



Association for
Palliative Medicine
Of Great Britain and Ireland

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

Role of the specialty and guidance to aid care

Version 4: 20 April 2020

Please check on the APM website (<https://apmonline.org>) to ensure that you are reading the most up-to-date version of this guidance

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, initially prepared and collated locally by the Northern Care Alliance NHS Group (NCA) and the Association for Palliative Medicine of Great Britain and Ireland (APM), is not intended to be comprehensive. The APM acknowledges the contribution made by Fiona Murphy MBE and other staff within the NCA to the first version of the guidance and colleagues nationally who have inputted into all versions via the APM.

While this work has informed national guidance, it is not endorsed by NHSE, but may be useful to colleagues 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 updates become available. The most recent version of the guidance will be available on the public-facing pages of the APM website (<https://apmonline.org/>). It is advised that you always check that you are referring to the most recent version.

Healthcare 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>. Your local palliative care, bereavement and mortuary teams as well as Register and Coroners' Offices may be able to provide additional support and guidance.

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, the APM cannot accept any responsibility for errors or omissions in this document. Healthcare professionals should always defer to NHSE, government or professional bodies' guidance where appropriate.

Dr Iain Lawrie

President, Association for Palliative Medicine of Great Britain and Ireland

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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).

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, but opinions on this are divided.

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.

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 come 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.

Where hospital visiting restrictions are 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 have a 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.

Guidance for use in the community setting has been produced by the Royal College of General Practitioners and is available at:

https://elearning.rcgp.org.uk/pluginfile.php/149457/mod_page/content/22/COVID%20Community%20symptom%20control%20and%20end%20of%20life%20care%20for%20General%20Practice%20FINAL%20v2.docx.pdf.

Guidance for those caring for paediatric patients has been produced by the Association for Paediatric Palliative Medicine and is available at: https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/04/C0249_Clinical-guidelines-for-children-and-young-people-with-palliative-care-needs_17-April-.pdf

All hospitals should 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; pain

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 local formularies. 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, e.g.

- 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 distressing symptoms, particularly in severe disease.

Typical starting doses 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 or similar presentations 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.

Management of breathlessness COVID-19 Outbreak



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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.

Reversible causes

- both COVID-19 and non-COVID-19 conditions (advanced lung cancer, SVCO, lymphangitis carcinomatosa, 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 (mild to moderate)

- opioids for breathlessness
 - morphine MR 5mg po bd (titrate to max 30mg daily then seek advice)
 - morphine 2.5-5mg po prn 2-4° (1-2mg sc if unable to swallow)
 - midazolam 2.5-5mg sc prn 2-4° for associated agitation or distress
- anxiolytics for anxiety
 - lorazepam 0.5mg sl prn 4°
- in the last days of life
 - morphine 2.5-5mg sc prn 2-4°
 - midazolam 2.5-5mg sc prn 2-4°
 - consider morphine 10mg +/- midazolam 10mg over 24 hours via syringe driver, titrating according to response in a step-wise approach with palliative care advice as needed

Pharmacological measures – severe breathlessness (akin to ARDS scenarios)

Patients with severe COVID-19 symptoms, especially severe breathlessness, who are not expected to survive their illness can deteriorate quickly over a short period of time. As a result, they may need higher starting and maintenance doses of opioids / anxiolytics than suggested previously for breathlessness and associated anxiety.

- morphine 5-10mg SC prn 2° (oxycodone 2.5-5mg SC prn 2° if low eGFR)
- midazolam 5-10mg SC prn 2-4° (may need in some cases to be hourly)
- consider morphine 10-20mg and / or midazolam 10-20mg over 24 hours via syringe driver
- syringe driver dosing may need to be reviewed 8-hourly rather than every 24 hours if the patient's prn requirements are escalating rapidly without control of their symptoms
- dosing requirements may not 'fit' with established practice and may have to be determined on a case by case basis – always prescribe safely, but don't be afraid to prescribe in line with your patients' requirements. **Seek specialist palliative care advice if you are unsure!**
- the bottom line is that, if a patient is going to die, we need to ensure they die without distress
- syringe drivers may be in short supply or needed for non-COVID-19 patients requiring palliative care support. Where possible, use 'as required' dosing for COVID-19 patients

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 (always start with lower dose and assess effectiveness)
or
- morphine sulphate immediate release solution 2.5mg po 4^o

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)
- if severe / end of life: morphine sulphate injection 10mg CSCI over 24 hours and 2.5-5mg sc



Management of delirium COVID-19 Outbreak

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 –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: mild to moderate to severe

Haloperidol is generally the drug of choice for both hyper- and hypo-active delirium:

- start with 500 micrograms / 24h CSCI or po/sc at bedtime and prn 2^o
- if necessary, increase in 0.5–1mg increments
- median effective dose 2.5mg/24h (range 250 microgram - 10mg / 24h)
- consider a higher starting dose (1.5-3mg po/sc prn 2^o) when a patient's distress is severe and / or immediate danger to self or others

If the patient remains agitated, it may become necessary to add a benzodiazepine, e.g.

- lorazepam 500 micrograms- 1mg po bd and prn 4^o
- or**
- midazolam 2.5-5mg sc prn 1-2^o

Pharmacological measures: end of life (last days / hours)

Use a combination of levomepromazine and midazolam in a syringe driver

Levomepromazine (helpful for delirium)

- start 25mg SC stat and prn 1^o (12.5mg in the elderly)
- if necessary, titrate dose according to response
- maintain with 50mg / 24h CSCI, titrating according to response / need
- alternatively, smaller doses given as an sc bolus at bedtime, bd and prn 6^o

Midazolam (helpful for anxiety)

- start with 2.5-5mg sc/iv stat and prn 1^o
- if necessary, increase progressively to 10mg sc/iv prn 1^o
- maintain with 10-60mg / 24h CSCI (start low and titrate appropriately)

If ineffective, seek specialist palliative care advice

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

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 4-6°
- **NSAIDs should be used with caution in COVID-19**** (NHSE, 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)

Normal body temperature: 98.6°F (37°C)



Body fever temperature: > 100°F (37.7°C)



Rectal fever temperature: > 100.5°F (38°C)



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 qds 4-6^o)
 - 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 qds 4-6^o **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 should be used with caution in COVID-19****
(NHSE, 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 IR 2.5-5mg po prn 4^o
- previously using regular weak opioid (e.g. codeine 240mg/24h)
 - morphine IR 5mg po prn 4^o or MR 20-30mg bd
 - frail/elderly: use lower starting dose of 2.5mg po prn 4^o 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 sc 4^o 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

Discussions about goals of care

(adapted from RCP, 2018)



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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)

Key points to consider when discussing ceilings of treatment

- 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
- all efforts should be made to 'de-escalate' confrontational situations in order to maintain a patient / professional or carer / professional relationship wherever possible
- 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.

Discussions about goals of care COVID-19 Outbreak



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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
read clinical records, ensure privacy, no interruptions
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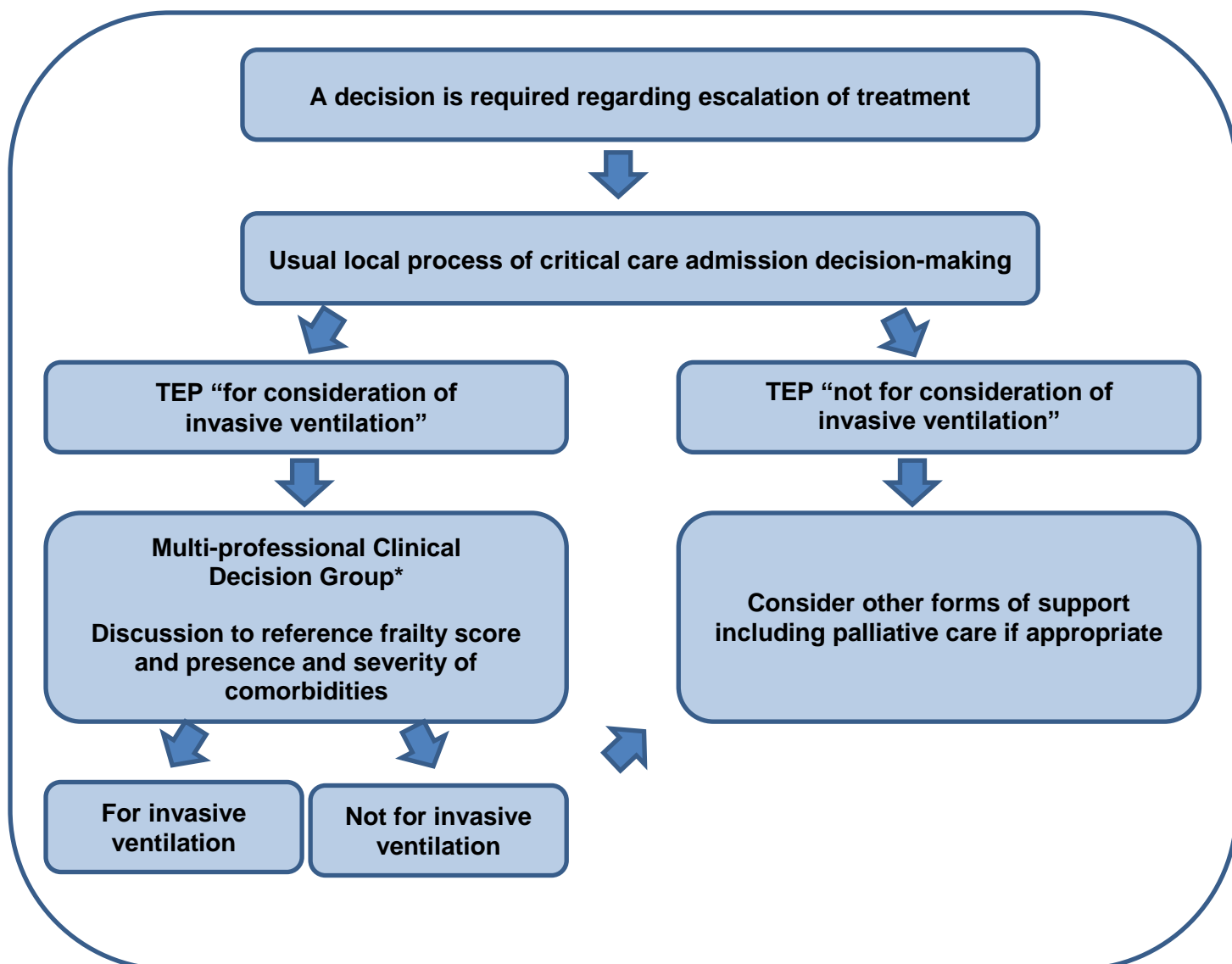
Clinical decision-making in respiratory failure COVID-19 Outbreak



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All emergency COVID-19 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>.

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.

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



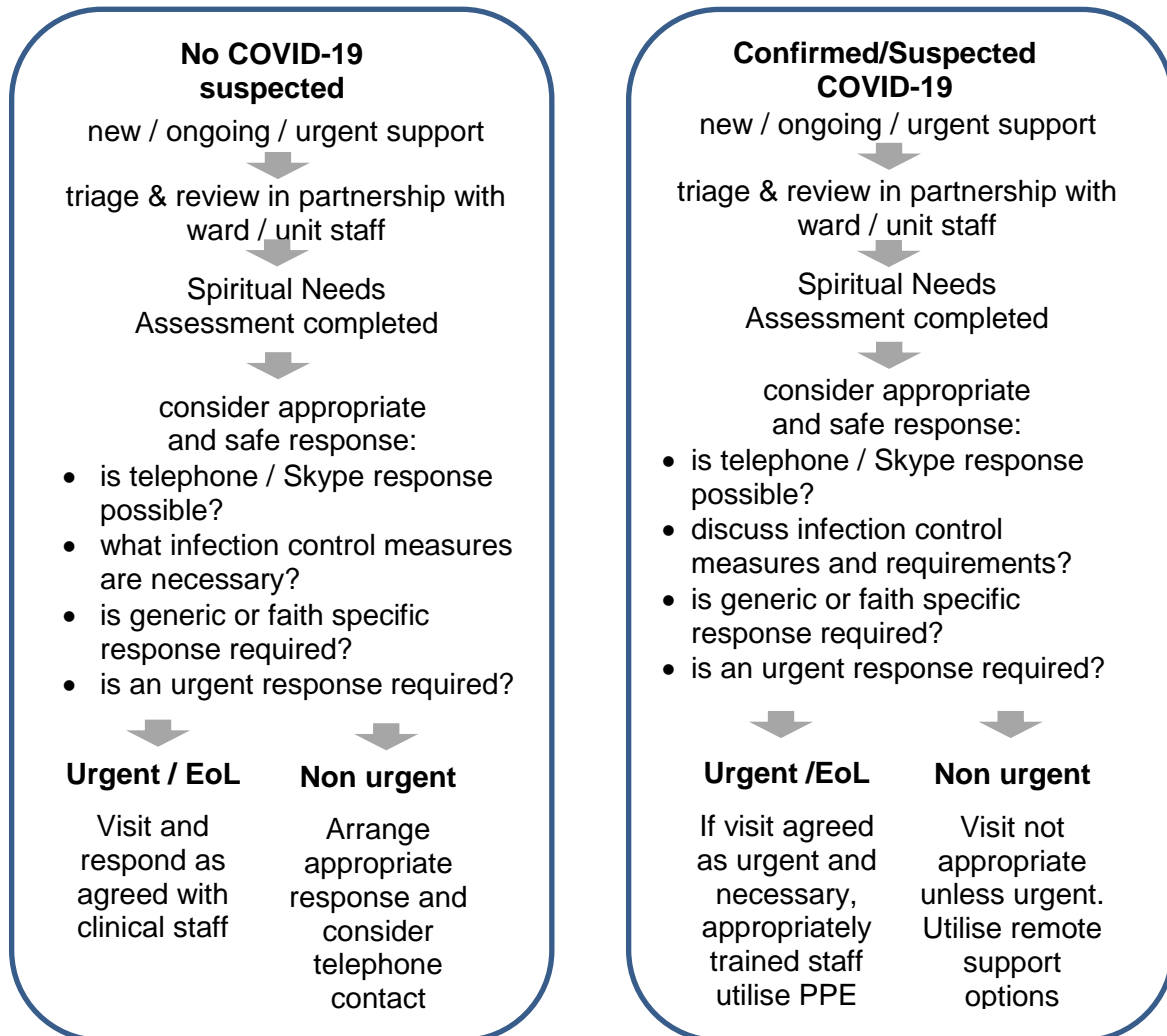
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All routine and intentional visits suspended

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

Chaplaincy & Spiritual Care support accessed through normal routes
Urgent / out of hours – hospital switchboard / local contact arrangements
 Non urgent – telephone or other local contact details

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



- 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

Visiting COVID-19 Outbreak



Association for
Palliative Medicine
Of Great Britain and Ireland

This section outlines guidance regarding visiting during the COVID-19 pandemic as well as communication with relatives when **visitors are not routinely permitted on the ward**.

During the surge in capacity with COVID-19, patients may be cohorted; communication with relatives will therefore be challenging. Relatives' access to patients and communication with clinical staff will be restricted due to:

- risk of infection transmission from patient to relative
- risk of infection transmission from relative to staff
- relatives self-isolating at home
- restricted PPE supplies prioritised to staff

It is important that we maintain the highest standards of communication wherever possible. Bedside nursing staff may be unable to update relatives by phone due to restrictions of PPE, the acuity of the patient and time pressures. In view of this, the ward will provide a daily communication bulletin (see Appendix 2) for relatives which can be delivered by a clinical or non-clinical member of staff. Friends and family should consider other ways of keeping in touch with those close to them (e.g. via phone calls, FaceTime, WhatsApp and Skype) and, where possible, staff should also facilitate such means of keeping in touch.

The exception to this is when end-of-life care is in place; the nurse in charge will enable **one family member to visit for one hour each day (no sharing of the hour)**. They will wear PPE in the same way as the staff caring for the patient.

There should be no exceptions to this rule
(local guidance may vary – please check)

This may obviously be distressing, both for the patients' families and for the staff caring for them, as this approach goes against everything we usually promote for the provision of sensitive end of life care. However, there are good reasons why we are being forced to take this approach, as outlined above and on page 19.

Every effort should be made to facilitate communication between patients and those close to them by whatever means available (e.g. via phone calls, FaceTime, WhatsApp and Skype). Hospital wards and units should explore sourcing iPads or similar devices to help aid communication, and an appropriate approach to infection control and supply of cleaning consumables should be available.

Visiting – ethical basis COVID-19 Outbreak



When patients are dying within hours or days, the presence of family at their side for short visits, or longer stays, is vital to palliative and end of life care and part of the human experience of life and death. It provides comfort not only to the dying patient, but also to those present, and inability to be present is a source of anxiety, distress and moral injury that may be long-lasting.

COVID-19 has created concerns relating to visiting. Visitors could contract infection from a patient and thus come to physical harm themselves. They could also spread the infection to others outwith the care setting where the patient is dying. Limiting 'footfall' through any inpatient or residential care setting forms an important aspect of risk reduction for staff and other patients

Concerns about visiting are legitimate but responses to them should be governed by principles of infection control at local and population level and also by moral and ethical principles.

1. **Respect**

All patients, wherever they are dying, and whatever they are dying from should be offered good quality and compassionate care.

2. **Fairness**

Family presence should be considered equally across all care settings, and for patients dying with and without COVID-19

3. **Minimising harm**

Harm from visiting can occur to visitors and those they come in contact with. The patient themselves may experience harm if they feel guilt about exposing visitors to infection. That harm must however be balanced against harm to the dying person occasioned by absence of family, harm to family who are unable to be present, and harm caused to care staff who substitute themselves for absent family and undertake difficult telephone communications.

4. **Working together**

Patients' current or previously known wishes about their own end of life care should be taken into account. Clinicians should act with honesty and integrity in their communication with patients and should communicate and document decisions regarding visiting and the reasons behind them transparently. Organisations have a responsibility to ensure that staff are aware of and engaged with the rationale for the local guidance. There must be transparency in how the competing factors of social responsibility, PPE resource, and direct and indirect risk of infection and of psychological harm are being balanced.

5. **Flexibility**

As the clinical situation evolves both at the individual and population level, decisions will need to be kept under review with clear guidance at the national level

6. **Reciprocity**

Where there are resource constraints, patients should receive the best care possible, while recognising that there may be a competing obligation to the wider population.

7. **Capacity and consent**

The capacity of family to provide informed consent relating to the risks associated with visiting should be taken into account as should the capacity of the patient to receive visitors.

Source: <https://www.scottishacademy.org.uk/covid-19-allow-families-equal-access-visit-dying-relatives>

Visiting – practical principles COVID-19 Outbreak



These principles **do not represent a series of rules**, to be applied rigidly. They are simply principles, to be considered and applied flexibly, humanely and sensitively in the particular context of each patient and their family.

1. All patients who are judged to be dying from COVID-19 or other conditions within hours or days are entitled to receive visitors. That entitlement is however qualified by the following.
2. Only one family member should normally visit at any time. In some situations however, a visitor may need assistance to be able to attend, and that should be taken into account. Where the required family member requires physical or emotional assistance to visit, the benefits and risks require careful consideration by the responsible senior clinician.
3. To the greatest extent possible, and recognising that visiting can be emotionally and physically exhausting, the same family member should represent the family over the period of the patient's decline and death.
4. When possible, the patient should consent to receive visitors, if not, their previously known wishes or judgement of a legally appointed proxy decision maker or closest relative should be taken into account.
5. When possible, visitors should provide informed consent that they understand the personal risks associated with visiting.
6. In all cases, visitors must agree to undertake the subsequent isolation and quarantine restrictions appropriate to the contact that has occurred in association with their visits.
7. In all cases, visitors must consent to wear Personal Protective Equipment and undertake all other relevant hygiene requirements equivalent to that used by care staff in the specific care facility. Support should be provided to doff and don equipment as necessary.
8. Anyone who is unwell +/- exhibiting symptoms of COVID-19 - a new, persistent cough and fever or high temperature - should NOT visit any patients in a hospital or other care facility.
9. Care facilities are entitled to limit the frequency of visits, duration of visits, or numbers of visitors in accordance with the risk to other patients, other care staff, or other practical considerations in the care setting. However, the reasons for this must be documented and be in accord with the framework outlined above.
10. Clinical teams in more acute settings, particularly ICU and HDU, should receive support in family liaison from other staff members, including chaplaincy, bereavement and counselling services, thus enabling them to focus on direct patient care
11. Care facilities should support family who cannot visit by providing access to and support in the use of mobile tablet or handheld communication devices to patient and family, particularly if a family cannot provide these for themselves.

Source: <https://www.scottishacademy.org.uk/covid-19-allow-families-equal-access-visit-dying-relatives>

Communication Bulletin COVID-19 Outbreak



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The communication bulletin for relatives will be underpinned by clinical staff documentation following review on the ward/board round; the clinical category for each patient will be documented each morning and afternoon by the clinical team in a designated daily communication book. The goals of treatment and uDNACPR status will also be recorded.

The clinical team will categorise each COVID-19 patient:

- Improving
- Progressing
- Stable
- Concern
- Deteriorating

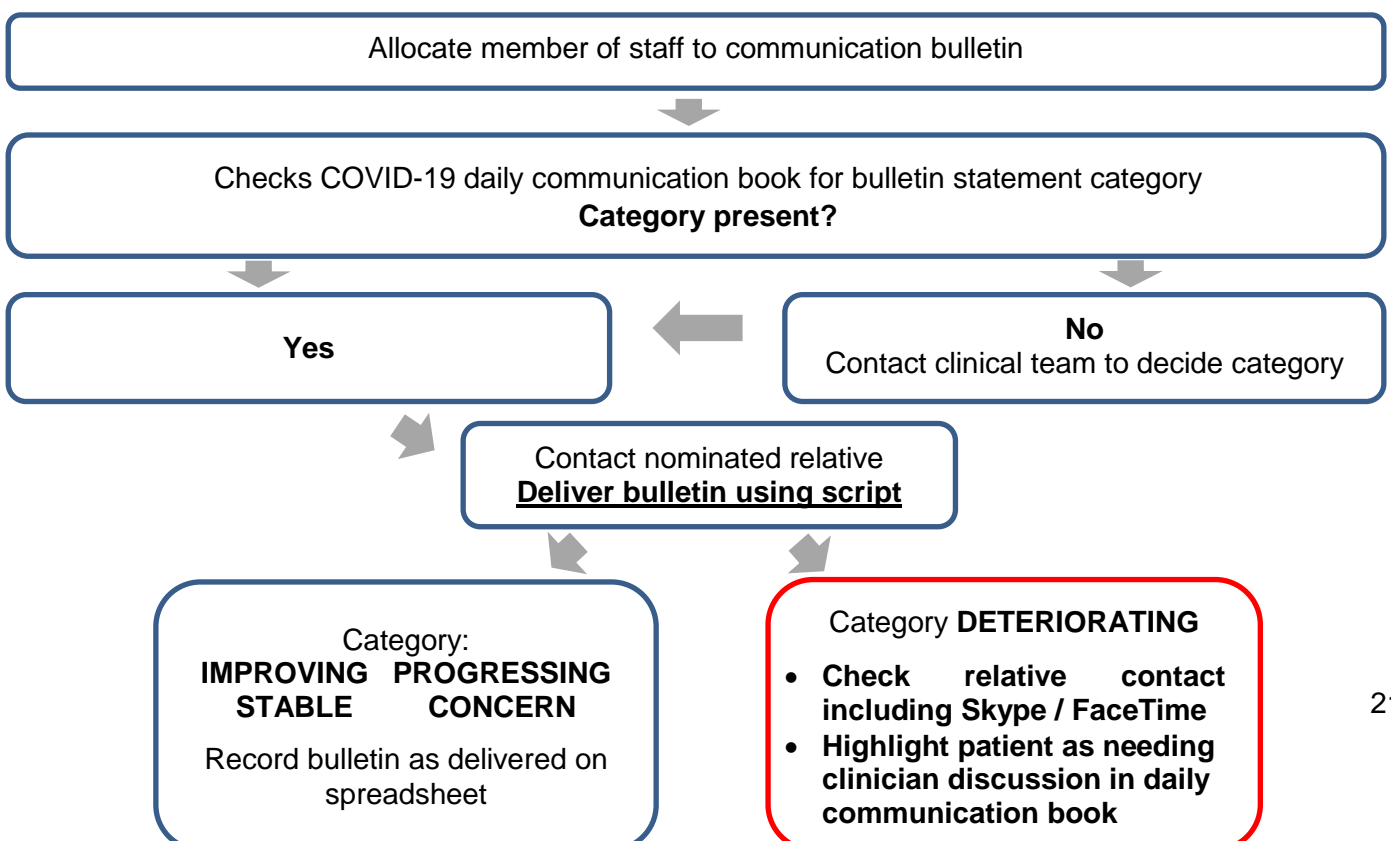
These are described on page 23 which provides an outline basis of a 'script' for staff to refer to during sharing bulletins. Once the bulletin has been conveyed to the nominated relative, record that this has been delivered by completing the daily communication book.

When patients are admitted to the ward, in addition to normal contact information, relatives should be asked to identify:

- a primary point of contact for clinical staff to call
- a secondary point of contact for clinical staff to call should the primary contact point fail
- whether they can be contacted by Skype (and record username)
- whether they can be contacted by FaceTime (and record phone number)

Significant conversations should be conducted by a member of the medical team either face to face with relatives in an appropriate safe environment outside of the cohort area or via teleconferencing (either video or telephone). These include, but are not limited to:

- limitation of treatment
- withdrawal of life-sustaining treatment
- patient death



Communication Bulletin COVID-19 Outbreak



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- confirm identity of relative
- confirm identify of the patient with relative with **two** of three identifiers:
 - name
 - date of birth
 - address



Give background statement

“This is a 12 hourly update on your relative’s condition. I am contacting you because the clinical staff are extremely busy looking after all the patients in the ward. The information I will give you has been provided by the doctors and nurses looking after your relative. I cannot answer specific questions about their condition”

Then provide the appropriate update

Improving

... is improving. It is hoped that they will be ready to discharge home soon / they are being discharged today.

Progressing

...is making some progress and is requiring oxygen support. We hope that they continue to improve.

Stable

... is stable at the moment. They still need a high amount of oxygen support. We hope that they improve but are concerned that they may get worse.

Concern

... is causing the doctors and nurses to be very concerned because they are not making the progress that was hoped for. They are receiving all possible treatment and will be reviewed by the doctors regularly.

Deteriorating and being transferred to a Critical Care area

.....is requiring high levels of oxygen and is being transferred to Critical Care in order to be placed on a breathing machine. The doctors and nurses are extremely concerned and will try to contact you to discuss this; it may be some time before they are able to do so due to they are extremely busy caring for your relative.

Deteriorating

(Patients for ward level care / uDNACPR)

..... is requiring high levels of oxygen and the doctors and nurses are extremely concerned and are worried that your relative may deteriorate further. The doctors and nurses will try and contact you to discuss this; it may be some time before they are able to do so due to they are extremely busy caring for your relative.

Important considerations for care immediately before and at time of death COVID-19 Outbreak



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. Palliative care, bereavement and mortuary teams, as well as Register and Coroners' Offices can be contacted for additional support and guidance.

Before death

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

If death is imminent one family member may be permitted to visit their loved one (maximum one hour per day); they should wear required PPE

Check re Permanent Pacemakers or Implanted Cardiac Defibrillators

- do they need to be deactivated? (can be deactivated using a magnet or deactivated by cardiorespiratory technicians through body bag material)
- contact your local Cardiology service for advice and support

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 and a doctor completes Medical Certificate of Cause of Death (MCCD)

- a doctor or any appropriately trained health professional may verify death
- only a doctor can certify death (i.e. complete the MCCD)

- 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 a healthcare worker may have contracted COVID-19 as a result of their occupation, their death must be referred to the Coroner**

If the deceased is to be cremated, doctors do not need to view the deceased patient (wording for cremation paperwork is on page 29)

If referral to HM Coroner is required **for any other reason**, the patient's death should be reported to HM Coroner's Office in the usual way and local guidelines should be followed alongside this guidance

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

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

Care after death COVID-19 Outbreak



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

Consideration of emotional / spiritual / religious needs of the deceased and their 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. They should be placed in a sealed bag and relatives must not open these for 14 days

Relatives of the deceased are not permitted to visit after death

Later mortuary viewing may also not be possible, depending on local arrangements

Required PPE should be worn for performing physical care after death

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 – use of a body bag is not essential for transferring the body (although local policies may differ ... check!) and those handling the body at this point should use required PPE

The outer surface of the body bag (if used) should be decontaminated immediately before the body bag leaves the anteroom area. This may require at least 2 individuals wearing required PPE

<https://www.gov.uk/government/publications/wuhan-novel-coronavirus-infection-prevention-and-control/wuhan-novel-coronavirus-wn-cov-infection-prevention-and-control-guidance#PPE>

Registered nurses on ward to complete Notification of Death forms (or local equivalent) fully including details of COVID-19 status and place in pocket on body bag (if used) 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 and porters contacted to transfer to mortuary

- the deceased's property should be handled with care as per policy by staff using required 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 be used for items that have been properly cleaned

Refer all suspected / confirmed COVID-19 deaths to the local bereavement team

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

Mortuary transfer and care COVID-19 Outbreak



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

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

Porters, wearing required PPE collect patient from ward and transfer to mortuary by way of the process in place for safe removal



Usual booking in procedures at the mortuary



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



There is no reason why a pacemaker or implanted cardiac defibrillator in situ cannot be removed after death, however there must be **appropriate, safe local capacity** to facilitate their removal. If appropriate, safe facilities and equipment are not available, these patients **may** need to be buried not cremated. Defibrillators should be deactivated in the mortuary.
(further Government guidance is awaited)



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 team will advise



Families that do wish to visit their loved one should be advised that this may be pursued via their chosen Funeral Director, but may not be possible



Mortuary Technicians to do checks on the name tags on body bag (if used); body bag should only be opened for identification



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 Director with, for example, Bioguard disinfectant



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

Doctors / Police viewing the deceased COVID-19 Outbreak



Doctors viewing deceased patients

As outlined in The Coronavirus Act 2020 (HM Government, 2020), examination of the body is not required for completion of form Cremation 4 if the deceased was seen by a medical practitioner (including video consultation) in the 28 days before death. However, in some areas, viewing of the body may be required (check local arrangements). Where doctors must view the deceased:

- staff will wear PPE and will remove the patient from the fridge and leave on the trolley
- the doctor will wear gloves, mask and apron on and will stay a secure distance away
- if the doctor wishes to see more than the wrist band, mortuary staff in PPE will open the body bag (if used) and cover the face of the deceased to reduce the risk of aerosol generation
- the doctor can then identify the deceased at the desired social distance to reduce the risk of contamination
- mortuary staff will return the patient to the fridge, remove PPE / place in bins required and decontaminate

Police viewing deceased to gather fingerprints for identification

In some circumstances, police officers may be required to take fingerprint information from deceased patients in the locality's forensic mortuary for identification purposes.

- staff will wear PPE and will remove the patient from the fridge and place the trolley in the post mortem room
- only the patient's hands are required to be on view to reduce the risk of aerosol generation
- the fingerprint team will wear appropriate PPE
- the fingerprint team will go in the post mortem room, take finger prints and leave while the patient is still on the trolley
- mortuary staff will return the patient to the fridge, remove PPE / place in bins required and decontaminate

As a result of the Coronavirus Act 2020, the procedure for registering a death has changed.

Medical Certificate of the Cause of Death (MCCD)

- a doctor who has seen / consulted with the deceased within 28 days before death (in person or via video link, but not telephone consultation) can issue a MCCD
- if it is impractical or that doctor is unable to issue a MCCD, another doctor who has not attended the deceased may do so if they can state the cause of death to the best of their knowledge and belief
 - they will still have to fully complete an original MCCD and sign it in the usual way, but must add to “*seen after death by me [date]*” the name & GMC number of doctor who has seen the patient after death
 - if another professional has verified the death, a doctor should view the deceased before completing the MCCD
- if no doctor had attended the deceased within the 28 day period any doctor can still issue a MCCD if they can state the cause of death to the best of their knowledge and belief and they have discussed the death with the Coroner
- COVID-19 can be stated on the MCCD on balance of clinical probabilities without testing
- if the deceased patient is a healthcare worker and the cause of death is COVID-19 (or includes it in the MCCD, the death **MUST** be reported to the Coroner, as it may be an occupation-related death

Registering a death

- it is still necessary for an original MCCD to be issued and fully completed and signed
- the MCCD still has to have an acceptable medical cause of death and not be a mode of dying – existing guidance on this still applies
- COVID-19 is an acceptable direct or underlying cause of death for the purposes of a MCCD
- MCCDs can be scanned or photographed and sent by email to the Registrar as an attachment to reduce unnecessary contact between individuals and accelerate processes
- the original copy of the MCCD should then also be sent to the Registrar in a timely manner
- where electronic transfer is not possible and informant is following self-isolation procedures, arrange alternative informant (not in self-isolation) to collect MCCD and deliver for registration purposes (check local arrangements with the Registrar)
- a qualified informant (including a Funeral Director authorised by a relative) who is required to give information about a death to the Registrar may give the information by telephone, or by any other means specified in guidance issued by the Registrar General

Further information is available at: <http://www.legislation.gov.uk/ukpga/2020/7/contents/enacted>

Cremation

- the Cremation Referee is still required to issue Form 10 giving permission for the cremation
- in order for a body to be cremated an application still has to be made – only Form 4 needs to be completed (not confirmatory Form 5)
- any medical practitioner can complete form Cremation 4, even if they did not attend the deceased during their last illness, if the following conditions are fulfilled:
 - the medical practitioner who attended is unable to sign the form Cremation 4 or it is impractical for them to do so and the MCCD has been completed because:
 - a medical practitioner has attended the deceased (including video consultation) within 28 days before death or viewed the body in person after death (including for verification) or after death by another medical practitioner (including verification)
 - the response to question 5 (*“Were you the deceased’s regular medical practitioner?”*) may be answered with “no”, but the subsequent box *“If No, please give details of your medical role in relation to the deceased”* should be answered: *“Hospital doctor: I have not seen the deceased prior to death and I am completing this Cremation Form under the new COVID-19 legislation as the attending doctor is not available”*
- the doctor who issues the MCCD and Form 4 does not have to see the body after death, but should enter on the cremation form
 - *“In accordance with the new COVID-19 legislation I have not examined the deceased patient but have provided all information from the deceased patient’s medical notes and available investigations, e.g. chest X-ray”*.
- the provisions relating to the issue of Form 6 by the Coroner still applies and a cremation take place if this is issued
- under new COVID-19 legislation, the doctor completing Cremation 4 Form does not have to examine the deceased patient after death prior to cremation, but the doctor **MUST** still check for and identify if any hazardous implants are placed in the body of the deceased (e.g. pacemaker, radioactive device, etc). Hospital doctors are advised to **always access secondary care records and view chest X-ray** images where available to check for pacemakers, implanted cardiac defibrillators, etc.
- be thorough and be safe when completing cremation forms. If you don’t have the full information or can’t confirm it, don’t complete the form

Source: <https://improvement.nhs.uk/documents/6590/COVID-19-act-excess-death-provisions-info-and-guidance-31-march.pdf>

Burial process – generic guidance COVID-19 Outbreak



COVID-19 body release from hospital ward to hospital mortuary

- released from hospital ward to hospital mortuary (a body bag may be used – check local policy)



COVID-19 body handling in hospital mortuary

- moving a recently deceased patient might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk and those handling the body should use required PPE
- if body is within a sealed body bag, required PPE is required only to minimise risk of transmission between the body handlers from person to person, rather than from deceased body
- PPE is therefore limited to gloves and basic face mask / visor (non-respiratory) only
- place the deceased into coffin using maximum of 2 persons
- seal the coffin



Placing coffin into the funeral hearse (direct to cemetery)

- disinfect and sanitise the coffin externals with bleach or equivalent sanitiser
- observe strictly restricted / limited numbers throughout
- no family members present (must be in self isolation)
- body handlers must be asymptomatic (no COVID-19 symptoms)
- main risk is transmission between body handling personnel
 - adhere to social distancing rules; wear gloves and face mask; wash hands
- proceed directly to the cemetery
- funeral at cemetery may be limited to body handlers only



Body reception at cemetery and burial

- restrict the number of mourners who attend so that a safe distance of at least 2 metres (3 steps) can be maintained between individuals
- only the following should attend:
 - members of the person's household
 - close family members
 - if the deceased has neither household or family members in attendance, then it is possible for a modest number friends to attend
- mourners should also follow the advice on social distancing when travelling to and from the funeral gathering
- individuals who have symptoms of coronavirus (COVID-19), or who are part of a household where someone has symptoms, or who are vulnerable to severe infection should not participate in rituals or religious gatherings
- mourners should not take part in rituals or practices that bring them into close contact with the body
- contact with the body should be restricted to those who are wearing PPE and have been trained in the appropriate use of PPE

Faith deaths – Islamic guidance COVID-19 Outbreak



Due to the increasing number of COVID-19 deaths and the highly infectious nature of this virus it will be acceptable to simplify the Muslim process of washing (ghusl). The deceased should be treated gently with dignity throughout this process, using the dignity sheet which is provided in the shroud pack to cover the body whilst washing with warm water.

- the body of the deceased should be placed on a table, all garments should be removed and private parts should be covered with a dark sheet of cloth (dignity cloth in pack provided) at all times during washing
- the head and the upper body should be raised slightly to insure the washing water and any discharges flow down and do not run back to the body; ensure some running water (e.g. from a sponge or cloth) runs down the face from top to bottom
- the body of deceased is washed (with soap where possible) and rinsed off from head to toe; ensure that an approach to running water is used for washing the forehead / face)
- dry body ready for shroud to be applied

Al-Kaffan (shrouding)

- the Kafan usually consist of three white wrapping sheets
 - outer sheet – Lifafah
 - second sheet – Izaar (loin cloth / skirt)
 - third sheet – Qamees (shirt) 3-4 ties
- for females there will be an extra cloth for a head scarf
- it is not appropriate for males to be present during female washing and shrouding

Steps of shrouding

- the Qamees is placed over the front of the body; once the body is covered then remove the covering sheet
- scent or perfume is put on those parts of the body upon which one rests during prostration, that is the forehead, nose, hands, knees, and feet
- if possible, the deceased's left hand should be placed on their stomach, then put their right hand on the left hand (as in Muslim Prayer)
- Izaar (loin cloth / skirt) is then folded over the lower half of the body
- for women the same procedure may be followed with the addition of a headscarf
- the last sheet is gently folded over the deceased from head to toe
- these sheets should be fastened with a piece of cloth (tie ropes), one above the head, another under the feet, and two around the body.
- this completes the shrouding

Releasing a body directly to the cemetery

- disinfect and sanitise the coffin externals with bleach or equivalent sanitiser
- place the coffin within the funeral hearse utilising the Masjid
- body handlers must be asymptomatic (no COVID-19 Symptoms) and ensure physical distancing rules and wear gloves, face masks and wash their hands appropriately
- body handlers must proceed from hospital mortuary directly to the cemetery
- funeral attendance limited to 6 people maximum, all of whom should be asymptomatic, not showing any signs of COVID-19 or been in contact with anyone with COVID-19
- no family members in self isolation can be present
- funeral prayers limited to a maximum of 10 people including Imam (check locally)
- ensure all social distancing protocols and hand washing are always maintained
- place the coffin within the burial site and proceed to complete the burial

COVID-19 body handling in hospital mortuary

- moving a recently deceased patient might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk and those handling the body at this point should use required PPE
- if body is within a sealed body bag, PPE is required only to minimise risk of transmission between the body handlers from person to person, rather than from deceased body
- PPE is therefore limited to gloves and basic face mask / visor (non-respiratory) only
- place the deceased into coffin using maximum of 2 persons
- seal the coffin



Placing coffin into the funeral hearse (direct to cemetery)

- disinfect and sanitise the coffin externals with appropriate sanitiser
- place the coffin in the funeral hearse
- no family members will be present at this point – those mourners who are permitted to attend will meet the hearse at the graveside at the cemetery
- body handlers must be asymptomatic (no COVID-19 symptoms)
- main risk is transmission between body handling personnel
 - adhere to social distancing rules; wear gloves and face mask; wash hands
- proceed directly to the cemetery



Body reception at cemetery and burial

- funeral: mourners limited to immediate family members - that is, spouse or partner, parents and children who are asymptomatic, not showing any signs of COVID-19 or been in contact with anyone with COVID-19
- the service can be live-streamed by phone or suitable technology to other people who want to witness it. The only other people present will be body handlers, who will not be members of the family
- body handlers must be asymptomatic (no COVID-19 symptoms)
- main risk is transmission between body handling personnel
 - adhere to social distancing rules; wear gloves and face mask; wash hands
- ensure all social distancing protocols and hand washing are always maintained as best possible
- body handlers place coffin in the burial site at the signal of the Christian minister, who will then lead the service
- no member of the family to be involved in the placing of the coffin in the grave
- perform normal Christian prayers with prescribed mourners present: spouse or partner, parents, children – each standing 2 metres apart, and each not showing signs of COVID-19 or been in contact with anyone with COVID-19
- complete the burial as soon as possible

COVID-19 body handling in hospital mortuary

- moving a recently deceased patient might be sufficient to expel small amounts of air from the lungs and thereby present a minor risk and those handling the body at this point should use required PPE
- if body is within a sealed body bag PPE is required only to minimise risk of transmission between the body handlers from person to person, rather than from deceased body
- PPE is therefore limited to gloves and basic face mask / visor (non-respiratory) only
- please note, ideally a representative of the Jewish Burial Society should be present at the time of shrouding, however if this is not possible, the shrouds can be applied by nursing staff following guidance
- private parts should be kept covered throughout
- it is inappropriate for any male to be present during the shrouding of a female
- this procedure assumes **NO** Tahara is going to be performed on the deceased; place open burial sheet into coffin, then Tallit and belt as usual
- place the deceased into the coffin using maximum of 3 persons from Tahara team (appropriate PPE should be worn)
- if not already shrouded with Jewish shrouds by nurses, then spread Tachrichin (shrouds) over body (close Tallit), tie belt and wrap burial sheet in the usual way



Placing coffin into the funeral hearse (direct to cemetery)

- disinfect and sanitise the coffin externals with bleach or equivalent sanitiser
- place the coffin in the funeral hearse
- body handlers must be asymptomatic (no COVID-19 symptoms)
- main risk is transmission between body handling personnel
 - adhere to social distancing rules; wear gloves and face mask; wash hands
- proceed directly to the cemetery



Body reception at cemetery and burial

- only immediate family may attend the funeral, continuously maintaining appropriate distancing
- no other family or community members to attend funeral, participation by conference call may be able to be arranged
- only funeral staff needed for the actual burial plus one Rabbi to attend
- all attendees must be asymptomatic, not showing any signs of COVID-19 or been in contact with anyone with COVID-19
- body handlers must be asymptomatic (no COVID-19 symptoms)
- main risk is transmission between body handling personnel
 - adhere to social distancing rules; wear gloves and face mask; wash hands
- ensure all social distancing protocols and hand washing are always maintained as best possible
- complete the burial as soon as possible
- perform normal burial prayers; ask forgiveness if no Minyan (Quorum)

Sustaining wellbeing – self-care COVID-19 Outbreak



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SELF-CARE DURING COVID-19



Most importantly this is unprecedented: It is okay to not be okay

- Seek information updates at specific times during the day once or twice. The sudden and near-constant stream of news reports can cause anyone to feel worried. Get the facts. www.gov.uk
- Feeling stressed is an experience that you and many of your colleagues are likely going through. It is normal to be feeling this way in the current situation. Stress and the feelings associated with it are by no means a reflection that you cannot do your job or that you are weak.
- Managing your stress/psychosocial wellbeing during this time is as important as managing your physical health.
- Take care of your basic needs and ensure rest and respite during work or between shifts, eat sufficient and healthy food, engage in physical activity, and stay in contact with family and friends.
- This is an unprecedented scenario, don't try to learn new strategies, use the ones that you have used in the past to manage times of stress.
- This is likely to be a marathon - pace yourself
- Consider your psychological energy levels - you will need to "fill up" after "emptying the tank"
- Be aware of your "bandwidth"- it might take longer to think things through and make sense of things if you are feeling overwhelmed
- Beware dramatic language that might panic your colleagues.
- Avoid using unhelpful coping strategies such as tobacco, alcohol or other drugs.
- Some workers may unfortunately experience avoidance by their family or community due to stigma or fear. If possible, staying connected with your loved ones including through digital methods is one way to maintain contact. Turn to your colleagues or team leader for social support - your colleagues may be having similar experiences to you.

STOP, BREATHE, then THINK- slowing your breathing slows the stress cycle and re-engages your frontal lobes - then you can think.

Author: Dr Julie Highfield, Consultant Clinical Psychologist, Cardiff Critical Care

www.ics.ac.uk

Sustaining wellbeing – critical-care COVID-19 Outbreak



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ADVICE FOR SUSTAINING **STAFF WELLBEING** IN CRITICAL CARE DURING AND BEYOND **COVID-19**



The anticipated needs of staff will vary across each of the phases, consider the following support mechanisms:

Phases	Issues and likely impact	Needs and recommended approach
Pre-phase: No cases on unit	Anticipatory anxiety about what's on its way. Inability to think clearly, feeling overwhelmed, planning. Communication errors. Tension in working relationships. "Readiness" burnout.	Increase a sense of control - the team are in a safe pair of hands. Reassurance and planning. Communication updates are key (you may be thinking ahead, they are thinking now). Escalation plan. Support to managers who are making plans and holding the stresses.
Initial phase: Case 1	Starting to get going, lots of trying out, lost time, repetition and frustration. Further anticipatory anxiety	War room - planning central to allow centralised communication. Management are visible and available. Regular communication bulletins and open forums.
Core Phase: Full scale -Multiple cases	Biggest risk period. Fear infection and implications for families. Overwhelming workload. Full go mode- adrenalin and automatic pilot. Exhaustion. Moral distress as healthcare rationed. Distress linked to personal or family experience of COVID-19. Experience fear or stigma when out in public.	Have runners in PPE areas. Promote peer support. It's okay to say you are not okay - Senior staff to model this. Rotate workers from high-stress to lower-stress functions. Small pre-brief and debrief the day. Partner inexperienced workers with their more experienced colleagues. Psychological first aid - drop in sessions for staff with employee wellbeing if you have it. Ensure the basics: Breaks, Facilities (food trolley in staff room), Sleep, Days off. Manage visitors
End Phase: Immediate aftermath	Exhaustion and post trauma recovery / stress	Debriefing. Staff 1-1 and group sessions. Learning and preparation for the future. Organise thanks and reward. Look out for signs of PTSD in staff: <ul style="list-style-type: none"> • on edge and hyper arousal, poor sleep • flashbacks or re-experiencing • avoidance of reminders.
Long term	Some ongoing PTSD Reflection and learning	

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Appendix 1: One page guide (pharmacological measures)

Due to the rapid progress of symptoms associated with severe COVID-19 disease, use of prn medication is first line (prioritising syringe drivers (CSCI) for existing palliative care patients. **Please consider when prescribing.**

Breathlessness – mild to moderate

- opioids may reduce the perception of breathlessness
 - morphine modified release 5mg po bd (titrate up to maximum 30mg daily according to need)
 - morphine 2.5-5mg po prn 2-4^o (1-2mg sc 2-4^o if unable to swallow)
 - lorazepam 0.5mg sl prn 4^o *or* midazolam 2.5-5mg sc prn 2-4^o for associated agitation or distress
 - **in the last days of life**
 - morphine 2.5-5mg SC prn 1-2^o *and / or* midazolam 2.5mg sc prn 1-2^o
 - consider morphine 10mg *and / or* midazolam 10mg over 24 hours via syringe driver, increasing to morphine 30mg / midazolam 60mg step-wise as required (advice from palliative care recommended)

Breathlessness – severe (akin to ARDS scenarios)

- morphine 5-10mg sc prn 2^o (oxycodone 2.5-5mg sc prn 2^o if low eGFR)
- midazolam 5-10mg sc prn 2-4^o (may need in some cases to be hourly)
- consider morphine 10-20mg and / or midazolam 10-20mg over 24 hours via syringe driver
- syringe driver dosing may need to be reviewed 8-hourly rather than every 24 hours if the patient's prn requirements are escalating rapidly without control of their symptoms
- dosing requirements may not 'fit' with established practice and may have to be determined on a case by case basis – always prescribe safely, but also in line with your patients' requirements

Cough

- simple linctus 5-10mg po qds *then* codeine linctus 30-60mg po qds *or* morphine sulphate immediate release solution 2.5mg po 4 hourly
- **if severe / end of life:** morphine sulphate 10mg CSCI / 24 hours and 2.5–5mg sc prn 1-2^o

Delirium

- **First line:**
 - haloperidol 500 microgram / 24h CSCI or po/sc at bedtime and prn 2^o
 - consider a higher starting dose (1.5-3mg po/sc) in severe distress
 - lorazepam 500 micrograms-1mg po bd and prn *or* midazolam 2.5-5mg sc prn 1-2^o
- **End of life (last days / hours):**
 - use a combination of levomepromazine (delirium) and midazolam (anxiety) in a syringe driver
 - **levomepromazine** 25mg sc stat & prn 1^o (12.5mg in elderly); titrate according to response
 - maintain with 50-200mg / 24h CSCI (must start low and titrate according to need; seek advice)
 - alternatively, smaller doses given as an sc bolus at bedtime, bd and prn
 - **midazolam** 2.5-5mg sc/iv stat and prn 1^o
 - if necessary, increase progressively to 10mg sc/iv prn 1^o
 - maintain with 10-60mg / 24h CSCI (must start low and titrate according to need; seek advice)

Fever

paracetamol 1g PO / IV / PR QDS (**NSAIDS should be used with caution in COVID-19**)
(NHSE, 2020)

Respiratory secretions

- options:
 - glycopyrronium 200-400 micrograms sc stat / prn 2^o & CSCI 600-1200mcg over 24 hours
 - hyoscine butylbromide 20mg sc stat / prn 6^o & CSCI 20-120mg over 24 hours
 - hyoscine hydrobromide 400 micrograms sc stat / prn 6^o & CSCI 1200-1600 mcg over 24 hours

Appendix 2: One page guide (non-pharmacological measures)



Reversible causes

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

Cough

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

Breathlessness

- 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

Delirium

- 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

Fever

- 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