

## II Recommendations for providing palliative care for adults with cancer and chronic or end-stage organ impairment in hospitals: Having COVID-19 or treatment limitation due to prevailing COVID-19 situation

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### Principles

1. Coronavirus Disease 2019 (SARS Cov 2/ COVID-19) is recognised as a rapidly progressing pandemic of high infectivity and moderate virulence causing major impact on the way we function.
2. Considering the current stage of pandemic in India, 'Universal safety measures' for Healthcare (HC) professionals, patients and community are considered appropriate.
3. The core responsibilities of Palliative Care (PC) to prevent, identify, and alleviate suffering irrespective of the aetiology is acknowledged.
4. Optimization of care inputs and justifications for resource utilisation are based on the Principles of Medical Ethics
5. Information, awareness and communication are emphasised as core elements of reorienting care.

### Summary of Recommendations

1. Reorient administrative policies with preparedness to provide quality PC within the constraints of the prevailing COVID-19 situation (Annexure 5.2.1)
2. Ensure source control by methodical implementation of universal safety precautions (Annexure 5.2.2)
3. Reorient clinical care processes to support ongoing PC programs (Annexure 5.2.3)
4. Manage complexities arising out of COVID-related situation; based on patient related, disease related and prognostication related factors. (Annexure 5.2.4)

5. Plan and prepare for a change in the profile/volume of patients with Cancer and other Non-communicable Diseases (NCDs) and prepare to respond. (Annexure 5.2.5)

Annexure 5.2.1. Reorient administrative policies with Standard Operating Procedures to provide quality PC within the constraints of the prevailing COVID-19 situation

1. Define the role of individual PC centre/unit based on the requirements of pandemic in the region; Identify gaps, priorities, change in profile and volume of patients and reorient policies for supervised implementation, review and refinement.
2. Adopt/activate universal safety measures for all aspects of work and facilitate required space, equipment, training, staff-work schedules.
3. Clarify policies, define roles, responsibilities and tasks of the HC team in virtual care<sup>1</sup>, direct clinical care, and education
4. Delineate roles and responsibilities and protect staff with higher risk and activate and work from home policies <sup>2</sup>
5. Organise virtual team meetings for internal coordination;
  - a. Clarify on universal safety policy as applicable to the facility -hand hygiene, proper use and disposal of mask, gown and eyeglasses/face shields, cough etiquette, and the significance of implementing safety measures to protect themselves and others.
  - b. Share updates on the situation, testing, triage and notification policy<sup>3</sup>
  - c. Obtain feedbacks, clarifications, review and refine processes.

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<sup>1</sup> Example: MSW prepares and hands-over the list for review calls by previous evening to the nurse, who makes the calls, communicates, clarifies and educates on nursing care, informs the physician on medical concerns, who responds, and finalizes the date for next review based on the intensity of care needs and completes documentation of clinical summary

<sup>2</sup>Example: Teleconsultation/evaluation of health-status of patients who are awaiting test results, review calls for discharged patients

<sup>3</sup> As recommended by the Union Ministry of health and Family welfare and those by State/ UT, Health Departments as well as District health authorities

6. Anticipate requirements for dispensing larger quantities and arrange to stock supplies and medications and non/disposables.
7. Ensure safe and rational prescriptions of Essential Narcotic Drugs (ENDs). (Box 5.2.1)

#### Annexure 5.2.2. Ensuring Source Control To Protect Healthcare Personnel, Patients, Visitors

1. Implement virtual care as a major pathway for care; Educate on the use of virtual platforms<sup>4</sup> with the etiquette to provide competent, compassionate and continuity of care
2. To address asymptomatic and pre-symptomatic transmission, mandate source control for everyone entering the facility (e.g., HCWs, patients, visitors) regardless of symptoms.

##### (Table 5.2.1)

- a. Prominent sign board in local language in waiting area and within the facility - to report possible infectivity<sup>5</sup>
  - b. Activate administrative controls - distancing > 1 metre to avoid crowding, face-mask, hand-washing, cough- etiquette.
  - c. Support through Information-Education-Communication (IEC)<sup>6</sup> (Figure 5.2.1)
  - d. Facilitate well-ventilated space for screening and triage with separate entry/exit, at the 1st point of contact
  - e. Define separate space for detailed evaluation of patients with positive history/symptoms. Ensure training and protection of staff manning this space.
3. Maintain safety within clinical spaces

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<sup>4</sup> Standard contents on creating awareness about the Pandemic and their role as families to protect themselves & help prevent spread, virtual brochures that may be shared through social media

<sup>5</sup> fever, dry-cough, sore-throat, breathlessness, travel to or from COVID-19 high risk areas and contact with diagnosed COVID-19 case.

<sup>6</sup> Hindi [https://www.mohfw.gov.in/pdf/Poster\\_Corona\\_ad\\_Hin.pdf](https://www.mohfw.gov.in/pdf/Poster_Corona_ad_Hin.pdf);  
English [https://www.mohfw.gov.in/pdf/Poster\\_Corona\\_ad\\_Eng.pdf](https://www.mohfw.gov.in/pdf/Poster_Corona_ad_Eng.pdf),  
[https://www.mohfw.gov.in/pdf/Poster\\_Corona\\_ad\\_Eng.pdf](https://www.mohfw.gov.in/pdf/Poster_Corona_ad_Eng.pdf)

- a. Mandate telephonic pre-screening and replace OPD consultations with virtual consultations as much as possible.
  - b. Consider open air OPD; appointment system as feasible to avoid waiting, with social distancing in waiting areas
  - c. Mandate handwash/sanitizers<sup>7</sup> and facemask<sup>8</sup> before entering facility OPD and to keep it on until leaving the unit.
  - d. Identify surfaces with higher chance of contamination, and implement regular timed cleaning of surfaces with proper cleansers<sup>9</sup>
  - e. Implement safety precautions during evaluation and clinical care
  - f. Modify processes in OPD, pharmacy, dispensing, e.g. E-prescription template, physical barriers: glass/plastic windows, trays for prescriptions, medicines and payment
  - g. Restrict HCWs not involved in direct care, from entering the rooms of patients
  - h. Restrict visitors: restrict number, time allowed, mandate hand hygiene & face-mask and distancing
4. Ensure due diligence and adherence to infection control protocols and policies by staff
- a. Identify those with higher risk of exposure and transmission (Table 5.2.2) and allow home-based work-engagement.
  - b. Activate shift duty for HCWs and back-up team, to reduce overall exposure

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<sup>7</sup> Hand wash with soap and water for 20 seconds before handling any patient and in between two patients; hand sanitizer that contains at least 60% alcohol; maintain adequate supply

<sup>8</sup> Consider being self-sufficient – Advisory on Homemade Protective Cover for face & mouth <https://www.mohfw.gov.in/pdf/Advisory&ManualonuseofHomemadeProtectiveCoverforFace&Mouth.pdf>

<sup>9</sup> Surfaces: Door knobs, table tops, chairs, bedside tables and lockers, trolleys, suction machines, light switches, counter tops, handles, desks, phones, keyboards, toilets, faucets, and sinks. Cardboard, steel and plastic-coated or laminated worktops and other hard surfaces allow longer duration of survival. Use 0.1% sodium hypochlorite, 62-71% alcohol, or 0.5% hydrogen peroxide, formaldehyde or glutaraldehyde for disinfection of surfaces. 10 Grams of household bleaching powder in a liter of water may be used for a period of 24 hours.

- c. Special emphasis on HC assistants and cleaners; ensure safety by clarifying gaps in understanding. E.g. drills on use of PPEs when cleaning
  - d. Facilitate quarantine space, testing for HCWs with positive history/symptoms
5. Facilitate availability of PPE by anticipating volumes and optimizing use.

### Annexure 5.2.3. Reorient Clinical Care Processes to support Ongoing Palliative Care Programs

1. Prudent selection of inpatients: define criteria for prioritizing/minimizing admissions
  - a. high intensity of care needs: high symptom burden, intractable symptom, difficult-pain management, distressful end of life
  - b. Multiple co-morbidities – a considered decision based on individual situation<sup>10</sup>
2. Maintain therapeutic connection and continuity of care using virtual interactions
  - a. Utilize pro-active calls, teleconsultations, video-based evaluations, sharing videos, photographs, messages, e-prescriptions and chats for maintaining care.
  - b. Need-based triaging with regard to tele-consultation, admissions or homecare
  - c. Optimize roles and engagement of physician, nurse and MDT team.
3. Maintain confidence, rapport and connection through proactive and need-based communications.
  - a. Challenges to expressing empathy with distancing and use of PPE, may be overcome by maintaining right tone, eye contact, using verbal cues
  - b. Reorient psycho-social support and bereavement care (Section 5.4)
4. Identify personnel and delegate tasks. e.g. re-orient roles of MSWs/Counselors /Volunteers for continuity of care irrespective of settings. (Box 5.2.2)
5. Reorient Homecare policy – (Section 5.5)
6. Prepare, plan for universal protection as per levels of contact<sup>11</sup>
  - a. Categorize PC procedures as per level of exposure (Table 5.2.2)
  - b. Cleaning and disinfection of stethoscopes, thermometers, SpO<sub>2</sub>-probes and BP cuffs between patients & between shifts<sup>12</sup>.

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<sup>10</sup> Benefit balanced with risk for acquiring COVID-19

<sup>11</sup> <https://www.rdash.nhs.uk/wp-content/uploads/2017/08/Appendix-46-Aerosol-Generating-Procedures.pdf>

<sup>12</sup> Stethoscope diaphragms and tubing should be cleaned with an alcohol-based disinfectant including hand rubs in between patients. As most NIBP sphygmomanometer cuffs are now made of rexine, they should also be cleaned by alcohol or preferably hypochlorite based (1% Sodium Hypochlorite) solutions

Annexure 5.2.4 Manage the complexities arising out of COVID-related situation: based on patient related, disease related and prognostication related factors.

1. Ensure competency in identifying high risk population, early infection, severity, defining goals and access to appropriate care (Table – 5.2.3)
2. Develop efficient responsiveness to COVID-19 within the facility
  - a. Every facility to have an explicit diagnostic algorithm for suspected COVID-19 infection to inform triage on testing/care setting
  - b. Display updates on treatment protocols, isolation, referrals, care
  - c. Identify professionals to manage in-house infections and train them on precautions, procedural care, donning and doffing PPE etc.
  - d. Identify those at high-risk for severe illness - 65 years and older, with underlying medical conditions<sup>13</sup> amongst HCWs and patients (Figure 5.2.2)
  - e. Encourage self-report of symptoms
3. Develop strategies for extra protection for those with higher risk
  - f. Maintain vigilance for early signs of infection
  - g. Implement stay home policy where relevant
    - i. Staff – roles and responsibilities to work from home
    - ii. Patients - early discharge, avoid direct visits, tele-consultation. Education of family on what safety precautions to ensure when a patient with higher risk is cared at home
2. Detect COVID-19 infections early, from clinical presentation
  - a. Typical COVID-19 symptoms - fever, dry-cough, body ache, anosmia, extreme fatigue, loose motion without cramps

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<sup>13</sup> chronic lung disease or moderate to severe asthma, serious heart conditions, smokers, obese, diabetes, CKD/ESRD, liver disease, and immunocompromised.

- b. Atypical presentations in elderly, malnourished and immunocompromised; new onset confusion or inability to arouse, breathlessness, pain/pressure in the chest, bluish lips or face
  - c. Vigilance for laboratory and radiological abnormalities (Table 5.2.4; Figure 5.2.3)
  - d. Identify what is most likely NOT infection by COVID-19: Fever of <3 days, fever  $\geq$  101<sup>0</sup> F; purulent sputum and presence of pleuritic pain, diarrhea with cramps<sup>14</sup>
3. Plan to evaluate, test and triage as per severity and regional policies (Table 5.2.3)
4. Prevent spread within the facility by defining the HCWs involved in the care of patients under isolation care
5. Recognize severity, triage, define criteria for transfers (Box 5.2.4), discharge and EOLC
- a. Manage COVID-19 per severity and local guidelines (Table 5.2.3; Table 5.2.5)
  - b. Ensure competent management of symptoms (Box 5.2.4)
  - c. For stable COVID-19 patients: Isolation facility in-house/ other (Table 5.2.3)
  - d. Particular attention to cardiovascular protection COVID-19 patients, as there's evidence of damage to myocardium
  - e. For critically ill: transfers to critical care units/ End of life care – (Section 5.1)
6. Discharge Plan: with chest radiographic clearance/ viral clearance in samples after two negative tests, done 24 hours apart<sup>15</sup>.
7. End of Life Care (Section 5.1)
- a. The epidemiological models predict high volume of deaths.
  - b. PC Units within institutions may take-on role for escalating /de-escalating care.
8. After death Care<sup>16</sup> (Box 5.2.5)

<sup>14</sup> <https://www.who.int/news-room/q-a-detail/q-a-coronaviruses>

<sup>15</sup> <https://www.mohfw.gov.in/pdf/Corona%20Discharge-Policy.pdf>

<sup>16</sup> [https://www.mohfw.gov.in/pdf/1584423700568\\_COVID19GuidelinesonDeadbodymanagement.pdf](https://www.mohfw.gov.in/pdf/1584423700568_COVID19GuidelinesonDeadbodymanagement.pdf)



## Annexure 5.2.5 Plan and prepare for a change in the profile/volume of patients with Cancer and other Non-communicable Diseases (NCDs) and prepare to respond

In the pandemic situation, the ethical value of maximizing benefits drives resource allocation.

The Non-Covid-19 patients have huge needs which have been kept on hold with the Pandemic riveting the attention of HC services. Cancer or other NCDs care-plans use triage policies to minimize direct-contact care. Proactive consultations, procedural care, and physical and laboratory monitoring of NCDs including cancer are all affected significantly. This might invariably disadvantage patients with advanced age and more severe NCDs, who will not be prioritized for advanced care provision.

Example- Cancer care:

1. Cancer related management being a balance between risk and benefit;
  - a. the need and intensity of treating cancer are being weighed against the risk of developing complications with COVID-19 infection.
  - b. Treatment pathways are modified to minimize the number of hospital & day care visits, risk of neutropenia and thrombocytopenia,
  - c. Pathways are limited based on prognostication which decides curative vs. palliative intent (Table 5.2.6; Figure 5.2.4)

Example -NCD: Chronic Kidney Disease

1. CKD patients of all stages are highly vulnerable to COVID-19 infection due to comorbidities, repeated unavoidable exposure to hospital environment and immunosuppressed state.
2. The Ministry of Health Guidelines for managing dialysis <sup>17</sup> gives high priority for dialyzing those with acute kidney injury. It also recommends also to avoid initiation of a new CKD patient on peritoneal dialysis.

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<sup>17</sup> <https://www.mohfw.gov.in/pdf/GuidelinesforDialysisofCovid19Patients.pdf>

3. Major access issues due to i) shortage of dialysis units<sup>18</sup>, ii) transport concerns to reach dialysis units
4. Interruptions to renal replacement therapy/ specialist care/suboptimal monitoring and constraints for accessing emergency services may cause patients to get sicker, and thus increase the volume of patients for renal supportive care.

Chronic obstructive pulmonary disease (COPD)<sup>19</sup>/ Cardio-vascular disease (CVDs)<sup>20</sup>

1. Care of COVID-19 patients with severe CVDs/ COPDs and poor prognosis might get downgraded to lower intensity levels, with ICU/ICCU beds in short supply
2. Patients with cardiac failure & severe COPD<sup>21</sup> are high-risk patients with complex symptom, difficult to manage and with poor prognosis.
3. They have limitations to specialist care/lab facilities/ or intensive care, due to constraints listed above

Given the sub-optimal access to specialist care and the constraints due to COVID-19 situation for many months to come, disease-directed therapy is likely to stay interrupted, especially in the elderly and sicker patients with multiple comorbidities. These patients are likely to access PC services for relief of symptoms and distresses. PC community may need to plan and prepare for gradual changes in patient profile and volumes..

General approach to care for patients with chronic conditions

1. Apply core principles of palliative care with whole person approach and non-abandonment (Box 5.2.4; Box 5.2.6)

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<sup>18</sup> shortage of manpower (dialysis technologists, renal nurses), fear of exposure/ staff quarantine

<sup>19</sup> <https://www.brit-thoracic.org.uk/about-us/covid-19-information-for-the-respiratory-community/>

<sup>20</sup> <https://www.escardio.org/Education/COVID-19-and-Cardiology/ESC-COVID-19-Guidance#p06>

<sup>21</sup> severe airflow obstruction with FEV1 < 50% of predicted, past history of hospital admission, need for long-term oxygen therapy or non-invasive ventilation, function limiting breathlessness, presence of frailty and multimorbidity.

2. Empower autonomy, support shared decisions (including advance care directives as applicable), and transitions in goals of care – be it directing to appropriate specialist facility, or accessing palliative care
  3. Educate all patients to continue taking their regular medicines in line with their individualized plan to ensure their disease is as stable as possible.
  4. Coordinate and provide maintenance medical care e.g. clinical review, pill-refill, care management through telephonic liaison with the specialist.
  5. Considering the higher risk, educate the patient/family on safety measures, and be vigilant about signs of COVID-19 infection<sup>22</sup>.
  6. Be vigilant with atypical presentations and complex symptoms. Patients presenting with cardio-respiratory symptoms to be presumed as COVID-19 positive, until proven otherwise<sup>23</sup>
  7. NCD Patients may reach PC facilities late in the COVID care pathway; time available for rapport-building, titration of medications and refining care-inputs are likely to be short.
  8. Be alert for new or increased issues with mental health and wellbeing due to difficult times, particularly anxiety and depression
  9. When prescribing, consider the degree of organ dysfunction/potential drug interactions
  10. Support generalist PC by non-PC physicians, utilize triage tools to facilitate referrals for specialist PC
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<sup>22</sup> The group of patients with NCDs vulnerable during this time include advanced heart failure, renal failure, stage 4 COPDs, chronic liver failure, persons suffering from immunosuppressive disorders like HIV, and patients on immunosuppressants

<sup>23</sup> <https://www.escardio.org/Education/COVID-19-and-Cardiology/ESC-COVID-19-Guidance#p06>