Palliative Care for COVID-19: Let Us be Prepared…

Sir,
Not very fortunately, we are in an unprecedented humanitarian crisis due to COVID-19 infection. Epidemiologists in India have predicted an alarming increase in the number of active cases. Dismally, we are not very well equipped to accommodate the exponentially increasing SARS-CoV2 patients, and there might be a time when patients would be denied access to critical care during the process of triaging, but they will have a right to expect high-quality palliative care in place of a ventilator.

Failure to provide benevolent and humane care to all would be an even more tragic state. This document provides in brief the preparedness required in tertiary care hospitals in India.

To Whom?
1. Symptom management for all the patients, on advanced life support or not
2. People whom we are not able to offer life-sustaining support while triaging, e.g., elderly patients presenting
with bilateral pneumonia with severe dyspnea, patients with a known advanced illness such as cancer, patients with end-stage organ failure such as kidney, lung, or liver, patients presenting with a superimposed SARS-CoV2[3,4]

3. Specialist palliative care for patients with refractory physical symptoms, depression, grief, anxiety, and existential crisis (spiritual concerns); patients with pre-existing drug use disorder; patients who are denied access to critical care owing to a triage protocol despite wanting aggressive care; and patients with drafting advance care plans.[4]

WHERE?

• Emergency department (ED)
• Triage area
• Isolation wards
• Intensive care unit (ICU).

WHAT?

1. Stuff
Symptom management kits including drugs (such as morphine, fentanyl, haloperidol, metoclopramide, midazolam, dexamethasone, hydrocortisone, and sedative drugs), subcutaneous and intravenous cannula, infusion systems (e.g., pumps or syringe drivers), general equipment for taking care of bed-bound patients, mouth swabs for dry mouth, opioid lock boxes, nasogastric tubes, urinary catheters, wound dressing, suction apparatus, portable oxygen, and personal protective equipment (PPE) for healthcare delivery personnel should be made available in the ED, isolation areas, and ICUs for all clinicians and paramedics.

2. Staff
During a surge in the number of patients as might be expected, palliative care specialist would not be able to provide care to all the dying patients, other professionals including junior residents, medical officers, staff nurses, nursing educators, pharmacists, psychologists, social workers must be roped in to adapt to various roles in symptomatic care, end of life care, communication, care of the separated family, managing grief and bereavement.

Education for all frontline health care providers such as primary care physicians, nurse practitioners, paramedics, emergency department staff and nurses in ICU regarding the use and titration of opioids for dyspnea. They should be confident in using opioids for breathlessness before development of respiratory failure.

3. Space
Identify a quiet and peaceful specialized in-patient ward to provide symptomatic care for patients dying with severe respiratory failure without advanced life support.

4. Separation preparedness
• Video calling for patients with family, with or without assistance.
• Making PPE available for family members who are allowed to visit.
• Anticipating and getting prepared for managing complex grief and bereavement by a team of psychologist or counselors.

5. Communication preparedness
Compassionate and honest communication to all will be the key to manage the panic accompanying this situation, particularly while informing poor prognosis to patients.

6. Documentation
Preparation of a standardized informed consent form for the plan of care especially end of life care, and advance care planning might prove useful while caring for massive numbers of patients.

7. Care of healthcare workers
Mental health of healthcare workers should be given priority. Making yourself (palliative care team) available and presenting these areas of preparedness to the administrative and quality teams would give us a head start. This will be an effort to help our administrators, primary doctors from EDs and triage departments, pulmonologists, and physicians in taking care of patients affected by SARS-CoV2 who would be in the frontline taking care of the most of the patients but would also be stressed while caring of the patients where priority of care might be to make patients and their families more comfortable rather than the curing the disease.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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Submitted: 08-May-20 Accepted: 14-May-20 Published: 30-Jun-20

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Cancer patients seek palliative care services for pain management and alleviation of various symptoms. To deliver prudent palliative care services, various procedures and interventions such as nerve blocks, neurolysis, pleurocentesis, paracentesis, and various image-guided procedures are being performed. When the whole medical system has been paralyzed by the COVID-19 pandemic, the availability and provision of these facilities has become challenging and prioritization should be done to utilize them judiciously.

As COVID-19 is hazardous for the health service provider as well as the seeker, all patients should be considered COVID-19 suspect and should be screened as per institutional guidelines before admission and performing any procedure. In wards, measures should be taken to avoid the transmission of infection to other patients and healthcare provider. A screening area should be established at the entrance of institution along with a separate exit area. All healthcare providers should be well trained for symptom recognition, screening procedures, and use of standard precautions and personal protective equipment. To avoid potential paper contamination, various documentations, such as clinical and procedural notes, consents, and nursing records, should be digitalized and protected with single-use plastic wraps.

A dedicated area should be established for performing procedures with a designated route of transport, to avoid cross contamination. A well-formulated plan for its decontamination and disinfection should be followed. During procedures, healthcare providers should wear protective gears and patients should also wear surgical mask. Only necessary personnel, drugs, and equipment should be allowed in the procedural areas.

Equipment such as ultrasound machine used for performing various procedures can be a potential source of transmission of COVID-19 infection. For decontamination of equipment and disinfection of clinical area, institutional guidelines should be followed.

Postprocedural management and observation for complications should be done in the same designated area. Patients should be discharged from the same area along with the advice of general precautionary measures and follow-up plan. Patients should be educated about telemedicine and should be advised to follow it for minor concerns so that their hospital visits could be minimized.

With the above said, challenges to deliver palliative care efficiently can be met prudently, along with the avoidance of exhaustion of healthcare system and provider.

Financial support and sponsorship
Nil.

Conflicts of interest
There are no conflicts of interest.

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Submitted: 23-May-20
Accepted: 26-May-20
Published: 30-Jun-20

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