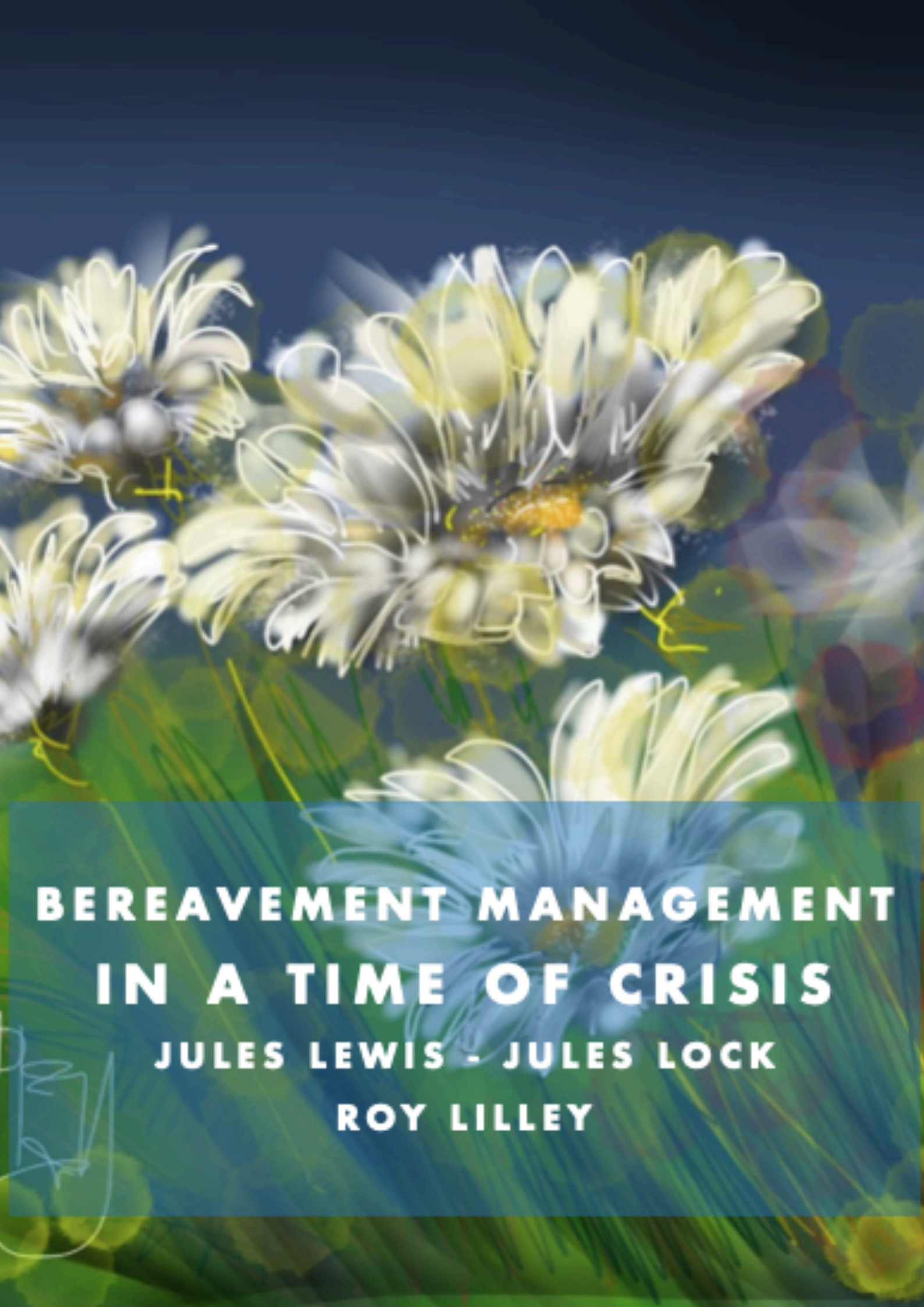

BEREAVEMENT MANAGEMENT IN A TIME OF CRISIS

JULES LEWIS - JULES LOCK

ROY LILLEY

This booklet has been compiled in the memory of

Joan Owen

Her family have made a generous donation to enable the work of The Swan Scheme and Swan Rooms, to support families at the hardest of times, to continue after the disruption of the Covid19 crisis.

This booklet is a companion-piece to '*Bereavement a Guide for Managers*', by the same authors.

It contains advice, ideas, questions for discussion and guidance on end-of-life care, in more normal times.

It was published in hard copy and on-line. In total around 50,000 copies have been distributed free, to the NHS and allied services.

You can download a copy, free, here

Dedication

This booklet is dedicated to the people in the NHS working without regard to self-risk, the unheralded people working to manage and administrate this emergency and the thousands working across the service who we may never meet but we know how vital their contribution is.

Jules Lewis
Jules Lock
Roy Lilley
Spring 2020

In the following pages you will find discussion points, ideas, advice, guidance and links to information, we hope you find it helpful.

Introduction

The virus, Covid-19, has impacted every part of our lives - the economy, society and the NHS.

It is hard to find a corner of the NHS where it is 'business as usual'.

The sad fact is, whilst the NHS will battle to save lives, sometimes - perhaps all too often, the battle will be lost. We are facing patients at the end of life in numbers we have not encountered before.

As well as this being a tragedy for the families and loved ones, and a huge emotional pressure on staff, the protocols and systems for dealing with end of life care that apply in normal times need to be modified and changed. These are *not* normal times.

Many of the changes will be emotionally draining for relatives and staff. The end of life arrangements could be brutal.

The pressure of numbers and the likelihood of spreading infection means a whole new approach will be needed.

All Trusts will be developing protocols and it can be expected that as events unfold, new guidance will come from NHSE and others.

This booklet is not designed to replace or supplant guidance. It raises numerous questions that we hope will lead to discussion and informed thinking about how to offer the best end of life care possible, in these unique circumstances.

What is different?

In short, the answer is everything…

When a patient enters Covid-19 care they will, effectively, be entering quarantine. Patient's relatives and friends may assume normal, or perhaps limited, visiting arrangements will be in place.

It is likely that they will not be.

Many hospitals have announced visiting restrictions, on both social media and hospital websites. Many relatives, however, will not have access to online information. They will be reliant on hearsay and getting mixed messages from the media because things are constantly changing.

Relatives with symptoms of Covid-19 or in isolation due to a family member having symptoms will *not* be able to visit.

If, however, relatives have no symptoms of Covid 19 and are not in isolation some Trusts will allow them and one other to visit, together – providing they are from the same household. Local guidance will vary, and the disparity may well be superseded by national guidance.

Leaders need to be clear with messages so that staff can inform relatives with confidence and give reasons for such changes.

The End of Life Care Team

For far too long end of life care was not given the importance in society nor in the NHS, that it deserves.

Over the last few years, we have begun to understand the need to celebrate someone's death as much as we celebrate someone's birth.

Hospitals have recognised the benefits of good End of Life Care (EOLC) to both patients and the families left behind. Good EOLC has also shown to reduce the number of complaints about these sensitive services.

Skills have been improved, understanding gained and professional practice has led the way.

During the crisis, much of the good that has been established in EOLC, stands to be eroded. This is inevitable due to the sheer number of deaths across all parts of the country. One important feature of this will be that patients will die, without their family with them.

Relatives must be assured that a health care professional will be there with their loved-one and that they will not die alone.

For the EOLC team, who spend all their time supporting patients and families through the most difficult of times, this is going to be very difficult.

The Teams will have probably spent time establishing specific schemes from scratch to develop exemplar

ways of working and supporting patients, sometimes with resistance from others.

They will need to be supported in restoring the balance and re-establishing the protocols they have in place at normal times.

They are likely to feel, during the crisis, they have let their patients and loved-ones down. It is, therefore, important to understand that what they had in place will emerge again as the passion from EOLC teams and colleague health workers, will ensure that patients will, once again, have the EOLC they want and deserve.

We also focus on all the people involved in end of life care that we, all, may not know about, or rarely encounter… for example the mortuary staff. Their work is unenviable at the best of times, but could now prove to be almost impossible, as the number of deceased patients they are dealing with is likely to exceed their physical capacity and temporary arrangements may have to be made.

Do they have enough support?
Who is directly responsible?
Who is their line-manager?

Contingency plans will be put in place to extend storage, but they will have to cope with unimagined problems, not least; how are they going to segregate the Covid 19 patients from normal deaths?

When this is over, they too will need access to help them discuss their feelings. They must not become the forgotten ones.

People, who's daily work is dealing with death, have special skills.

As their systems and practice is pushed to the edge, they are driven to compromise and deliver care in a way they would never countenance in normal times, they will be as emotionally drained as the staff on the wards struggling with life.

When they are through this national emergency they will need help to decompress and talk about their experiences.

We must find new ways to support and thank them.

Thinking about staff in a post-Covid environment.

The long-term impact of Covid 19 will be felt for years to come.

Society will slowly come to terms with the loss of a huge number of people across the UK and across the world.

People are likely to lose family members here and abroad with little or no chance to grieve in the normal way.

NHS staff will experience a grief that will be difficult to come to terms with. They will have witnessed first-hand, the death of people across all age groups and communities. They will have had emotionally, very upsetting experiences.

Structures must be established to support staff once this pandemic is over.

Debriefing is a conventional tool, used to address the immediate impact on the front-line during, following a crisis. In the longer term clear systems must be put in place, both nationally and within Trusts to support staff beyond their immediate experiences.

There are various approaches but it must be accepted there is unlikely to be a one-size-fits-all solution. Just as with grieving for a loved one, individuals respond in different ways and have different needs.

For some, formal counselling will be the answer. There is, however, a national shortage of skilled, experienced counsellors. In-house counselling may provide a solution, and training opportunities should be

created as soon as possible to ensure there is an adequate service, for what is likely to be a high demand. Appropriate funding should be set-aside from the general Covid funding provided by the Treasury.

Some clinical staff may feel they can no longer work in front-line healthcare. They will need to be supported as their skills, hard won through experience, are invaluable.

An alternative approach might be through informal peer-to-peer listening. Some organisations already have this in place. This allows staff to simply 'off-load' in the knowledge that what they are saying is said in complete confidence and at a time which suits them.

Some organisations have used clinical staff, clerical staff, well-being staff and volunteers to do this.

They are also able to signpost people to other areas of expertise if they would like to explore other avenues of help. It is likely Trusts will see this as a practical first step and probably adopt it more widely.

Peer-to-peer volunteers will play a valuable part in filling the gaps in a post-Covid service, and help reduce the pressure in other parts of the service.

They add value to a system that they are happy to support and give their time to. Some are retired professionals from a range of backgrounds such as HR, clinical and teaching. Others work within the organisation in a variety of settings.

The service, however it is provided and whatever resource is available, it will be needed and planning for it *now*, even under the current day-to-day pressures, will pay dividends in dealing with what is an inevitability.

Bereavement services in a changing environment.

Bereavement services at this time and for some time after the crisis, will have to establish different ways of working and devise new emergency protocols.

This may require extra training, developing clear guidelines and support mechanisms for bereaved relatives.

It is important to recognise that some of the bereaved will be staff who are continuing to work on the front-line of care.

There is no doubt everyone will experience difficult and different responses from families.

Our people will have to work at a distance with relatives and other outside organisations.

Contact with families of the deceased will be key; keeping them updated and responding calmly and knowledgeably, to the questions they will have.

The distribution of MCCD certificates will need careful organising as collection from the hospital may not be possible.

Registering a death will also prove a challenge; there must be clear and helpful guidelines on how to achieve this.

It is highly unlikely that the belongings of Covid-19 deceased will be returned to families. This will need to be handled with compassion and dignity for what the family will have lost.

Up-to-date bereavement booklets, including information and contact details about the external help that is available, will be difficult to distribute in the normal way. This information should be made available as a download from a website and in a pdf format that can be emailed.

Translation services will be needed to inform relatives and friends whose first language is not English. It will be important to chose an experienced translator.

If the hospital has a Medical Examiner, their role will be to link between the family and the bereavement service.

During this time most families will recognise the difficulties and constraints the NHS is working under.

When faced with being unable to see a loved one in the last hours of their life, unable to visit the deceased person, unable to take back clothing or even jewellery, means even the most understanding people may react badly.

With grief there is likely to come anger, frustration, desperation and inevitably, complaints.

Documentation must be meticulous, conversations noted and actions recorded.

Support for families will be difficult for the Chaplaincy team. Their role is to support patients and their families whatever their faith or not. Working at arm's length is not their practice and they will find it difficult.

They too, will have to establish new ways of working.

They could well provide telephone help for both staff and relatives. If they do we must consider how their contact numbers can be widely circulated.

The use of retired clergy and lay preachers could be a vital help in ensuring these conversations are not rushed and set at the pace the relative, or member of staff, can cope with and they are given time to digest and discuss their feelings.

Important conversations

Hospitals and care homes have become very different places.

The opportunity for a quick conversation, a quite word, moments of personal intimacy are gone… disappeared behind personal protective equipment and tightening rules on visits.

Gloves, apron and surgical mask must be worn - sometimes visors or safety spectacles these turn staff into anonymous workers. The sight will be alarming for visitors, relatives and friends and maybe frightening for some patients perhaps particularly those with dementia.

This will make conversation, so often reinforced by body language, very difficult and places an additional burden on communication.

Don't underestimate the loss of 'the person' in the equation of conversation, messaging and explaining.

Wearing a photo of the person on their PPE -"Hello my name is…." with a picture of the face can really help.

Seeing the Doctor, Nurse, HCA, AHP, Cleaner, Porter and others, as they normally look can help put patients and relatives at ease - seeing the person behind the mask.

These are extremely difficult times for our NHS and now more than ever we need to have frank and honest conversations.

It is important that all frontline staff are prepared to do this.

Ensuring that staff are confident to do this is important to their wellbeing and the wellbeing of the families who will be grieving.

At this time doctors and nurses may not have the luxury of selecting the right environment, time or place to break bad news.

The conversation, however, must still be sensitive to the needs of the patient and their family. Time will be of the essence, and conversations must be frank and honest.

Trust managers will have to consider putting in place mechanisms for having these conversations, as it is unlikely that the family will be at the bedside.

This, alone, will be difficult. The family will not have had the end of life care we would want and might expect. No opportunity for a family goodbye, so much part of the grieving process.

Families, because of the publicity and the government response, will have some understanding of their loved one's condition and the possible outcome.

As we know, however, from our experiences of End of Life Care, medical staff must never assume that someone knows their loved one is dying.

Families may have seen them very ill and recover, perhaps several times before.

At this time staff must be very clear about outcomes and ensure the relatives fully understand. They must not be afraid to use the words death and dying.

To a family this will be a sudden death as they would not have been expecting their loved one to die at this stage of their life. Dignity and respect are paramount in your communication with them.

How you make them feel now will impact on them forever.

Some trusts have established 'prompt-cards' for junior doctors which give them key points in having important conversations.

Now, more than ever, with the possible increase in junior doctors and medical students in the front-line trusts need to support them. They should put in place, however, basic guidance for staff for having these conversations.

They will be talking to large numbers of families in the coming weeks. Getting it wrong at the start, means they could be fearful of getting it right in the future.

Finding time to debrief after an event is difficult at the best of times. These will be the most challenging conditions your staff will possibly ever encounter in their careers and it is very important that staff are able to talk about their concerns and feelings.

They will be asked to make decisions - possibly about who lives and who dies.

Trusts need to safeguard all staff and must find ways of making non-frontline staff available to talk or just listen when staff need to. This will be key to their well- being now and in the future.

Questions for us to think about, prompts for discussion and talking points.

What is in place to warn relatives and others that it may not be possible to visit their loved one, once they have been admitted into hospital care?

What can be put in place to enable relatives to keep in touch with loved ones, whilst they are in isolation, using Smart-Phones and Tablets?

Can the Trust or care-home receive emails on behalf of patients or residents and pass them on?

What plans and protocols are in place to keep relatives and others up to date with the condition of a patient, on a regular basis?

Precautions to protect staff from the virus means they will be working wearing personal protection equipment. Human exchanges, eye contact and even a tender touch will be difficult, if not impossible. What means can you devise to help maintain personal contact at the bedside?

Can staff have their names written on or attached to protective equipment?

Wearing a mask and eye shields muffles the voice. Patients may be elderly, hard-of-hearing and may not be wearing hearing aids. What processes are in place to make sure they wear their hearing aids?

At the end of life, it is customary for the person's clothes to be returned to the family or friends. Because of the risk of infection, this may not be possible. Patient's clothes may not be returned. They will be disposed of or returned doubled bagged telling family of the risks and not to open them for seven days.

How will you warn relatives that this will happen?

Will we advise relatives, who have been visiting, to go into 14 days self-isolation after their loved one dies?

Rings and other items of personal jewellery are usually taken into secure care and returned to the relatives, should that be the deceased persons wishes… presently jewellery will not be removed from the deceased person.

Is it wise to point this out to relatives at the time of admission and encourage them to take property home - or remove it before admission.

How will we clean equipment? Could this damage some equipment?

Can we offer a lock of hair? Some Trusts are, with permission, obtaining this, at the end-of-life stage or on death, placing it in a sealed bag and telling families not to open it for 7 days.

On-going, this might not be possible.

It is unlikely that normal religious protocols will be observed. The deceased person will be sealed in a bag, taken from ward, checked by mortuary staff and funeral undertakers unopened.

What arrangements can be made with religious leaders to obtain a dispensation for relatives to forgo tradition and rituals, during these difficult times?

It may be the case, if the number of deaths crescendo over a short period, that suitable storage facilities for dead people will be overwhelmed.

It could become necessary, for public health reasons, that deceased persons will not be returned to relatives for burial or cremation and dealt, by the authorities, by way of pubic burial.

This is a very sensitive issue. How will you train staff to advise relatives?

Some guidance is stating if a pacemaker or defibrillator is in situ these patients will need to be buried not cremated due to the unnecessary risk to mortuary staff who normally remove such items.

This may not be your local guidance, so be clear what and why you are following, with the safety of your staff paramount.

Questions for discussion

- What mechanisms are in place, currently, for breaking bad news and how will they change?
- What support is there for front-line staff in having these important conversations?
- How are conversations conducted if both patient and family are in isolation?
- Do you offer de-brief sessions for staff?
- Who is responsible for conducting the de-briefing sessions, what is their training?
- Are staff rotas arranged to give a mix of experience in having those life and death conversations?
- How are you currently utilising staff to share the load?
- What support is there in place for bereaved relatives?
- What support is there in place for bereaved staff?
- If restrictions are in place, how are families informed of them?
- What arrangements are in place for returning belongings of deceased patients?
- Guidance and information will be constantly changing, who is responsible for making decisions and changing policy?

- Will we have enough care after death resources?
- How will staff obtain more resources outside normal working hours?
- Do you have out-of-hours Swan Scheme resource cupboards for staff to get resources if their stocks get low or they run out?
- How are the deceased to be handed over for burial?
- Due to the possible number of deaths, who in the Trust is responsible for making the decision about not burying in the normal way?
- What is the current role of the bereavement office?
- Given the likely numbers using the office services, can the staffing be supplemented?
- Have the staff had additional support/training for Covid 19?
- Do staff have easy access to translation services, particularly out of hours?
- How have the guidelines been updated for different religious groups? Especially in regard to the washing of the deceased person and the quick return for burial?
- Does the bereavement team have up to date contacts for families to access external support?
- Is there extra support within the hospital?

- Do you have an up to date bereavement booklet, encompassing the changes brought on by current events?

- What are the arrangements for signing death certificates?

- How will the bereavement office distribute the Medical Certificate of Cause of Death?

- How will families register the death? What advice can you give them?

- Do you have a registrar at the hospital? Has this service been stopped because of Covid-19?

- If no registrar at the hospital how will families register the death?

- Do you have a Medical Examiner?

- What is their role in this crisis?

- What support can they give provide for the staff?

- What documents already in place e.g. End of Life Care Plans, DNAR, ReSPECT, Advanced Care Plans, that will support clinical decisions at this time?

- Do we have enough staff to verify the expected number of deaths? If not, could we train staff to do this?

- What is in place to support the mortuary staff?

- What is in place to support porters with the increased workload? Could we redeploy staff or ask volunteers to help in needed areas?

- Do you have enough storage on site, in the mortuary?
- Are specific schemes in place to support death and dying?
- Do you have an EOLC team?
- How are the staff from this team going to be supported and used at this time?
- What practical support is there for families? e.g. car parking?
- What are the management doing to maintain morale?
- How are the management ensuring the staff know how valued they are?
- Who's taking care of you?

Can any good come of the Corona-virus?

We will not know the true impact of the months of January and into the spring and summer of 2020. The struggle may continue for many months, perhaps into the autumn and winter. Who knows?

Our ways of working will change to reflect the challenge, but perhaps not all for the worst. There will be things we will learn to do different and better.

It is important that we remember them and take the best of them into the future.

Perhaps the most outstanding changes are the ways in which the NHS has enabled relatives to keep in touch with Patients in isolation. Creating email message centres, using iPads for live conversations, are just two examples of how NHS nurses and others have made it possible for families to keep connected in such difficult times.

The Academy of Fabulous Stuff has created a repository of innovations and ideas that are emerging, new, every day.

This is where you will find changes, across the whole of the NHS, not just End of Life Care, that people think are worth being part of the future.

Please look at these links and think about the things you are doing that can form part of better services for the future and make something positive out of the Corona-Legacy.

Useful Resources

… collected from a variety of valuable sources, the next pages contain information, guidance and approaches to various aspects of understanding complex issues and helping people at this difficult time

COVID-19 – ethical issues.

An extract from the guidance note published by the BMA

In brief

During this pandemic, doctors are working under extreme pressure. Many are being diverted into new and unfamiliar areas of work and finding themselves working at or even beyond the ordinary limits of their competence or expertise. Retired doctors are returning to practice, and final year medical students are being fast-tracked into front-line roles. Resources are becoming increasingly restricted and choices of available care limited. The pandemic is fast-moving, relatively unpredictable and of uncertain duration. Providing care to existing standards is likely to be difficult. Where they become necessary, prioritisation and triage decisions will be professionally challenging. Doctors will understandably be concerned about their ability to provide safe and ethical care, and their own health and safety as well as those of their family and friends. They will also be concerned that their actions may attract criminal, civil or professional liability.

This guidance note addresses some of the main ethical challenges likely to arise during this pandemic. Wherever possible, links to other sources of advice are provided. From an ethical and professional regulatory perspective – which is also likely to govern the approach of the Courts if there are any legal challenges – doctors should be reassured that they are extremely unlikely to be criticised for the care they provide during the pandemic where decisions are:

- – reasonable in the circumstances
- – based on the best evidence available at the time
- – made in accordance with government, NHS or employer guidance
- – made as collaboratively as possible
- – designed to promote safe and effective patient care as far as possible in the circumstances. Should decisions be called into question at a later day, they will be judged by the facts available at the time of the decision, not with the benefit of hindsight.

Introduction and background

Current data suggest that those most at risk include those over 70 and those with underlying co-morbidities, with men being at higher risk than women.

COVID-19 is likely to affect a large proportion of the population. It is already creating significant personal and economic disruption and loss. Given that it may last several years, sustained pressure will continue to be placed on essential services such as health, energy, food and pharmaceutical production and distribution, water supply and waste disposal.

Given the lack of pre-existing immunity, it is likely that a considerable percentage of the population will seek, and may at some point require, medical attention. There is little or no surge capacity in the NHS although vigorous attempts are being made to reduce demand through social distancing and to increase the availability of intensive care beds. Nevertheless, it is possible that serious health needs may outstrip availability and difficult decisions will be required about how to distribute scarce lifesaving resources. Although we profoundly hope this will not be happen, it is important that we begin to think now about how we would respond should that situation arise in the future.

To date, much of the focus has been on conventional public health tools for the management of the early stages of an outbreak, such as quarantine and other forms of social distancing. As the pandemic develops and health services are put under greater pressure, it is possible that decisions about the allocation of potentially life-saving treatment to individual patients will fall to health care providers and individual health professionals. This would give rise to searching ethical – and procedural – questions and it is to those and related issues we now turn.

An ethical framework

There has always been an ethical tension in medicine between a doctor's concern for the health and welfare of the individual patient and concern for the health of populations. In dangerous pandemics the ethical balance of all doctors and health care workers must shift towards the utilitarian objective of equitable concern for all – while maintaining respect for all as 'ends in themselves'.

Prior to the 2009 pandemic, the Government issued an ethical framework – revised in 2017 – designed to help people think through strategic aspects of decision-making during a pandemic, as well as providing an ethical compass for clinicians. It took the form of several guiding principles which are set out briefly below.

- – **Equal respect:** everyone matters and everyone matters equally, but this does not mean that everyone will be treated the same

- – **Respect:** keep people as informed as possible; give people the chance to express their views on matters that affect them; respect people's personal choices about care and treatment

- – **Minimise the harm of the pandemic:** reduce spread, minimise disruption, learn what works

- – **Fairness:** everyone matters equally. People with an equal chance of benefiting from a resource
  should have an equal chance of receiving it – although it is not unfair to ask people to wait if they
  could get the same benefit later

- – **Working together:** we need to support each other, take responsibility for our own behaviour and share information appropriately

- – **Reciprocity:** those who take on increased burdens should be supported in doing so

- – Keeping things in proportion :information communicated must be proportionate to the risks; restrictions on rights must be proportionate to the goals

- – **Flexibility:** plans must be adaptable to changing circumstances

- – **Open and transparent decision-making:** good decisions will be as inclusive, transparent and
  reasonable as possible. They should be rational, evidence-based, the result of a reasonable process and practical in the circumstances.

Resource allocation

During this pandemic, it is possible that demand on health services may outstrip the ability of the NHS to deliver services to pre-pandemic standards. As we have seen in China, Italy and Spain, deaths frequently follow hospitalisation and critical care interventions. In Wuhan, 5% of those infected were admitted to ICU, and 2.5% required mechanical ventilation.[5] It is possible therefore that restrictions in the availability of mechanical ventilation may for a period become severe.

Although not everyone will become ill at once, the initial wave of illness can be extremely rapid, over a few days to a few weeks. In these circumstances, if demand outstrips the ability to deliver to existing standards, more strictly utilitarian considerations will have to be applied, and decisions about how to meet individual need will give way to decisions about how to maximise overall benefit.

We know that health professionals would find decision-making in these circumstances ethically challenging. Such extreme situations bring about a transformation of doctors' everyday moral intuitions. The obligation to persevere in the face of an extremely ill patient would be challenged by quantitative decisions based on maximising the overall reduction of mortality and morbidity, and
the need to maintain vital social functions. Doctors would be obliged to implement decision-making policies which mean some patients may be denied intensive forms of treatment that they would have received outside a pandemic. Health professionals may be obliged to withdraw treatment from some patients to enable treatment of other patients with a higher survival probability. This may involve withdrawing treatment from an individual who is stable or even improving but whose objective assessment indicates a worse prognosis than another patient who requires the same resource.

Although doctors would likely find these decisions difficult, if there is radically reduced capacity to meet all serious health needs, it is both lawful and ethical for a doctor, following appropriate prioritisation policies, to refuse someone potentially life-saving treatment where someone else has a higher priority for the available treatment.

These are grave decisions, but the legal principles were established in relation to the allocation of organs for transplantation and have been recently upheld by the Court of Appeal.[6]

In relation to adults lacking capacity, these prioritisation decisions are not 'best interests' decisions under capacity legislation. The fact that a patient lacks capacity does not

import a ‘best interests’ decision-making model. In short, there is no automatic priority for those who lack capacity and decisions about their treatment should be made in the same way as for all other patients requiring treatment. If there is a need to limit the availability of intensive care for patients because of the COVID-19 pandemic and a critical shortfall in ICU capacity, it would be unethical to apply those limits differently to patients with or without appointed surrogate decision-makers or those with or without particular religious views.

It is essential that, should they be required to, doctors make these decisions in accordance with decision-making protocols rolled out by employing or commissioning organisations. This would need to be both practical and sufficiently flexible to respond in a timely manner to uncertainty and rapidly changing circumstances.

All decisions concerning resource allocation must be:

- – reasonable in the circumstances
- – based on the best available clinical data and opinion
- – based on coherent ethical principles and reasoning
- – agreed on in advance where practicable, while recognising that decisions may need to be rapidly revised in changing circumstances
- – consistent between different professionals as far as possible
- – communicated openly and transparently
- – subject to modification and review as the situation develops.

Where a decision is made to withhold or withdraw some forms of treatment from patients on the grounds of resource allocation, it is crucial that those patients still receive compassionate and dedicated medical care and attention, as far as possible in the circumstances. This should include appropriate symptom management and, where patients are dying, the best available end-of-life care. If it becomes necessary to make these decisions, they are likely to have a significant emotional impact on health workers, both in the short term and, in some cases, more enduringly. Such decisions may adversely affect the family and friends of healthcare staff. Doctors and other frontline health workers are already overstretched, and the ability of the health system to respond to the pandemic will be dependent upon their wellbeing.

It is essential that employers take steps to provide appropriate support, including clinical ethics committee support and psychological support, to all health professionals working during the pandemic, many of whom may find working in the unfamiliar and strenuous conditions of a pandemic both practically difficult and morally and emotionally challenging.

It is essential that their wellbeing is prioritised, both for its own sake and as part of maintaining effective clinical services. Health professionals should seek to ensure their own wellbeing, and the wellbeing of their colleagues as far as possible in the circumstances. It is vital that all those working in health systems endeavour to work collaboratively and supportively both within teams and more widely.

Triage

If services are overwhelmed during this pandemic, health providers will put in place – or expand systems of triage.

Triage is a form of rationing or allocation of scarce resources under critical or emergency circumstances where decisions about who should receive treatment must be made immediately because more individuals have life-threatening conditions than can be treated at once.

Triage sorts or grades persons according to their needs and the probable outcomes of intervention.

It can also involve identifying those who are so ill or badly injured that even with aggressive treatment they are unlikely to survive and should therefore receive a lower priority for acute emergency interventions while nonetheless receiving the best available symptomatic relief.

It is possible we could reach a point where the decisions made in triage will determine whether potentially large numbers of individuals will receive life-saving treatment or not. It is essential therefore that the principles underlying the decisions are systematically applied.

In these circumstances it is likely that priority will ordinarily be given to those whose conditions are the most urgent, the least complex, and who are likely to live the longest, thereby maximising overall benefit in terms of reduced mortality and morbidity. Priority decisions will be dependent upon the relationship between the availability of resources and the demand. If serious depletion of resources arises, decisions about which patients should receive treatment will change over the course of the pandemic.

We know that current data about COVID-19 show a strong correlation between older age and mortality. Although work has not been done yet to establish whether this reflects an actual effect of age, or simply a correlation between age and co-morbidities that will affect survival rates, it is likely that the most challenging triage decisions will be made for these groups.

If they become necessary, these decisions must not be solely based on age. Ethically, triage requires identification of clinically relevant facts about individual patients and their likelihood of benefiting from available resources. Younger patients will not automatically be prioritised over older ones.

A pandemic will obviously not prevent people being ill in other ways. Triage decisions will therefore not only relate to those patients directly suffering from COVID-19. Similar criteria will need to be applied to all varieties of medical need. Consequently, thresholds for granting access to, for example, intensive care or ventilation will have to be changed for all patients with all presenting criteria. By itself, infection with COVID-19 should not guarantee priority.

The presence of co-morbidity may exclude individuals from eligibility. In these circumstances, it may be necessary to discontinue treatment that has already been started, as there are patients in need whose outcomes are likely to be more favourable. Difficult decisions will arise where strenuous intervention could reduce mortality significantly but would mean that individual patients use resources that could lead to better outcomes for a larger number of other patients.

The pandemic, and the restricted availability of intensive care, will influence other clinical decision- making within the hospital. For example, it will be important for clinicians to review and document the appropriateness of cardiopulmonary resuscitation for all inpatients (with or without COVID-19 associated illness) where there is a possibility of acute deterioration. If patients have sufficient background illness, co-morbidity and/or frailty that they would not be admitted to intensive care (because of the necessary restrictions on admissions), it is important that cardio-pulmonary resuscitation is **not** commenced in the event of a collapse.

Performing advanced resuscitation for a patient for whom post-resuscitation intensive care cannot be provided would potentially cause harm to the patient, consume limited resources at a time of considerable strain, and potentially put the resuscitation team at unnecessary personal risk.

Medical utility

The focus of health professionals' attention during triage will be on delivering the greatest medical benefit to the greatest number of people. Behind such a deceptively simple principle lurk challenging decisions. Such a strategy requires an epidemiological judgment about at-risk groups that will vary according to the epidemiology of the disease.

To maximise benefit from admission to intensive care, it will be necessary to adopt a threshold for admission to intensive care or use of scarce intensive treatments such as mechanical ventilation or extracorporeal membrane oxygenation. Relevant factors predicting survival include severity of acute illness, presence and severity of co-morbidity and, where clinically relevant, patient age.[7] Those patients whose probability

of dying, or of requiring a prolonged duration of intensive support, exceeds a threshold level would not be considered for intensive treatment, though of course they should still receive other forms of medical care.

The difficulty will lie in applying the general principles to a complex, unpredictable and evolving health crisis of uncertain duration and extent. Ethical questions are likely to arise, however, where the requirements of medical utility have been met, but choices between individuals with equal need still have to be made. One likely challenge during the current pandemic is that large numbers of people requiring intensive care are likely to have similar chances of survival and anticipated lengths of stay in ICU. In these circumstances, consideration will have to be given to an egalitarian approach that ensures a fair distribution of resources.

The most likely approach in the first instance is a modified queuing system, based on the well- established and understood principle of 'first come, first served'. This would mean that those patients who become critically ill earlier in the pandemic would be more likely to be admitted to intensive care or receive mechanical ventilation than those who become similarly ill at a later stage, albeit they may only be offered intensive support for a defined but limited period. While such an approach is procedurally simple to apply, and arguably fair, it is not without its challenges. It is, for example, likely to give priority to those who are mobile, who have access to transport, or who live close to hospitals and other sites of health provision.

Withdrawing or withholding treatment?

There is likely to be significant ethical attention to decisions about withholding therapies from patients at the time of deterioration. However, there is no ethically significant difference between decisions to withhold life-sustaining treatment or to withdraw it, other clinically relevant factors being equal – although health professionals may find

decisions to withdraw treatment more challenging.

Depending upon the nature of the pandemic, there may be a need during its progress to shift from one level of service rationing to a more or less severe one, the details of which should be set out by management in protocols. The WHO talks about the 'phasing' of a pandemic, with different phases requiring different decision-making criteria.

Direct and indirect discrimination in prioritisation decisions

Where patients are refused access to life-saving treatment as a result of triage or prioritisation decisions it is likely that questions about possible discrimination may be raised. During the peak of the pandemic, doctors are likely to be required to assess a person's eligibility for treatment based on a 'capacity to benefit quickly' basis.

As such, some of the most unwell patients may be denied access to treatment such as intensive care or artificial ventilation. This will inevitably be indirectly discriminatory against both the elderly and those with long-term health conditions, with the latter being

denied access to life-saving treatment as a result of their pre-existing health problems. A simple 'cut-off' policy with regard to age or disability would be unlawful as it would constitute direct discrimination. A healthy 75-year-old cannot lawfully be denied access to treatment on the basis of age.

However, older patients with severe respiratory failure secondary to COVID-19 may have a very high chance of dying despite intensive care, and consequently have a lower priority for admission to intensive care.

Although a 'capacity to benefit quickly' test would be indirect discrimination, in our view it would be lawful in the circumstances of a serious pandemic because it would amount to 'a proportionate means of achieving a legitimate aim', under s19 (1) of the Equalities Act – namely fulfilling the requirement to use limited NHS resources to their best effect.

Maintaining essential services

Although we are not there yet, it is possible we may reach a stage where decisions about beneficial distribution of resources can no longer be restricted to medical utility alone. Given the potential for widespread social and economic disruption, decisions about which groups will have first call on scarce resources may also need to take account of the need to maintain essential services, in a situation where the workforce providing those services is severely depleted. This may mean giving some priority to those who are responsible for delivering those services and who have a good chance of recovery, in order to get them back into the workforce. In addition to delivering maximum clinical benefit, priorities during a severe pandemic may include:

– limiting social disruption
– ensuring maintenance of health care systems – ensuring integrity of social infrastructure
– limiting economic losses.

In addition to those individuals involved in tackling the immediate health and social care aspects of the pandemic, and particularly those with scarce and irreplaceable skills, many public and private actors are necessary to ensure that essential services are maintained. This could include personnel in the emergency services, security, essential products and services, the maintenance of critical infrastructure such as transportation, utilities such as electricity, water and sewage systems, telecommunications and sanitation.

Priority will also need to be given to the continued function of governance structures. Key individuals who are involved in the production of countermeasures, including prioritised group. In our view it will be for Government to define the categories of essential workers and the tests to be applied. This is not a responsibility that should lie with doctors.

Giving priority to those working in essential services in this way would move beyond our usual system of resource allocation and decision-makers could face criticism for discriminating between individuals on the basis of social, rather than solely medical, factors. Should such an eventuality arise, procedures for decision-making must be transparent, reasonable and based on defensible moral principles and great care must be taken in clearly communicating the rationale for this approach and the critical importance for all of maintaining these vital services.

Management of risk to health professionals

As we have seen in China, Italy and elsewhere, health professionals are directly at risk of illness, and those with underlying morbidities may be particularly vulnerable. Obligations on health professionals to accept a degree of risk in providing treatment impose strong reciprocal obligations on employers. All employers have both a legal and ethical responsibility to protect their staff and must ensure that appropriate and adequate personal protective equipment is available, and that staff are trained in the use of it. Health staff, and other staff essential to the running of health services, cannot be expected to expose themselves to unreasonable levels of risk where employers have not provided, or have been unable to provide, appropriate protective equipment.

Where health professionals have a reasonable belief that their protective equipment is insufficient – that it falls short of expected professional standards – they need to raise this as a matter of urgency with their managers. Risk assessments must be made based upon the specific facts of the case, and consideration should be given to finding alternative ways of providing the care and treatment needed. In the BMA's view, there are limits to the level of risks doctors can reasonably be expected to expose themselves to as part of their professional duties. Doctors would not be under a binding obligation to provide high-risk services where employers have failed to fulfil at least minimal obligations to provide appropriate safety and protection and to protect doctors and other health professionals from avoidable risks of serious harm.

If BMA members are concerned that they are being asked to see patients who are infected, or who are suspected to be infected, without adequate safeguards being in place, this should be raised immediately with the BMA via local representatives or First Point of Contact, the BMA's telephone advice service.

The impact on general practice

During the peak of a pandemic, it is possible that hospital facilities may effectively lose much of their capacity to admit new patients, and GPs will effectively be unable to refer. In these circumstances, it is possible that the overwhelming majority of serious health needs will be met in the community. Even with effective services available, GPs will be dealing with most health need in the community. As such, they are going to be under even more intense pressure. Individual GPs will also be exposed to the virus and may require isolation. In these circumstances, it is reasonable for general practices to engage in different ways of working.

These may include:

- – a reduction or cancellation of non-essential services
- – a reduction or cancellation of homevisits
- – widespread use of telephone triage
- – increased use of telephone and video consultations
- – greater use of email and messaging apps
- – the cancellation of all non-urgent appointments.

As discussed earlier, GPs, like their hospital doctor colleagues, may find work pressures and the nature of the decisions they are forced to make emotionally distressing during a pandemic. It is vital that support is provided and GPs seek to ensure their own wellbeing and that of their professional colleagues.

The importance of fair process

For responses to a pandemic to be ethically defensible, consideration must be given to procedural ethics – to ensuring that decisions at all levels are made openly, accountably, transparently, by appropriate bodies and with full public participation (to the extent possible within the timescale within which decisions need to be made). There may also be a role for scrutiny of individual decisions by a second doctor, or where appropriate by properly constituted clinical ethics committees, where time permits.

Given the threat presented by a pandemic, the widespread media interest in the issue, and some of the more sensational recent coverage, the arrival of a pandemic raises the spectre of public alarm and, in *extremis*, the possibility of civil disobedience. Public acceptance of rationing decisions, and cooperation in a health emergency, are more likely if citizens accept the fairness and legitimacy

of allocation decisions and have been informed beforehand of the anticipated response. There are several factors that are likely to influence such acceptance. Firstly, who is charged with responsibility for making the decisions? Where decisions are made

clandestinely and without oversight by elected or other appropriate representatives or appointees, confidence in decisions may be lost. Transparent and accountable decision-making processes, including explicit discussion of the ethical principles and reasoning upon which decisions are made, are likely to lead to greater public acceptance. It is also important that the public is kept informed, and that there are opportunities for participatory decision-making when feasible, and for public feedback and comment.

Liability issues

During the pandemic, health professionals are likely to be exposed to considerable amounts of stress, may be working well beyond their normal hours, and will be subject to anxiety about their own health and that of their families. In emergency situations, it may also be ethical for health professionals to consider intervening to provide treatment at the limits of or even beyond their competence in order to prevent serious harm. Retired health professionals are returning to practice and final year medical students are being fast-tracked. The skills of these professionals may not meet pre- pandemic expected standards of fitness to practise, but they may nevertheless be able to make a vital contribution. In extreme circumstances, even untrained staff may be required to undertake some functions. This will inevitably give rise to questions about professional and legal liability and indemnity. In relation to concerns raised about a doctor's fitness to practise during the pandemic, the GMC states:

Whenever a concern is raised with us, we always consider it on the specific facts of the case, taking into account the factors relevant to the environment in which the doctor is working.

We know that health services are under intense pressure, and managers and clinicians are making difficult decisions about how to provide care to patients often in extremely challenging circumstances. The scale of the challenges to delivering safe care would be relevant to a question about the clinical care provided by a doctor.

In addition, we'd consider the resources available to the doctor, the problems of working in unfamiliar areas of practice and the stress and tiredness that may affect judgment or behaviour. We would also take account of any relevant information about resource, guidelines or protocols in place at the time.

The primary requirement for all doctors is to respond responsibly and reasonably to the circumstances they face.[11]

This overall approach is reinforced in a letter to medical staff from the Chief Medical Officers of the four nations and the medical directors of the GMC and NHS England.

The arrival of a pandemic will also require the rapid development and deployment of vaccinations and anti-virals. The urgency of the event will mean that the normal procedures for development and licensing may have to be suspended or adapted to the demands of the emergency. In turn this could lead to health professionals using large

numbers of relatively novel and untested pharmaceutical interventions. Mass use of untried vaccine could result in numerous adverse events. Issues of liability will therefore have to be addressed as a matter of urgency by the Government.

Key information/guidance from other bodies

Advice from the General Medical Council on its regulatory approach to doctors working during a pandemic: https://www.gmc-uk.org/news/news-archive/coronavirus-information-and-advice.

A joint letter to doctors from the CMOs of the four nations and the medical directors of NHSE and the GMC about support during a pandemic: https://www.gmc-uk.org/news/news-archive/supporting- doctors-in-the-event-of-a-covid19-epidemic-in-the-uk.

A UK Government advice portal on COVID-19: https://www.gov.uk/government/topical-events/ coronavirus-covid-19-uk-government-response.

NHS England's operating framework for managing the response to pandemic influenza:

https://www.england.nhs.uk/publication/operating-framework-for-managing-the-response-to- pandemic-influenza/.

Health Protection Scotland's guidance on COVID-19:

https://www.hps.scot.nhs.uk/guidance/.

Guidance on COVID-19 from Public Health Wales:

https://phw.nhs.wales/topics/latest-information-on-novel-coronavirus-covid-19/.

Guidance on COVID-19 for Northern Ireland:

https://www.health-ni.gov.uk/coronavirus.

A CHEST consensus statement on triage and care of the critically ill during pandemics and disasters:

https://journal.chestnet.org/article/S0012-3692(15)51990-9/pdf.

A useful BMJ comment on triage during the COVID-19 outbreak: https://blogs.bmj.com/bmj/2020/03/09/covid-19-triage-in-a-pandemic-is-even-thornier-than-you-might-think/.

The Government's ethical framework for decision-making during a pandemic:

https://www.gov.uk/guidance/pandemic-flu#ethical-framework.

https://gov.wales/sites/default/files/publications/2019-04/health-protection-guidance-2010.pdf.

1. Is there evidence of advanced care planning or conversations having taken place in the patient's notes? This could have been in clinics, the community or through contact with palliative care.
2. Select the right environment and time so that the patient, the family and you are comfortable. Leave your bleep with a colleague. Remember you may have done this before but for some families it could well be the first time.
3. Ensure the right people are present in the room. Make sure the patient has a voice.
4. Be sensitive to the needs of all present. Determine the level of information needed by listening to everyone in the room.
5. Find out what is important to the patient and their family. What is their preferred place of care? Home, care home, hospice or hospital. Start fast track if appropriate.
6. Ensure that all present are clear about the outcomes. Do not rush as they will all need time to focus on what has been said and the impact that will have on them. Don't be afraid to ask and answer questions.
7. Contact the registrar or consultant to initiate the EOLC plan if appropriate. Contact the EOLC team if support is required for next steps. Remember you will not have another chance to get this right, to ensure the patient has the end of life they want and deserve.
8. Thank you for having this important end of life care conversation, now it's time for you to take a moment to reflect & have a cuppa.

Contacting Relatives by Phone to Communicate Death of a Patient

STEP 6B: IF THE PATIENT HAS CHILDREN UNDER 25 YEARS DISCUSS HOW TO TALK TO THE CHILDREN

- Telling children about a parent's death is emotionally challenging. People don't want to cause distress, but children need to know.
- Discuss children's awareness of what has been going on. Remind them that even very young children will have noticed changes in their environment and will be looking for explanation.
- If person expresses fear about how to tell the children, consult 'How to tell children' document which includes suggestions on answering children's common questions.
- Reassure it will not cause harm to tell children how adults are feeling, but careful not to over share extreme emotions.
- If parents are separated, confirm who will tell the children and encourage consistent messaging by adults to avoid confusion.
- In lockdown situations there will be very little privacy and time for people to prepare themselves or get support from a friend or relative.

- *"Thinking about talking to [children's names] about this probably feels the hardest thing in the world. It's completely understandable that you want to protect them from this news."*
- *"I understand you are worried that telling the children will be upsetting for them. Even very young children need an explanation for what's going on"*
- *"I know in the current situation there is not much time or space for you to think about how you will tell the children. Would it be helpful for us to talk through how you might do that?"*
- *"It's very natural for children to feel very upset and sometimes they may even feel angry. But talking is very important in helping them through this difficult time."*
- *"It's OK to talk with children about how upsetting and sad this news is for everybody."*

STEP 6C: HELPING TO PREPARE FOR CHILDREN'S COMMON QUESTIONS

- Prepare people for common questions that children may ask.
- People need to consider the child's age and level of understanding.
- Encourage person to check what the children know and understand already; ask children if they would like more information or have questions about what has happened.
- See 'How to tell children' document which includes how to answer children's common questions for different age groups.

- *"Children often want to know what caused the death and are worried that it might have been their fault."*

Emphasise that parent had Coronavirus, were cared for by the medical team and that it was nobody's fault.

- *"Children may ask you if you are going to die, who will look after them and whether they will catch it. Shall we plan how you might deal with these questions at home?"*

Focus on practical information and steps everyone is taking to stop the spread of the Coronavirus (washing hands, distancing...) Remind children other people in the family and their friends love and care for them.

STEP 7: MAKE A PLAN

- Finish by explaining what will happen next, using most up to date hospital policy regarding death certification, mortuary etc.
- Reassure them they will not have to manage this alone; direct to established bereavement services and online resources.
- Repeat your name and which department you are calling from.
- Update patient file and tell other staff that the next of kin have been told.
- These are emotionally exhausting conversations. Take a minute to check how you are feeling. Do you need to take 5-mins/a cup of tea/snack/ talk to your team?

- *"I know this has been a very difficult conversation. There has been a lot to take in; is there anything you do not understand?"*
- *"Just to recap, the next steps will be [refer to latest hospital protocol re bereavement services for Coronavirus related deaths]"*

TOP TIPS

1. Find a quiet place. Make sure you have the key information. Use a landline if possible.
2. Speak slowly, clearly, with pauses.
3. Counting to 3 in your head can help slow you down, particularly if you're feeling nervous.
4. Silences can feel uncomfortable and longer than they actually are on the telephone. Don't feel you have to fill the silence.
5. Remember that the patient may be a parent; it is essential to help adults think about how to tell children as soon as possible.
6. These are difficult conversations; take time to look after yourself, it may be helpful to 'off load' to a colleague or reflect with your team.

Dr Louise Dalton, Dr Elizabeth Rapa, Helena Channon-Wells and Prof Alan Stein | louise.dalton@psych.ox.ac.uk | March 2020 | thelancet.com/series/communicating-with-children

Contacting Relatives by Phone to Communicate Death of a Patient

STEP 1: PREPARE

- Take a moment to compose yourself. A few slow deep breaths will help you focus.
- Check patient's information: patient name? Did they have children/a partner?
- Check latest protocol following death of a patient and what bereavement support is available.
- Consider rehearsing/role playing what you are going to say with a colleague.
- Find a space where you won't be interrupted. Pass your bleep/phone to a colleague. If possible, use a landline to make the call.

STEP 2: STARTING OFF

- Introduce yourself by name.
- Clearly explain which team and hospital you are calling from.
- Establish who you are speaking to and their relationship to the patient.
- Check they can talk privately.
- Speak slowly with pauses between sentences. Counting to 3 in your head can help slow you down, particularly if you're feeling nervous.
- If the person is very distressed they may ask straight away if their relative has died - still use the 'warning shots'.
- If the person does not answer the phone - DO NOT leave a voicemail.

- *"Hello, my name is xx. I am part of the xx team who has been looking after [Name]"*
- *"Is there somewhere quiet that you can talk at the moment?"*
- *"Can I just check who is at home with you now?"*
- *"Shall I call you back in 5 minutes when you've had a chance to put a DVD on for the children?"*

STEP 3: WARNING SHOTS

- Briefly set context for telephone call.
- Ask if there is anyone else (e.g. partner) they want to be in on the call too.
- Remember to speak slowly, clearly and with pauses.

- *"I'm calling to talk about [Name]."*
- *"What have you been told so far about their condition?"*
- *"I am sorry to have to tell you this over the phone and not in person"* ***PAUSE***

STEP 4: GIVING KNOWLEDGE AND INFORMATION

- Talk VERY slowly, honestly and realistically.
- Avoid euphemisms (do not say passed away) and technical jargon.
- After you have told the person that the patient has died, STOP for a few seconds to allow the person to take in what you have said.
- Listen for reactions to gauge when they are ready for more information.
- Remember pauses are important as you can't see the other person's reaction to what you are saying.

- *"I'm very sorry to tell you that [Name] became very unwell and has died. I'm so sorry."*
- *"I am very sorry to give you this news over the phone"*
- *"Do I need to slow down? Would you like me to repeat anything?"*
- *"I understand this might be very difficult to take in.... just take a few moments"*

STEP 5: RESPONDING TO THE EMOTIONAL IMPACT OF THE NEWS

- Support person with their own feelings/distress about the bereavement.
- Distress may limit their capacity to absorb information.
- Silences can feel uncomfortable and longer than they actually are on the telephone. It is difficult to know how a person is reacting when you can't see them; there may be other people in earshot including children.
- Don't feel you have to fill the silences.
- Using sounds and words, e.g. 'uh-huh', 'mmm', "take your time — I'm still here" replaces eye contact or touch, and confirms your presence.

- If person is crying or shouting: *"I understand that it is very upsetting news, particularly by telephone."*
- If person repeatedly says "it's not true, it can't be": *"I understand this is very difficult for you to take in."*
- If person goes very quiet or says 'thank you for letting me know': *"This news can be very difficult to take in; would you like me to help you think about what you need to do next?"*

STEP 6: ESTABLISH IF THE PATIENT WAS A PARENT

- Check if the patient was a parent; names and approximate ages of children.
- If patient was a parent and children are under 25 years, go to Page 2.
- If children are over 25 years, or patient was not a parent, go to Step 7.

- *"Does [Name] have any children who will need to be told?"*
- *"Are they with you at home right now?"*

STEP 7: MAKE A PLAN

- Finish by explaining what will happen next, using most up to date hospital policy regarding death certification, mortuary etc.
- Reassure them they will not have to manage this alone; direct to established bereavement services and online resources.
- Repeat your name and which department you are calling from.
- Update patient file and tell other staff that the next of kin have been told.
- These are emotionally exhausting conversations. Take a minute to check how you are feeling/take 5-mins/cup of tea/snack/talk to your team.

- *"I understand this has been a very difficult conversation. There has been a lot to take in; is there anything you do not understand?"*
- *"Just to recap, the next steps will be [refer to latest hospital protocol re bereavement services for Coronavirus related deaths]"*

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(https://www.library.sath.nhs.uk/)

Coronavirus (COVID-19) resources

Links to information and resources to support the response to the COVID-19 outbreak. For e-learning resources, visit the COVID-19 e-learning page (http://www.library.sath.nhs.uk/covid-19/e-learning/) and for e-books, visit the COVID-19 e-books page (http://www.library.sath.nhs.uk/covid-19/e-books/).

COVID-19 Evidence Bulletin

Our new Evidence Bulletins collate the latest national guidance, evidence and research on COVID-19

- COVID-19 Evidence Bulletin 2, 6th April 2020 (http://www.library.sath.nhs.uk/wp-content/uploads/2020/04/COVID-19-Evidence-Bulletin-2.pdf)
- COVID-19 Evidence Bulletin 1, 1st April 2020 (http://www.library.sath.nhs.uk/wp-content/uploads/2020/04/COVID-19-Evidence-Bulletin-1.pdf)

You can also keep up to date with COVID-19 by subscribing to KnowledgeShare Evidence Updates (https://www.library.sath.nhs.uk/knowledgeshare/) which offer fortnightly personalised alerts on healthcare topics of your choice.

NHS England information

- Advice for clinicians (https://www.england.nhs.uk/ourwork/eprr/coronavirus/)
- Information for the public (https://www.nhs.uk/conditions/coronavirus-covid-19/)
- Get coronavirus (COVID-19) advice from NHS 111 (https://111.nhs.uk/covid-19)

UK Government information

- Number of coronavirus (COVID-19) cases and risk in the UK (https://www.gov.uk/guidance/coronavirus-covid-19-information-for-the-public)
- Travel advice (https://www.gov.uk/guidance/travel-advice-novel-coronavirus)
- Guidance for health professionals (https://www.gov.uk/government/collections/wuhan-novel-coronavirus)

World Health Organization (WHO) information (https://www.who.int/emergencies/diseases/novel-coronavirus-2019)

(http://library.sath.nhs.uk/blog/category/news/feed/) Latest News (https://www.library.sath.nhs.uk/)

Free access to the LWW Health Library e-book collection (https://www.library.sath.nhs.uk/blog/2020/04/09/free-access-to-the-lww-health-library-e-book-collection/)

Keep up to date with the latest guidance on COVID-19 (https://www.library.sath.nhs.uk/blog/2020/04/06/keep-up-to-date-with-the-latest-guidance-on-covid-19/)

Access e-books anywhere, anytime, on any device (https://www.library.sath.nhs.uk/blog/2020/04/03/access-e-books-anywhere-anytime-on-any-device/)

Support your mental health and wellbeing with these free apps (https://www.library.sath.nhs.uk/blog/2020/03/30/support-your-mental-health-and-wellbeing-with-these-free-apps/)

New edition of the Royal Marsden Manual is now available online (https://www.library.sath.nhs.uk/blog/2020/03/27/new-edition-of-the-royal-marsden-manual-is-now-available-online/)

- Technical Guidance (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance)
- Travel Advice (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/travel-advice)
- Advice for Public (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public)
- Situation Reports (https://www.who.int/emergencies/diseases/novel-coronavirus-2019/situation-reports/)
- Coronavirus General Information (https://www.who.int/health-topics/coronavirus)

Evidence summaries

- UpToDate (https://www.uptodate.com/contents/coronavirus-disease-2019-covid-19) [for information on accessing UpToDate off-site or on a mobile device, visit our website (https://www.library.sath.nhs.uk/uptodate/)]
- BMJ Best Practice (https://bestpractice.bmj.com/topics/en-gb/3000168)
- DynaMed (https://www.dynamed.com/condition/covid-19-novel-coronavirus)
- Cochrane Library (https://www.cochrane.org/coronavirus-covid-19-cochrane-resources-and-news)
- Oxford COVID-19 Evidence Service (https://www.cebm.net/oxford-covid-19/). The CEBM is putting together evidence syntheses on relevant topics

Clinical guidelines

- Coronavirus guidance for clinicians and NHS managers from NHS England (https://www.england.nhs.uk/coronavirus/)
- Coronavirus guidance from NICE (https://www.nice.org.uk/guidance/conditions-and-diseases/infections/covid19)
- Coronavirus (COVID-19) infection and pregnancy (https://www.rcog.org.uk/globalassets/documents/guidelines/coronavirus-covid-19-virus-infection-in-pregnancy-2020-03-09.pdf). Guidance published by the Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Paediatrics and Child Health, Public Health England and Health Protection Scotland.
- Resuscitation Council UK Statements on COVID-19 (Coronavirus), CPR and Resuscitation (http://www.resus.org.uk/media/statements/resuscitation-council-uk-statements-on-covid-19-coronavirus-cpr-and-resuscitation/)

Professional Guidance

- Guidance for Doctors (https://www.gmc-uk.org/news/news-archive/coronavirus-information-and-advice/our-guidance-for-doctors). Professional guidance from the General Medical Council.
- Coronavirus (Covid-19): Information and advice (https://www.nmc.org.uk/news/coronavirus/). Professional advice for the nursing profession from the NMC.

Journal and Publisher Sites

A number of publishers are offering free access to articles and other information relating to COVID-19

- The Lancet: 2019-nCoV Resource Centre (https://www.thelancet.com/coronavirus)
- New England Journal of Medicine: 2019 Novel Coronavirus (2019-nCoV) (https://www.nejm.org/coronavirus)
- Elsevier: Novel Coronavirus Information Center (https://www.elsevier.com/connect/coronavirus-information-center)
- Wiley Journals (https://novel-coronavirus.onlinelibrary.wiley.com/)
- Ovid Discovery (https://coronavirus.ovidds.com/discover/results?q=Coronavirus%20OR%202019-nCoV%20OR%20nCoV)

Quick Links

Renew your loans (http://www.shelib.nhs.uk/webview/?infile=user.glu&auth_this=y&style=user)

Join the Library (/joining)

UpToDate (/uptodate)

Browse E-Journals (https://browzine.com/libraries/1791/)

OpenAthens (https://library.sath.nhs.uk/services/athens)

Royal Marsden Manual (/royal-marsden)

e-Learning for Healthcare (e-LfH) (https://portal.e-lfh.org.uk)

Research Hub (/research)

Resources for patients and the public (/find/patients)

Well-Being @ Work (/wellbeing)

Sign up for Library Updates (https://feedburner.google.com/fb/a/mailverify?uri=KnowledgeSource&loc=en_US)

Shrewsbury and Telford Health Libraries

(https://www.facebook.com/sathlibraries)
(https://www.instagram.com/sathlibraries/)
(https://library.sath.nhs.uk/blog/category/news/feed/)
(https://www.twitter.com/sathlibraries)

Contact Us

Shrewsbury Health Library
(http://library.sath.nhs.uk/shrewsbury)
Learning Centre
Royal Shrewsbury Hospital
Mytton Oak Road
Shrewsbury, SY3 8XQ
Tel: 01743 492512 or ext. 2512

sath.shrewsbury.library@nhs.net
(mailto:sath.shrewsbury.library@nhs.net)

Telford Health Library
(http://library.sath.nhs.uk/telford)
Education Centre
Princess Royal Hospital
Apley Castle
Telford, TF1 6TF
Tel: 01952 641222 ext 4440

sath.telford.library@nhs.net
(mailto:sath.telford.library@nhs.net)

Opening times 8.30-5 Monday-Friday
Access outside these hours
(http://library.sath.nhs.uk/services/out-of-hours) is available on application.

Tweet to @sathlibraries
(https://twitter.com/intent/tweet?screen_name=sathlibraries)

Using the Library

Shrewsbury Health Library
(https://www.library.sath.nhs.uk/shrewsbury/)

Telford Health Library
(https://www.library.sath.nhs.uk/telford/)

Joining the Library
(https://www.library.sath.nhs.uk/services/joining/)

IT, Printing and WiFi
(https://www.library.sath.nhs.uk/it-facilities/)

Out of Hours Access
(https://www.library.sath.nhs.uk/services/out-of-hours/)

Room Bookings
(https://www.library.sath.nhs.uk/services/room-bookings/)

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Well-Being @ Work
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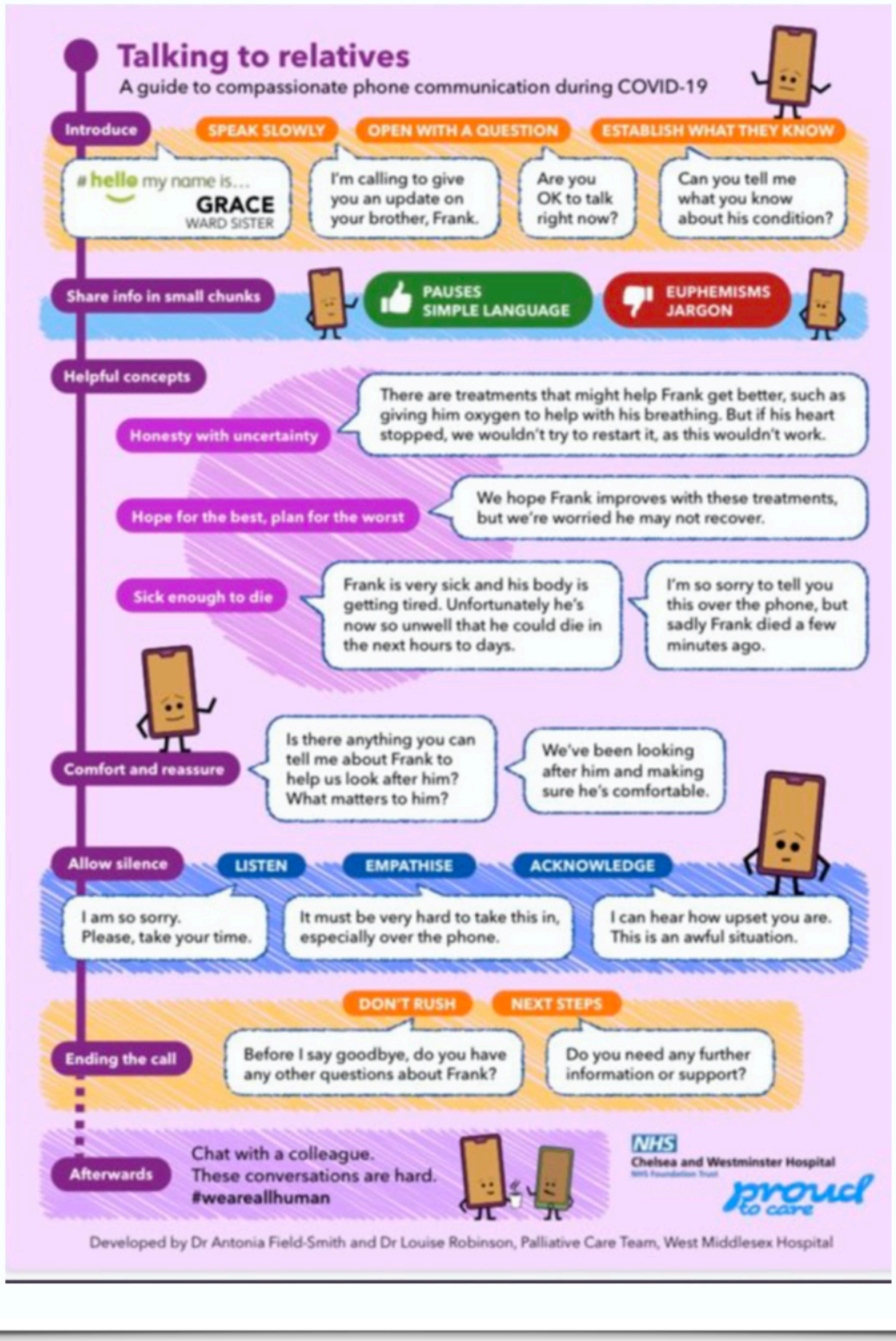
(http://library.sath.nhs.uk/wp-admin/)


Talking to relatives
A guide to compassionate phone communication during COVID-19
Introduce
SPEAK SLOWLY
OPEN WITH A QUESTION
ESTABLISH WHAT THEY KNOW
#hello my name is...
GRACE
WARD SISTER
I'm calling to give you an update on your brother, Frank.
Are you OK to talk right now?
Can you tell me what you know about his condition?
Share info in small chunks
PAUSES
SIMPLE LANGUAGE
EUPHEMISMS
JARGON
Helpful concepts
Honesty with uncertainty
There are treatments that might help Frank get better, such as giving him oxygen to help with his breathing. But if his heart stopped, we wouldn't try to restart it, as this wouldn't work.
Hope for the best, plan for the worst
We hope Frank improves with these treatments, but we're worried he may not recover.
Sick enough to die
Frank is very sick and his body is getting tired. Unfortunately he's now so unwell that he could die in the next hours to days.
I'm so sorry to tell you this over the phone, but sadly Frank died a few minutes ago.
Comfort and reassure
Is there anything you can tell me about Frank to help us look after him? What matters to him?
We've been looking after him and making sure he's comfortable.
Allow silence
LISTEN
EMPATHISE
ACKNOWLEDGE
I am so sorry. Please, take your time.
It must be very hard to take this in, especially over the phone.
I can hear how upset you are. This is an awful situation.
Ending the call
DON'T RUSH
NEXT STEPS
Before I say goodbye, do you have any other questions about Frank?
Do you need any further information or support?
Afterwards
Chat with a colleague.
These conversations are hard.
#weareallhuman
NHS
Chelsea and Westminster Hospital
NHS Foundation Trust
proud to care
Developed by Dr Antonia Field-Smith and Dr Louise Robinson, Palliative Care Team, West Middlesex Hospital

Facilitating compassionate care for patients dying with COVID-19

Infection Prevention Society and British Association of Critical Care Nurses Joint Statement

Position Statement

End of life care is a fundamental pillar of nursing care and relates to both the care of the person at the end of life and their family. The current COVID-19 epidemic has resulted in all normal hospital/ hospice and care home visiting being suspended except for special circumstances. The Infection Prevention Society and British Association of Critical Care Nurses agree that being with a loved one at the end of their life constitutes a special circumstance and, that wherever possible, the health/social care organisation should instigate safe and compassionate approaches that allow an immediate family member/ significant other to be with a dying person at the end of life.

1. Facilitating the visit

We are aware that some organisations are already facilitating end of life visiting and that there are different approaches to managing this. These are dependent upon the acuity of the person's condition and the resource pressures that exist in the organisation, including the staff and personal protective equipment available. Key principles include:

- Limiting the number of next of kin/ significant others to one or two immediate household or close family contacts.
- Coordination of hospital/ hospice visiting by the palliative care team with involvement of the infection prevention and control team and using redeployed healthcare staff to support relatives and escort them to and from care settings.
- In a Care Home setting the coordination of the visit will be undertaken by the nurse in charge or the manager.
- The use of appropriate protective equipment for the visitor and attention to hand hygiene to minimise the risk of transmission of infection.
- Providing a detailed description of the setting and what to expect when they see their loved one and instructions related to wearing personal protective equipment and cleaning their hands.

2. Location of the dying person

Where possible the dying person should be nursed in a single room with ensuite toilet facilities. However, in the current situation or where the person in being care for in the Intensive Care Unit or a Nightingale/Field Hospital this may not be possible.

3. Getting to the hospital/ hospice/ care home

- The next of kin/ significant other should be able to drive or be driven to the hospital/ hospice/ care home. This minimises the risk of exposure to others, particularly if the household is self-isolating as contacts of the dying person.

Date of Release 15 April 2020

- On arrival the next of kin/ significant other should call the ward/unit so that someone can be sent to meet them at an agreed meeting point, escort them to the care setting and provide them with PPE.

4. Minimising the risk of infection

- The next of kin/ significant other should be asked to minimise the number of personal belongings that they bring with them e.g., bags, handbags, electronic devices.
- The member of staff meeting the next of kin/ significant other should take with them surgical masks, plastic aprons and alcohol hand gel if the local policy requires PPE to be put on before reaching the care setting.
- The member of staff should escort the next of kin/ significant other to the care setting by the shortest possible route.
- The next of kin/ significant other should remove outer clothing e.g., coat or jacket, roll up their sleeves and clean their hands before putting on an apron and surgical facemask to enter the care setting. They should understand that the front of the surgical mask must not be touched or removed while they are with their relative.
- If entering the ICU/ High Dependency area a higher level of protection may be required and staff should assist with putting it on and taking it off safely.
- Gloves are not required for contact and hands must be washed prior to leaving the care setting. This level of protection will minimise the risk to the visitor and allow him/her to hold the hand of their loved one.

5. Care of the next of kin/ significant other

- Prepare the relative/ significant other for what they will see when they arrive in the care setting.
- If there is a limit to the length of time that they can stay this needs to be explained.
- Notify the nurse caring for the person that his/her next of kin/ significant other has arrived.
- Ensure that the next of kin/ significant other knows how to use the call bell if they need anything or signal when they want to leave.
- Provide comfort if the person is distressed, hold the persons hand(s), provide a cup of tea.
- Provide the relative with information about what will happen next if their loved one has died.
- Reassure the relative/ significant other that self-isolation is not required following the visit as they have been protected from the risk of transmission by using PPE and performing hand hygiene.

6. At the end of the visit

- Help the person to remove their PPE in a safe way and dispose of it in an orange bag.
- **NB** If the visitor is self-isolating or COVID19 positive they should continue to wear the surgical facemask until they leave the premises and dispose of it in the household rubbish when they get home.

NOTES