ and patients.⁵ A recent systematic review concluded that further research into VC in palliative care is required to decide how and when VC can replace face-to-face consultations.⁶ We performed a service evaluation to explore hospice professionals' (HPs) and patients' experiences of VC during the COVID-19 pandemic, assessing satisfaction and acceptability of this new service and to make recommendations to optimise the use of VC in the future.



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METHODOLOGY

Design and sample

A convenience sample of HPs working at a hospice (Surrey, UK) who had provided VC to patients and their family/carers during the COVID-19 pandemic was surveyed alongside a convenience sample of patients and their carers who had participated in VC with a range of HPs.

Survey development

Online 38-item (for HPs) and 32-item (for patients) anonymous questionnaires were designed to collect both quantitative and qualitative data using the Survey Monkey software platform as well as a corresponding paper version.

Procedure

An email explaining the purpose of the service evaluation and the survey URL was sent to HPs who may have conducted a VC with patients, and to patients who had participated in a VC. Patients without a recorded email address were sent a paper questionnaire. Patients were invited to ask family members/carers to provide feedback. We sent 53 emails and 7 letters to patients. Forty-seven additional patients who had a VC were deemed inappropriate to contact for the purposes of the evaluation (in hospital, too unwell or died in intervening period). Completion and submission was considered as implied consent to participate in the survey.

Analysis

Data were exported from Survey Monkey to Excel. Qualitative free-text comments were subjected to content analysis.

RESULTS

Thirty-one HPs (6 doctors; 16 nurses; 2 physiotherapists; 3 social workers; 1 complementary therapist; 2 well-being team members; 1 speech and language therapist) completed the HP survey.

Twenty-three patients and three carers completed the patient survey.

Preparedness for VC

Twenty-nine (93.5%) HPs had never conducted VC and 22 (84.6%) patients/carers had never participated in VC for healthcare reasons prior to the COVID-19 pandemic.

Twenty-three (88.5%) patients/carers had used video-conferencing technology for reasons other than healthcare; none had participated in VC for palliative care support.

Twenty-two (71%) HPs stated that they did not have any formal VC training. All patients/carers stated they were given clear (verbal) instructions explaining how to use video-conferencing technology.

Twenty-three (74.2%) HPs had concerns about providing VC such as inability to perform physical

examinations, fear of missing signs, technology inexperience or failure, and overcoming barriers to communication.

Eleven (35.5%) HPs had concerns about confidentiality and security of the video platform (Zoom) (table 1).

Inclusion of families and external HCPs

Twenty-three (74.2%) HPs stated that family members/carers had joined the VC with a patient.

Eighteen (58.1%) HPs had included an external HCP in their VC.

Inclusion of family/carers and HCPs in VC was viewed positively by both HPs and patients (table 1).

Range of hospice support provided via VC

Nineteen (61.3%) HPs carried out symptom assessments; seventeen (54.8%) undertook first assessments, twelve (38.7%) performed medication reviews, twelve (38.7%) discussed advance care planning, eleven (35.5%) discussed resuscitation, ten (32.3%) provided psychosocial support, five (16.1%) provided well-being sessions (eg, guided relaxation, fatigue/anxiety management, complementary therapy advice) and two (6.5%) provided bereavement support.

Barriers to VC

Twenty-seven (87.1%) HPs stated that some patients declined VC. Practical reasons included lack of confidence in or availability of technology, poor internet connection, 'Zoom fatigue', or clear preference for other means of communication, for example, telephone. Clinical reasons were also relevant such as mental health conditions, anxiety, and cognitive or sensory impairment. Surprisingly, no patients/carers in this survey reported problems with technology (see table 1).

Overall views of VC

Overall, nineteen (61.3%) HPs scored their VC as very good or good.

HPs thought VCs were convenient and efficient for both HPs (80.6%) and patients (67.7%).

Nineteen (61.3%) patients/carers stated they felt comfortable communicating with HPs via video.

Future use of VC in the hospice setting

Twenty-five (80.6%) HPs stated they would like the option to offer VC in the future.

Twenty-two (84.6%) patients/carers stated they would be happy to use video to consult with HPs again, but 10 (38.5%) stated they would always prefer face-to-face consultations if given the choice.

Twenty-one (80.8%) patients/carers stated they would recommend the use of video to consult remotely with HPs to others.

HPs recommended providing patients/carers with a choice to receive hospice support via VC and this

Table 1 Survey results

	Hospice professionals	Patients/carers
Preparedness for VC	<p>"Concerns about missing something—non-verbal communication, physical signs." (physiotherapist)</p> <p>"... if the patient or relative would find this a stressful process and if they could cope with the technology." (nurse)</p> <p>"not always easy to find an undisturbed place at home, concern neighbours may hear through open window." (nurse)</p> <p>"Concerns about the technology and the internet cutting out and therefore making conversations quite fragmented." (doctor)</p>	<p>"... had never heard of Zoom or how to use it, but it is so easy." (patient)</p>
Inclusion of family and other HCPs in VC	<p>"... it ensured the GP and I were both aware of the patient's concerns, what the plan is and encouraged collaborative working..." (doctor)</p> <p>"Doctor and clinical nurse specialist present so could have a multiprofessional team discussion with the patient and family." (physiotherapist)</p> <p>"Patients/carers often tell us that they enjoy being in the sessions with their loved ones as they feel less isolated, and more relaxed." (member of the well-being team)</p> <p>"Supported... patient to use technology... able to see all supporting members, as well as patient, and help(ed) to also understand their needs as would in home visit." (nurse)</p> <p>"... we were able to have ACP conversations together and the patient's husband was able to help with the tablet for the zoom, whereas the patient may not have had the strength/ capability to do this on her own as she was fatigued in bed..." (doctor)</p>	<p>"My wife attended the first Zoom session which was good because we both met the nurse for the first time and understood the objectives of the sessions and the palliative role as a whole." (patient—new referral to hospice during pandemic)</p> <p>"I am unable to speak so my husband was my voice." (patient)</p> <p>"I just wanted them to participate in case they wanted to ask something." (patient)</p>
Barriers to VC	<p>"... lack of right equipment, fear of using video, prefer to talk on telephone..." (nurse)</p> <p>"Preferred face-to-face as felt his voice was too weak on the phone or video call." (doctor)</p> <p>"The perception for some has been that it would be too technically difficult. Some patients/carers were open to us helping them set it up over the phone and have subsequently been delighted that they are now able to access this technology..." (member of well-being team)</p> <p>"I have had several consultations that have been quite disjointed due to the patient's Wi-Fi dropping out and this can be quite disruptive, especially when you are in the middle of a sensitive conversation." (doctor)</p> <p>"It is not appropriate for all our patient population for example, those with communication difficulties such as MND, very deaf patients, elderly patients who are not familiar or do not have access to devices..." (doctor)</p>	<p>"There may be times when the complexity of the subject is such that a face-to-face is strongly advantageous to a virtual consultation." (patient)</p> <p>"It helps significantly if the patient is comfortable with the technology and has the equipment." (patient)</p> <p>"In times of serious issues being shared. In times of serious upset." (patient)</p> <p>"... will always be second best to face-to-face but a close second and a lot better than telephone." (patient)</p> <p>"Sometimes I think an examination would also work." (carer)</p>
Future use of VC in hospice care	<p>"I feel that there needs to be a mixture of video calls and visits/face-to face interaction as a video call would be sufficient in some cases." (nurse)</p> <p>"We can use the technology to talk to people who are scared of visiting the hospice and give them an idea of what this is really about." (member of well-being staff)</p> <p>"I have found it possible to contact more patients and offer advice and assess whether a face-to-face visit is necessary." (physiotherapist)</p> <p>"Very beneficial for patients who are at home and can't leave the house for variety of reasons—seeing a face can be more reassuring than a voice at the end of the phone." (speech and language therapist)</p> <p>"It gives professionals and patients a choice especially if they are hard to reach due to travel problems and mobility issues." (social worker)</p> <p>"We need to ensure all staff have the correct equipment and have an SOP in place to ensure safety and consistency across the team." (nurse)</p>	<p>"I think you should maintain it as an option and offer it to patients when face-to-face is not warranted or difficult to schedule." (patient)</p> <p>"Video is great when you can do things easily as it's a long drive there. Nice to have been to the hospice at least once to be introduced and see facilities and people." (patient)</p>

ACP, advance care planning; GP, general practitioner; HCPs, healthcare professionals; MND, motor neuron disease; SOP, standard operating procedure; VC, video consultation.

was echoed by patients. HPs suggested that specific types of hospice services were better suited to VC such as outpatient clinics, follow-up/non-urgent reviews, introductory sessions providing information about hospice care and social support.

HPs suggested that VCs are more likely to be successful for specific patient groups such as those earlier in their disease trajectory, when too unwell/fatigued or have poor mobility to attend the hospice, cases benefiting from external HCP input or if no physical examination is required.

Specific clinical situations less suitable to VC were also proposed by HPs such as mental health conditions, significant anxiety, agitated/delirious patients, fine motor limitations (eg, motor neuron disease, Parkinson's disease), communication difficulties, cognitive impairment and sensory impairment (eg, deafness). Specific end-of-life scenarios, such as very difficult/sensitive conversations, discussing resuscitation, breaking bad news and imminent death, were also considered less suitable. Physiotherapists and speech and language therapists noted that many of their assessments/treatments are unsuitable to be optimally provided via VC.

HPs stated that formal training around conducting VC and the development of a standard operating procedure and a patient information leaflet would be helpful (table 1).

DISCUSSION

Using VC during the COVID-19 pandemic facilitated the continuation of holistic support such as virtual well-being sessions, alongside remote clinical care. Our service evaluation illustrates that hospice support, even when involving potentially sensitive conversations, can still be provided remotely using video-conferencing technology and this is acceptable to patients and carers and consistent with recent studies.^{7,8}

Although most HPs had not supported patients using video-conferencing technology prior to the COVID-19 pandemic nor had any formal training, and despite many having concerns about providing VC, the majority were successfully able to offer a range of hospice services to patients/carers including some of a sensitive nature. It was noted by HPs and patients that there were many situations, including existing medical conditions, which may present barriers or cause a patient to decline a VC. We therefore need to carefully consider individual patients' circumstances to optimise the use of VC.

Patients/carers felt comfortable communicating with HPs via video link and it was encouraging that few had difficulties with using the technology which is consistent with data from Australia.⁹ Despite HPs reporting that some patients had declined VC, most patients/carers having experienced a VC stated they would be happy to participate using VC again when appropriate. Unsurprisingly however, many stated

that, given the choice, they would always prefer face-to-face consultations.

A clear drawback to consulting via video is technology failure. Internet connectivity in people's homes is not within our remit to solve, but it is essential that our own video platforms are used optimally and there is an alternative backup in place (eg, telephone). Using hospice volunteers to help support patients and carers who are less confident in the use of technology could also be considered to expand access to this service.

The ability to include family members and carers in the consultation was reported as beneficial by both patients and HPs which is consistent with previous studies.⁸ The ability to include external HCPs in VC was described positively by HPs and using technology for this purpose has clear advantages to improve patient outcomes and collaborative working.

CONCLUSION

VCs provided by a range of HPs to provide holistic care are acceptable to patients, when individual patient circumstances and preferences are taken into consideration. The use of VC could allow hospices to expand access to their services and deliver better multiprofessional care. To use VC effectively as part of the hospice service, investment in information technology support and training is needed.

Limitations

Weaknesses of this service evaluation include its limited size and specific locality (a single hospice in Surrey, UK). This may mean the data are not wholly representative of elsewhere within the UK. Most importantly we were unable to capture the patients who had declined VC or for whom the VC had failed. Most patient/carer respondents were already proficient in the use of technology. Our main method of inviting participants was via email and an online questionnaire which may have excluded those who were not comfortable/unable to complete an online survey. Most of the patient/carer respondents had previously used video-conferencing technology for reasons other than healthcare so may have already been familiar with the technology. However, none had a prior VC for palliative care support. A larger collaborative study across UK hospices should be planned to address these limitations.

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