Strategies maintaining hospice and palliative care quality during COVID-19 pandemic in Taiwan

To the Editor:

The pandemic COVID-19 has wreaked havoc on public health across the globe. Despite the proximity to China, Taiwan has come out relatively unscathed through this worldwide crisis. Up to 19 May 2021, among the total 24 million people in Taiwan, 14 991 cases were diagnosed as having COVID-19.[1] Compared with other epidemic areas, the relatively small inflow of patients with COVID-19 did not burden the healthcare system in Taiwan. However, hospice and palliative care professionals were experiencing a profound change in their daily practice. All the administrative control measures aiming to prevent virus spread also precluded interpersonal communication, which was valued most for a good death in hospice and palliative care. To further clarifying and investigating this ongoing problem, Taiwan Academy of Hospice Palliative Medicine (TAHPM) held a nationwide online meeting for information sharing and problems solving. We categorised important issues and formulated some practical suggestions to maintain the palliative care quality. We prepared this letter with a humble intention to share with experts across the world the nature and the extent of influence we have gone through and also a few lessons learnt. We summarise all issues in table 1, complemented by the following texts.

Table 1 Strategies maintaining hospice and palliative care quality

Fields influenced	Issues identified	Strategies
Inpatient palliative care	Increased psychospiritual suffering. Delayed treatment initiation/withdraw. Availability of part-time therapists.	Introduce real-time video–audio products, electronic recording devices. Appropriate hardware/software support for online meeting. Online self-learning course for spiritual therapy.
Palliative home care	Increased home care patients and increased complexity of their conditions. Increased risk of exposure.	Introduce telemedicine. Appropriate manpower resource allocation. Offer palliative home care SOP for reference.
Palliative team member stress	Increased work loading, fear of virus infection, inappropriate labelling.	Cautious task assignment. Enhance public health education.
Terminal patient consultation	Inconvenience for family meeting arrangement.	Early but timely hospice consultation. Appropriate hardware/software support for online meeting.
Terminal patient admission	Time-consuming screening for COVID-19.	Tailored pathway for admission.
Patients with COVID-19	Rapid progressing and unpredictable disease course.	Early but timely hospice consultation. Implementing advanced care planning.

SOP, standard operation procedure.

MAINTAINING THE QUALITY OF IN-PATIENT PALLIATIVE CARE

Since the outbreak, to avoid occurrence of intramural transmission, visitors needed to pass a screening station at the hospital's doorstep. Those who had fever, a out-of-country travelling history or a cluster history were not allowed to enter hospitals. All time in-patient visiting was cancelled. This is an unfortunate change for palliative ward care in several aspects below:

A. In the epidemic period, patients' psycho-spiritual condition may become more complicated because of the restrictions on in-patient visiting. We suggest palliative care units use face-to-face online meeting to facilitate emotional communication. Families were encouraged to send their words, daily life files through online videos or USB flash drive. Ward staff can also video tape patients' touching moments to share with their families.
B. Decision-making process was hampered by the absence of significant others. Timely treatment initiation or withdrawal became more difficult without consensus of families, thus compromising quality of palliative care. Although a face-to-face meeting could not possibly be totally replaced, teleconference might be the best solution to overcome communication barriers.[2] Appropriate hardware/software for online meeting should be ready in palliative care ward. Videotaped family meeting should be included in medical record system.
C. Some palliative care team members are not full-time employees, such as art, music and spiritual therapists/volunteers. During epidemic period, these personnel are not allowed to enter hospital and quality of palliative care was compromised. Online interventions, though not a perfect substitute, are practical under the situation. Pre-recorded online treatment courses, well-designed apps for step-by-step self-healing and interactive AI (Artificial Intelligence) devices for accompany. are of great potential to be developed for future outbreak.

INCREASED NEED FOR PALLIATIVE HOME CARE

In epidemic period, many patients would rather request to be discharged even when the condition was not stable enough for a regular discharge. The loading of home care nurses increased because of the number of patients and the complexity of their conditions.

National administrative and legislative departments might seriously consider the feasibility of telemedicine use in an emergency of similar nature,[3] as the feasibility and cost-effectiveness have been proved in one randomised trial.[4] Home care nurses obtain key information by online transferring images, lab data and physiological measures. This decreases their infection risk efficiently from decreasing contact frequency. If online information

was adequate for a health professional to make medical decisions, a face-to-face evaluation could be spared. The extra time and labour saved could be more efficiently allocated.

Currently, we suggested hospital administrative staff to examine, adjust and allocate appropriate manpower to the palliative home care unit. We also offered a palliative home care standard operation procedure (SOP) for reference to guide safe nursing practice during the epidemic period.

INCREASED PALLIATIVE TEAM MEMBERS' STRESS

During the outbreak, palliative team members' loading increased substantially both physically and psychologically. With patient becoming more stressful and the absence of spiritual therapists, palliative care nurses spent much time relieving their patients' worries and anxiety. Everyday ward nurses detailed patients' condition to families set apart on phone calls. They also struggled to arrange limited opening time slots for permitted visitors and enforce the sanitation protocol, which often ended up with dissatisfaction and complaints. Additional psychological stress included fears for being infected or being labelled as potential COVID-19 carriers, which has been described in the previous literature.[5] Collective burnout will be triggered if the disaster drags on. Considerate task assignment is imperative.

EARLIER PALLIATIVE CARE CONSULTATION FOR CRITICAL AND TERMINAL PATIENTS

Arranging a family discussion is time consuming in epidemic period. Outside palliative care unit, if a patient's condition is worsening rapidly or if she/he is dying, families may have little chance to express patient's preference for life-sustaining treatments. We suggest primary care physicians consult palliative care personnel in a timely way when an irreversible terminal condition occurs or when the patient is asking for comfort-oriented care.

EFFICIENT AND APPROPRIATE FLOW PATH FOR ADMITTING PALLIATIVE HOME CARE PATIENTS

Admitting a dying patient with fever is a much more complicated issue. Protocol for excluding COVID-19 infection is time consuming and may delay timely hospice care. We suggest administrative staff take this seriously when trying to set a new SOP for admitting a palliative care patient.

PROVIDING TOTAL CARE FOR PATIENTS WITH COVID-19

Different from advanced cancer or organ-failure patients, the disease trajectory of patients with COVID-19 is unpredictable. However, all patients with COVID-19 are generally ill prepared for facing end-of-life issues. Psycho-spiritual support may be as important as anything else in treating the patients with COVID-19. In addition, advance care planning should be initiated as early as possible.

Through this online meeting by TAHPM, participants reached consensuses and suggestions on these issues to sustain the palliative care quality. We would like to share our experience and, hopefully, to work together with palliative care professionals around the world to wade through the fearful darkness of COVID-19 pandemic.

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