INTRODUCTION

There is a growing global need for palliative care, with numbers expected to increase by 51% by 2038 in Aotearoa/New Zealand (McLeod, 2016). Healthcare services are under economic pressure in the context of increased healthcare complexities associated with multi-morbidity and chronic illness along with burgeoning technology. Concurrently, there has been a shift towards ‘ageing in place’ and home-based care (Wiles, 2004). This shift is accompanied in many Organisation for Economic Co-operation and Development (OECD) countries, with an agenda to reduce the length of hospital stays and minimise the use of hospital beds by transferring care to the home (Williams & Botti, 2002). Patients who are frail, older or have multiple comorbidities are at the highest risk of death from COVID-19 (Kastora et al., 2021). As a vulnerable group (Son & You, 2015), older adults are already at greater risk of receiving end-of-life care that is inadequate to their needs (Wenger & Rosenfeld, 2001). For example, the Health Needs Assessment for
Palliative Care conducted under the auspices of the New Zealand Palliative Care Council concluded that fifty percent of long-term care residents would benefit from specialist palliative care advice and support (Naylor, 2011).

Palliative care in New Zealand is defined as ‘care for a person of any age who has a life-limiting illness’ (Ministry of Health [NZ], 2016). In Aotearoa/New Zealand, generalist palliative care and specialist palliative care are provided. Generalist palliative care is palliative care provided as a key component of standard clinical practice by any healthcare professional who is not part of a specialist palliative care team (e.g. general practice teams, Māori health providers, allied health teams, district nurses, and residential care staff, etc.) (Ministry of Health [NZ], 2007). A patient is referred by a generalist provider to specialist services when an individual’s needs exceed the resources of the generalist team in any aspect of care – physical, psychological, spiritual, etc. (Ministry of Health [NZ], 2007). Specialist palliative care providers have specific training and/or accreditation in palliative care. The goal is to provide integrated care that both optimises an individual’s quality of life and supports the family, whanau (extended family) and other caregivers (Ministry of Health [NZ], 2007).

1.1 | Hospice response

As a result of COVID-19, community palliative care services needed to adapt rapidly and creatively to find new ways of working, revising and establishing new policies (Etkind et al., 2020). These responses have been necessary to meet increased demand in countries with high numbers of cases of COVID-19. They have also been required in Aotearoa/New Zealand due to lockdown restrictions and COVID-19 risk despite relatively low numbers of cases. Because of COVID-19, we have witnessed the extraordinary adaptive capacity of healthcare services to respond to unprecedented challenges, and hospice/palliative care is no exception. There is a critical need to harness the lessons learnt and evaluate practice changes and innovations. This is imperative if we are to provide safe and high-quality palliative care and to optimise services, including making the best use of the limited specialist palliative care workforce available for those who need it most.

1.2 | Aim

This study explored the impact of and response to COVID-19 for hospice/palliative care community services in Aotearoa/New Zealand.

1.3 | Objectives

Specifically, we wanted to understand the adaptive practices developed to deliver palliative care to the community in light of the challenges posed by COVID-19.

What is known about this topic?

- Hospices are under increasing pressure to meet the growing demand for palliative care delivered in the community context.
- Frail, older patients or those with multiple comorbidities are at the highest risk of death from COVID-19.
- As a result of COVID-19, community palliative care services needed to adapt to meet patient needs.

What this paper adds?

- The pandemic has provided the impetus for increased use of telehealth by the study hospices.
- Home visits adaptations included a division of community staff into teams and a triaging of needed resources.
- Maintaining a ‘human connection’ posed a challenge in the face of infection control requirements.

2 | METHODS

2.1 | Study design

This study is framed in a realist approach. A realist approach looks further than whether a policy or intervention is effective by asking, ‘What works for whom, in what circumstances, in what respects and why?’ (Blamey & Mackenzie, 2007) p.441. Currently, there are 33 hospice palliative care services available across New Zealand (Hospice NZ, 2021). Structured interviews were conducted with sixteen purposively sampled community hospice/palliative care services. The study forms part of a larger yearlong project examining hospice palliative care delivery in New Zealand and Scotland. As an essential service, most hospice funding in New Zealand comes from government funding, while the remainder is through charitable donations (Hospice New Zealand, 2021). While most of the hospices in New Zealand have inpatient units, all deliver services in the community, including medical and nursing care, allied healthcare, support groups and cultural and spiritual care (Hospice New Zealand, 2021). The hospices were recruited from regions across New Zealand based on the number of cases of Covid-19 in the community in 2020 (Costantini et al., 2020), with a slight oversampling of high prevalence areas. Purposive sampling as a non-probability sampling method has been selected based on the characteristics of a population and our research question (Alvi, 2016). Results provided a snapshot of community hospice/palliative care service’s adaptive practices.

2.2 | Recruitment

Hospice managers across New Zealand were initially contacted by email by (DB). Consenting hospice managers sent an invitation email to staff who held roles in delivering palliative care in...
the community. Interested staff contacted the manager's administrative assistant, who emailed the contact details of potential participants to (DB). Participants had the option of survey completion either over the telephone, via zoom, written responses or face to face (if COVID-19 restrictions permitted). The questionnaire served as the script for the oral modes of completion. Consent forms were emailed to participants and signed before the interviews commenced. Written consent was obtained from the hospice managers and individual staff participants. Inclusion criteria included hospice staff (managers, nurses and physicians) who delivered palliative care services to the community. Exclusion criteria included staff not involved in delivering palliative care in the community (i.e. inpatient clinical staff).

2.3 | Procedure

Eighteen structured interviews with staff from hospices involved in the delivery of palliative care in the community were conducted by telephone. The structured interview guide was kept brief (~30 min) (see Supplementary File) because of the anticipated time pressures for the respondents. Interview guide content was developed based on our research question and a literature review (Etkind et al., 2020). Questions were both objective (informational) and subjective (experiential). The content included participant role, community service delivery, communication practices, risk assessment and response in service delivery during 2020 Covid-19 restrictions. Some questionnaire sections (objective information about service provision) were specific to hospice managers (identified by 'for Managers'), while other sections (subjective experience) were asked of all participants. The interviewer (DB), who has extensive experience in ethnographic methods, read the questions to respondents, and then (DB) audio recorded their responses verbatim with permission. DB was previously unknown to the participants. Digital recordings were transcribed by a professional transcriptionist who had signed a confidentiality agreement. Participants were offered the opportunity to review transcripts of their interviews. Participants had two weeks from the date of their interview to contact the research team if they wished to add or make changes to their story. Data collection occurred between 10 February and 18 August 2021. As per Glaser and Strauss (1967), the interviews continued until data saturation was reached and no new categories emerged. A regional health ethics committee granted ethical approval for the study.

2.4 | Data analysis

Informed by Schulz's theory of social phenomenology (Schutz, 1967), analysis of the open-ended responses utilised deductive and inductive thematic analyses (Fereday & Muir-Cochrane, 2006). Drawing on May (1993), the research acknowledges the phenomenological perspective that subjective perceptions of the social world shape peoples' behaviour. However, understanding of this type may be "partial or incomplete" (May, 1993). Thus, the analysis was approached from the perspectives of both the subject and the object and reflected both inductive and deductive approaches. Analysis initially drew on relevant demographic factors (hospice service area, Covid-19 case prevalence) to inform the coding (in QSR NVivo 11) to help identify pertinent textual material (Elo & Kyngäs, 2008). These factors were utilised to capture the range of experiences across New Zealand. An inductive exploration of the responses to experiential questions answered by all participants followed to identify core themes. Open codes were first assigned to describe all aspects of the content. Both authors (RF and DB) were involved in the analysis and coding. An initial coding scheme was constructed to establish consistency between coders as well as an accurate depiction of participant views. Categories were then created from the open codes. Categories were combined into higher order headings by merging categories with similar content (Fereday & Muir-Cochrane, 2006). The main themes were agreed upon between the authors (RF and DB). Given the small number of participants and hospices, exemplary quotes for each theme are associated with a participant identifier to maintain confidentiality.

3 | FINDINGS

3.1 | Overview of participants

Eighteen health professionals from 16 hospices participated in the study. All of the participants were involved in the delivery of palliative care in the community in 2020. The majority of participants were female (16), and ages ranged between 40 and 72 years. In terms of role, participants included six nurses, three clinical services managers, two clinical nurse leads, one community nurse lead, two medical staff, one nurse practitioner, one nurse educator, one infection control nurse and one hospice leader. Two facilities had more than one participant. In the case of one of these two facilities, two participants held the same role but varied in time in the position. In contrast, the other service had two participants who varied in role (manager versus nurse). The amount of time reported by participants in their role varied from less than a year to 20 years, with an average of 8.6 years (Table 1).

Using the Statistics New Zealand (2021) definition based on resident population, eight of the hospices were located in major urban areas (100,000+), four were located in large urban areas (30,000–99,000) and four were located in medium urban areas (10,000–29,999). Seven of the hospices were located in regions where in 2020, there were more than 25 Covid-19 cases per 100,000 residents, six hospices were in regions with 15–25 cases per 100,000 residents and the remaining three hospices were in regions with <15 cases per 100,000 residents (Table 2).

3.2 | Themes

Participants described the ways in which their hospices addressed community palliative care delivery, what challenges they faced.
when doing that work and what adaptations were initiated in light of Covid-19 restrictions to accomplish that work. Two overarching themes emerged: ‘challenges’ and ‘adaptations’. Challenges emerged in three key areas: communication, visiting and allied health and volunteers. Themes were represented in hospices across the country regardless of population size, level of Covid-19 cases present in the community and across interview participants, regardless of role. Interviewees spoke from their vantage point within their respective hospices, thus providing a richer perspective on the various challenges and adaptations. Themes and illustrative quotes are presented below:

### 3.3 Challenges

#### 3.3.1 Communication challenges

Communication challenges were experienced on a number of levels extending through the system from the communication of Ministry of Health directives down to challenges with communications between hospice staff and patients.

**Government communication**

The developing nature of the pandemic meant that messaging received from both national and regional health agencies often changed and did not necessarily fit local conditions. This mismatch made the formulation of hospices response and development of care plans difficult.

So they [Ministry of Health] were putting out guidance on PPE, for instance, if you’re in a community environment and these are the situations you wear this…. But, they would change them slightly; the thresholds kept changing. So that was hard. P7

Ours was a little bit different to everybody else’s, so we were taking bits from [A] DHB, some information from them, some from [B DHB] leading together with what hospice said as well about how we should deal with everything. So it was a little bit of everything. P14

**Hospice communication**

Hospice staff often felt they lacked input into the decisions as to how governmental guidance was to be enacted. One participant reported:

There would be a COVID meeting…and that was often done in a Zoom environment…. We were excluded from it. We would have a briefing that would be given to us, and we would enact it. P9
Intra-professional communication

Instances of miscommunication between hospice nurses, general practitioners, and district nurse services were recalled. A nurse stated:

So, the nurses are supposed to going back to the GPs [general practitioners] and saying, your patient is looking like this, this, this. This is my suggestion, blah, blah, blah, do you agree? Shall we prescribe a syringe driver? But because we assumed that the GPs were too busy, we just took over, and so...all these GPs found out that their patients had syringe drivers prescribed for them...but the GP wasn’t aware of that ‘cause we didn’t communicate that very well. So, yeah, there were some upset, especially... some GPs who were actually home visiting during COVID. P18

The restrictions on visits by hospice nurses led to a feeling of abandonment by district nurses. In New Zealand, sixty-five separate district nursing services provide a wide range of home, clinic and community-based health care services, usually seven days a week. The services (which are free of charge for New Zealand residents) are provided by a combination of regional health boards, non-governmental organisations and community trusts) (Ministry of Health [NZ], 2011).

It was very difficult for staff here because then they felt that they weren’t allowed to go in, and the district nurses were being permitted entry by the patients... it was confusing in the beginning... So that connection with district nursing...I think they felt abandoned by us, and I don’t know that they understood that it was their employers who had told us not to go in. P1

Communication with patients

The use of telemedicine for palliative care assessments presented significant communication barriers. In particular, it was more challenging to read nonverbal communication during a telemedicine visit than an in-person visit.

The nurses were just so used to going out and visiting and chatting, and then as things fell out of conversation, they would do something about it. But having to do that thinking stuff on the phone, they found... exhausting, and some of them could only phone three or four people in a day. P18

3.4 | Visiting challenges

The essence of palliative care is patient-centred care, but the reality of Covid-19 imposed restrictions on visiting, which shifted the patient slightly off centre.

3.4.1 | Infection risks

In 2020, Covid-19 posed a series of unknown infection risks. These risks were particularly apparent for nurses during home visits. A nurse stated, 'But that then meant that...our nurses that were visiting were gonna be at risk.' P16

3.4.2 | Relationships

The necessity of infection control measures created a barrier to building trusting relationships. The needs of the family and all of those grieving were lost within those restrictions, and as perceived by a nurse, this felt terribly wrong:

Over that time, the hardest thing was not being able to give people a cuddle. Yeah, I visited one dear lady who, her husband had just died; I’d been supporting him pre-death. And I had to stay that distance from her with a mask on; she had to wear a mask. Her husband dead in the bed waiting for the funeral directors, and she was crying. Her family could not come and visit, her friends could not come and visit, and I just couldn’t give her a cuddle that was horrible. P12

3.4.3 | Residential aged care restrictions

Healthcare workers were identified as significant and unknowing vectors for importing COVID-19 into residential aged care. Therefore, access to facilities was restricted. A nurse described this reality.

That was challenging; it was really challenging because, of course, the rest homes really shut down tight, really tight. So we hardly went in there at all. P2

3.4.4 | Allied health and volunteers

Covid-19 restrictions meant that the services of allied healthcare and volunteers were severely curtailed or stopped altogether. As a nurse stated, "Art therapists, we have music therapists. So all of those things had to go by the by." Another nurse further explained the reason behind this loss.

Age or their fear. We had a number of staff that were very fearful of the impact it would have on their families, and so they were so distressed they weren’t actually safe to be at work. P18
3.4.5 | Adaptations

Hospices responded rapidly and flexibly, finding adaptive methods to address the challenges outlined.

3.4.6 | Communication

Adaptations to the challenges to communication by Covid-19 restrictions were addressed, extending from the governmental to the individual level.

**Government communication**

Messaging from local and national health authorities was often modified to meet local conditions. A nurse reported, “Yeah, and we get most of our policies and procedures from N [hospice name] Hospice in [location], and then we just adjust them to what we're doing here.” P2

**Hospice communication**

A participant explained how the frictions created by management communication over the long run led to the opportunity for self-insight and improvements in the team's culture.

“I've learned a lot about myself. I've learned about my team members and about ...the team. And we had a little, you know, we went through the storming, forming, and performing phases and at one point. P7

**Intra-professional communication**

The relationship between hospices, GPs, and district nurses improved during restrictions. A manager spoke of the changes in the relationships.

“We're also trying to liaise more with the GPs to share care, you know. Whereas before the GPs were finding it, you know, not wanting to see people or trying to do things remotely, now we're like well actually you can see your GP for this. You know, we're not doing everything. Yeah, so I’d say the practice has changed a little bit, yeah. P9

A nurse commented

We got a lot of support from district nursing. We had the best communication that we've ever had with district nursing, and that has been a positive and has been continuous outcome... So we worked really hard to support them, and they worked really hard with us to ensure that the patients and families were well supported. P1

**Communication with patients**

Out of necessity, clinical contact and patient assessments were more often remote. A nurse recalled

“So yeah, it was really the connections were virtually. So we used Microsoft Teams, and we used Zoom. Again we made essential visits. P5

It should be noted that the eight hospices in major urban areas (six of which were also in areas with more than 25 Covid-19 cases per 100,000 residents) tended to use a greater variety of virtual tools for communication with patients in comparison to hospices located in areas with lower case numbers. When asked about technology use with patients, a manager in an area with less than 15 cases per 100,000 inhabitants during 2020 recalled, “I think it was phone calls. I don't think we used Zoom.” P9.

3.5 | Visiting

3.5.1 | Infection risks

The reality of Covid-19 resulted in changes to the practice of visiting when required. A nurse explained the changes to practice if a patient required a syringe driver:

“So before, the nurse would go out with four different bags, and they would take a drug bag and a wound care bag, and they'd take a urinary bag, and they'd take out all sorts of stuff. And they'd take it all into the home, and then they do the Assessment, and then whatever they needed, everything was in the bag somewhere. It changes to they were ringing every morning, they were triaging the symptoms on the phone. If the symptoms sounded under control, then the syringe driver would stay the same, and the driver medication contents would be made in the drug room, and the syringe would be created. And then just the syringe would go into the home. And everything else stayed in the car. P18

A workforce division was also instituted to reduce the risk of Covid-19 transmission between staff members. A nurse explains

Immediately we split our groups into two teams. So we identified the staff who have face-to-face contact with the patients and their families, and we asked them to work from home... We decided that we'd have 50/50 of the team front-facing patients and families. And then we'd have 50 percent in the background in case. P1
3.5.2 | Relationships

The reality of Covid-19 resulted in changes to the practice of visiting when required. Establishing and maintaining a trusting relationship were key to easing patient and family fears. One hospice’s approach was thus:

I think the way the team couched it was that we will be sort of triaging your care to mitigate visits because it’s best for both worlds. But, if a visit is required, we will be asking you to allow us to come in, and by doing that, we will be making sure that all the precautions you need or want will take as much [PPE] as what we’re told to take. You know it wasn’t, it didn’t happen very often because they trusted us. And that’s the important thing; we had a trust relationship with all our patients. P7

3.5.3 | Residential aged care

Most hospices adopted remote visits to residential aged care patients.

So all the ARC [aged residential care] nurses did everything by phone. They didn’t visit any patients; they weren’t allowed in the facilities. P15

3.5.4 | Allied health and volunteers

Allied health

Allied health services transitioned to electronic communication where possible. A nurse related how contact was maintained with patients and families:

Some of it was done by Zoom, like for example, counselling was done by Zoom. I think the social worker did some work by Zoom. But mostly, it was telephone conversations, just keeping up with people. yes. P1

Volunteers

Despite the restrictions, the services of volunteers were in some instances redeployed to address the challenges of the pandemic. One hospice experienced noteworthy community support

The community rallied for us as well, so; it was really amazing period. And the other thing that the volunteers did for us very early was start making cloth masks. Disposable, washable cloth masks. P7

4 | DISCUSSION

This study explored the impact of and response to COVID-19 for hospice/palliative care community services in Aotearoa/New Zealand. Specifically, the study sought to understand the adaptive practices that were mounted to address the challenges posed by Covid-19. Findings indicated that the response led to creative and flexible adaptations to meet the needs of patients and families. These adaptations were identified in three main areas as outlined below:

4.1 | Communication

The pandemic has provided the incentive for an unprecedented shift in the healthcare delivery for patients requiring palliative care. Motivated by the desire to decrease the risk of exposure of both patients and healthcare workers, many institutions, including hospices, shifted their focus from face-to-face consultation to teleconsultation (Garg et al., 2020). Nurses could manage cases with teleconferencing, connecting patients and families beyond in-person visits. In the UK, for example, teleconsultation and video conferencing have been broadly used by general practitioners and palliative care teams (Antunes et al., 2020; Kasaraneni, 2020). In line with other studies, however (Allen Watts et al., 2021; Pastrana et al., 2021), these successes did not come without a cost, particularly noted with regard to the challenges to effective telehealth assessments (e.g., inability to always identify nonverbal cues) and related staff exhaustion from the additional work involved. This point illustrates that in moving forward, teleconsultation should not be seen as a replacement for visits in person but should be gradually integrated into care delivery.

Findings from this study also support the view that palliative care is not purely the responsibility or the domain of ‘specialists’ but needs to involve community colleagues and volunteers. Recent studies have demonstrated that intra-professional collaboration in home-based community care programmes positively impacts patient outcomes (Manojlovich et al., 2014; Van Vuuren et al., 2021). However, intra-professional collaboration can be difficult when professional groups construct silos around their work to protect their domain of practice, particularly when their services begin to overlap (Farahani et al., 2019), as witnessed in this study. These long-standing difficulties were further exacerbated in the face of Covid-19, leading to duplication of services provided. Findings from this study indicate that support for patients and families was enhanced when hospice community nurses functioned as full contributory members of a multidisciplinary team.

4.2 | Visiting

Traditionally, hospice team members have depended on listening, eye contact, physical presence, and now out of necessity, the integration of virtual care. There was little research evidence to guide care provision during pandemics (Etkind et al., 2020; Mitchell et al., 2020). The hospices in this study adopted several measures to meet the challenges of home visits, including a division of community staff into teams and a triaging of needed resources. However, the pandemic has required the use of personal protective
equipment, creating a barrier from all physical connections that are traditionally used to create that bond (Bowers et al., 2021).

4.3 | Allied health and volunteers

Many hospices rely on a significant volunteer workforce to deliver their services and support people in the hospice and community. During the COVID-19 pandemic, hospices found tension between the need for volunteers and the infection risk (Walshe et al., 2021). Previous research has demonstrated that some hospices could redeploy volunteers to new roles that support service users (Walshe et al., 2021). Similarly, in the current study, volunteers at one hospice rallied to produce cloth masks.

4.4 | Strengths and limitations

Given that only one staff member per hospice was interviewed for most hospices included, the findings do not provide a generalised overview of each service. However, the intent was not to provide a descriptive overview, but rather to identify common challenges across the services and adaptive practices developed during the Covid-19 restrictions. The analysis of the interviews allowed for the in-depth exploration of the experiences, challenges and adaptations of hospice palliative care professionals in the community. This approach conveyed experiences that may not have been captured using a quantitative design, as identified in Dunleavy et al. (2021). Data were also collected from a cross section of hospices, providing a snapshot of adaptive practices across New Zealand during Covid-19. Cross-sectional designs are recommended for exploratory research (Spector, 2019). For the most part, themes did not differ in frequency based on the number of Covid-19 cases in the community. As of December 2020, New Zealand identified a total of 2162 cases (1806 confirmed and 356 probable) in the community with 25 deaths (Ministry of Health (New Zealand), 2020). The low number of cases nationwide during the data collection period may underlie this lack of distinction in the importance of themes based on Covid-19 cases in the community. Differences in communication technology use with patients may also have been partly due to resources available to the hospices in large urban areas rather than the number of cases in the community. The use of a structured interview rather than a more open-ended approach may not have allowed free flowing data to emerge. The sample size and purposive recruitment method for this study also necessarily limit the generalisability of the findings.

4.5 | Implications for practice and research

In the first instance, further attention is required regarding equitable technological resourcing for hospices regardless of location. Technologies for telehealth are expensive and require ongoing technical assistance, staff skills development and infrastructure outlay, which can create barriers in resource-limited hospices (Chávarri-Guerra et al., 2021) and impede patient care (Luckett et al., 2021). Increased local intra-professional collaboration and coordinated action are required to optimise resource use and avoid duplication to maintain high standards of care. Perceived vulnerability resulted in the loss of volunteer services on which hospices usually depend. While some creative means for redeployment were reported, volunteer services were absent for the most part. Hospice volunteers typically are derived from vulnerable older age cohorts (Vanderstichelen et al., 2020). As Walshe et al. (2021) recommended, consideration should be given to recruiting a wider age range of volunteers. Finally, guidance from national and local health authorities should be both clear and setting-specific to support effective care delivery. Future research should focus on which hospice service adaptations provide the most benefits, for whom, and in what way, within the context of increasingly complex patient and family needs.

5 | CONCLUSION

Providing holistic care in a pandemic places extreme pressure on hospice services. Findings from this study demonstrated that hospice community palliative care services alleviated this by maintaining the ability to respond rapidly and flexibly; adapting health advice to local contexts; using technology to communicate with patients and families; triaging cases, creating separate teams to reduce risk and redeploying volunteers to provide other services. These adaptations did not come without a cost in terms of workload pressures for staff and a lack of human connection for patients. Greater intra-professional collaboration is vital to building hospice resilience by reducing duplication of effort and resource use. Governments must also acknowledge the vital contribution of hospice and palliative care to the COVID-19 pandemic and ensure that these services are better incorporated into the healthcare system response.

ACKNOWLEDGEMENTS

The authors would like to thank Dr. Aileen Collier, the University of Auckland, NZ, and Prof Bridget Johnston, the University of Glasgow, UK, for their collaboration on the larger project.

CONFLICT OF INTEREST

No competing interests to declare.

ETHICAL APPROVAL

Ethical approval for this component of the larger study was obtained from the University of Auckland Human Participants Ethics Committee (ref. AH3480).

DATA AVAILABILITY STATEMENT

Due to the nature of this research, participants of this study did not agree for their data to be shared publicly, so supporting data are not available.
Son, Y., & You, M. (2015). Transitional care for older adults with chronic illnesses as a vulnerable population: Theoretical framework and future directions in nursing. *Journal of Korean Academy of Nursing, 45*(6), 919–927. https://doi.org/10.4040/jkan.2015.45.6.919

Spector, P. E. (2019). Do not cross me: Optimizing the use of cross-sectional designs. *Journal of Business & Psychology, 34*(2), 125–137. https://doi.org/10.1007/s10869-018-09613-8

Statistics New Zealand. (2021). Functional urban areas – methodology and classification. Statistics NZ. Retrieved November 24, 2021 from https://www.stats.govt.nz/methods/functional-urban-areas-methodology-and-classification#fua-classifications

van Vuuren, J., Thomas, B., Agarwal, G., MacDermott, S., Kinsman, L., O’Meara, P., & Spelten, E. (2021). Reshaping healthcare delivery for elderly patients: The role of community paramedicine; a systematic review. *BMC Health Services Research, 21*(1), PMid:33407406, https://doi.org/10.1186/s12913-020-06037-0

Vanderstichelen, S., Cohen, J., Van Wesemael, Y., Deliens, L., & Chambare, K. (2020). Volunteers in palliative care: A healthcare system-wide cross-sectional survey. *BMJ Supportive & Palliative Care*, https://doi.org/10.1136/bmjspcare-2020-002321

Walsh, C., Garner, I., Dunleavy, L., Preston, N., Bradshaw, A., Cripps, R. L., Bajwah, S., Sleeman, K. E., Hocaoglu, M., Maddocks, M., Murtagh, F. E. M., Oluyase, A. O., Fraser, L. K., & Higginson, I. J. (2021). Prohibit, protect, or adapt? The changing role of volunteers in palliative and hospice care services during the COVID-19 pandemic. A multinational survey (CovPall). *International Journal of Health Policy and Management*, https://doi.org/10.34172/ijhpm.2021.128

Wenger, N., & Rosenfeld, K. (2001). Quality indicators for end-of-life care in vulnerable elders. *Annals of Internal Medicine, 135*(8_Part_2), 677–685. https://doi.org/10.7326/0003-4819-135-8_Part_2-200110161-00006

Wiles, J. (2004). Home as a new site of care provision and consumption. In G. Andrews, & D. Phillips (Eds.), *Ageing and place* (pp. 95-113). Routledge.

Williams, A., & Botti, M. (2002). Issues concerning the ongoing care of patients with comorbidities in acute care and post-discharge in Australia: A literature review. *Journal of Advanced Nursing, 40*(2), 131-140. https://doi.org/10.1046/j.1365-2648.2002.02355.x

**SUPPORTING INFORMATION**

Additional supporting information may be found in the online version of the article at the publisher’s website.

**How to cite this article:** Frey, R., & Balmer, D. (2022). COVID-19 and hospice community palliative care in New Zealand: A qualitative study. *Health & Social Care in the Community, 00*, 1-10. https://doi.org/10.1111/hsc.13810