ANZSPM

Palliative Care Communication in the COVID-19 context

INTRODUCTION

This summary document explains the palliative care approach to communication with patients and families in the context of the COVID-19 pandemic.

Usual healthcare communication will be affected by many factors, such as infection control measures, miscommunication and challenging emotional responses to the pandemic. There may be limited opportunity to provide focussed, timely, COVID-19-specific communication skills training for health professionals, and hence our guidance and support will be vital to many clinicians.

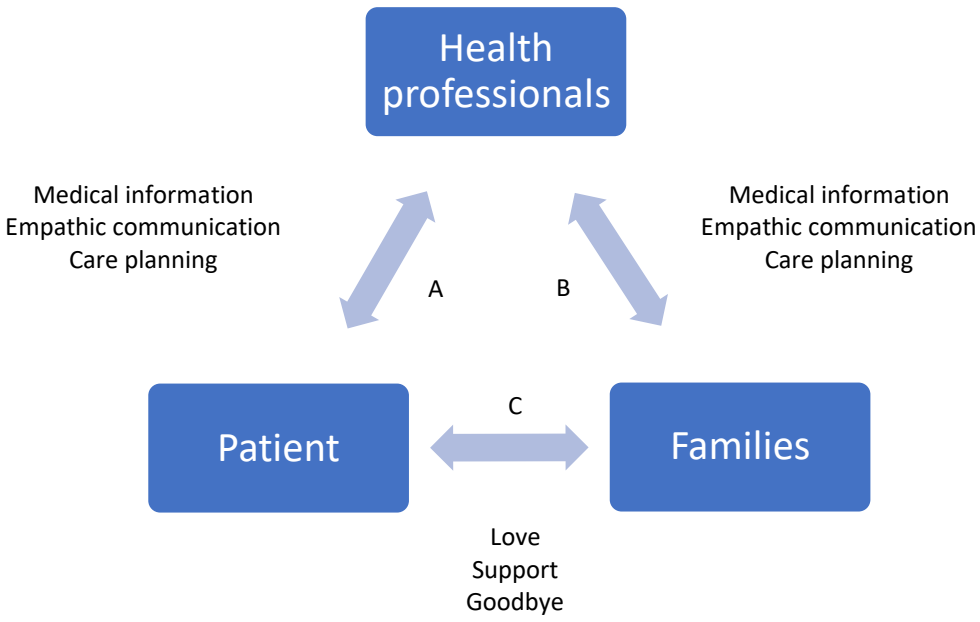
The extent of the COVID-19 surge remains unknown, but we can guarantee that we will be challenged to optimise the connections that exist to facilitate compassionate care.

COMMUNICATION WITH PATIENTS AND FAMILIES

Communication is a cornerstone of quality palliative care. As outlined in the points that follow, efforts should ideally facilitate lines of communication despite the challenges and barriers presented by the COVID-19 pandemic. In addition to the ideas within this paper, achieving good communication will require healthcare professionals to remain curious and creative in their approach to interacting with patients and their families, and responsive to the unique challenges of their care setting.

Communication between healthcare professionals, families and patients receiving palliative care amid the COVID-19 pandemic can be conceptualised as in *Figure 1*. This schema can also inform practice in different contexts as it applies to palliative care communication in acute hospitals, aged care facilities and community settings. Additionally, the recommendations that follow are intended for use in caring for patients with suspected or confirmed COVID-19 infection, but they may also be useful in supporting patients without COVID-19 infection who are affected by visitor restrictions or by staff delivering care remotely.

Figure 1: Lines of communication in the palliative care context



NOTICE: This **ANZSPM guidance document** has been prepared by the ANZSPM COVID-19 SIG. It is subject to regular review and revision in response to the changing COVID-19 environment. Check anzspm.org.au for updates and speak to your local Palliative Care Team.

1. Communication between health professionals and patients (line A)

Context

Healthcare communication between clinicians providing direct clinical care and patients will be impacted by local risks of infection and guidelines responding to these risks. This communication may be:

- face-to-face (using masks and personal protective equipment (PPE) and/or social distancing), or
- at a distance using mobile phones, video tablets or baby monitors.

When wearing masks and other PPE, we recommend the use of photographic name badges affixed to PPE on each use (Figure 2) including name and role. This enables patients to recognise staff (and staff to recognise each other) and allows a connection to be established, where otherwise absent faces would have existed. Laminated, re-useable name badges pose additional infection control risks, but stickers could be disposed of along with the PPE after each use. Additionally, photographs of each regular staff member can be displayed on a board in the patient's room.

When wearing masks, we recommend modifications to usual communication style to avoid misunderstandings (Box 1). It is also helpful to note that when wearing full PPE, safe physical contact is still possible, and touch will remain an important element of communication.

Figure 2: Example of photographic name tag

Box 1. Communication tips when wearing a face mask

- Introduce yourself and your role
- Speak loudly and slowly but explain why: "the mask muffles my voice so I'm speaking loudly to compensate" – a declaration of intent turns shouting into helping
- Convey information clearly and unambiguously
- Use more explicit empathic statements than usual, since you can't convey warmth through the usual facial expressions or physical closeness
- Ask the patient to repeat instructions and plans back to you to check comprehension

Alternatively, staff can use two-way radios (such as baby monitors) or video tablets to communicate at length without masks and other PPE from outside the patient's room. Baby monitors can provide two-way connection outside the room for dialogue. Staff can check-in on the patient frequently and have more extended conversations with the patient unhampered by PPE. This approach can also support the involvement of interpreters when needed. Importantly, use of two-way radios allows the patient to specify what help they need when it is needed, unlike their usual bedside buzzers which only allow them to raise an alert. Use of multiple individual two-way radios in the same location may result in crossed signals if the same radio frequency is inadvertently used, which could breach patient confidentiality (i.e. if one patient's conversation is broadcast into another patient's room). However, use of multi-monitor devices controlled at a single base unit can avoid this.

Video tablets can be used at the nursing station and also remotely to create an audio-visual connection. They will need good quality internet connections to avoid frustration for the users and should not be moved from patient-to-patient due to the potential for contamination. Given the high-pressure environment for staff working in the context of a highly infectious disease and wearing PPE, it is strongly recommended that all devices intended for bedside operation by staff be the same type (model and make) with the same platform installed to minimise the need for learning, adapting and trouble-shooting when fatigued. Speaker accessories

for amplification may be needed, especially for patients with hearing impairments or in noisy environments. The chosen device and platform should ideally be compatible with 3-way interactions involving an off-site interpreter when required.

Health professionals not providing direct physical care, e.g. social workers, spiritual care practitioners or psychologists, can continue their psychosocial and existential care via phone or video tablets remotely.

Health professionals providing care to patients in the community will need to use local telehealth platforms. We recommend that any practitioner intending to conduct telehealth consultations balance any perceived risks against the clinical imperative and needs of the patient. A guide has been provided in Box 2.

Box 2. Guidance for telehealth consultations

Is telehealth appropriate for this consultation?

For new patients:

- Review the referral letter and any other patient information you may be able to access

For all patients:

- Might a physical examination be required? Can another health care worker be with the patient?
- Might you be prescribing Schedule 8 medications?

If you decide to proceed with a telehealth consultation:

- Obtain patient consent for telehealth and protect patient privacy and rights for confidentiality
- Identify yourself and any others in the room with you to the patient
- Confirm the patient's identity to your satisfaction and record how you did it (e.g. photo ID and Medicare Card, vouched for by another health care practitioner)
- Establish who else is in the room with the patient and their relationship to the patient
    - Is the patient accompanied by a health care worker (possible proxy physical examination)?
- Explain how the telehealth consultation will work
- Take full clinical history including presenting problem, past health, medications, allergies, social
- Ensure clinical justification and no contraindication for the proposed treatment
- Complete your medical record
- Communicate with patient's referring doctor plus general practitioner to arrange ongoing care

Prescribing Schedule 8 Medications

If you or a practice colleague has not previously seen the patient in person – **NOT RECOMMENDED**
If you or a practice colleague has previously seen the patient in person – **ACCEPTABLE**
If you choose to write a prescription for a Schedule 8 medication for a patient that you are not seeing in person:

1. Hand write the prescription and sign it by hand
   If you use printed prescriptions, you need to hand write the drug name, dose, and quantity in numbers and words and sign it by hand – electronic signatures are not acceptable
2. Fax the prescription to the patient's pharmacy and post the original paper copy to the pharmacy – email is not permitted for Schedule 8 medications

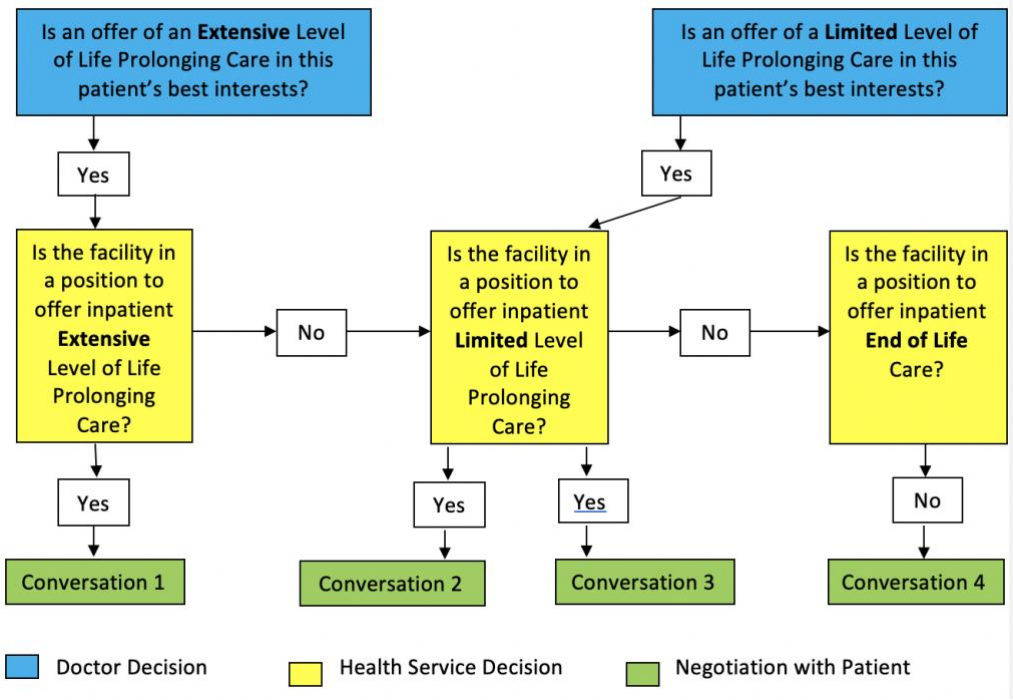
References

Australian Government Department of Health – Fact Sheet – A Guide for Prescribers – Interim Arrangements for Prescriptions for Supply of Medicines (6 April 2020)
Royal Australasian College of Physicians – Telehealth Guidelines and Practical Tips
NSW Health Agency for Clinical Innovation – Telehealth in Practice (August 2019)
Royal Australian College of General Practitioners – Telehealth Video Consultations Guide (May 2019)
Royal Australasian College of Physicians – Fact Sheet – Practical Guide to Telehealth for Physicians (September 2015)
Medical Board of Australia – Guidelines for Technology-Based Patient Consultations (16 January 2012)

Content

Empathic communication and care planning present particular challenges in the context of the COVID-19 pandemic. We highly recommend the US VitalTalk resources and the NZ TalkingCOVID Serious Illness Conversation Guide Training. The schema in Figure 3 from Nepean Blue Mountains Local Health District also helpfully delineates the ethical complexities of Goals of Care discussions.

Figure 3: Schema for Goals of Care discussions



Getting to know each patient is essential to delivering patient-centred care but this may be more challenging to achieve in the context of COVID-19. We recommend the use of the Confused Hospitalised Older Persons (CHOPS) Sunflower Communication Tool. The patient and/or family can be assisted by staff to fill in a number of questions on a sunflower picture. The flower's centre identifies the patient's name or what they would like to be called, and the petals collect important individualised information about that person. The completed sunflower can be displayed both inside and outside the patient's room in order to facilitate patient-centred communication and care (Figure 4). This may be particularly helpful for patients with dementia or confusion.

Figure 4: Example of CHOPs Sunflower Communication Tool

More specifically for patients with confused thinking, memory problems and/or communication difficulties, we recommend 'TOP5' as a process to engage with family caregivers to identify and share specific, unique strategies to promote communication and help settle, calm and personalise care (Box 3). Information may include:

- Established routines or rituals
- Specific preferences for communication
- Objects of significance

- 'Must haves'
- Ways to comfort or calm the person
- Information to engage the patient and to develop rapport (e.g. interests, hobbies, pets)

Box 3. Examples of TOP5 Strategies

- Dad becomes agitated around 4pm every day. If you tell him the car is in the garage he will settle.
- If unsettled, give Mary her handbag. She will place it under her pillow.
- Ernie must have his keys and wallet with him at all times. If he can't find them, he will become agitated and aggressive.
- Betty is very modest. It would be distressing to her to have male staff bathe or toilet her.
- Danny gets aggravated when you ask about his bowel movements. He will indicate he has defecated by putting his cap on his head and will leave it on until his next meal.

Communication over telehealth is different to communication in person in several ways. We recommend the following resources from Hospice NZ and the Centre to Advance Palliative Care as guidance for this context of interaction and have summarised key learnings in Boxes 4 and 5. For examples of optimal and suboptimal Telehealth practice, view the helpful resources by the University of Arkansas for Medical Sciences – South Central Telehealth Resource Centre: Telehealth Video Etiquette Series.

Box 4. Tips for Telephone Consultations in Palliative Care

- Prepare – make sure you have all relevant information at your fingertips
- Introduce yourself and your role clearly. Ask for verbal consent for the consultation
- Ascertain who is present with the patient, and the environment they are taking the call in – if unsuitable (e.g. public transport), arrange another call
- Acknowledge the differences from face to face contact while expressing confidence that care can still be given
- Use supporting statements early to develop rapport[1]
- Give verbal encouragement for the patient to speak – "mm...mm…, aha…yep..." or "I see…go on…tell me a bit more…yes…yes…"[1]
- Overtly pick up on patient's cues "I can hear from your voice that you are anxious about …"[1]
- Be aware of the risk of rushing the patient while they are processing information. Allow silence and time for emotional responses to bubble up. After pausing, you may need to directly encourage expression of responses "I'm wondering how you are reacting to the news I've just shared?"
- Pay extra attention to demonstrating empathy, acceptance, sensitivity and support – with the loss of the non-verbal 'channel' this needs to be done verbally[1]
- Exaggerate signposting "Now I'd like to think about the other problem you mentioned …" so that the patient can follow the conversation flow
- Use summary to help transitions between topics "So you've been feeling concerned about … and it's affecting ... Could you tell me a bit more about the treatment your previous doctor tried for this problem?"
- Pay extra attention to negotiating acceptable plans – remember you are missing non-verbal feedback – clarify carefully understanding, concerns and concordance
- Encourage Teach-back of advice given.[2] Encourage patient to write down plans or agree to send a follow-up email[3]
- Screen for outstanding questions/concerns at conclusion of call
- Enhance safety netting – give clear instructions and time frames. When giving 'things to watch for' – generally 3 or less. When giving timeframes make them precise – "in the next 2 days", not "in the next few days". Ask the patient to write down safety plans or agree to send a follow-up email
- Document, including relevant verbatim statements – theirs and yours

Box 5. Tips for Video Consultations in Palliative Care

- Preparation is essential – think about placement of your screen – try to elevate your screen and camera so that you are not looking down on the camera and are meeting the patient at eye level. When the patient joins you help them get their device propped up also[3]
- Ensure privacy – put a Do Not Disturb note on the door and try to control outside noise
- Look the part – avoid wearing distracting patterns/accessories
- Consider what the patient will see – neutral background, good lighting, consider camera placement – if a door is visible in shot (even closed) this might heighten concerns re privacy[4]
- Avoid placing the camera too close to yourself – if the viewing distance is correct you will see the patient on the monitor and the camera simultaneously[5]
- At the beginning of the call check-in re connection quality "Can you see me?" "Can you hear me?". Have a back-up contact you can call or email to troubleshoot issues. Let the patient know to alert you if problems develop during the call
- Acknowledge the awkwardness if telehealth is unfamiliar to both parties – but then move on[3]
- Be sure to clearly introduce yourself, your role and your location – and introduce anyone else in the room. Gain consent for the call to proceed. Ask the patient to introduce anyone else with them
- Pay attention to building rapport – try to make a non-medical connection with the patient.[3] Ease in to worrying topics (e.g. Covid-19) rather than launching – 'Small talk before Big talk'[6] e.g. "Did you have any trouble getting set up for the call today?"
- Explain any tasks that might be misinterpreted as inattention – e.g. "I'm just going to jot down a couple of notes …" "I'm just going to take a look at your scan where you are noticing that pain…"[7]
- Empathy is no less important in telemedicine.[7] Be deliberate in expressing empathy. Interestingly the 'mirror' aspect of videoconferencing can assist in this intention, as we are able to see in real-time how we are responding to emotion[3]
- Replicate real eye-contact patterns by looking directly into the webcam to connect (rather than only looking at the projected image of the patient's eyes on the computer screen)[4]

2. Communication between health professionals and families (line B)

Context

Communication is an essential component of holistic care and should be prioritised appropriately. Amid visitor restrictions, the necessity for the following is important:

- Updates and information
- Response to queries and concerns
- Engagement in shared decision-making as required via phone or video tablet.

Social workers and spiritual care practitioners will be important in the provision of more extended conversations and counsel.

The COVID-19 pandemic is likely to result in a high volume of phone calls to clinical services from worried families. On admission, we recommend that the primary next-of-kin (NOK) is determined as the main contact and advised of the frequency and method of regular updates. For any patient unable to communicate with their family, we would recommend that clinicians offer daily communication to the family at a minimum. This would ideally occur at an agreed time, but flexibility should be available according to need.

If the demands of the pandemic exceed the capacity for medical and nursing staff to be able to communicate adequately with families, as a last resort we recommend that teams nominate a staff member to assume a role that focusses on bridging this gap by relaying a daily clinical update. Social workers, family support workers and spiritual care practitioners have the necessary communication skills and experience in acknowledging and 'bookmarking' concerns without necessarily being able to address or resolve them in the

moment. Medical or nursing staff could quickly complete a daily update form (Box 6) to be relayed and thus enable up-to-date, empathically delivered remote communication to families.

Box 6. Daily Update Form – use "ASK-TELL-ASK" format

INTRODUCTION
· INTRODUCE self clearly and check OK to talk
· ACKNOWLEDGE difficulty of not being able to visit loved one
· SIGNPOST role of facilitating update and connection with loved one. Clarify NOT medical or nursing clinician caring for family member but can relay concerns

ASK
· EXPLORE current understanding of loved one's condition and how they are coping

TELL
· OFFER daily update from clinical team
(Your XXXX/or name) is currently in location _____ and is being cared for by team _____
NB: May need warning shot if bad news, e.g. I'm sorry to say that the news is not what we'd been hoping
On the (doctor/nurse) assessment today (your XXXX/or name)

- ☐ Appears to be improving
- ☐ Appears to be stable
- ☐ Appears to be deteriorating
- ☐ Has seriously deteriorated and I'm sorry to say has entered the dying phase

ASK
Respond to emotions – acknowledge with empathy/ give space for and acknowledge initial concerns
Ask permission to give more info, e.g. OK to tell you a bit more about how (your XXX/or name) is today?

TELL
He/she/they are generally:

- ☐ Awake and able to interact
- ☐ Sleeping most of the time
- ☐ Unconscious

He/she/they are:

- ☐ Comfortable
- ☐ Experiencing some symptoms of ……, AND we are doing everything possible to ease these
  [Clinical team to document significant symptoms if present
  ☐ Shortness of breath ☐ Pain ☐ Nausea/vomiting ☐ Confusion/agitation]

Staff to document current care being given (share if info desired by family member)
· Oxygen …. Etc

ASK
Respond to emotions – acknowledge with empathy/ give space for and acknowledge concerns
I can help you connect with them now if you would like to do that – explain how (use video tablet)

At end of connection:
ASK
· Acknowledge difficulty of situation with empathy
· Check re immediate needs e.g. questions or messages to pass to medical/nursing team
· Safety check for relative – who is there to support you?

TELL
· Plan for next contact, reassurance will contact if significant change in XXXX's condition

ASK
Anything important they would like to ask or tell us before end the conversation?

Furthermore, we recommend consideration be given to public-facing phone lines as internal telecommunication capacity may be exceeded. Staff may need dedicated phonelines in order to gain timely connection. Families should be encouraged to communicate via the primary NOK, to prevent frequent calls and repeated conversations, as part of a proactive communication plan as described above.

Content

The guidance provided in relation to patients would equally apply for communication with families. We recommend that staff providing clinical care at the time of death record some notes regarding the quality of the patient's death – their symptoms, level of comfort, who was with the patient, any requested rituals that were performed and any final words. These could later be relayed to the family by a social worker, family support worker, spiritual care practitioner or bereavement support worker.

In the community context, we recognise the reduced supports from community services during the COVID-19 pandemic. The infection control measures, insufficient PPE and workforce shortages will restrict usual home visits. For those caring for any patient, regardless of COVID status, we recommend the following resources:

- Canadian Virtual Hospice - resource include videos on how to move people who are bed-bound, how give sublingual medications etc
- Helix Centre tool kit - includes general carer instructions, symptom management and training videos for carers on how to draw up subcutaneous medications

For COVID-specific guidance we recommend this resource from Cardiff University in Wales

3. Communication between patients and families (line C)

Conscious patient

For the conscious patient, who is able to interact meaningfully, clinical staff can facilitate the use of phones and video tablets. Staff may also write a note or email dictated by the patient for the family. All devices will need good quality internet connections and should not be moved from patient-to-patient due to the potential for contamination.

Seriously unwell or unconscious patient

For seriously unwell or unconscious patients, it can be argued that facilitating connection with family is 'essential care' (as essential as giving IV fluids or medications), and thus should be prioritised by staff providing direct clinical care. Families should be encouraged to communicate with their loved one and utilise written or recorded messages. These provide an opportunity to convey love or say goodbye to the patient. Prompts may include those from Ira Byock's 'Four things that matter most' book – "*please forgive me*", "*I forgive you*", "*thank you*" and "*I love you*". Staff tasked with supporting communication could assist families with this. Families could also create a playlist of music for the patient's room. With permission from the family, clinical staff can also (where appropriate) record videos of the patient to be played back to the family.

There are many ways for the family to remain connected and involved in the care we provide. Understanding the relationships that exist with the person we are caring for, as well as the things that matter to them, can facilitate this connection. The family, as part of the care team, can provide ideas and information that we can use to personalise our care as much as possible.

HEALTHCARE COMMUNICATION TELEHEALTH RESOURCES

Relevant sources for Australia include:

https://www.psa.org.au/wp-content/uploads/2020/04/200406_DoH_Info_for_prescribers.pdf

https://www.psa.org.au/wp-content/uploads/2020/04/200406_DoH_Info_for_dispensers.pdf

https://www.health.gov.au/resources/publications/covid-19-national-health-plan-primary-care-package-mbs-telehealth-services-and-increased-practice-incentive-payments

https://www.health.gov.au/resources/publications/covid-19-national-health-plan-primary-care-fast-track-electronic-prescribing

https://www.racp.edu.au/docs/default-source/advocacy-library/telehealth-guidelines-and-practical-tips.pdf

https://www.racgp.org.au/running-a-practice/technology/clinical-technology/telehealth/telehealth-video-consultations-guide

Relevant sources for New Zealand include:

https://www.mcnz.org.nz/assets/standards/06dc3de8bc/Statement-on-telehealthv3.pdf

https://www.health.govt.nz/our-work/diseases-and-conditions/covid-19-novel-coronavirus/covid-19-novel-coronavirus-information-specific-audiences/covid-19-novel-coronavirus-resources-health-professionals/managing-patients-and-reporting-using-telehealth-and-online-tools

https://www.medicalprotection.org/newzealand/casebook-resources/articles-and-features/view/video-coronavirus-advice-and-guidance-for-members

https://www.medicalprotection.org/newzealand/casebook-resources/articles-and-features/view/covid-19-and-remote-consultations-how-we-can-help

References

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2. DeWalt D, Callahan L, Hawk V, et al (2010). **Health Literacy Universal Precautions Toolkit**. AHRQ Publication No. 10-0046-EF. Rockville, MD. Agency for Healthcare Research and Quality. April 2010. Available at: http://www.ahrq.gov/qual/literacy/healthliteracytoolkit.pdf Accessed April 21st 2020.

3. Fratkin M (2020). Telemedicine: Virtual connection in an age of social distancing. Centre to Advance Palliative Care. March 2020. Available at: https://www.capc.org/blog/telemedicine-virtual-connection-age-social-distancing/ Accessed April 19th 2020.

4. Heath S (2020). Communication tips for a good telehealth patient experience. Patient Engagement HIT.com. Available at: https://patientengagementhit.com/news/communication-tips-for-a-good-telehealth-patient-experience Accessed April 19th 2020.

5. American Telemedicine Association Human Factors SIG/Home Telehealth and Remote Monitoring SIG (2018). A concise guide for telemedicine practitioners: human factors quick guide eye contact. Available at: https://www.americantelemed.org/?s=eye+contact. Accessed April 21st 2020.

6. The Academy of Communication in Healthcare (2020). Covid-19 telemedicine: relationship-centered communication skills. Available at: https://www.achonline.org/Portals/36/COVID-19%20Resources/Covid-19%20telemedicine%20FINAL_1.pdf Accessed April 20th 2020.

7. Esher-Blair M (2020). Bedside manners via telehealth – understanding how your screenside manners matter. Available at: https://telemedicine.arizona.edu/blog/bedside-manners-telehealth-understanding-how-your-screenside-manners-matter Accessed April 21st 2020.

THIS INFORMATION IS OF A GENERAL NATURE AND SHOULD BE ADAPTED DEPENDING ON LOCAL PROTOCOLS. For further assistance, please contact THE PALLIATIVE CARE TEAM on _____.