International COVID-19 palliative care guidance for nursing homes leaves key themes unaddressed

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IMPACT STATEMENT

What this research specifically adds:

• This paper reports on the first directed documentary and content analysis of guidance documents from across the world concerning palliative care in nursing homes in the context of COVID-19. Findings can support future palliative care guidance development for COVID-19 in nursing homes, by highlighting unaddressed topics that require urgent attention.

• Twenty-one documents (both international and country-specific) provided recommendations regarding palliative care in nursing homes in the context of COVID-19, albeit mostly with a very limited focus (e.g. regulating visits for dying residents, hospitalizations at the end of life).

• Key aspects of palliative care were largely unaddressed, including protocols for holistic assessment and management of symptoms and needs at the end of life (including stockpiling medications), education of staff concerning palliative care, referral to specialist palliative care or hospice, advance care planning communication, support for family including bereavement care, and support for staff.
ABSTRACT

COVID-19 mortality disproportionally affects nursing homes, creating enormous pressures to deliver high-quality end-of-life care. Comprehensive palliative care should be an explicit part of both national and global COVID-19 response plans. Therefore, we aimed to identify, review and compare national and international COVID-19 guidance for nursing homes concerning palliative care, issued by government bodies and professional associations. We performed a directed documentary and content analysis of newly developed or adapted COVID-19 guidance documents from across the world. Documents were collected via expert consultation and independently screened against pre-specified eligibility criteria. We applied thematic analysis and narrative synthesis techniques. We identified 21 eligible documents covering both nursing homes and palliative care; from the World Health Organization (n=3), and eight individual countries: USA (n=7), the Netherlands (n=2), Ireland (n=1), United Kingdom (n=3), Switzerland (n=3), New Zealand (n=1), Belgium (n=1). International documents focused primarily on infection prevention and control, including only a few sentences on palliative care related topics. Palliative care themes most frequently mentioned across documents were end-of-life visits, advance care planning documentation, and clinical decision-making towards the end of life (focusing on hospital transfers). There is a dearth of comprehensive international COVID-19 guidance on palliative care for nursing homes. Most have a limited focus both regarding breadth of topics and recommendations made. Key aspects of palliative care, i.e. symptom management, staff education and support, referral to specialist services or hospice, and family support, need greater attention in future guidelines.

Key words: COVID-19; Nursing homes; Long-term care; Palliative care
INTRODUCTION

Nursing home residents, who are often frail and affected by multimorbidity, account for between 42% and 57% of all deaths related to COVID-19 [1, 2], although these data are unsystematically reported. The high mortality in nursing homes is likely due to the vulnerability of the population and the close physical proximity between residents and staff, as well as insufficient staff training and equipment for infection control [3, 4].

While guidelines to support nursing homes in preventing and managing the current crisis are evolving rapidly across the world, there is urgent need specifically for clear guidance on end-of-life care for these settings [5, 6]. Palliative care has a key role in the care for older people affected by COVID-19 [7]. It is an approach that aims to improve people’s quality of life and that of their families, facing the problems associated with life-threatening illness. It includes not only impeccable symptom management - including for respiratory distress - but also psychological, social and spiritual care and support in medically and ethically difficult end-of-life decision-making [8].

We sought to inform the update and development of new guidelines by examining and synthesizing existing national and international COVID-19 guidance documents for nursing homes concerning palliative and/or end-of-life care, and by studying which specific recommendations they make.

METHODS

We conducted a directed documentary and content analysis of guidance documents across the world concerning palliative care in nursing homes in the context of COVID-19.
Representatives of regional, national or international networks with expertise in geriatrics, long-term care or palliative care identified eligible guidance documents. Additionally, government and professional associations’ websites were hand-searched. We collected data from March 25th to April 8th, 2020. We included publicly available documents concerning COVID-19 that were specifically developed for or included a separate section on nursing homes (‘long-term’, ‘aged’, ‘post-acute long-term’, ‘residential’ care, ‘care homes’ or ‘care retirement communities’); included advice concerning palliative or end-of-life care, advance care planning (ACP), end-of-life decisions, or critically ill/terminal/end-stage patients; were endorsed by a representative body (i.e. association of healthcare professionals, governments); and written in English, German, French, or Dutch. Eligibility of documents was evaluated independently by JG, LP and LVdB against inclusion criteria. In case of disagreement, decisions were discussed until consensus was reached. Excerpts were extracted by JG applying inductive bottom-up coding of common themes and performing content analysis using NVIVO (QSR) software. Initially coded themes (by JG) were discussed with LP and LVdB, after which a final coding instruction was prepared by JG. Final themes were reviewed and discussed by all authors to reach consensus. Results are reported using narrative synthesis techniques.

No ethics approval was required.

RESULTS

Characteristics of guidance documents

Of 81 identified guidance documents 21 were eligible (Additional file 1), three being from the WHO and eight from individual countries: United States (US, n=7) [9–15], the Netherlands (NL,
n=2) [16, 17], Ireland (IE, n=1) [18], United Kingdom (UK, n=3) [19–21], Switzerland (CH, n=3) [22–24], New Zealand (NZ, n=1) [25] and Belgium (BE, n=1) [26] (Additional file 2).

We identified five types of documents, based on the relative extent of their focus on nursing homes and/or palliative care:

1. primary topic is palliative care specifically in nursing homes (n=4 from CH, NL and US).
2. primary topic is nursing home care, with recommendations specifically for palliative care (n=4, NL, CH and BE).
3. primary topic is palliative care, with recommendations specifically for nursing homes (n=1, UK).
4. primary topic is nursing home care, with limited focus on palliative care (n=10, WHO, US, NZ, UK and IE).
5. cover one specific end-of-life care theme relevant for nursing homes, i.e. dead body and funeral arrangements or symptom management in severe respiratory infection (n=2, WHO).

Recommendations for nursing homes concerning palliative or end-of-life care

Across documents, nine general and eight palliative/end-of-life care-specific themes are addressed, often to a limited extent (Table 1). Documents provide guidance regarding restrictions to visits in end-of-life situations (n=12 documents), ACP (n=14), and clinical decision-making regarding the appropriateness of hospital/ICU admissions (n=11). Are addressed in fewer than 10 documents: symptom management at the end of life (n=8), need for specialist palliative care advice and involvement of palliative care teams (n=7), preparations of the body and funeral arrangements (n=4), and spiritual care (n=3). One document mentions foreseeing stock of medication and a prescription chart to enable palliative care. Almost all lack practical and
operational recommendations for staff or facility managers, i.e. who should do what, and when. 
Documents for example indicate “plans should be made for palliative care” or “accompany 
relatives in coping with grief” without further explanation, referrals or guidance.

Twelve documents state that exceptions to restrictions can be made for family visits to 
residents who are at the end of life, called “compassionate situations” in US. However, all 12 
documents state these visits are restricted to a certain maximum number of visits a day, one 
visitor at the time, and that respiratory, hand hygiene and distancing measures must be observed. 
Two documents recommend two weeks of self-isolation of visitors. Some documents are more 
strict that others regarding who might visit in these circumstances, i.e. no children, persons who 
are not chronically ill, and without COVID-19 symptoms.

Fourteen documents that mention ACP primarily refer to transfers to hospital and/or 
focused primarily on written plans or orders (such as Provider Orders for Life-Sustaining 
Treatment or POLST) to guide emergency situations. In particular, eight documents state that 
consulting a person’s advance care plan is crucial to take into account when deciding whether 
they should be hospitalized. A matter of urgency is acknowledged in all documents, stating that 
residents’ advance directives/advance care plans should be completed and up to date; in US 
documents it is added that written physician orders must reflect patients’ wishes. Seven 
documents are more specific to what the advance care plan should at least entail: who is the 
Lasting Power of Attorney (n=1), whether or not it is desirable to initiate CPR (n=5), admission 
to the hospital or ICU (n=5), endotracheal intubation (n=2), non-invasive mechanical ventilation 
(n=3), fluids (n=1), antibiotics (n=1), pharmacological hemodynamic support (n=1), renal 
replacement therapy (n=1), or comfort care (n=4). Four documents acknowledge that plans may 
need to be made in emergency situations, with little time available. Six documents highlight the
importance of involving representatives/family in goal-setting or ACP. Three documents explicitly state that ACP is a person-centered approach to care, that involves “effective” or “adequate, sympathetic” communication and a thorough understanding of a person’s life, values, priorities and preferences.

Ten documents generally advise against hospital/ICU admissions of COVID-19 patients from nursing homes, unless “clinically indicated”. Documents differ in the strength with which they advise against admissions. While some, especially in Belgium and Scotland, say that this is not advised, US documents make less prescriptive statements. Four documents suggest using the Clinical Frailty Scale (CFS) to decide whether to hospitalize, but different CFS cutoff scores are suggested in the different countries.

DISCUSSION

In the 21 COVID-19 guidance documents concerning palliative or end-of-life care in nursing homes we identified worldwide, a wide range of palliative care topics were addressed, albeit to limited extent. Most recommendations concern very specific clinical tasks or subjects such as visits or hospital admissions, while several key aspects of palliative care, practical guidance, and broader structural and coordination considerations are largely absent [27]. International WHO guidance focused on infection prevention and control, body and funeral arrangements and respiratory symptom management only, while including limited recommendations on palliative care-related topics. Essential aspects of palliative care [6, 28] that were not fully addressed include: holistic symptom assessment and management at the end of life (including stockpiling medications and equipment), staff training (in particular for care assistants who deliver the majority of hands-on care in these settings) regarding communication, decision-making and
comfort for dying residents, referral to specialist palliative care or hospice, comprehensive ACP communication (not limited to documentation), support for family including bereavement care, support for staff, and leadership and coordination related to palliative care [6, 8, 27, 28].

Documents also did not provide guidance on deployment of staff such as moving (palliative care) staff from acute settings to the community [6, 28].

Several specific observations should be highlighted. First, while most documents addressed early physical symptom management in COVID-19, only a few made specific recommendations regarding symptoms at the end of life. Non-physical (psychological, social or spiritual) needs were hardly addressed. Moreover, attention to dementia was limited to ‘wandering’ residents. This is an important omission given that the majority of nursing home residents have dementia, and the current crisis poses many challenges to them [29, 30]. Several Alzheimer’s associations have started drafting COVID-19 guidance specifically for this population [31, 32], and future nursing home guidance should integrate this. Second, many documents highlight that the restriction of visits can be lifted for dying residents (although strict criteria apply) but fail to provide guidance on supporting family, especially regarding bereavement - even though measures, such as physical distancing, might negatively impact the grieving process [33]. Third, although it is remarkable that ACP is mentioned in many documents, it is discussed in a very limited way. The emphasis lies on treatment preferences in writing (i.e. do-not-hospitalize or DNR), while the actual communication process is less frequently mentioned [34].

This is the first published study that reviewed international COVID-19 guidance for a highly vulnerable population. Its strengths include its international focus - although all included documents are from high-income countries, despite our search including low- and middle-income countries - and use of rigorous and established methods for documentary and qualitative
analysis. We may have missed eligible documents, given reliance on country representatives to make a first selection. Also, we did not analyze countries’ different regulatory, healthcare and cultural contexts.

Given rapid development of the pandemic and deficits in palliative and end-of-life care in nursing homes even prior to this pandemic [35], the dearth of guidance is perhaps not surprising. However, important efforts are needed to fulfill the call for high-quality palliative care for people with COVID-19 [5], specifically for the highly vulnerable population of nursing home residents.

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Conflict of interest

The authors have no conflicts of interest. Kathleen Unroe is the founder and CEO of Probari, a healthcare start-up designed to disseminate the OPTIMISTIC clinical care model to reduce nursing home to hospital transfers.

Author Contributions

Conception and design: JG, LP, LVdB. Subject recruitment and data collection: JG, LP, LVdB. Analysis: JG. Interpretation of data: JG, LP, LVdB, KU. Preparation of paper: JG, LP, LVdB, KU. All authors drafted the work and revised it critically for important intellectual content. All authors also approved the final version of the paper to be published.

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Nursing and Support]; 2020.
### Table 1. General themes and palliative/end-of-life care themes identified in guidance documents (n=21)

<table>
<thead>
<tr>
<th>Themes</th>
<th>Subthemes</th>
<th>Examples of excerpts underlying theme (source)</th>
<th># of different guidance documents covering theme</th>
<th># of excerpts underlying theme</th>
<th>Documents that addressed theme</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GENERAL THEMES</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Theme 1: Preparation of the nursing home for COVID-19 outbreak (capacity for staffing, equipment, supplies)</td>
<td>“All care homes should have a business continuity policy in place including a plan for surge capacity for staffing, including volunteers.” (13)</td>
<td>10</td>
<td>15</td>
<td>6; 7; 8; 10; 11; 12; 13; 14; 15; 20</td>
<td></td>
</tr>
<tr>
<td></td>
<td>“RCF settings must have COVID-19 preparedness plans in place to include planning for cohorting of residents (COVID-19 separate from non-COVID-19), enhanced IPC, staff training, establishing surge capacity, promoting resident and family communication.” (12)</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Theme 2: Prevention, outbreak management and control measures</td>
<td>2.1. Preventive and control measures, including outbreak management in residents and staff</td>
<td>“Minimum precautions to reduce the general risk of transmission of acute respiratory infections:...” (20)</td>
<td>14</td>
<td>90</td>
<td>1; 3; 5; 6; 7; 8; 11; 12; 13; 14; 15; 19; 20</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Physical distancing in the facility should be instituted to reduce the spread of COVID-19” (1)</td>
<td></td>
<td></td>
<td>5; 8; 12</td>
</tr>
<tr>
<td></td>
<td>2.2. General communication about precautions to family</td>
<td>“Creating/increasing listerv communication to update families, such as advising to not visit.” (5)</td>
<td>3</td>
<td>4</td>
<td>5; 8; 12</td>
</tr>
<tr>
<td></td>
<td>2.3. Alternative ways of in-person visits with family and physicians</td>
<td>“Primary care providers are encouraged to work with care home staff to enable video consultations” (15)</td>
<td>9</td>
<td>14</td>
<td>1; 5; 6; 8; 9; 10; 13; 14; 15</td>
</tr>
<tr>
<td>Theme 3: Education and information about prevention, control and early COVID-19 symptom recognition and treatment</td>
<td>3.1. Education and information for residents and family</td>
<td>“Provide information sessions for residents on COVID-19 to inform them about the virus, the disease it causes and how to protect themselves from infection” (1)</td>
<td>10</td>
<td>25</td>
<td>1; 3; 5; 6; 12</td>
</tr>
<tr>
<td></td>
<td>3.2. Education for staff</td>
<td>“We recommend facilities re-educate all staff, clinical and non-clinical on proper use of personal protective equipment (PPE) and infection control practices.” (7)</td>
<td>8</td>
<td>20</td>
<td>1; 5; 7; 8; 12; 13; 14; 15</td>
</tr>
<tr>
<td>Theme 4: Surveillance/monitoring and identification of suspected COVID-19</td>
<td>4.1. Early COVID symptom recognition and general screening advice</td>
<td>“The facility should ensure that there is active monitoring of residents, twice daily, for signs and symptoms of respiratory illness or changes in their baseline condition e.g. increased confusion, falls, and loss of appetite or sudden deterioration in chronic respiratory disease.” (12)</td>
<td>13</td>
<td>40</td>
<td>1; 3; 5; 6; 7; 8; 12; 13; 14; 15; 19; 20</td>
</tr>
<tr>
<td></td>
<td>4.2. Typical symptoms and multimorbidity in older adults</td>
<td>“Elderly persons often have non-classic respiratory symptoms” (12)</td>
<td>7</td>
<td>15</td>
<td>3; 8; 11; 12; 13; 14; 15</td>
</tr>
<tr>
<td>Theme 5: Testing for CoV-SARS-19</td>
<td></td>
<td>“Any suspect case in these facilities should be under investigation and tested.” (20)</td>
<td>13</td>
<td>40</td>
<td>1; 2; 12</td>
</tr>
<tr>
<td>Theme 6: Hospital admission and transfer procedures</td>
<td>6.1. Transfer of healthy adults to home/other setting</td>
<td>“Any request to transfer a resident from the ARC bubble to the family household bubble during the period of lockdown should be determined on an exceptional basis.” (20)</td>
<td>12</td>
<td>40</td>
<td>1; 2; 12</td>
</tr>
<tr>
<td></td>
<td>6.2. New admissions into the LTCF</td>
<td>“Care homes should remain open to new admissions as much as possible” (15)</td>
<td></td>
<td></td>
<td>1; 3; 5; 6; 7; 8; 12; 13; 14; 15; 19; 20</td>
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<tr>
<td></td>
<td>6.3. Procedures for hospital transfers (how and what staff should do and communicate to emergency staff and geriatric departments)</td>
<td>“Where there is evidence of a cluster or outbreak of COVID-19 ... the facility should close to admissions day care facilities and visitors.”(14)</td>
<td>5</td>
<td>8</td>
<td>5; 8; 11; 14; 19</td>
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<td></td>
<td>6.4. Triage advice regarding hospital or ICU transfers</td>
<td>“Prior to transfer, emergency medical services and the receiving facility should be alerted to the resident’s diagnosis, and precautions to be taken including placing a facemask on the resident during transfer.” (5)</td>
<td></td>
<td></td>
<td>1; 2; 12; 13; 14</td>
</tr>
<tr>
<td></td>
<td></td>
<td>“Decisions to deny or prioritize care should always be discussed with at least 2, but preferably 3 physicians with experience in the treatment of respiratory failure in the ICU.” (21)</td>
<td>2</td>
<td>5</td>
<td>15; 21</td>
</tr>
</tbody>
</table>
"GP and ambulance services may aim to triage residents remotely, based upon the level of carer concern and their vital signs." (15)

6.5. (re)admissions to nursing home (from hospital)

"Residential facilities must support the return of their residents from hospital once they are medically stable" (20)
"Nursing homes should admit any individuals that they would normally admit to their facility, including individuals from hospitals where a case of COVID-19 was/is present." (5)

Theme 7: General treatment advice for early COVID-19 symptoms

"Approach for fever - Non-pharmacological approach: Icepacks at the groin region of body - A wet washcloth - Refresh the patient regularly - Change sheets and clothes - Install a fan" (21)

Theme 8: General psychosocial support regarding loneliness, stress and anxiety not related to end of life

"Ensure family members have access to psychosocial support." (18)
"Regularly and supportively monitor all staff for their wellbeing and foster an environment for timely communication and provision of care with accurate updates." (1)

Theme 9: Specific considerations for people living with dementia

"Care homes should have standard operating procedures for isolating residents who ‘walk with purpose’ (often referred to as ‘wandering’) as a consequence of cognitive impairment. Behavioral interventions may be employed but physical restraint should not be used." (16)

PALLIATIVE CARE THEMES

Theme 1: Saying goodbye, visits at the end of life and bereavement

1.1. Family preparation for impending death or severe symptoms of resident

"The procedure for patients with severe pneumonia should be discussed with their relatives" (19)
"Communicating openly with everyone involved about the impending death" (21)

1.2. Visits in end-of-life/compassionate situations

"Family & friends should be advised that all but essential visiting (for example end of life) is suspended in the interest of protecting residents at this time." (12)
"Facilities should restrict visitation of all visitors and non-essential health care personnel, except for certain compassionate care situations, such as an end-of-life situation." (4)

1.3. Family bereavement

"Geef reeds aan hoe de postmortale zorg geregeld is" [Indicate how bereavement care is arranged] (10)

Theme 2: Symptom management at end of life

2.1. Comfort care in general without reference to specific symptoms

"medications meant to provide comfort, including at the end of life ... morphine, lorazepam, and similar agents." (8)

2.2. Delirium

"Delier - Haloperidol <70 jaar: x mg ..." [medication for delirium] (10)

2.3. Dyspnea

"DYSPNOE in the terminal phase: in patient who does not use opioids - start morphine continuously ..." (21)

2.4. Anxiety, agitation or terminal restlessness

"For agitation / restlessness: METHOTRIMEPRAZINE ..." (16)

2.5. Breathlessness or respiratory secretion

"Respiratory secretions / congestion near end-of-life Advise family & bedside staff: not usually uncomfortable, just noisy, due to patient weakness / not able to clear secretions" (16)
"Oxygen should not be boosted based on oxygen saturation; it is part of normal dying that a patient desaturates" (21)

2.6. Adapting or discontinuation of (burdensome) medication

"No longer measure saturations in a terminal phase" (21)
"Early detection of inappropriate medication prescriptions is recommended to prevent adverse drug events and drug interactions" (3)

2.7. Palliative (deep) sedation

"If the measures described above with morphine and low dose benzodiazepines (midazolam) provide insufficient symptom control and the shortness of breath or choking sensation is refractory, initiate DEEP SEDATION if possible after consultation with family and caregivers." (21)

Theme 3: Spiritual care, including religious or cultural support at the end of life

"Specialists in pastoral care as a discipline for spiritual care are present and part of the expanded care team available and make residents, relatives and relatives as well as employees offer spiritual support" [translation by
Theme 4: Clinical decision-making towards the end of life

| 4.1. Frailty/capacity screening to guide clinical decision-making | Healthcare professionals may find the Clinical Frailty Scale (CFS) to be a useful resource in making and discussing escalation decisions” (15) | 13 | 41 |
| 4.1. Frailty/capacity screening to guide clinical decision-making | “Nursing home population mainly has CFS below 6-9, at which stage hospital admission for COVID-19 might not be adding much value” (translation by authors) (11) | 4 | 8 |
| 4.2. Specialist advice and multidisciplinary collaboration in clinical decision-making | “The GP and/or ARC facility (when GP is unavailable) will access specialist advice by telephone (Geriatrician/General Medicine) prior to any transfer to hospital.” (20) | 4 | 5 |
| 4.2. Specialist advice and multidisciplinary collaboration in clinical decision-making | “Ensure multidisciplinary collaboration among physicians, nurses, pharmacists, other health care professionals in the decision-making process to address multimorbidity and functional decline” (3) | 3 | 13; 15; 20 |
| 4.3. Appropriateness of CPR, oxygen administration or mechanical ventilation | “Extracorporeal Membrane Oxygenation (ECMO) should never be considered in this age group regardless of COVID-19.” (21) | 3 | 6 |
| 4.3. Appropriateness of CPR, oxygen administration or mechanical ventilation | “very few mechanically ventilated elderly patients with acute respiratory distress syndrome (ARDS) survive” (17) | 6; 9; 12 |
| 4.4. Appropriateness of hospital/ICU admission | “For residents with mild illness, we recommend to treat-in-place. For those with moderate to severe symptoms, consider hospital transfer if that is part of their goals of care.” (8) | 11 | 22 |
| 4.4. Appropriateness of hospital/ICU admission | “the question whether hospital admission is indicated for elderly COVID-19 patients with multimorbidity needs to be very carefully considered; it may only be appropriate in the event of complications of concurrent diseases” (17) | 3; 8; 11; 12; 13; 14; 15; 17; 19; 20; 21 |

Theme 5: Foreseeing stock of medication and prescription chart to enable palliative care

| 5.1. Foreseeing stock of medication and prescription chart to enable palliative care | “Care homes should work with GPs and local pharmacists to ensure that they have a stock of anticipatory medications and the community prescription chart, to enable, at short notice, palliative care for residents” (15) | 1 | 2 |
| 5.1. Foreseeing stock of medication and prescription chart to enable palliative care | “If a difficult course is to be expected, a specialized palliative care team can also be called in for palliative care...” (19) | 7 | 10 |
| 5.1. Foreseeing stock of medication and prescription chart to enable palliative care | “If required, MPC [mobile palliative care] teams are also to be called in to residential and nursing homes to ensure optimal treatment” (17) | 8; 10; 15; 16; 17; 19; 21 |

Theme 6: Need for specialist palliative care advice and involvement of palliative care teams

| 6.1. Need for specialist palliative care advice and involvement of palliative care teams | “BEFORE enacting these recommendations, PLEASE clarify patient’s GOALS OF CARE these recommendations are consistent with: DNR, no ICU transfer, comfort-focused supportive care” (16) | 14 | 33 |
| 6.1. Need for specialist palliative care advice and involvement of palliative care teams | “Assess the appropriateness of hospitalization: consult the resident’s Advance Care Plan/Treatment Escalation Plan and discuss with the resident and/or their family” (13) | 3; 5; 8; 9; 10; 11; 13; 14; 15; 16; 17; 19; 20; 21 |

Theme 7: Communication about wishes regarding care and treatment, advance care planning and goals of care discussions in emergency situations

| 7.1. Communication about wishes regarding care and treatment, advance care planning and goals of care discussions in emergency situations | “To date there is no evidence of persons having become infected from exposure to the bodies of persons who died from COVID-19” (2) | 4 | 10 |
| 7.1. Communication about wishes regarding care and treatment, advance care planning and goals of care discussions in emergency situations | “It is crucial to abide by guidance on the preparation of the body and transportation” (14) | 2; 12; 13; 14 |
E-mail sent to 63 representatives of international and national organizations or networks: WHO, Age Platform, European Geriatric Medicine Society, Global Brain Health Institute, Atlantic Fellows network, PACE EU FP7 consortium, Belgium, Germany, Poland, Netherlands, Finland, Australia, New Zealand, Spain, United Kingdom, Ireland, Norway, Sweden, Switzerland, Italy, Austria, USA, South Korea, Japan, France, Singapore, Nigeria, Jordan, Mexico, South Africa, Egypt, Canada, Jamaica, Columbia, Ecuador, Pakistan, Albania, Vietnam, Venezuela, Turkey, Trinidad & Tobago and Indonesia.

We received responses from 34 representatives:
WHO (n=2), Belgium (n=2), Poland (n=1), Netherlands (n=5), Australia/New Zealand (n=4), Spain (n=1), UK (n=2), Norway (n=1), Switzerland (n=1), Austria (n=1), USA (n=4), South Korea (n=1), Japan (n=1), France (n=1), Singapore (n=1), Nigeria (n=1), Egypt (n=1), Jamaica (n=1), Columbia (n=1) and Ecuador (n=2).

Search for updates and additional guidance documents via websites referred to by representatives of WHO, European Association Palliative Care, US Centers for Disease Control & Prevention, Società Italiana di Cure Palliative, Center to Advance Palliative Care, Worldwide Hospice Palliative Care Alliance, International Long-Term Care Policy Network and Hospice New Zealand.

62 documents received:
International (n=4), USA (n=9), Japan (n=1), Italy (n=1), Portugal (n=2), Germany (n=2), Netherlands (n=5), UK (n=7), AUS/NZ (n=15), France (n=5), Canada (n=1), Kenya (n=1), Spain (n=2), Austria (n=1), Switzerland (n=3) and Belgium (n=3).

81 documents included for screening (7 duplicates removed):

21 documents included in analysis:

Number of guidance documents per country/region included in analysis:
International (n=0), USA (n=6), Netherlands (n=2), Ireland (n=1), UK (n=3), Canada (n=1), Switzerland (n=3), New Zealand (n=1), Belgium (n=1).

60 documents excluded:
Most important reason for exclusion:
not a guidance document (n=3)
not developed/adapted for COVID-19 (n=3)
no reference to palliative care (n=10)
no focus/specific section on nursing home (n=31)
not accompanied by written guideline (n=2)
not from representative body/network (n=2)
<table>
<thead>
<tr>
<th>No</th>
<th>Issuing body</th>
<th>Title</th>
<th>Date issued (last update included in this study)</th>
<th>Country in which issued</th>
<th>Target audience (as mentioned in document)</th>
<th>Purpose of guidance (as mentioned in document)</th>
<th>Type**</th>
<th>Number of palliative care themes addressed in document</th>
<th>Methods and sources used to develop guideline</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>WHO (World Health Organization)</td>
<td>Infection Prevention and Control (IPC) guidance for long-term care</td>
<td>21/03/20</td>
<td>International</td>
<td>This interim guidance is for LTCF managers and corresponding IPC (infection prevention and control) local persons in LTCF.</td>
<td>To provide guidance on IPC in LTCFs in the context of COVID-19 to 1) prevent virus from entering the facility, 2) prevent COVID-19 from spreading within the facility, and 3) prevent from spreading to outside the facility.</td>
<td>Type 4</td>
<td>1 (end of life visitations)</td>
<td>NA</td>
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<tr>
<td>2</td>
<td>WHO (World Health Organization)</td>
<td>Infection Prevention and Control for the safe management of a dead</td>
<td>24/03/20</td>
<td>International</td>
<td>For all those, who tend to the bodies of persons who have died of suspected or confirmed COVID-19, including managers of health care facilities and mortuaries, religious and public health authorities, and families.</td>
<td>Guidance on how to tend the bodies of persons who have died of suspected or confirmed COVID-19.</td>
<td>Type 5</td>
<td>1 (preparation of body and funeral arrangements)</td>
<td>NA</td>
</tr>
<tr>
<td>3</td>
<td>WHO (World Health Organization)</td>
<td>Clinical management of severe acute respiratory infection (SARI) when COVID-19 disease is suspected</td>
<td>13/03/20</td>
<td>International</td>
<td>Clinicians involved in the care of adult, pregnant and pediatric patients with or at risk for severe acute respiratory infection (SARI) when a SARS-CoV-2 infection is suspected</td>
<td>To strengthen clinical management of patients who are at risk for SARI when SARS-CoV-2 infection is suspected, and to provide up-to-date guidance.</td>
<td>Type 5</td>
<td>3 (clinical decision-making, symptom management at end of life, ACP)</td>
<td>Based on evidence-informed guidelines developed by multidisciplinary panel of health care providers with experience in the clinical management of patients with COVID-19 and other viral infections.</td>
</tr>
<tr>
<td>4</td>
<td>Centers from Medicare and Medicaid (CMS) and National Hospice and Palliative Care Organization (NHPCO)</td>
<td>Coronavirus Disease 2019 (COVID-19) in Nursing Homes with Hospice Patients Guidance for Infection Control and Prevention (Additional guidance on compassionate situations)</td>
<td>13/03/20 (14/03/20 by NHPCO)</td>
<td>US</td>
<td>For hospice workers in nursing homes</td>
<td>Specific guidance for visitation for certain compassionate care situations, such as end-of-life, and details for hospice workers in nursing homes</td>
<td>Type 1</td>
<td>1 (end of life visitation)</td>
<td>NA</td>
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<tr>
<td>5</td>
<td>Centers from Medicare and Medicaid (CMS), department of Health &amp; human Services, Center for Clinical Standards and Quality, Safety and Oversight Group</td>
<td>Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in Nursing Homes (REVISED); including updated version of 03/04/2020</td>
<td>13/03/20 (03/04/20)</td>
<td>US</td>
<td>State Survey Agency Directors (nursing homes)</td>
<td>Guidance to nursing homes to help them improve their infection control and prevention practices to prevent the transmission of COVID-19, including revised guidance for visitation.</td>
<td>Type 4</td>
<td>2 (ACP and end of life visitation)</td>
<td>NA</td>
</tr>
<tr>
<td>6</td>
<td>The Society for Post-Acute and Long-Term Care Medicine - American Medical Directors Association (AMDA), and American Assisted Living</td>
<td>Guidance &amp; Resources for Assisted Living Facilities and Continuing Care Retirement Communities During COVID-19*</td>
<td>01/04/20</td>
<td>US</td>
<td>For Assisted Living (AL) Communities, Personal Care Homes, Senior Living Communities and Continuing Care Retirement Communities</td>
<td>To address the challenges that are distinctive to these communities and offer resources</td>
<td>Type 4</td>
<td>1 (end of life visitation)</td>
<td>NA</td>
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<tr>
<td>ID</td>
<td>Source</td>
<td>Document Title</td>
<td>Date</td>
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<td>Type of Document</td>
<td>Description</td>
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<td>7</td>
<td>The Society for Post-Acute and Long-Term Care Medicine - American Medical Directors Association (AMDA)</td>
<td>COVID-19 guidance for PALTC: (Post-Acute and Long-Term Care Medicine)</td>
<td>27/03/20</td>
<td>US</td>
<td>Type 4 1</td>
<td>end of life visitation</td>
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<td>8</td>
<td>The Society for Post-Acute and Long-Term Care Medicine - American Medical Directors Association (AMDA)</td>
<td>Frequently Asked Questions Regarding COVID-19 and PALTC</td>
<td>31/03/20</td>
<td>US</td>
<td>Type 4 4</td>
<td>specialist PC, symptom management, ACP, end of life visitation</td>
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<td>9</td>
<td>Alzheimer's Association</td>
<td>-------------------------------------------------</td>
<td>no date</td>
<td>US</td>
<td>Type 4 2</td>
<td>preparing family, ACP</td>
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<td>10</td>
<td>Verenso (beroepsvereniging van verpleeghuisartsen en specialisten ouderengeneeskunde)</td>
<td>------------------------</td>
<td>24/03/20</td>
<td>The Netherlands</td>
<td>Type 1 5</td>
<td>end of life visitation, symptom management, clinical decision-making, ACP, specialist PC</td>
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<tr>
<td>12</td>
<td>Ireland Health Services (HSE) and the Health Protection Surveillance Centre (HPSC)</td>
<td>Preliminary Coronavirus Disease (COVID-19) Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities (RCF) and Similar Units [new title after update: Interim Infection Prevention and Control Guidance including Outbreak Control in Residential Care Facilities (RCF) and Similar Units for pandemic COVID-19]</td>
<td>30/03/20</td>
<td>Ireland</td>
<td>Type 4 4</td>
<td>preparation of body and funeral arrangements, clinical decision-making, spiritual care, end of life visitation</td>
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<tr>
<td>13</td>
<td>Department of Health &amp; Social care, Public Health</td>
<td>Admission and Care of Residents during COVID-19 Incident in a Care</td>
<td>02/04/20</td>
<td>UK</td>
<td>Type 4 5</td>
<td>clinical decision-making, ACP, end of life visitation, symptom management</td>
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<td>England, Care Quality Commission and NHS</td>
<td>Home’</td>
<td>and residents, ensuring that each person is getting the right care in the most appropriate setting for their needs.</td>
<td>making, specialist PC, preparation of body and funeral arrangements, ACP</td>
<td>Type 4</td>
<td>NA</td>
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<tr>
<td>Scottish Government/Riaghaltas na h-Alba (gov.scot)</td>
<td>Coronavirus (COVID-19): clinical guidance for nursing home and residential care residents’</td>
<td>Those working with adults in long term care such as residents of nursing home and residential care settings</td>
<td>This guidance provides targeted clinical advice about COVID-19.</td>
<td>Type 4</td>
<td>6 (spiritual care, symptom management, preparations of body and funeral, clinical decision-making, ACP, end of life visitation, incl bereavement)</td>
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<tr>
<td>British Geriatrics Society (BGS)</td>
<td>COVID-19: Managing the COVID-19 pandemic in care homes’</td>
<td>Firstly, care home staff, many of whom feel isolated and exposed as part of the COVID-19 pandemic. Secondly, NHS staff who plan for, work with and support care home staff, many of whom are trying to develop standardized approaches to care home residents in light of the pandemic.</td>
<td>To help care home staff and NHS staff who work with them to support residents through the pandemic.</td>
<td>Type 2</td>
<td>5 (specialist PC, clinical decision-making, end of life visitation, foreseeing stock, ACP)</td>
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<tr>
<td>BC Centre for Palliative Care Guidelines</td>
<td>Symptom management for adult patients with COVID-19 receiving end-of-life supportive care outside of the ICU’</td>
<td>Not stated</td>
<td>Symptom management for adult patients with COVID-19 who receive end-of-life supportive care outside ICU</td>
<td>Type 3</td>
<td>3 (ACP, symptom management, specialist PC)</td>
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<tr>
<td>Roland K. &amp; Markus, M. (Geriatrics and Palliative Medicine, Stadtspital Waid und Triemli &amp; Spital Affoltern am Albis); compiled by Association for Geriatric Palliative Medicine (FGPG)</td>
<td>COVID-19 pandemic: palliative care for elderly and frail patients at home and in residential and nursing homes'</td>
<td>Not stated</td>
<td>To provide recommendations for practice (palliative care for older adults in nursing homes)</td>
<td>Type 1</td>
<td>4 (end of life visitation, clinical decision-making, specialist PC, ACP)</td>
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<tr>
<td>Schweizerische Gesellschaft für Palliative Medizin, Pflege und Begleitung [Swiss Society for Palliative Medicine, Nursing and Support]</td>
<td>COVID-19 - Pandemie – Merkblatt zu Spiritual Care und Seelsorge in Langzeitpflegeinstitutionen' [Spiritual care and chaplaincy in LTCFs for COVID 19 patients]</td>
<td>Intended as a recommendation for: specialists in pastoral care in retirement and nursing homes, health professionals and those responsible in medical institutions, responsible for the appointing authorities for pastoral care and pastoral care in long-term care</td>
<td>Guidance regarding spiritual care and pastoral care in long-term care</td>
<td>Type 2</td>
<td>2 (spiritual care, end of life visitation)</td>
<td>Recommendations are based on a handout from the Reformed Church of Bern-Jura-Solothurn.</td>
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<td>Country/Region</td>
<td>Document Description</td>
<td>Date(s)</td>
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<td>Switzerland</td>
<td>Leaflet for general practitioners and palliative treatment of COVID19 at home and in a nursing home</td>
<td>24/03/20 (updated: 06/04/20)</td>
<td>Type 1</td>
<td>To ensure good palliative care at home or in nursing homes for elderly and seriously ill patients who no longer want (or no longer receive) intensive care treatment</td>
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</table>
| New Zealand            | 1) 'Update for Disability and Aged Care Providers on Alert Level 4' (30/03/20)  
2) 'COVID-19 Guidance for admissions into aged residential care facilities at Alert Level 4' (02/04/20)  
3) 'Updated advice for health professionals: novel coronavirus' (COVID-19) (08/04/20)                                                                 | 30/03/20 (updated: 02/04/20; updated: 08/04/20)                        | Type 4 | To provide update on COVID Alert Level 4  
1) To provide guidance for admissions into aged residential care  
2) To provide guidance on how to identify and investigate any cases of novel coronavirus (COVID-19), as well as how to apply appropriate contact tracing and infection control measures to prevent its spread |
| Belgium                | COVID-19 Guideline regarding Symptom Management and Clinical Decision-Making in Nursing Homes'                                                                                                                  | 25/03/20                                                               | Type 2 | To support nursing home staff in symptom management and clinical decision-making regarding hospital admission at the end of life                                                                  |

**WHO World Health Organization; NA not available; BG S British Geriatrics Group; ACP advance care planning; PC palliative care**  
*Guidance document is developed specifically for nursing homes and includes palliative care recommendations explicitly 'OR' developed specifically about palliative care and includes specific section about nursing homes (yes/no)*.  
**Type of guidance document: 1) Palliative care document with substantial section of specific recommendations for nursing homes; 2) Nursing home document with substantial section including specific recommendations regarding palliative care; 3) Palliative care documents specifically for nursing homes; 4) Nursing home document with limited advice for palliative care; 5) Document that relates to specific end of life theme which is highly relevant for nursing home population. Note that the fact that some documents cover multiple palliative care themes does not imply that all themes are addressed in equal depth.  
†Guidance document is aimed at healthcare providers working for people living with dementia; not specifically for nursing homes. Given that nursing home population has high prevalence of dementia, we considered this to be a guidance document specifically for nursing homes.