Palliative Care in COVID-19

Resource Toolkit for Low and Middle Income Countries: E-book

'Not all people can be cured. But all people can be comforted'

Edited by

Task Force in Palliative Care (PalliCovidKerala)

KERALA

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CONTENTS

Advisors and Contributors

Advisors:

Dr. M.R. Rajagopal
Director,
Trivandrum Institute of Palliative Sciences,
WHO Collaborating Centre for Training and Policy on Access to Pain Relief
Chairman – Pallium India
Thiruvananthapuram, Kerala

Dr. K. Suresh Kumar
Director,
WHO Collaborating Centre for Community Participation in
Palliative Care and Long-Term Care
Technical Advisor -Institute of Palliative Medicine
Calicut, Kerala

Contributors:

Dr. Chitra Venkateswaran
Professor and Head, Department of Psychiatry
Senior Consultant in Palliative Care and Psycho Oncology,
BC MCH, Tiruvalla, Kerala, India
Clinical Director - Mehac Foundation, Kochi, Kerala

Dr. Sunil Kumar M M
MBBS, DPPM, MSc Palliative Medicine (Cardiff, UK)
Additional Director
Trivandrum Institute of Palliative Sciences
Thiruvananthapuram, Kerala

Dr. Shoba Nair
MBBS MD MRCP (Edinburgh) MSc (Australia)
Current PhD student, Lancaster University, UK
Professor, Department of Pain and Palliative Medicine
Amrita Institute of Medical Sciences, Kochi, Kerala

Dr. Vineetha Rijju
MBBS , BCCPM, FPM , MSc Pall Med (Cardiff)
Associate Specialist in Medical Oncology
Aster Medcity , Kochi, Kerala

Dr. Rajashree. K.C
MBBS, MD (Anaesthesiology)
Fellowship in Palliative Medicine
Certificate Course on Mental Health in Palliative Care
Director - Academic Wing for Professional Certificate Programs, Trivandrum Institute of Palliative Science, Thiruvananthapuram
Asst. Professor- Amrita Institute of Medical Sciences, Kochi
Palliative Care Trainer - Institute of Palliative Care, Thrissur, Kerala

Dr. Seema Rao
Consultant, Department of Palliative Medicine and Supportive Care,
Kasturba Medical College and Hospital, Manipal
Honorary Tutor, School of Medicine, Cardiff (UK)

Dr. Poornima Sunder
Consultant Psychiatrist
Mehac Foundation, Kochi, Kerala

Dr. Sunitha M Daniel
MRCP (Gen. Med) MRCP (Pall .Med)
Specialist Medical Officer, Palliative Medicine
General Hospital, Ernakulam, Kochi, Kerala
PhD Student (Part time), Hull York Medical School, UK
Locum Consultant Palliative Medicine,Holt Doctors, UK

Dr. Athul Joseph Manuel
Medical Officer,
Dept of Palliative Care,
General Hospital Ernakulam.
Nodal Officer, Covid19 Tele Health Center, Ernakulam

Dr. Charu Singh
Professor, Anesthesiology and Palliative Medicine
MD Anesthesiology
Fellowship in Critical Care, Benaras Hindu University
Diploma in Palliative Medicine, Cardiff University
Graduate Certificate in Health (Palliative Medicine), Flinders University, Adelaide, 3T course in Bioethics, UNESCO Chair, Haifa

Dr. Mhoira Leng
Palliative Care Physician FRCP (Ed and Glas)
Makerere University and Palliative care Education and Research Consortium, Uganda,
Cairdeas International Palliative Care Trust, UK

Ms. Anupama Prabhu
Clinical Psychologist
Mehac Foundation, Kochi, Kerala

Dr. Biju Raghavan
Sr. Consultant and Head
Pain and Palliative Medicine
Rajagiri Hospital, Aluva, Ernakulam, Kerala

Dr. Geetha Vijay
MBBS, PG Diploma in Palliative Care
General Hospital, Ernakulam, Kerala

Dr. Odette Spruijt
MBChB, Dip. Obs., FRAChPM
Associate Professor, Palliative Medicine
Western Health Network
Melbourne, Victoria, Australia

Ms. Uma Parameswaran
Clinical Psychologist, MeHelp Project
Mehac Foundation, Kochi, Kerala

Supported by:

Dr. Samin Sameed
MBBS, MD
Psychiatrist, Urban Health Mission

Dr. Hariprasad PG
Associate Professor
Department of pediatrics
Government Medical College, Kalamassery
Ernakulam, Kerala

Ms. Smriti Rana
MSc -Integrative and Holistic Psychological Counselling
Director-Programmes Pallium India
Thiruvananthapuram, Kerala

Dr. Harimohan Narayanan
Associate Consultant,
Pain and Palliative Care,
VPS Lakeshore Hospital, Ernakulam, Kerala

Ms. Bhavana Issar
Founder and CEO, Caregiver Saathi,
Sambhaavna partners
MBA, Certifies Process Facilitator and Gestalt OD Practitioner

Dr. Deepak Varughese
MBBS, MD (CMC Vellore), CCPPM
Public Health Consultant
Trivandrum Institute of Palliative Sciences
Pallium India, Thiruvananthapuram, Kerala

Preface

COVID-19 pandemic has hit the world causing major impacts on health and economy. In many European countries, it has resulted in challenging scenarios of an ethical dilemma to the professionals. Healthcare systems and healthcare professionals are stressed in managing an influx of affected patients as the COVID-19 crisis is unpredictable. The disease presents as a severe acute care crisis of unknown duration. Potentially hundreds of thousands of people get sick, some critically, and tens of thousands may die.

In this context, the usual concerns of palliative care like symptom management, goals of care discussion, advance care planning, and support for patients and caregivers, all aiming at enhancing the quality of life, seem gloomy. However, Palliative Care has never been more important!

The Palliative Care team in Kerala has formed a task force to develop guidelines to support the Government initiative in combating COVID-19 crisis. Dr. Rajagopal and Dr. Suresh Kumar are the two experts from Palliative Care in the advisory body to the Government. The present document is the product of valuable inputs and discussion among national and overseas faculty.

The task force has immense pleasure in bringing the document as an e-book to facilitate the health care professionals in their tireless battle against the pandemic.

Executive Summary

COVID-19 pandemic presents as a severe acute care crisis of unknown duration. Potentially hundreds of thousands of people will get sick, some critically, and tens of thousands may die.
In this context, the core concerns of holistic palliative care, such as symptom management, goals of care discussion, advance care planning, and psychosocial support for patients and caregivers, all aimed at enhancing the quality of life and dying process, is of extreme relevance. The current pandemic is reported to present as a rapidly changing situation, requiring palliative care interventions at different levels, focusing different domains. There are also many patients and families with pre-existing chronic disease who need holistic care. Many palliative care interventions can be provided by a wide range of health and social care workers with appropriate training and guidelines and supported by specialist practitioners and hence the urgent need for this e-book and training package. We encourage the earliest preparation of frontline and keyworkers and offer this training package supported by experienced facilitators to achieve this.

The major domains identified from evidence available globally:

1. **Triage including Decision making and Ethical Framework Algorithm**
2. **Symptom control including access to essential medicines.**
3. **Management of distress**
4. **End of Life Care**
5. **Supporting compassionate care and addressing burnout for health care workers algorithm**

1. Triage including Decision making and Ethical Framework Algorithm (*Algorithm 5*) We describe the strategy and process being rolled out by the government of Kerala which can be contextualized for different settings. The process of triage assesses the clinical condition, informs the interventions needed and determines the appropriate referral and place of care. At each stage of triage, communication, and goals of care discussion are essential alongside holistic care. These crucial goals of care discussions must be supported by clear ethical frameworks with assessment based on co-morbidities, age and pre- COVID-19 functional status as well as clinical findings. For ease of use in generalist settings we recommended the WHO performance status scale at community and district levels. Our goal is to individualize decision making on clinical grounds with patient and family involvement while taking into account the available resources. This triage is sensitive and should not delay referral to intensive care for those likely to benefit. Patients and families who are triaged for conservative management should be cared for in clinical areas where refractory symptom management, psychosocial and spiritual support as well as end of life care can be optimized.
2. Symptom control including access to essential medicines. Essential medicines should be accessible and affordable for all palliative care needs but particularly for the main symptom challenges. This is particularly acute for opioids which are already unavailable in many settings. The list of essential medications identified is given in *page 62*. Protocols should be available and training completed alongside expert back-up by phone or in person. The most common symptom cluster is breathlessness and agitation and this will need prompt and careful attention. Titration of medications against symptoms needs to include the severe refractory symptoms seen in those who may deteriorate fast and may not be triaged to an intensive care setting. As in any setting, careful assessment, appropriate investigations, correcting the correctable and non-pharmacological and pharmacological interventions are needed. Breathlessness is often accompanied by agitation where a combination of opioids and benzodiazepines will be the mainstay; but delirium due to other causes must be considered where anti-psychotics have a role. Algorithms were developed for the management of breathlessness (*Algorithm 1*) and management of agitation with and without disorientation (*Algorithm 2*). Other symptoms such as cough and secretions (*Algorithm 3*) and advice on routes of medication and care in different settings are included.
3. Management of distress including psychological, social and spiritual support and the accompanying areas of grief, bereavement and loss are perhaps some of the most essential. Assessment is encouraged using a distress visual analogue scale embedded in the Making sense of distress algorithm (*Algorithm 4*) with advice for offering psycho-education, effective communication, pharmacological interventions and red flags to initiate referral. Tips for *'dos and don't's'* are included as well as examples of empathetic responses and problem-

solving approaches. Adequate information to address stigma is particularly important. Staff on health phone lines or trained volunteers may well be able to engage in effective psychosocial interventions using protocols. Social and practical help is very important and needs to be coordinated alongside government planning systems. Mobilizing and empowering community groups and faith-based organizations is also crucial not only for the current pandemic control but also to look for, identify and support at-risk populations with significant vulnerability.

4. End of Life Care algorithm (*Algorithm 7*) outlines the symptom control, nursing care and holistic issues at this crucial time. This is a time where communication is vital to act as a bridge between patient and families to alleviate the distress of isolation. The innovative use of technology is recommended such as recorded messages, music or prayers, or facilitated live virtual conversations. The opportunity to say goodbye is particularly important and the reassurance that a loved one is not alone or abandoned. For families who cannot be present, conveying a message about the care received is an important part of bereavement care. When frontline staff are under significant pressure, we suggest a team approach where initial conversations be followed up by dedicated psychosocial and spiritual care workers.

5. Supporting compassionate care and addressing burnout for health care workers algorithm (*Algorithm 8*): Working in stressful environments, dealing with stigma and anger, lack of protective equipment for oneself and others, balancing scarce resources, personal needs and being seen as superheroes who do not need rest or protection are all challenges for health care workers. Some cope by blocking out or emotional distancing and many feel a sense of compassion-fatigue or even moral distress if support is not given. Yet precisely the need for compassionate care and mutual humanity demands that we must take care of our health care workers and ourselves as we also care for patients and families in need.

We also encourage the use of the PalliKare app (free download) by all health care workers as this provides a ready and comprehensive approach to symptom management for palliative care in usual settings.

Online training on palliative care in COVID-19 using the Project ECHO (Extension for Community Healthcare Outcomes) has begun from April 6th 2020. To register, go to https://palliumindia.org/courses/events

ECHO for doctors treating patients with COVID-19 on palliative care (PalliCovid ECHO)

An Initiative by Pallium India and PalliCovidKerala
Timing: 3:00 PM to 4:15 PM

SCHEDULE

Sl No	Day	Topic
1	**Monday**	Ethical Issues, Goals of Care and Triage
2	**Tuesday**	Symptom Control
3	**Wednesday**	Communication and Self Care
4	**Thursday**	End of Life Care and Bereavement
5	**Friday**	Making Sense of Distress

Relevance of Palliative Care in COVID-19

The coronavirus presents to the health care system an acute and severe crisis with so many uncertainties especially related to the time boundary. We are witnessing a crisis in which potentially millions may get sick, some will get critically ill, of which many may die. WHO is reporting the average death rate from COVID-19 is between 2% and 4%, with a higher rate of 15 to 22% in elderly.[1]

Those who are elderly, frail, and/or with underlying chronic or serious illness, children, migrants, those with disabilities and other vulnerable groups are most at risk from the novel coronavirus; who are already palliative care's core patient population[1]. Utilizing the unique skills and strengths found in palliative care must be a part of care for patients. While the biological and physical repercussions of the disease get disproportionately more attention, the mental health aspects also demand dynamic attention. Epidemics have also imparted a vital realization that the absence of effective mental health and psychosocial support system increases risks of psychological distress and progression to psychopathology.

The stigma of the illness with its resultant labeling, stereotyping, and discriminating, the lack of knowledge about the disease, the uncertainties of the outbreak, the constant media reactions, and the false information all add to the distress. In a country like India, there are added worries of social and economic disruption that can further complicate mental health problems[2].

Fear of and worries about infecting family and friends, especially the elderly are magnified among healthcare workers in isolation and quarantine. The pandemic has kicked off a grieving process in the community, in anticipation of the perceived collective loss and death, increasing the vulnerability to grief and burn out [3].

Palliative care with its biopsychospiritual approach focuses on enhancing the quality of life of the patients with serious health-related suffering and their family members. It essentially gives thrust to symptom control, empathic communication, psychosocial support, end of life care and bereavement care. It has proven as a cost-effective model for caring for patients with long-term illnesses. The network of professionals and the trained volunteers in Kerala has been successful in bringing the Palliative Care coverage of the State (40%) above the global average (14%). Kerala is the first among the Indian States to bring a Palliative Care Policy across the three-tier system of health care institutions of the State Government.

The values of compassion and total care that palliative care brings if required as an essential component in health care and the community in this humanitarian crisis.

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Communication Tips in COVID-19

Physicians across specialties find communicating with patients about serious illness challenging. Numerous studies have proven physicians' discomfort stems from an inability to handle strong emotions and lack of time[1]. The current COVID-19 pandemic has amplified these challenges, even for those familiar with these conversations.

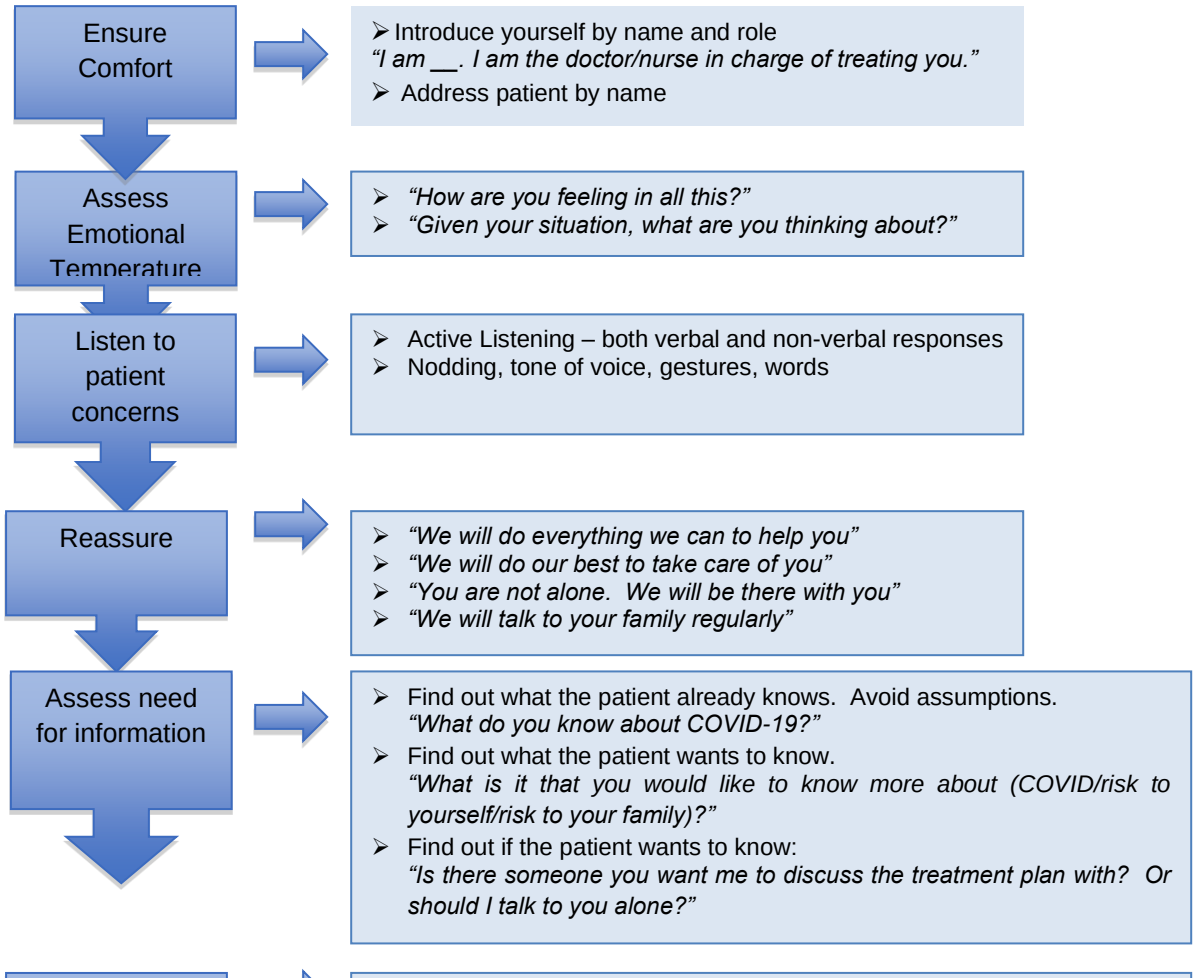
The goals of patient-family-physician communication in this scenario would include:

a) To share information in a clear, timely and complete manner to empower decision-making.

b) To treat patients and families with dignity and compassion by honoring the patient/family values and providing care that is in concordance with those values.

c) To enhance participation and collaboration of the patients/families with healthcare providers and state/local policies.

The brief outline will provide basic communication tips for frontline healthcare workers dealing with the COVID-19 pandemic. Often these communications are done face-to-face with personal protective equipment or over the phone/Skype/WhatsApp/teleconferencing/FaceTime.



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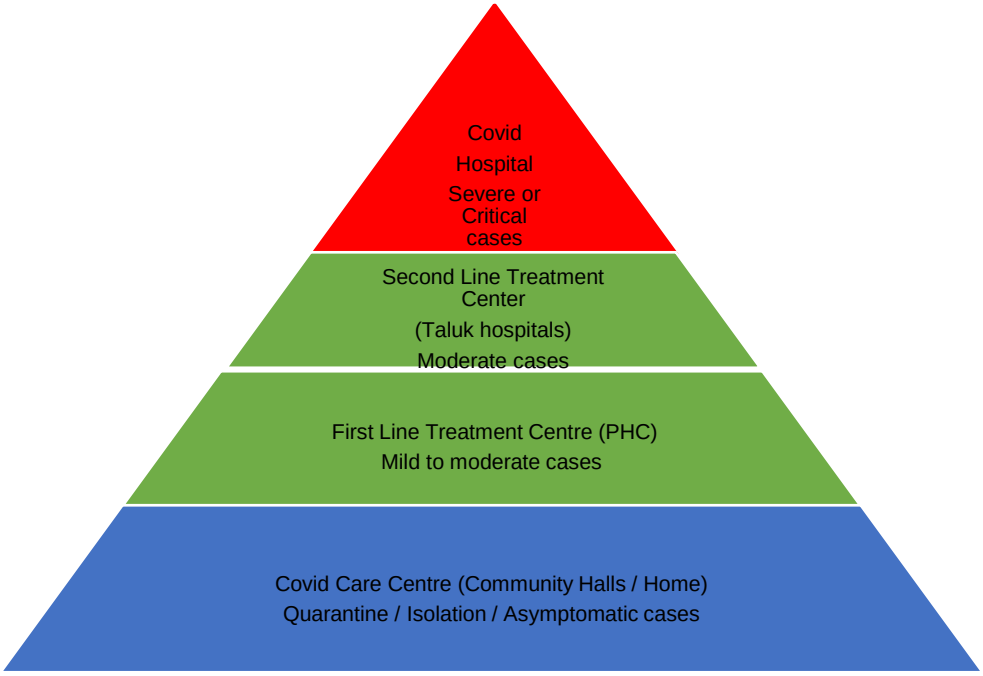
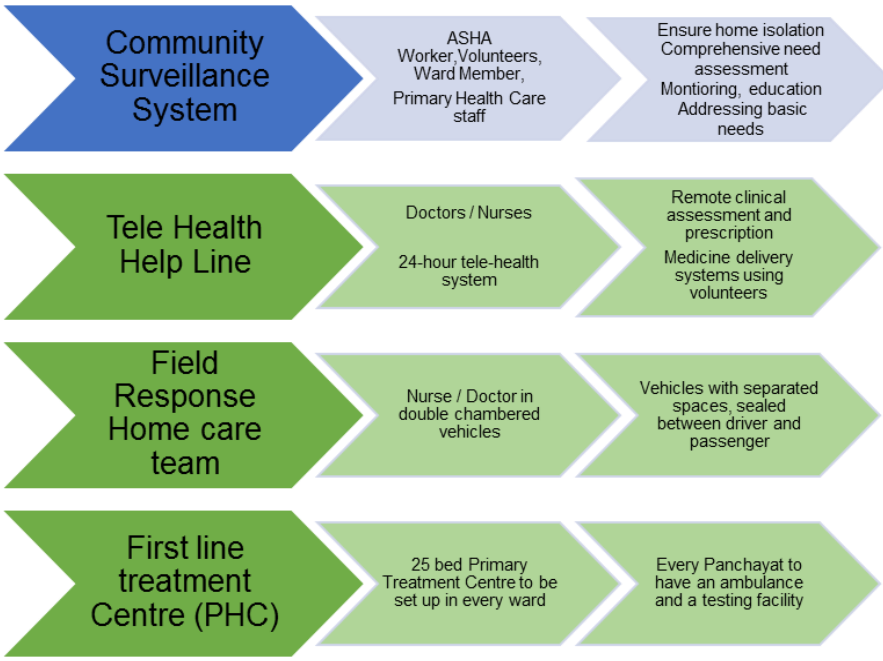
- https://www.vitaltalk.org/guides/covid-19-communication-skills/

Triaging Process of Government of Kerala

Pyramid of Clinical Care for COVID-19 Treatment planned by Kerala State Government



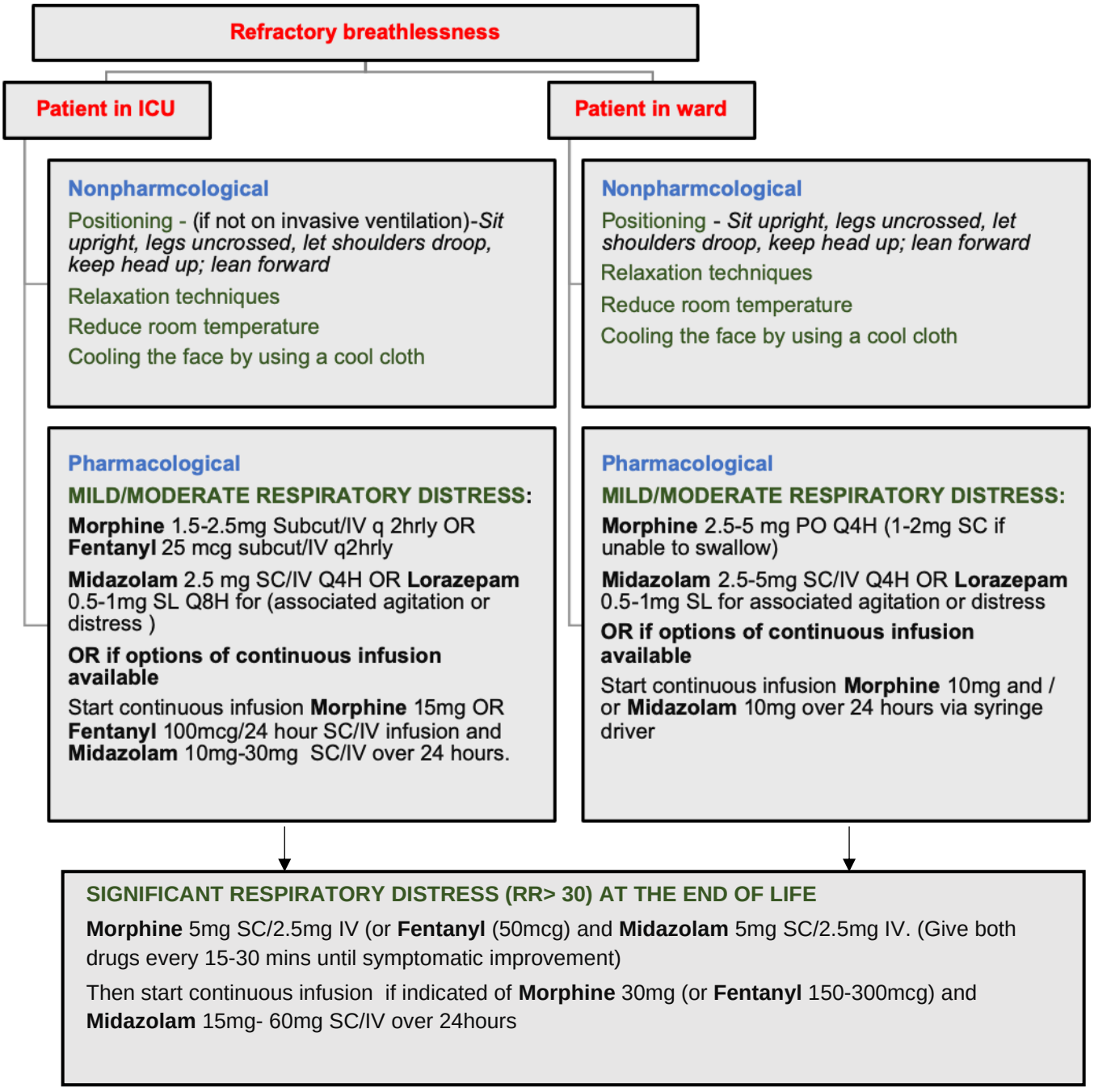
Support Systems



ASHA: Accredited Social Health Activist

Symptom Management: Breathlessness - *Algorithm* 1

These guidelines can be used along with active treatment for COVID-19 including any correctable problems like superadded infection or bronchospasm. They can be continued for symptom management at the end of life.



Notes:

- If the peripheral oxygen saturation (SpO2) is < 92% to start supplemental oxygen that SpO2 to be maintained no higher than 96%.
- Non intubated patients with moderate ARDS can also be nursed in prone position with high flow of oxygen as tolerated which may help to avoid intubation.
- Start an antiemetic - Metoclopramide 10 mg Q8H or Haloperidol 0.5-1mg daily (haloperidol is more suitable in patients with agitation) for the first 3 days of opioid therapy) if indicated. Note: Extrapyramidal side effects are extremely rare at this dose).
- Always start a stimulant laxative like Tab Bisacodyl 10 mg PO at bed-time **on the same day of starting morphine** and ensure regular bowel movement.
- Fentanyl or Morphine can be used depending on availability
- Fentanyl is preferred if creatinine > 2mg/dl
- Oral Morphine can be administered in the same dose per rectally if the patient unable to swallow and parenteral morphine is not available.
- If symptoms not settling contact a specialist in palliative care, critical care, or respiratory medicine as advised.
- Morphine conversion: 60 mg oral morphine is equivalent to 25 microgram/ hour of Fentanyl patch

Glossary

1) **Refractory breathlessness:** Breathlessness not improving despite optimal medical management
2) **Non-pharmacological interventions:** Treatments that do not use medications to alleviate symptoms.
3) **Subcut**: Subcutaneous(under the skin) route of drug delivery In this type of **injection**, a short needle is used to **inject** a drug into the tissue layer between the skin and the muscle. (eg like insulin)
4) **SL**: Sublingual (under the tongue) route of drug delivery
5) **Continuous infusion:** Continuous dosage of medication given parenterally either subcutaneously or intravenously.
6) **Extrapyramidal side effects:** Symptoms (including tremor, slurred speech, akathisia, dystonia, anxiety, distress, and paranoia) that are primarily associated with or are unusual reactions to neuroleptic (antipsychotic) medications.
7) **Antiemetic:** A drug used for preventing or alleviating nausea and vomiting.

Guidelines for management of Cough in patients with COVID-19

Cough Etiquettes

- Cover your face with a disposable tissue and discard it carefully. If using a handkerchief, wash it thoroughly with soap and water and dry
- Wash hands thoroughly with soap and water/ hand sanitizer

Non- Pharmacological Measures

- Oral fluids, saline gargle, avoid smoking, home remedies like ginger and honey.

Pharmacological Measures

- Dextromethorphan 10-20mg Q4H
- If cough intractable: Tab Morphine 2.5mg-5mg P0/SC Q4h-Q6H
- At EOL Morphine sulphate injection 10mg continuous infusion SC/IV over 24 hours

References:

- King S, Hanks GW, Ferro CJ, Chambers EJ (2011) A systematic review of opioid medication for those with moderate to severe cancer pain and renal impairment: a European palliative care research collaborative opioid guidelines project. Palliative Medicine, 25(5), 525-552.
- Palliative Care Expert Group (2010) Therapeutic guidelines: palliative care (Version 3), Melbourne: Therapeutic Guidelines Limited.
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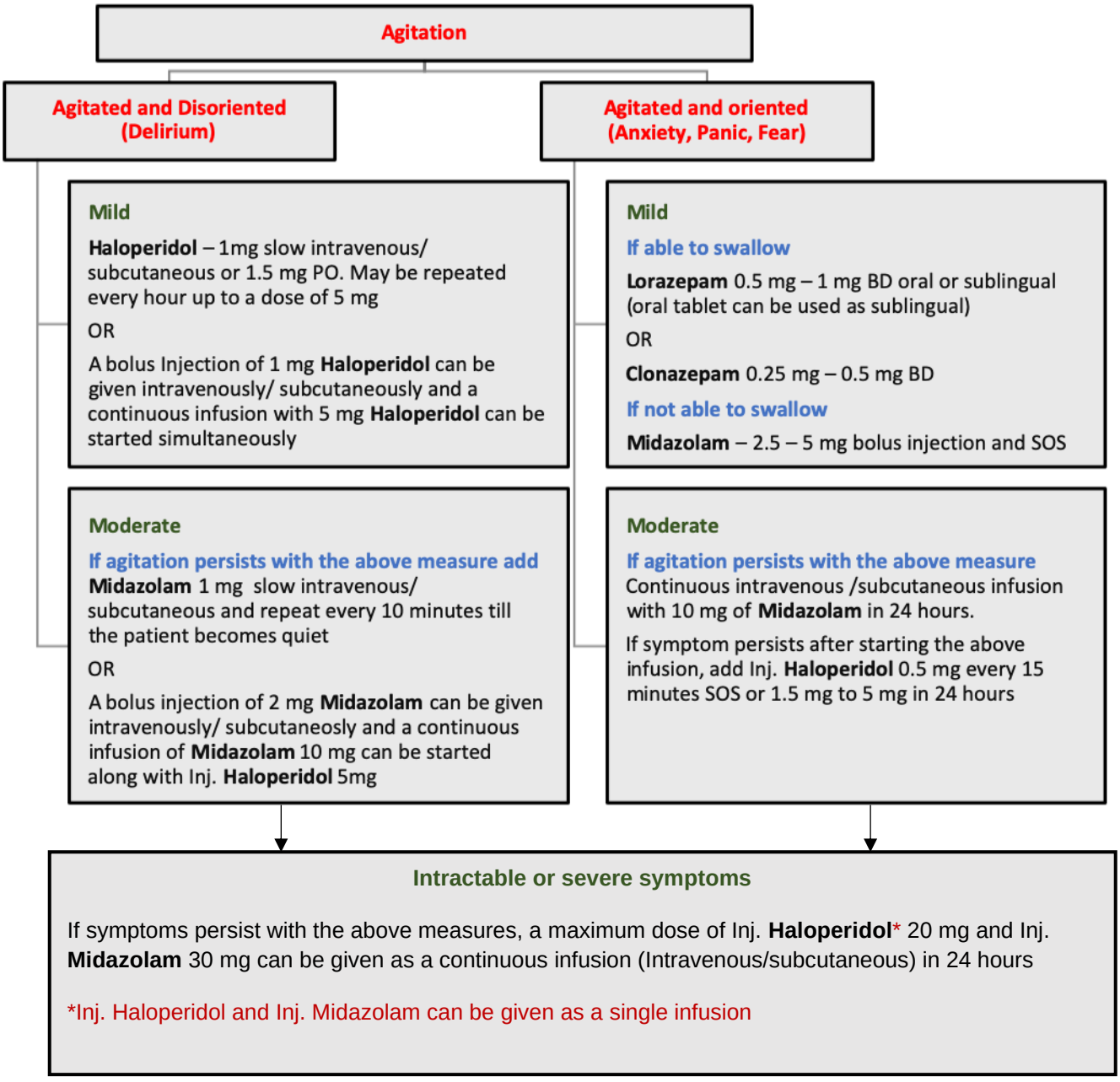
Symptom Management: Agitation and Delirium - *Algorithm* 2



General Principles

1. Agitation could be a common symptom in COVID-19 patients if the disease progress
2. The primary aim is to control agitation with minimum sedation
3. Agitation could be because of anxiety, stress or a sense of impending doom, where the patient is oriented. Agitation accompanied by disorientation is delirium.
4. If the patient develops refractory breathlessness, agitation and delirium, particularly at EOL, a combined infusion of Morphine, Midazolam and Haloperidol can be given.

Guidelines

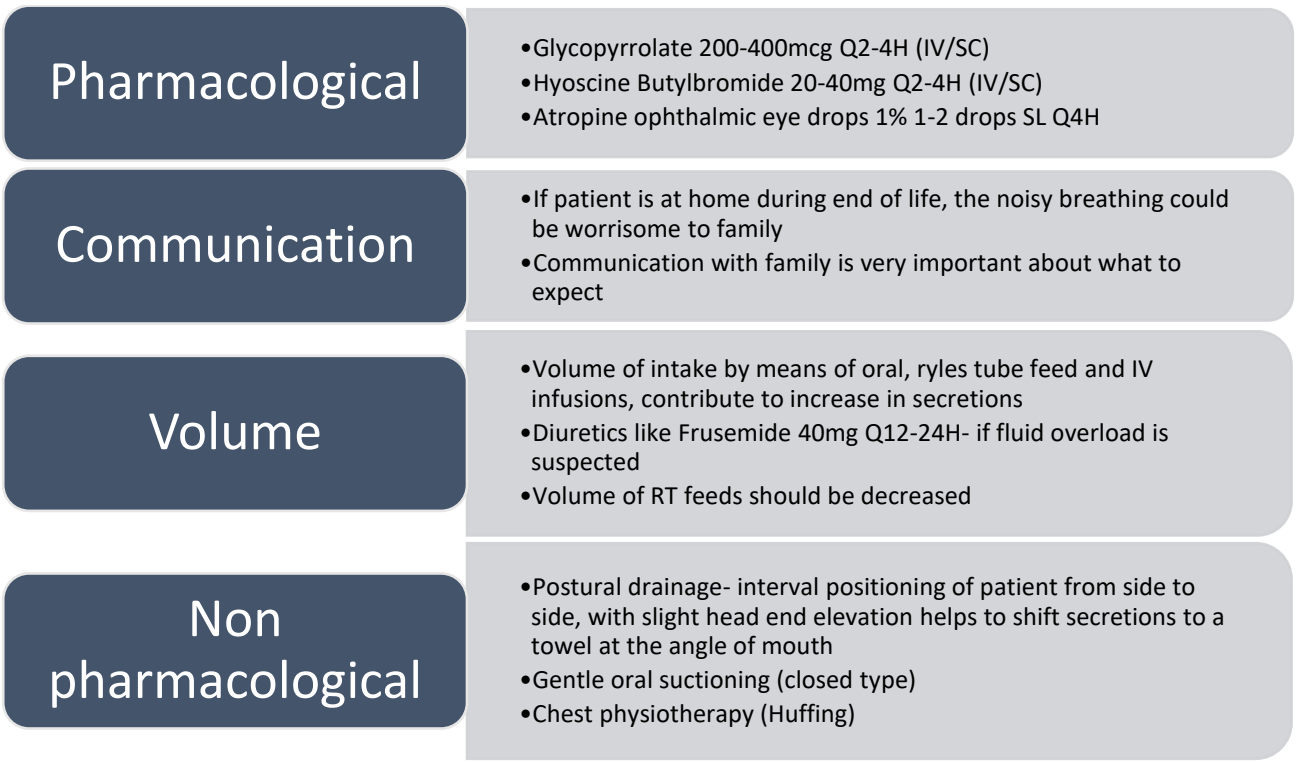
1. Assessment of agitation can be done by using a simple tool like 4AT delirium assessment tool. Alertness, abbreviated mental test, attention and acute changes are looked at in this tool.
2. Look for reversible causes of delirium like constipation, urinary retention, substance withdrawal, etc and correct where appropriate.
3. Administration of a Mini-Mental State Examination (MMSE) tool might not be possible in an acute state to identify whether the patient has decision-making capacity or not.
4. Agitation can be managed with pharmacological and non-pharmacological settings. The non-pharmacological management of agitation in COVID patients would include well lit, aerated room, as other measures like being with someone familiar might not be feasible in COVID -19 infection.
5. For intractable (severe) agitation higher doses mentioned in the algorithm or other medications can be given under the guidance of a palliative care specialist.

References:

- Cohen-Mansfield J, Werner P. Management of verbally disruptive behaviors in nursing home residents. J Gerontology A Biol Sci Med Sci 1997;52A:M369-77.
- The 4AT˜ test for detecting delirium in acute medical patients: a diagnostic accuracy study Health technology assessment, 2019, 23(40), 1-193 | added to CENTRAL: 31 January 2020 | 2020 Issue 01PubMed Embase
- NICE publishes first rapid COVID-19 guidelines | https://www.nice.org.uk/news/article/nice-publishes-first-rapid-covid-19-guidelines
- Formulary - © palliativedrugs.com. https://www.palliativedrugs.com

Symptom Management: Oropharyngeal / Respiratory Secretions - *Algorithm* 3

Oro pharyngeal / Respiratory secretions symptom management



These simple guidelines can be used for patients with symptoms of noisy breathing due to increased broncho-pulmonary secretions or pooling of salivary secretions in hypopharynx during end of life. Antisecretory drugs only decrease further production of secretion.

The predominant pattern observed in COVID-19 patients is dry cough. However distressing symptoms can be observed in those patients with secondary bacterial infections / difficulty to clear secretions / positive fluid balance / heart failures/ at terminal phase (death rattle). Control of these secretions decreases the noisy breathing.

The risk of transmission is high for those who are in contact with secretions. Family and staff should be alerted to take necessary airborne precautions during aerosol generating procedures like *Nebulisations and Chest physiotherapy, which are best avoided. MDIs are preferred over nebulisations. Surgical mask is recommended for non-intubated patients.

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- Wildiers H, Menten J. Death rattle: prevalence, prevention, and treatment. Journal of pain and symptom management. 2002 Apr 1;23(4):310-7.
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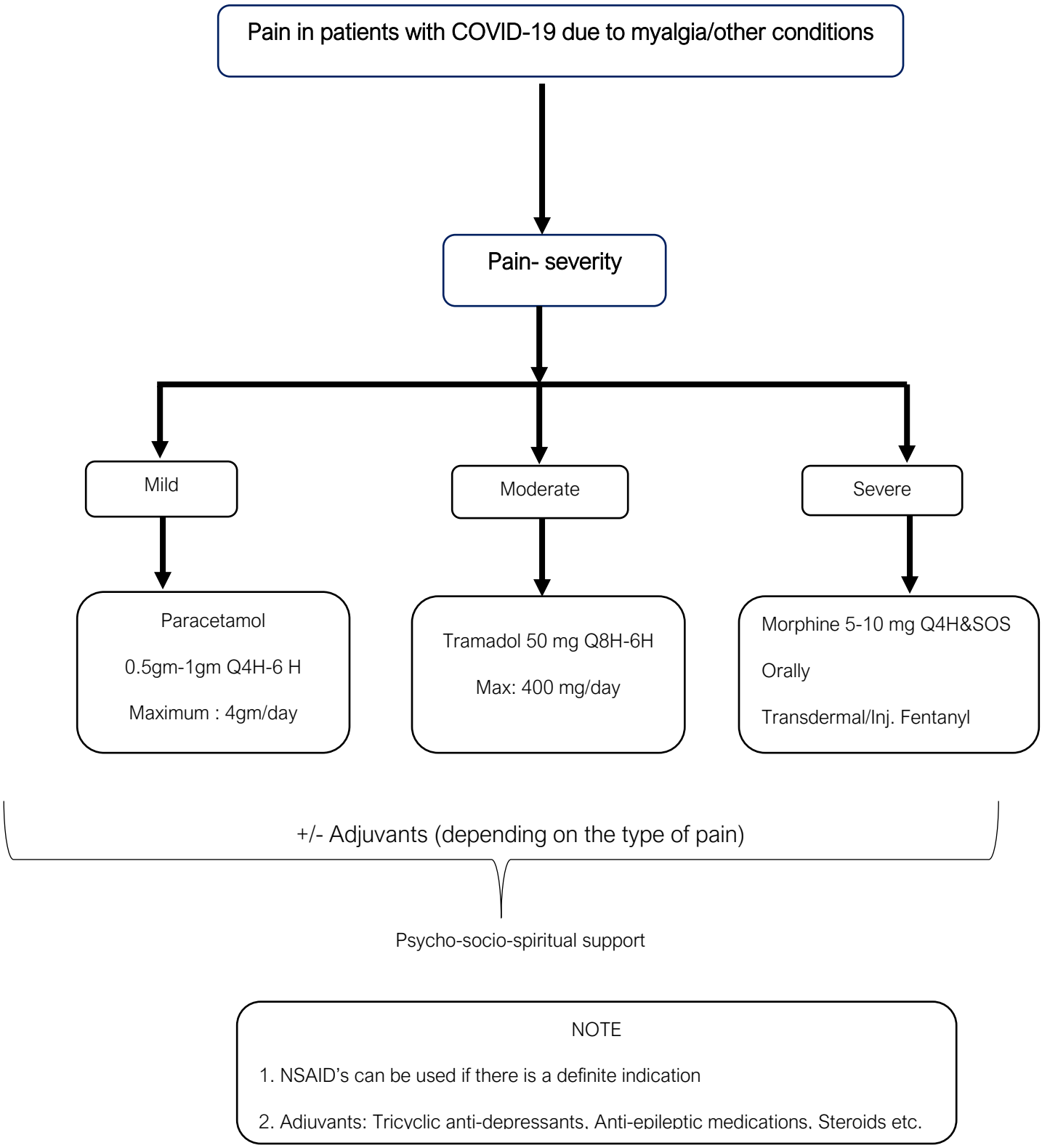
Management of Pain and Fever

Management of Pain in COVID 19



Management of fever in adults

Oral fluid intake (Not more than 2 litres/day)

Paracetamol 0.5-1gm 4-6 hourly (Maximum 4 gm /day)

Tab. Ibuprofen 400 mg three times a day

References

- https://www.nice.org.uk/guidance/ng163/chapter/5-Managing-fever (Accessed 03.05.2020)

Management of distress including psychological, social and spiritual support

First Level

Patients with confirmed COVID19 (moderate to severe illness)

Front line medical staff

Front line disease control staff

Front line management staff

Targeted Interventions	Target Population
Psychosocial Intervention (including stigma and spirituality)– *Algorithm* 4 Grief and Bereavement – *Algorithm* 9	Patients with confirmed COVID19 (moderate to severe illness) Front line medical staff Front line disease control staff Front line management staff
Goals of care communication – *Algorithm* 6	Front line medical staff
Stress and Burnout- *Algorithm* 8	Front line medical staff Front line disease control staff Front line management staff

Second Level

Patients with mild symptoms (fatigue, cough, fever)

Close contacts of confirmed patients

Patients in self-isolation or quarantined individuals

Targeted Interventions	Target Population
Psychosocial Intervention (emphasis on stigma, psychoeducation) – *Algorithm* 4 Grief and Bereavement – *Algorithm* 9 Stress and Burnout – *Algorithm* 8	Patients with mild symptoms (fatigue, cough, fever) Close contacts of confirmed patients Patients in self-isolation or quarantined individuals

Third Level

People related to the first and second level (family members, colleagues, friends, volunteers, healthcare workers)

Targeted Interventions	Target Population
Psychosocial Intervention (emphasis on stigma, psychoeducation) - *Algorithm* 4 Grief and Bereavement- *Algorithm* 9	People related to the first and second level

Fourth Level

Residents of the geographic area affected by the epidemic

General public

Targeted Interventions	Target Population
Psychosocial Intervention (emphasis on stigma, psycho-education, social issues)- *Algorithm* 4 Grief and Bereavement - *Algorithm* 9	Residents of the geographic area affected by the epidemic General public

Who will provide?

Team – the primary care team offering possible interventions, standalone or along with the medical team (psychiatrist, psychologist, psychiatric nurse, psychiatric social worker)

Hotline team – volunteers and mental health workers with the help of specialists

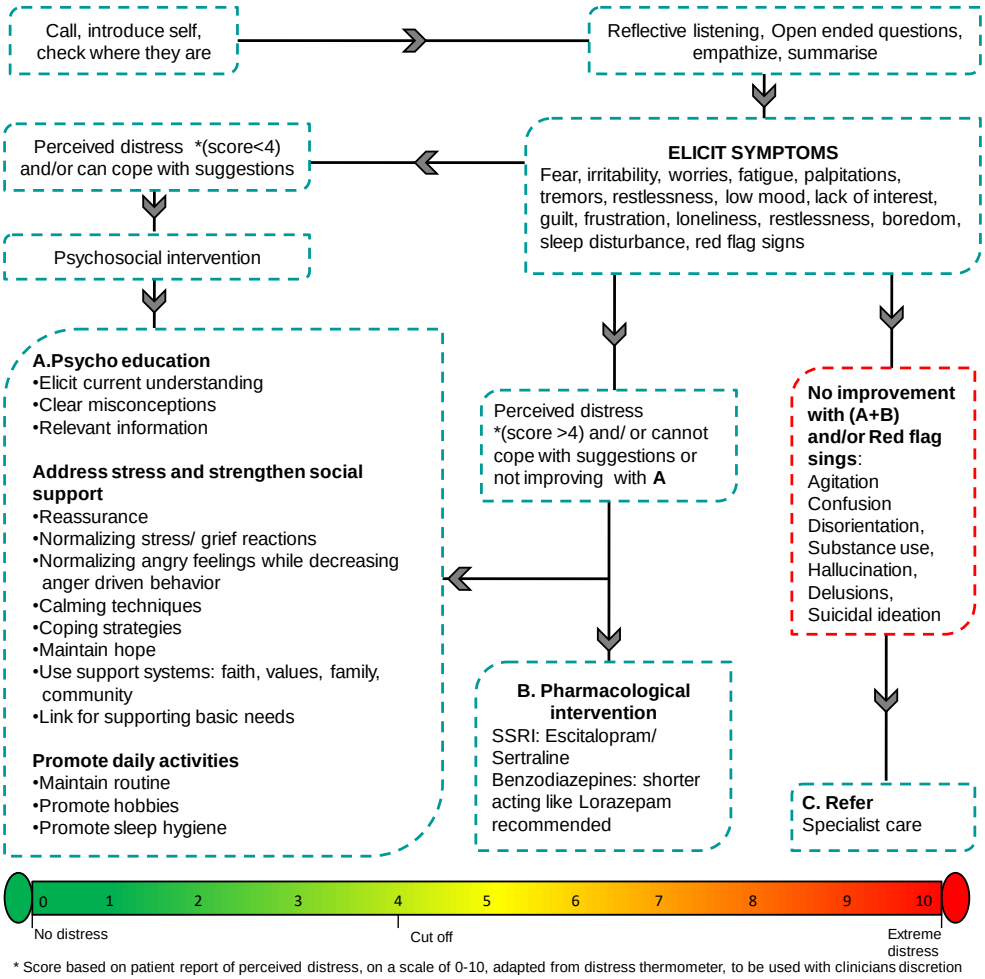
Method

Face-to-face maintaining distance with full PPE whenever possible

Skype/Facetime/WhatsApp/Phone/Videoconferencing

Making Sense of Distress - *Algorithm* 4

PSYCHOSOCIAL INTERVENTIONS FOR COVID 19



* Score based on patient report of perceived distress, on a scale of 0-10, adapted from distress thermometer, to be used with clinicians discretion

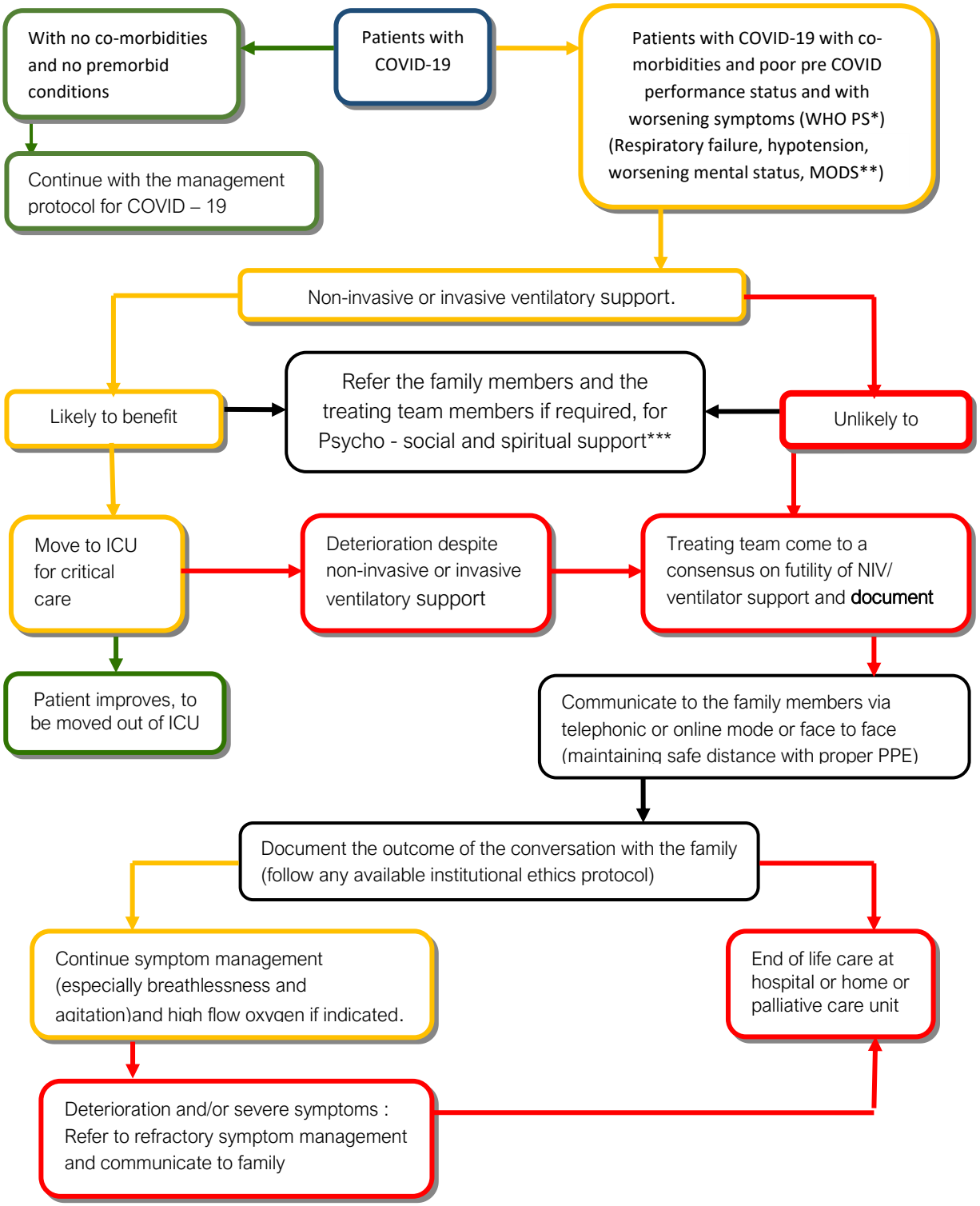
Follow-up recommendation: follow up after 24 hours and then as required

Do's:
- Be honest and trustworthy.
- Respect people's right to make their own decisions.
- Set aside your own biases and prejudices.
- Make it clear to affected people that even if they refuse help now, they can still access help in the future.
- .Ensure confidentiality unless issues mentioned affect the safety of the individual or others
- Provide information about COVID 19. Be honest of what you don't know. This is a new virus that we are all learning about.

Dont's:
- Don't exploit your relationship as a helper..
- Don't make false promises or give false information.
- Don't exaggerate your skills.
- Don't force help on people and don't be intrusive or pushy.
- Don't pressure people to tell you their story.
- Don't judge the person for their actions or feelings
- Don't talk about yourself or personal issues or troubles.
- Don't philosophize, moralize, preach or impose your own religious perspectives

Key psychosocial phrases conveying interest and empathy
I understand your concerns and most people do think a lot about the situation ...
It is very natural to be sad, angry, upset or ....
What has helped you in the past… What are the sources of hope and strength for you..
What we can offer is ...

Decision making and Ethical Framework - *Algorithm* 5



* World Health Organization Performance Status
** Multiple Organ Dysfunction Syndrome
*** Should be incorporated at all stages

Guidelines for Management of Ethical Issues

General principles

Medical ethics is the basis on which clinical decision making is implemented by a treating team

The four cardinal principles of ethics are Autonomy, Beneficence, Non- Maleficence and Justice

Ethical dilemmas are often complicated. In patients with COVID-19, ethical decision making can be difficult and stressful for health care workers and family members, as it is likely that the patients may deteriorate rapidly and time to communicate and implement the outcome of ethical discussion might be insufficient

It is likely that health care professionals may need psychological support if the patient number rises and they rapidly deteriorate

Guidelines

Communication and documentation are inevitable aspects of ethical decisions

Futility in treatment needs to be established quickly if the patient deteriorates. A system of triaging can be incorporated where the triaging team will make a decision about futility. They can then communicate and document the outcome of the discussion with the family members. Accordingly, patients can be either shifted to the ward or ICU for further management.

When patients are triaged and moved to the ward, they can have distressing refractory symptoms. Kindly refer to refractory symptom management guidelines.

End of life care is important in these patients as well as bereavement support for their families. Refer to the respective guidelines.

Glossary

* WHO PS Scale – WHO Performance Scale

WHO performance status classification

The WHO performance status classification categorizes patients as:

0: able to carry out all normal activity without restriction.
1: restricted in strenuous activity but ambulatory and able to carry out light work.
2: ambulatory and capable of all self-care but unable to carry out any work activities; up and about more than 50% of waking hours.
3: symptomatic and in a chair or in bed for greater than 50% of the day but not bedridden.
4: completely disabled; cannot carry out any self-care; totally confined to bed or chair.

** MODS – Multi-Organ Dysfunction Syndrome

References :

- Beauchamp TL, Childress JF. Principles of Biomedical Ethics, 6th ed, Oxford University Press, 2009
- Chiu T, Hu W, Cheng S, et al. Ethical dilemmas in palliative care: a study in Taiwan Journal of Medical Ethics 2000;26:353-357.
- Fromme E K et al. Ethical Issues in Palliative Care. Uptodate. Jan 2020
- N.I. Cherny. Esmo clinical practice guidelines for the management of refractory symptoms at the end of life and the use of palliative sedation . Ann oncol (2014) 25 (suppl 3)
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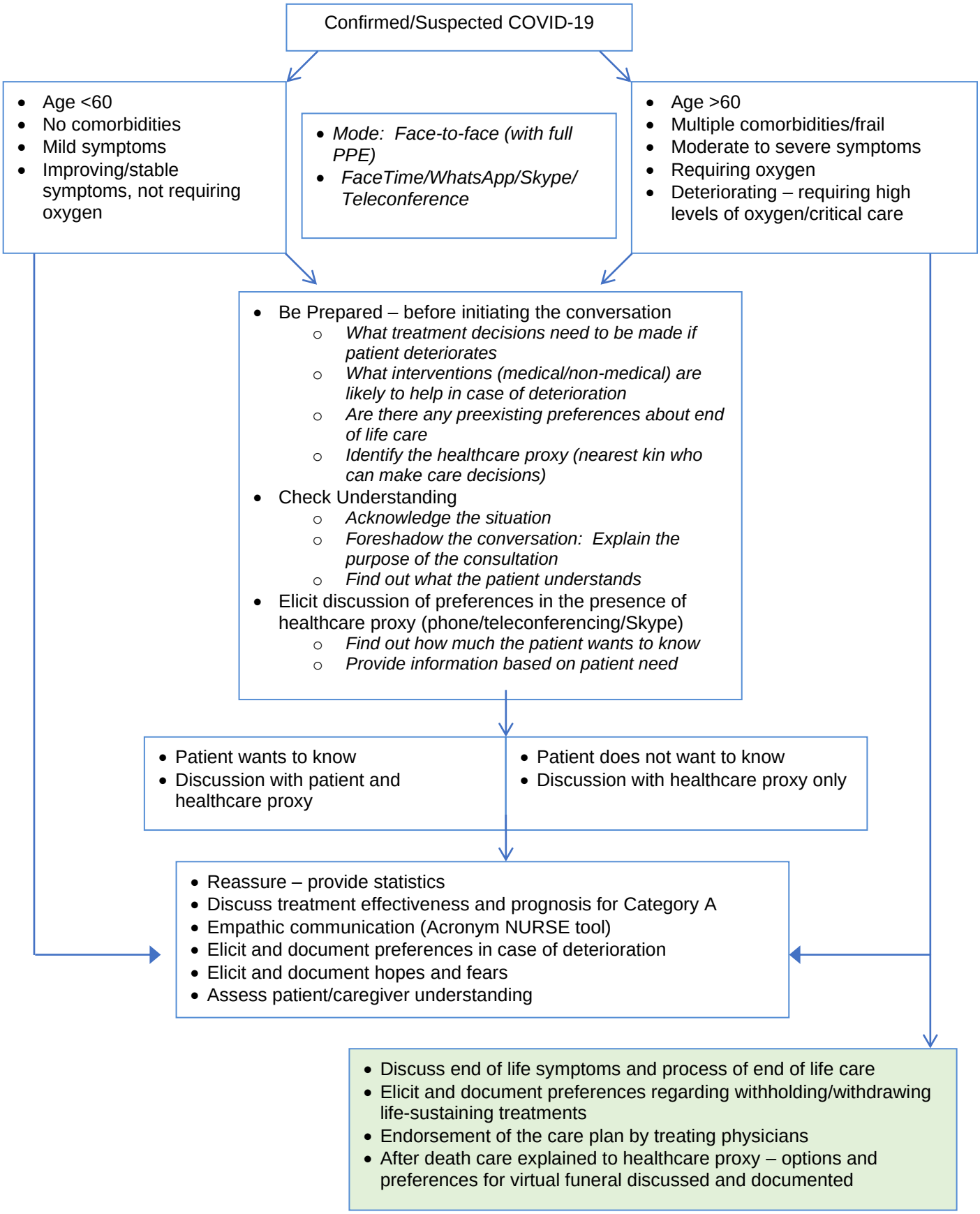
Goals of Care Discussion Framework - *Algorithm* 6



- Conversations about goals of care, patient preferences and priorities should be initiated early in patients with severe COVID-19 disease
- SPIKES a six-step protocol can be used for conveying bad news
    - **S**etting up the interview – read clinical records, no interruptions
    - Assessing the patient's **P**erception – what do they already know?
    - Obtaining the patient's **I**nvitation – how much do they want to know?
    - Giving **K**nowledge and Information to the patient – explain the situation, go slow, avoid jargon, cliché
    - Addressing the patient's Emotions with **E**mpathic Responses – show that you care
    - **S**trategy and **S**ummary – explain the next steps
- Ensure holistic and dignity conserving end of life care which is responsive to patient and caregivers spiritual/emotional needs
- Remember in this situation (COVID-19 pandemic) these conversations can be challenging given the rapid deterioration, absence of rapport, isolation and illness among multiple family members, absence of face-to-face communication
- Be prepared for anger/questioning/blaming – acknowledge and validate the emotions, be empathetic
- Empathetic approach includes NURSE protocol:
    - Name or mirror the emotions – *"You seem very angry"*
    - Understand the emotion – *"I can imagine how stressful this is…"*
    - Respect the patient/caregiver – *"I respect your feelings, but…"*
    - Support the patient using words – *"Is there someone you can talk to about this…"*
    - Explore the emotion further – *"Tell me more about your concerns…"*
- Healthcare proxy is the next-of-kin in the following order: spouse/adult children/parents/sibling/lawful guardian

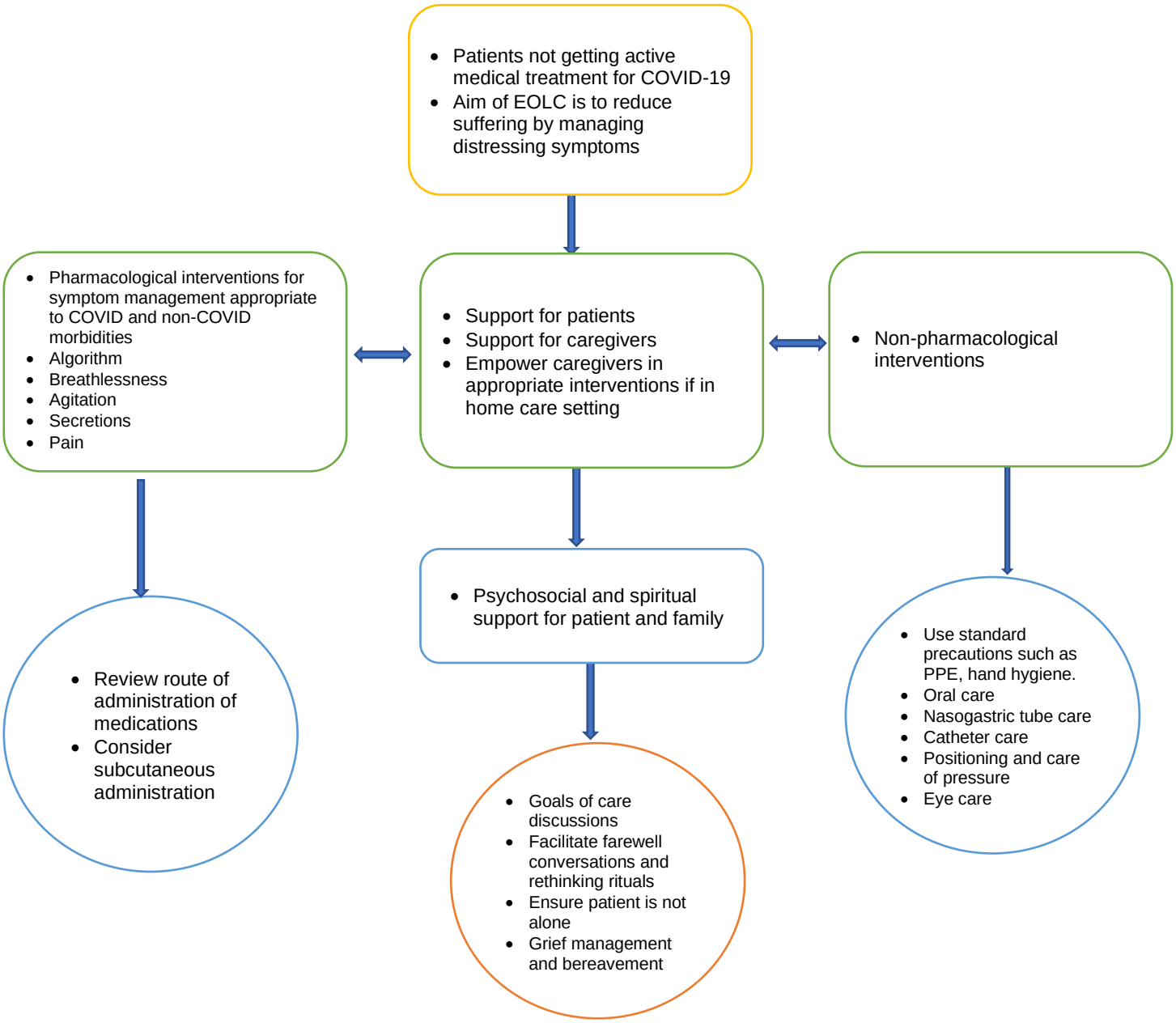
- Conversations to convey death of a loved one occur over the phone. Some standard phrases would include:
    - *"I am afraid I have some serious news. Your _____ may die shortly"*
    - *"I am afraid I have some very bad news. Your _____ passed on today"*
    - *"I am so sorry this has happened…I can imagine how difficult this is for you"*
    - *Explain the circumstances of the death – Your ___ was comfortable. She passed on at (time)."*
    - *Explain the process with regard to burial, cremation, funeral arrangements – the precautions that need to be followed*
    - *Offer to arrange for the family to attend the funeral virtually through social media*

References:

- https://www.vitaltalk.org/guides/covid-19-communication-skills
- COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care Role of the specialty and guidance to aid care" (March 22, 2020)
- Borasio GD, Gamondi C, Obrist M, Jox R, For the COVID-Task Force of Palliative Ch. COVID-19: Decision Making and Palliative Care. Swiss Med Wkly. 2020.

End-of-life care in the context of COVID-19 – *Algorithm* 7

Algorithm for End of life care (EOLC) in patients with COVID-19



Health Care professionals can provide meticulous care in the following domains

- Oral care
- Eye Care
- Nasogastric tube care
- Catheter care
- Care of pressure points

Standard Instructions

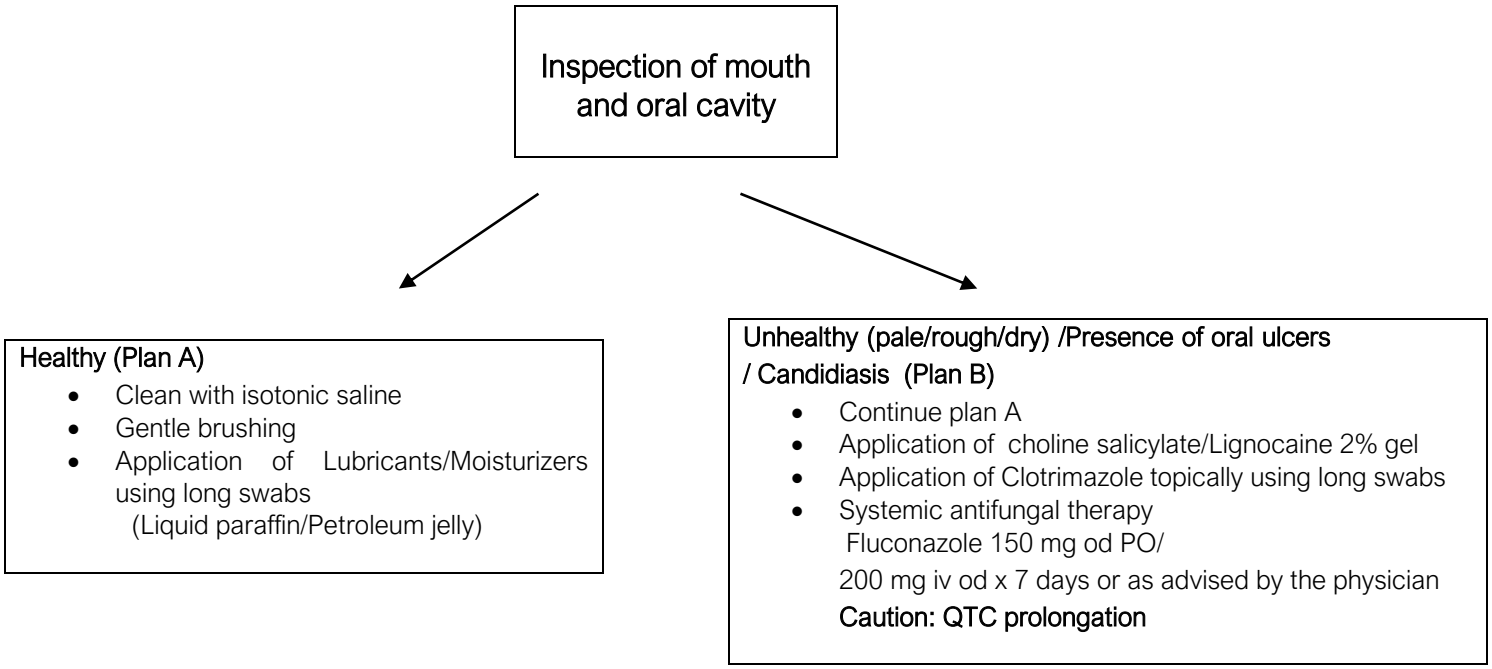
Do's

- Health care professionals **must** wear personal protection equipment (PPE) while doing **all** procedures.
- Collection of samples and disposal of waste should be done according to COVID-19 protocol

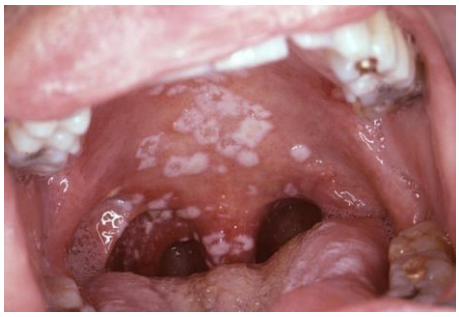
Don'ts

- Nebulizers and fans should not be used in the wards or patient rooms as it increases aerosol spread
- Suction should not be done as a routine procedure.

ORAL CARE



ORAL CANDIDIASIS



Management of excessive secretions: refer to *Algorithm 2* for secretions

Oral care can be highly compromised in view of compromised immune status, medications like steroids and respiratory supportive measures like endotracheal tube and oxygen therapy.

Eyecare

Eyes are sensitive organs in any illness that require ICU admission and life supportive measures. They are more vulnerable in semi responsive /unresponsive patients who are sluggish with the protective blinking response. In COVID-19, eyes come in the 'T zone' through which droplet infection can reach body

Guidelines for eye care

- Eyes can be cleaned with swabs soaked in isotonic saline from inner canthus to outer canthus
- In patients who are sedated/ unresponsive/on ventilator, eyes may be covered with protective pads and antibiotic ointment, if required

Nasogastric tube care

Patients who are mechanically ventilated and in semi-responsive/unresponsive states have to be fed by a nasogastric tube to maintain hydration and nutrition

The important nursing considerations in a patient with a nasogastric tube (NGT) in place are as following

- Check the position of the NGT before each feed by aspiration of gastric contents
- Restrict the feed to 200ml at a time
- Cleanse the tube before and after each feed with 20 ml of clear water
- An interval of 2 hours should be maintained between each feed
- Keep the head end of the patient who is **not** intubated and fed through a nasogastric tube, **elevated for 24 hours** (low Fowler's position i.e. 30 -45 degree)
- Clean the nostrils with saline moistened swabs
- Look for erosions on nasal cartilage from pressure

Catheter care

The patients with severe symptoms and those on mechanical ventilators will be on continuous bladder drainage to maintain an intake output chart. A catheter in place is a source of infection too. Maintaining catheter care is part of maintaining good health care.

The important points for proper catheter care

- Maintain good perineal hygiene from the umbilicus to mid-thigh with soap and water daily, if possible twice a day
- Ensure adequate fluid intake, according to the physical status of the patient and the advice by the physician (ideally 2l/day)
- Empty the collection bag 2 hourly
- Place the collection bag below the waistline
- Avoid pulling or dragging the tube which may lead to trauma to the urinary tract
- Ensure regular bowel movement. The patient is likely to get constipated from the drugs and inactivity. Constipation predisposes to urinary tract infection
- Check the appearance of urine and plan appropriate measures as needed

Care of pressure points

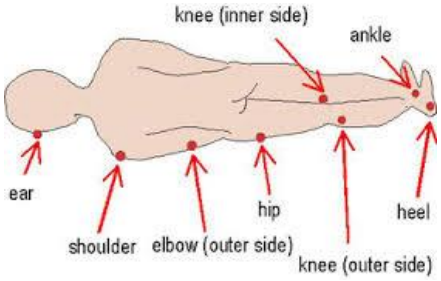
When the patients become mechanically ventilated/very sick, it will be very difficult for them to turn on a bed by themselves which will predispose them to injury to pressure points. Prevention of pressure injury is of paramount importance in the nursing care of sick patients

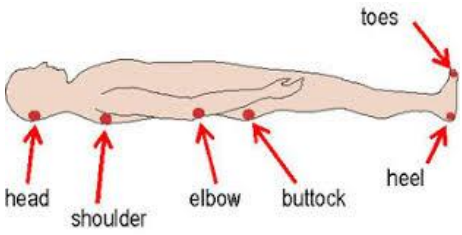
The following points should be meticulously carried out while caring a bedbound patient

- Check for pressure points twice a day
- Avoid soiling of skin
- Prevent dryness of skin using emollients/ moisturizers
- Pressure reducing mattress is not the mainstay to prevent pressure injury
- **Change position 2 hourly**. If the patient is actively dying, turning schedule should be made less rigid
- Avoid dragging the patient for procedures /position change
- If pressure ulcer develops, clean with isotonic saline and apply topical antibiotics, if necessary.

Footnote: In stage I pressure injury, there will not be any loss of skin, but only non-blanchable erythema will be seen. The pressure injury caused by medical devices like an oxygen mask, endotracheal tube and nasogastric tube also should be looked for

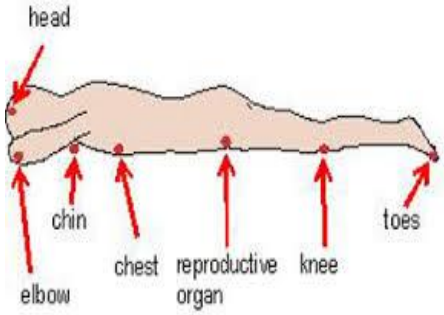
Pressure points

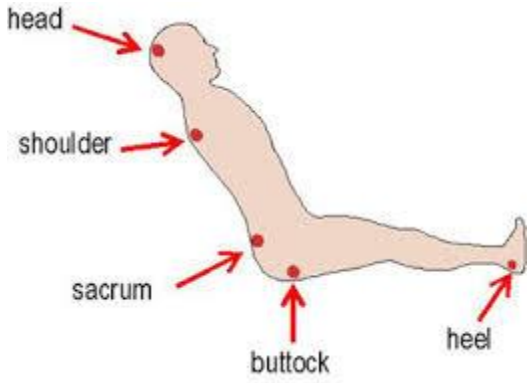




LATERAL POSITION

SUPINE POSITION





PRONE POSITION.

FOWLER'S POSITION

Subcutaneous administration of drugs

The administration of drugs through the subcutaneous route is common and practically useful in many palliative care scenarios. This mode of drug administration has a place in treating COVID patients in whom accessing an intravenous route is difficult.

The drugs **without an oil base** can safely be administered through subcutaneous route e.g. Morphine, Haloperidol, Lorazepam, Midazolam, Dexamethasone, Metoclopramide, Ondansetron, etc

Guidelines

- Needle size : 23 to 25 G, 3/8 inch (90 - degree angle) - 5/8 inch (45 -degree angle) long
- Volume of single injection: 1- 2 ml
- Speed of injection: Slow
- Sites: the upper outer area of the **arm**.

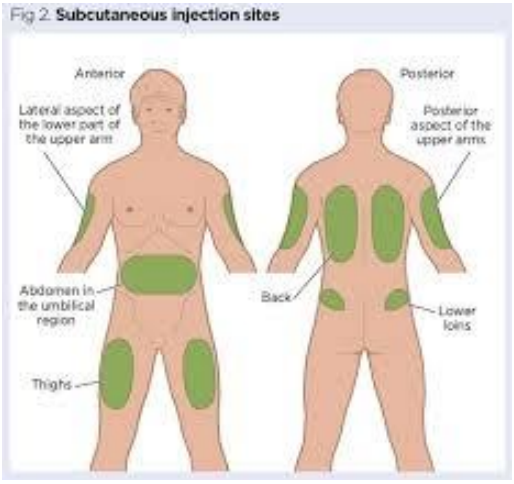
  the front and outer sides of the **thighs**.

  the **abdomen**, except for a 2-inch area around the navel.

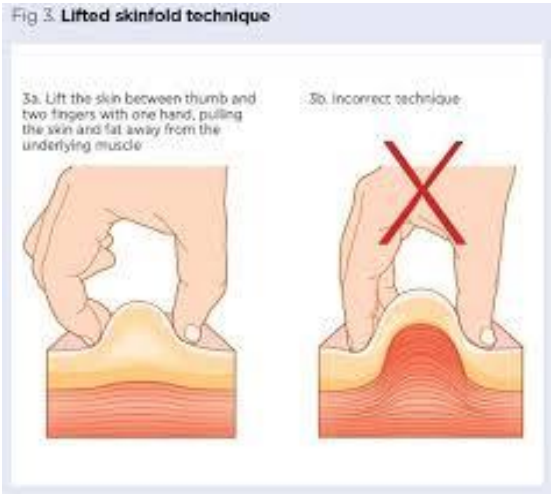
  the **upper hip**

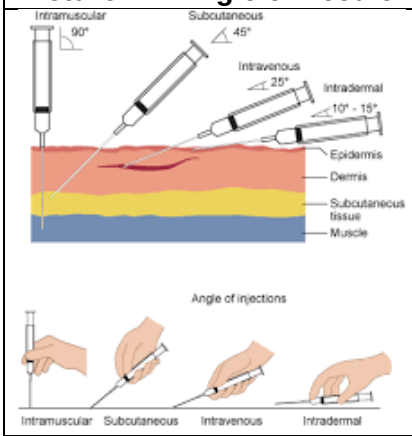
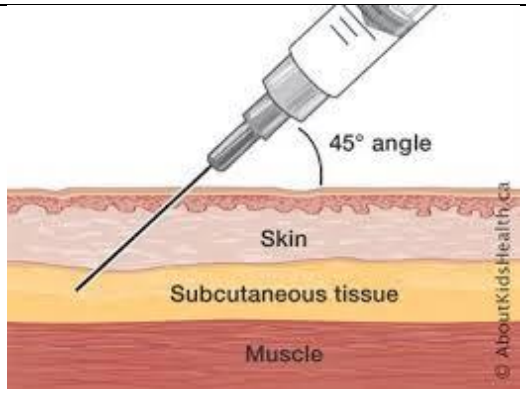
  the upper outer area of the **buttocks.**
- Angle: 45 degrees, where 1 inch of tissue can be grasped
  90 degree, where 2 inches of tissue can be grasped (buttocks)

Picture I - Sites for subcutaneous injection.

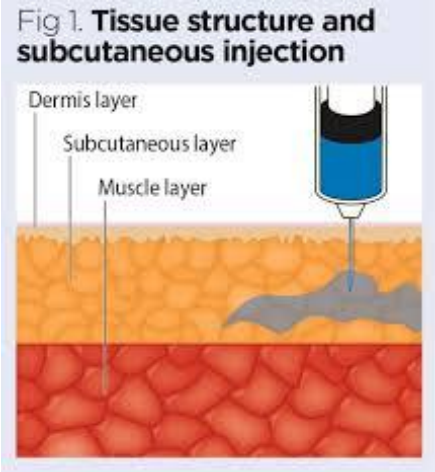


Picture II - Holding the tissue for injection



Picture III - Angle of needle insertion	Picture IV - Needle in the subcutaneous plane at 45°
	

Picture V – Needle in the subcutaneous plane at 90 degree angle



Conclusion

Nurses provide compassionate care to COVID-19 patients but the nature of work puts them at risk. They might feel vulnerable because of the nature of the pandemic and limited supply of PPE

References:

- End of life nursing consideration - COVID-19 patients, Hospital Palliative Care New Zealand (HPCNZ)
- Nurses, Ethics and the Response to COVID-19 Pandemic - American Nurse Association
- Textbook of Certificate Course in Essentials of Palliative Care; 5th edition (2017)
- Revised National Pressure Ulcer Advisory Panel Pressure Injury Staging System, Laura E. Edsberg et al in J Wound Ostomy Continence Nursing 2016;43(6)585-597
- Kozier and Erb's Fundamentals of Nursing - Concepts, Process and Practice; 9th edition (2013) edited by A. Berman and S. Snyder

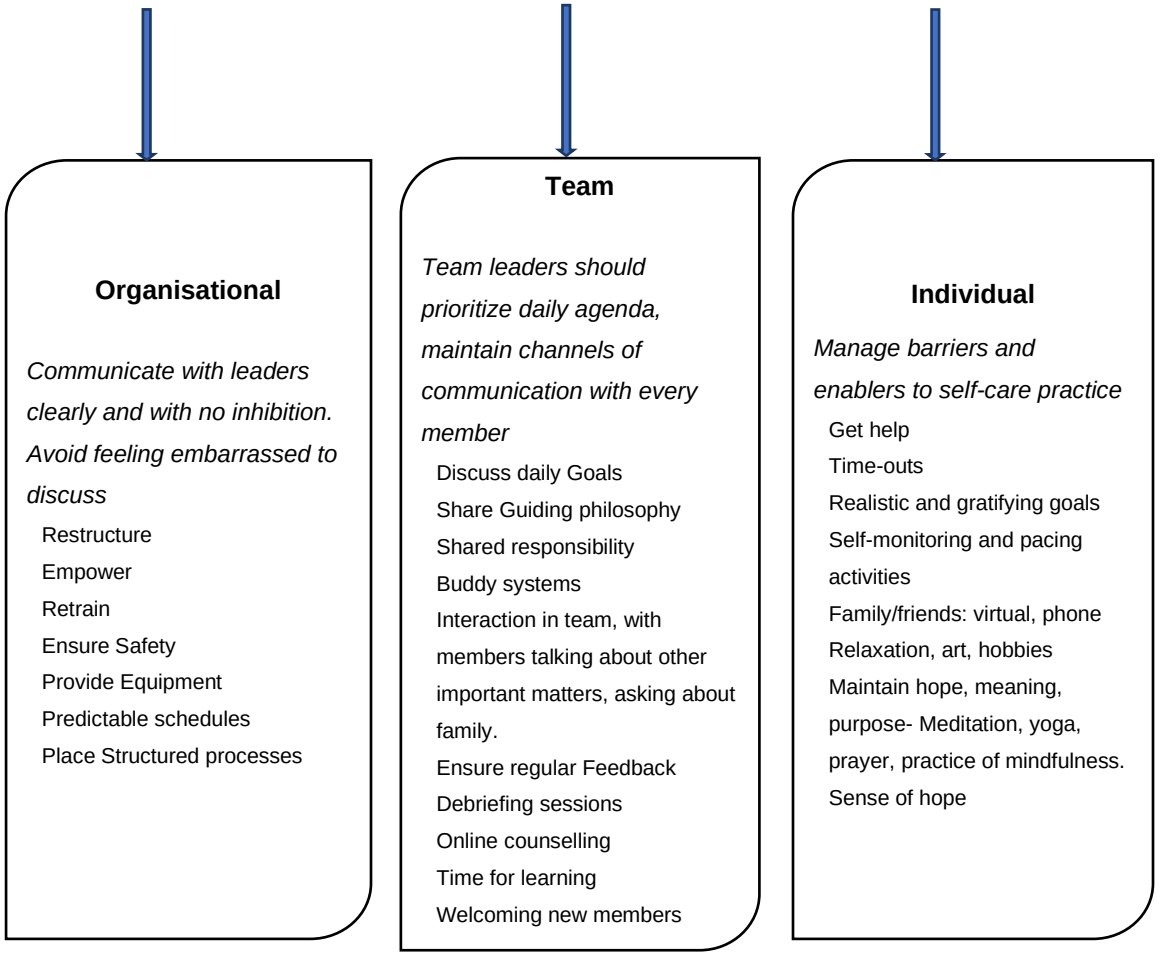
Supporting Compassionate Care and Addressing Burn Out for Health Care Workers – *Algorithm* 8

- The COVID-19 pandemic bringing in social distancing, the fear of spread, illness, death is contributing to people becoming stressed, anxious and frustrated. Specific groups such as health care workers working in frontline care, and those working for vulnerable populations in diverse settings, are exposed not only to the risk of becoming ill with COVID-19 themselves but also to the risk of increasing anxiety.
- The disturbed work schedules, extended shifts, disrupted sleep patterns, blurring of roles, exposure to morbidity and mortality, the need for increased intensity of team communication and discussions leading to frequent changes in practice and decision-making, information overload including fake news on social media, all contribute to harmful exhaustion. At such times, the risk of burn-out increases.
- "Burn-out is a syndrome conceptualized as resulting from chronic workplace stress that has not been managed successfully. It is characterized by three dimensions:
    - Feelings of energy depletion or exhaustion;
    - Increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and
    - reduced professional efficacy.

    Burn-out = Emotional Exhaustion+ Disillusionment+ Withdrawal
- Burn-out refers specifically to phenomena in the occupational context and should not be applied to describe experiences in other areas of life [1].[2]"
- Burn-out often goes unrecognized in routine clinical practice but must be attended to in humanitarian crises such as the COVID-19 pandemic.
- Emotions including guilt, blame, not being able to contribute to frontline work while being in quarantine, fear of ignoring or bring an infection back home, feeling responsible for negative outcomes could be predominant expressions of distress.
- Burn-out is not just equivalent to an increased load of work but is a psychological condition that has a huge impact on carers and patients alike. This state leads to errors, poor quality of care and poor satisfaction for patients and families.
- "Moral distress/injury" resulting from the inability to deliver care despite taking an oath to provide medical care, maybe compounded by the lack of available essential resources such as beds, face masks PPE, ventilators. These factors, alongside fatigue, inner conflict, uncertainty and the ever-present risk of violence directed at health carers, all contribute to a heightened risk of burn-out.
- Amid the coronavirus disease 2019 (COVID-19) pandemic, the American Academy of Sleep Medicine has issued a position statement noting the significance of sufficient sleep among physicians. An insufficient amount of sleep has been linked to physician burn-out[3].
- All types of health workers, their families and patients' families can experience high levels of burn-out.

Principles of interventions to reduce Burn out

- Teamwork, establishing and maintain a sense of belonging at work
- Enabling and building emotional and social connectedness
- Focusing on a blend of work and life
- A proactive and holistic approach to promoting personal health and well-being to support professional care of others



References:

- https://www.who.int/mental_health/evidence/burn-out/en/ Accessed on 29/03/2020
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- Kancherla BS, Upender R, Collen JF, et al. Sleep, fatigue and burnout among physicians: an American Academy of Sleep Medicine position statement [published online February 28, 2020]. *J Clin Sleep Med*. doi: 10.5664/jcsm.8408.

Grief and Bereavement in COVID-19 - *Algorithm* 9

The COVID-19 pandemic brings about a collective, community-oriented loss experienced not only at the family level, but also at a social, economic and political level. Grief and the rituals of mourning are healthy adaptations to loss. But the social distancing, isolation, and quarantine for contacts make the grieving process challenging. The family, which may be isolated, will find it difficult going through preparatory (anticipatory) grief not knowing how the loss is going to be. Though the majority of infected people are expected to recover, the uncertainty, fear and anxiety of loss will be enormous.

The person with the illness will also be isolated, with only the medical team around him, again maintaining a distance and wearing PPE. The usual methods of communication, of establishing trust, rapport, non-verbal gestures especially touch, and presence of family will not be possible. Family's wishes will be discussed at a distance, over the phone, or using technology.

Bereavement is more complicated due to the changes in the traditional societal mourning process. Funerals, burials, and gatherings are not allowed, with these being carried out according to the government policy. This is completely new to all of us and brings in the potential for prolonged grieving. The nature of loss and the measures to limit spread compound the trauma.

The complete impact on those who are bereaved for the measures taken by the systems, heath and government as a result of COVID-19 is not yet known.

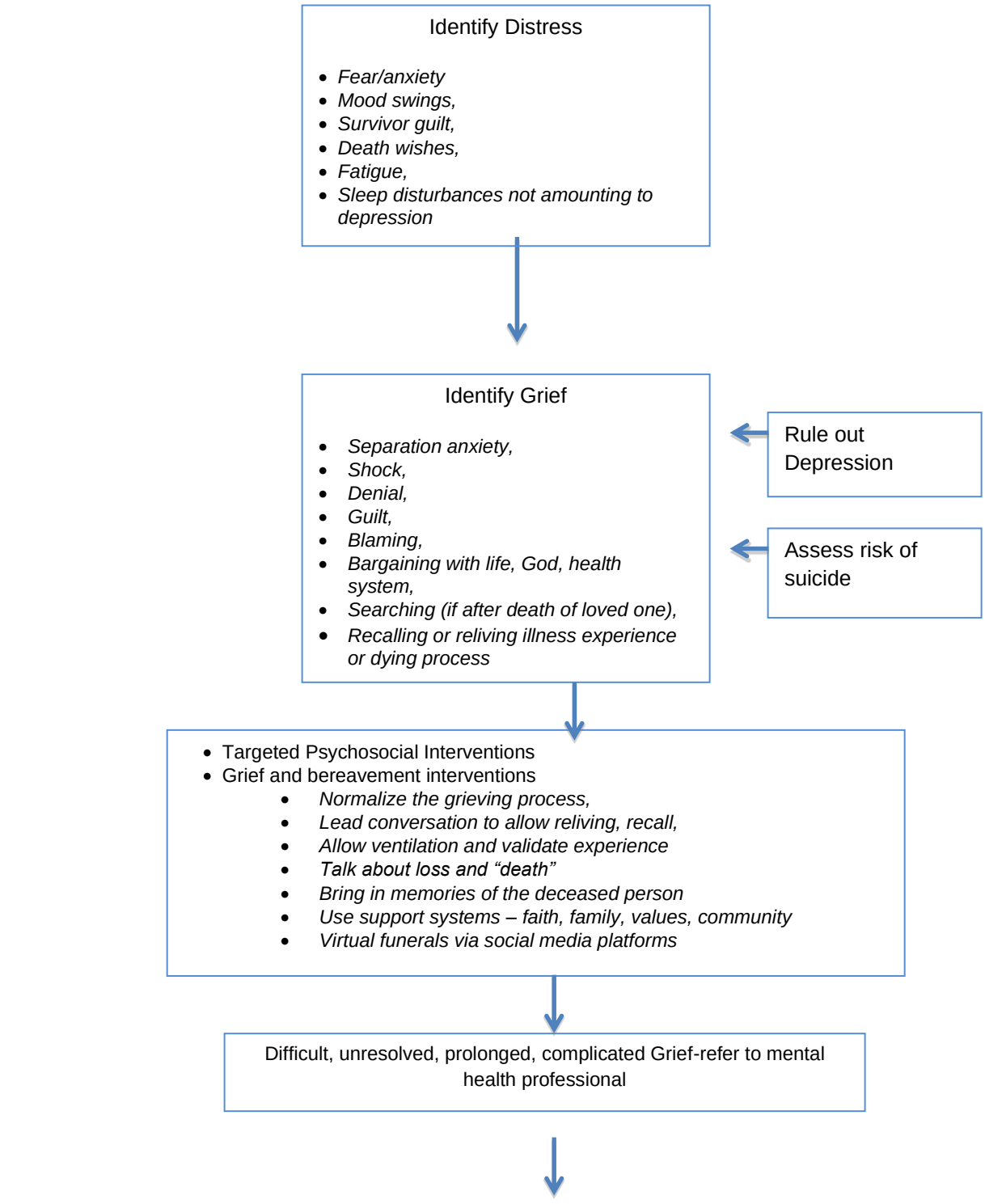
The possible measures are to stay connected with technology and other methods essential to continue providing support and a presence for the grieving family.

Stay connected

This present era is familiar to using emails, texts and phones for all communication. Its application is more acceptable and necessary as the restrictions on gathering size and social distancing are in effect.

Facebook/Whatsapp and other video conferencing could be used routinely.

In addition to the use of technology, the telephone and mobile phone remains a powerful and effective way to stay connected and support the bereaved family.


Identify Distress
Fear/anxiety
Mood swings,
Survivor guilt,
Death wishes,
Fatigue,
Sleep disturbances not amounting to depression
Identify Grief
Separation anxiety,
Shock,
Denial,
Guilt,
Blaming,
Bargaining with life, God, health system,
Searching (if after death of loved one),
Recalling or reliving illness experience or dying process
Rule out Depression
Assess risk of suicide
Targeted Psychosocial Interventions
Grief and bereavement interventions
Normalize the grieving process,
Lead conversation to allow reliving, recall,
Allow ventilation and validate experience
Talk about loss and "death"
Bring in memories of the deceased person
Use support systems – faith, family, values, community
Virtual funerals via social media platforms
Difficult, unresolved, prolonged, complicated Grief-refer to mental health professional
Regular follow-up, identify resources in community for support, systems to offer support which could be volunteer groups, faith groups, palliative care units, mental health professionals

Glossary:

Grief is the individual's response to the event of the loss. Grief is generally experienced in three ways: psychologically through feelings, thoughts, attitudes; socially through behavior with others; and physically through health and bodily functions.

Bereavement can be defined as the objective event of loss associated with death, changes in relationships or economic status, as well as geographic relocation.

Distinguishing grief from depression is necessary and to understand that grief is a part of the normal dying process.

Preparatory (anticipatory) grief is experienced by virtually all patients who are dying and their family members and can be facilitated with psychosocial support and counseling. Ongoing pharmacotherapy is generally not beneficial and may even be harmful to patients who are grieving.

References:

- Am Fam Physician 2002;65:883-90,897-8. Copyright© 2002 American Academy of Family Physicians.
- https://www.shiva.com/learning-center/coping/a-new-grief-staying-connected-to-help-covid-19-coronavirus/

Psychosocial interventions for COVID-19- Supporting document

As a public health emergency of international concern, COVID-19 with its uncertainties about spread, novelty of the virus itself and unparalleled containment efforts has compounded the dilemma the society faces at multiple levels. While the biological and physical repercussions of the disease get disproportionately more attention, the mental health aspects also demand dynamic attention. Epidemics have also imparted a vital realization that the absence of effective mental health and psychosocial support system increases risks of psychological distress and progression to psychopathology. [1]

A survey conducted in China during the initial outbreak of COVID-19 found that 53.8% of respondents rated the psychological impact of the outbreak as moderate or severe; 16.5% reported moderate to severe depressive symptoms; 28.8% reported moderate to severe anxiety symptoms, and 8.1% reported moderate to severe stress levels [1]. The psychological impact of the outbreak was higher among women and students, with higher reports of stress, anxiety and depression. In order to reduce the risk of negative psychological outcomes of the COVID-19 outbreak and to promote social stability, the National Health Commission of China (NHC) has integrated psychological crisis intervention into the general deployment of disease prevention. Similar measures have been necessitated in other countries fighting the pandemic as well [2,3].

The stigma of the illness with its resultant labeling, stereotyping and discriminating, lack of knowledge about the disease, uncertainties of the outbreak, constant media reactions and false information compounds the problem. In a country like India, there are added worries of social and economic disruption that can further complicate mental health problems[3].

Fear of and worries about infecting family and friends, especially the elderly. The thought that one may be asymptomatic but still have the potential to infect others is quite disturbing. These worries are magnified among healthcare workers in isolation and quarantine. The pandemic has kicked off a grieving process in the community, in anticipation of the perceived collective loss and death, increasing the vulnerability to grief and burn out .[4]

The mental health impact of pandemics extends beyond the period of the pandemic; hence, it is vital that we understand individual and collective behavior, emotions, and reactions to the crises and their coping behaviors. It will enable us to mitigate the effects of the ongoing crisis and also be better equipped for future [1].

Palliative care teams, with their bio-psycho-socio-spiritual approach, have much to contribute in these times and can in addition to physical symptom management, help in providing care that is in line with patient and family values, and improve connectedness. They can also help by training healthcare workers in bereavement counseling, enhancing their communication skills especially in the context of PPE, and implement measures to mitigate the effects stress in this population. '

Palliative care also focuses on supporting the person with the illness throughout their journey. From the period of isolation, or quarantine, to end-of-life and beyond, addressing grief and bereavement of the families coping with the loss of their loved ones. The risk of having posttraumatic stress symptoms for extended periods is significant in this scenario, in which the palliative care teams, with their home-based approach are capable of addressing in the community.

Rapport building and reflective or active listening:

Effective healing after trauma begins from within, remember we are here to help people gain understanding about their current situation and make informed decisions by themselves.

Start with introducing yourself and enquiring about the caller or person seeking help. Focus on who they are, where they are calling from and their current situation, which would include quarantine/ isolation status. Idea is to encourage them to talk and verbalize their concern …is it about a family member, themselves?

Remember to speak slowly, clearly and calmly. Convey that you understand their situation, acknowledge their distress, use phrases to normalize their current feelings and allow for ventilation. Where ever possible, conveying a sense of all being in it together and as a society, we are helping each other to be safe by complying with lockdown/ quarantine.

Preferably use open-ended questions. For example, more of "how are you doing?" rather than "are you doing fine?" questions. A well-framed question conveys a sense of understanding.

Be empathetic and address issues by literally employing the approach of " walking in another person's shoes". Our best guide can be the cascade wherein empathy leads to trust, which in turn leads to compliance.

Summarizing is a useful skill that involves taking somebody else's words and turning them into your own. It gives the person the confidence that his concerns have been heard, understood, and validated. It also ensures that you got the right perspective after listening to the conversation. The situation can be pretty tricky as we can end up in a lot of assumptions, especially when the part of non-verbal communication is almost nil. Paraphrasing and rephrasing, when done with empathy, enables the person seeking help to gain a better perspective about their current situation.

Key psychosocial phrases conveying interest and empathy :

- I understand your concerns and most people, are facing similar doubts...
- It is very natural to be sad, angry, upset
- I hear what you are saying, about having to...
- I fully understand that you are feeling this way...
- In this situation, your reaction is quite natural...
- What has helped you in the past?… Are you religious?… Because some people are depending on their faith to give strength
- Maybe we can discuss possible solutions...
- What we can offer is...
- I am concerned about you, and I would like to suggest to refer you to someone who can help you …

Symptoms:

Common mental/emotional reactions:

- Feeling stressed or overwhelmed
- Feeling anxious or worried, thoughts about own health and that of loved ones
- Sadness, low mood
- Frustration
- Irritability
- Difficulty concentrating
- Loss of interest in activities
- Trouble relaxing
- Worsening of ongoing mental health problems

Common physical symptoms:

- Increased heart rate
- Restlessness or agitation
- Stomach upset,
- multiple aches and pains (not associated with fever)

Common Behavioral Reactions:

- Fatigue, or other vague/ uncomfortable sensation
- Changes in eating patterns
- Difficulty sleeping
- Worsening of chronic health problems
- Increased use of alcohol, tobacco, or other substances

Common symptoms can be divided in to:

- Panic -anxiety type- palpitations, tremors, restlessness, irritability, fear
- Depressive type-low mood, lack of interest, irritability, sleep disturbance,
- Social - loneliness, boredom, worries, frustration

Red flag signs

These are the warning signs that when present should warrant immediate referral. If elicited during a conversation, immediately report to concerned authorities.

Agitation: This can result in a risk of harm to self or others. The history is usually elicited from caregivers. It is usually indicative of other serious underlying conditions.

Confusion or Disorientation: can be due to delirium. History elicitation will include, worsening towards evening, disorientation to time, place or person, agitation, hallucinations, fearfulness, etc. Also, clarify for alcohol use. It is an emergency, requiring immediate referral for further management

Substance use: There can be an increase in substance use that can worsen existing mental health problems. With lockdown being in place, withdrawals will also be common. In the case of substance use history being elicited it is always better to refer for further evaluation.

Hallucination and delusions: They can be part of an acute transient psychosis or worsening of pre-existing psychiatric conditions. It can also be indicative of delirium or alcohol withdrawal. Hence when elicited, it's always better to refer for detailed evaluation and further management.

Suicidal ideation: if a person seeking help indicates wanting to end life either directly or indirectly, immediate referral for risk assessment and further management is warranted. If the person sounds distressed and extremely anxious, clarify for any suicidal ideations as people might not spontaneously come up with the same due to stigma. Before referring to a specialist, ensure that the family or caregivers are aware of the suicidal risk and the precautions to be followed. Also, you can give them details about various suicide helpline numbers. (refer Helplines)

Perceived distress

The concept is adapted from distress as a vital component that needs to be addressed in cancer patients. It is defined as "a multifactorial unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms, and its treatment" the concept was thought to be more appropriate in the current context as it also provides us simple way to measure distress.

After symptoms are elicited, use a distress thermometer to quantify perceived distress. Ask the patient to rate the distress they have been feeling over the past one week on a scale of 0-10, if required give prompts like to rate in terms of percentage or commonly used currency etc.,

A score of above 4 with significant distress due to presenting symptoms would warrant further psychosocial evaluation. (ANNEXURE 1 for distress thermometer)

Psychosocial interventions

COVID-19 with the requirements of quarantine and lockdown has invariably resulted in interesting challenges of delivering mental health services. However, we can be mindful of a few techniques that will help people tide over this crisis.

Psychoeducation:

General strategies when communicating:

a. Explain the source of the information and how reliable it is, use statistics where possible
b. Say only what you know – do not makeup information or give false reassurances;
c. Disclaimer that this is latest, we are still learning about the virus and that research is going on in parallel
d. Keep messages simple and accurate, and repeat the information to be sure people hear and understand it
e. It may be useful to give information to groups of affected people so that everyone hears the same message
f. Let people know if you will keep them updated on new developments, including where and when.
g. When giving information, be aware that the helper can become a target of the frustration and anger people may feel, especially when their expectations of help have not been met by you or others. In these situations, try to remain calm and be understanding.
h. Try to keep yourself informed of the latest updates on the outbreak.

i. Try using official written information, such as posters and leaflets in the local language, or pictorial form for people with low literacy, to complement the information you are giving

Relevant sources of information: Try to stay updated about the news by relying only on authentic news.

Limit the news time by listing the program to watch, such as limiting it to only some of the reliable resources: WHO website/ WhatsApp chatbot, Government press meets and apps, information by Governing bodies like the Ministry of Health and family welfare.

Addressing stress and strengthening social support

Reassurance:

Reassurance must be honest. The person seeking help must believe that the reassurance is based on an understanding of his or her unique situation. Reassurance that is given before the person has detailed his or her concerns is likely to be doubted. Limit reassurance to areas in which you have dependable common information. It is never acceptable to offer reassurance that is simply what the patient (or family) wants to hear. If the patient demands reassurance and this reassurance is outside your expertise the basis for the reassurance should be made explicit.

Example :

Caller: Why aren't they testing everybody?

Health professional: We don't have enough test kits (if the data support the statement). I wish it were different.

Normalizing grief/ anxiety:

It is a form of reassurance. Remember, stress reactions are a normal reaction to an abnormal situation. Normalising allows us to reassure the person seeking help that their experiences, thoughts, and feelings are not unusual or pathological under the current circumstances. Reassurance and normalizing must not extend to pathological fears or relationships. You may use the technique from a position of authority as in the following example

Example :

Caller: I am scared, will I get corona? I want to live.

Health professional: This is such a tough situation. I think anyone would be scared. We are doing everything we can. Would you like to tell me more about your concerns...

Normalizing feelings of anger, and at the same time decreasing anger-driven behaviors:

Feeling angry in the current situation of quarantine and lockdown is normal. When a person seeking help complains about the same or is noticed to be irritable or frustrated try to normalize the same for them. Explain to them that even though in this case their anger is justified, fueling anger will not help them to respond effectively. Don't give in

to the urge of giving in to anger, practice doing the opposite, e.g., When you have the experience of anger, relax your body and redirect your attention away from building a case against the object of my anger.

Example:

Caller: I have not been able to go for work because of lockdown and it just makes me so angry.

Health professional: Under current circumstances your anger is normal… I can wait till you calm down (suggest calming techniques if needed) and then we can discuss your concerns and see how we can help you out.

Calming techniques: When a person seeking help feels anxious or worried tell them todo whatever relaxes them, in a healthy way, such as listening to music, dancing, yoga, taichi, deep breathing, etc. For some people, routine chores like sweeping, mopping, cooking relax them. Getting cardiovascular exercise done is also an important and often overlooked resource in calming down. A brisk walk around the house, or outside in nature, if at all possible, also calms the mind. Inform the caller, that focusing on the "here and now" rather than on uncountable events can help clear the mind.

Some specific calming techniques like deep breathing and mindful observation are explained in ANNEXURE 2

Maintain hope: Believe in something meaningful, whether it be family, faith, country or values. Before this pandemic all of us had some purpose in life, be it studying to become somebody, providing a safe future for your kids, building that dream home. Therefore, remember those purposes, and (unless you are seriously affected by the virus) realize that things have not changed much and hopefully you can still continue in your pursuit of your purpose.

Guilt: People can feel guilty about getting others infected in current circumstances. Address the same by reassuring them about following hygiene practices and physical distancing, as these are the proven and effective ways of containing spread of infection. As long as they are practising the same, the chances of unknowingly spreading the infection is low.

Physical distancing by maintaining social connectedness: Stay connected with your family and friends using social media, mail. etc. Have a virtual chat using apps, read books, watch same films again. This can be the time to catch up with lost or forgotten friendship. It can also be a good excuse to mend that broken relationship.

Play: is a great stress buster and play can invigorate anybody. Play for fun and not solely for competition. When quarantined, it is usually indoor play activities. However, what one can play is limited only by one's imagination. One can play using board games and indoor sports activities. You can play with children, partners, parents, or with anybody available.

Link for supporting basic needs: Basic needs like provisions, medicines, etc., are essential for everyone. Refer to Helplines for further information.

Promote daily activities

Routine your daily activities: Plan and uphold a daily routine, create a well-being plan for the days and weeks.

Be active by setting goals: Set goals that are realistic in the given circumstances. Such as creating a list of books to be read or written, music to listen, food to cook, paint, knit, learn a new language, clean the house etc

Plan time alone and time together (if living with others): Create a list of things to do together, read books aloud to each other, listen to and discuss radio, TV and podcasts. Take turns caring for children and doing household chores.

Sleep Hygiene is used to describe good sleep habits. It is a variety of different practices and habits that are necessary to have good nighttime sleep quality and full daytime alertness. Advice to Exercise early in the day, have a regular sleep-wake routine, eliminate caffeine and alcohol near bedtime, if you don't fall asleep within 30 minutes, do not watch TV or the Internet if you can't sleep and not to worry about sleep- it makes it worse. For more details refer ANNEXURE 3.

Pharmacological management:

General principles:

Here we discuss pharmacological intervention for anxiety and depressive symptoms which are predominantly seen in this group of people. Start medications only when the person seeking help has significant distress or behavioral symptoms warranting a pharmacological intervention. Medications should be considered with caution, weigh it against the risks of medication side effects as well as the probability of recovery with just supportive therapy and lifting off quarantine/ lockdown in the near future. Start at a low dose and titrate slowly as needed.

Recommended medicines include Selective Serotonin Reuptake Inhibitors (SSRI's):

Escitalopram minimum effective dose is10 mg/ day and the maximum dose is 20 mg/day

Sertraline minimum effective dose is 50 mg/ day and the maximum dose is 200 mg/ day

When prescribing, also talk about lag effect, where the beneficial effect of medication might appear in a few weeks only. Common side effects include nausea, GI upset and headache. In some, SSRI can cause restlessness and insomnia. Start at a lower dose and titrate slowly. In the elderly, a potential complication includes hyponatremia.

Medications when needed, can be prescribed for a short duration (6-9 months) and then can be considered to be tapered off slowly.

In view of the respiratory symptoms of COVID-19, shorter-acting benzodiazepines like lorazepam at lower doses can be prescribed to lower anxiety symptoms and address insomnia. However, care should be taken to taper and stop the same once the patient is better, as benzodiazepines have addictive potential.

Ending the conversation:

Summarize the conversation by highlighting key issues discussed and action points.

Example: "We talked about where you can find reliable sources of information, and how you can stay in touch with your loved ones even though living alone and having food delivered. Also, taking up your old interest could help pass time in a nice way."

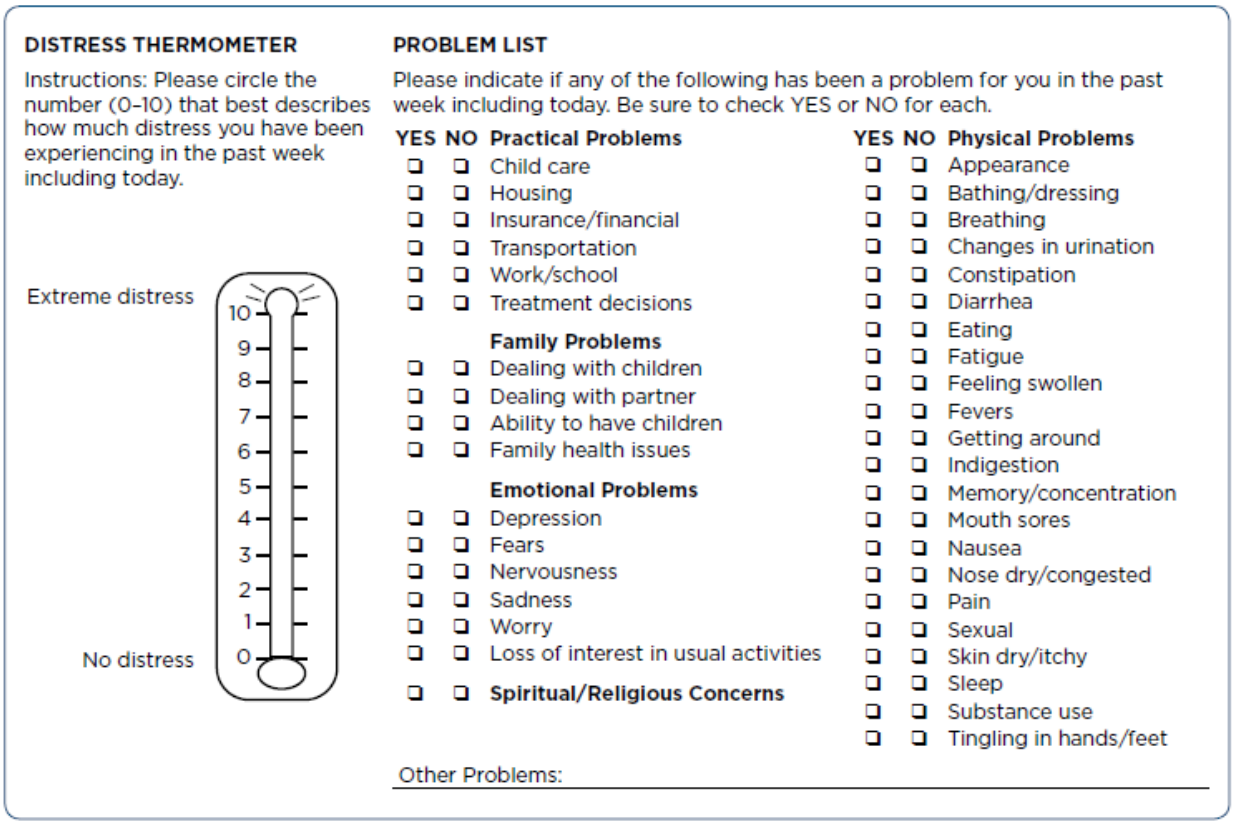
"I will say goodbye and wish you a pleasant day."

Agree if a follow-up conversation is needed, and if so, find a suitable time.

Example: "If you would like to talk another time, please don't hesitate to call again and talk to me or one of my colleagues. Of course, I cannot be sure, I will be in to take the call, but you are most welcome to call again."

End the call by thanking for the conversation. In the end, also take a minute to relax yourself before you move onto helping others.

ANNEXURE 1
Distress thermometer:



DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress — 10 9 8 7 6 5 4 3 2 1 0 — No distress

PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today. Be sure to check YES or NO for each.

YES	NO	Practical Problems
❑	❑	Child care
❑	❑	Housing
❑	❑	Insurance/financial
❑	❑	Transportation
❑	❑	Work/school
❑	❑	Treatment decisions
		Family Problems
❑	❑	Dealing with children
❑	❑	Dealing with partner
❑	❑	Ability to have children
❑	❑	Family health issues
		Emotional Problems
❑	❑	Depression
❑	❑	Fears
❑	❑	Nervousness
❑	❑	Sadness
❑	❑	Worry
❑	❑	Loss of interest in usual activities
❑	❑	**Spiritual/Religious Concerns**

YES	NO	Physical Problems
❑	❑	Appearance
❑	❑	Bathing/dressing
❑	❑	Breathing
❑	❑	Changes in urination
❑	❑	Constipation
❑	❑	Diarrhea
❑	❑	Eating
❑	❑	Fatigue
❑	❑	Feeling swollen
❑	❑	Fevers
❑	❑	Getting around
❑	❑	Indigestion
❑	❑	Memory/concentration
❑	❑	Mouth sores
❑	❑	Nausea
❑	❑	Nose dry/congested
❑	❑	Pain
❑	❑	Sexual
❑	❑	Skin dry/itchy
❑	❑	Sleep
❑	❑	Substance use
❑	❑	Tingling in hands/feet

Other Problems: _____

Image from NCCN distress thermometer version 2.2018

ANNEXURE 2
Calming techniques:

Breathing Exercise:

1. Ask to sit in a comfortable position
2. Suggest to focus gently on their breathing
3. Suggest to put one hand on the belly just below the ribs and the other hand on the chest
4. Ask to take a deep breath in through the nose, and to focus how the hands on the belly goes in (Chest should not move)
5. Ask to breathe out through the mouth (as if you were whistling). Feel how the hands on the belly goes out, and hands-on the chest goes in
6. Ask to do this breathing 3 to 10 times
7. Ask them to notice how they feel at the end of the exercise

Mindful Observation
It is a psychological process of purposefully bringing one's attention to the present moment without any judgment. It can be used as a technique to calm down anxiety, and can also be used as a distraction method to relieve anger. The exercise is as follows:- Firstly, suggest noticing 5 things that the person can see. Try to avoid things that we usually notice, try to become aware of the environment.

Secondly, notice 4 things that the person can feel. Suggest bringing attention to something the person feels, such as the texture of the dress, the surface of the table he/she is sitting, the air that he /she is breathing, etc.

Thirdly, suggest noticing 3 things that he/ she can hear. Listen and notice for things in the background such as the chirping of birds etc.

Fourthly, suggest noticing 2 things that the person can smell. Suggest bringing the attention of the scent, or smell of food, etc. Finally, suggest focusing attention on 1thing that the person can taste, such as to take a sip of water, etc.

ANNEXURE 3
Sleep hygiene techniques

Sleep routine: Set fixed times for sleeping and waking up (daily, whether it is weekend or weekdays). Curb the tendency to extend sleep time.

Go to sleep when you're sleepy: Go to bed when you feel sleepy at night. If possible, try to associate bed with sleep and not as a place for watching movies/ reading and other leisure activities. Avoid staying in bed turning and tossing. If not falling asleep within 30 minutes get out of the bed, read something or hear calming music and then go back to bed when you feel sleepy.

Restrict screen usage an hour before bedtime, and avoid using the phone or watching TV at least half an hour before bedtime.

Controlling stimulant use: Avoid intake of stimulants such as coffee, carbonated drinks 4-6 hours before bed. Have a warm glass of milk as it can induce sleep. Also, avoid heavy meals before bed.

It's better to avoid day time naps. If it's unavoidable, it should not be more than 30 minutes and should be preferably before 3 pm.

Avoid watching clock: Repeatedly checking the clock during the night can wake you up more. It also increases anxious thoughts related to the inability to sleep, which can further worsen the sleep disturbance.

Exercise: Walking around the office, gardening, etc. can keep you active during the day and can also help to get good sleep at night.

Modify your environment: Control unnecessary noise, do not keep lights ON while sleeping.

Relaxation therapy: The practices of various relaxation therapy can reduce anxiety or worries and can induce sleep, the commonly used techniques are meditation, breathing exercise.

Sleep diary: Maintain a sleep diary. It will help you evaluate your own sleep.

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Spiritual care in COVID-19 pandemic – Supporting document

- Spirituality is a core expression of being human and relates to the way we all find meaning and purpose in our lives and our experience of the transcendent. Our spirituality is expressed in being connected to others, to nature, to the sacred dimension of our life 1. As people, we need to maintain a connection to ourselves, to what makes us whole and sustained.
- It is useful to remember that faith and other individual value systems are a means to attain/pursue spirituality. Religion is not synonymous with spirituality and every human being can go through spiritual crises despite belief in God.
- In a pandemic, being and expressing this connection is deeply impacted. Losing our sense of self can happen when there is great uncertainty and when our usual practices, roles, daily habits are removed. Due to the need to stay at home and avoid social gatherings, we may no longer visit our places of worship, be physically with those we love, mingle with others in markets, community groups, sporting teams, schools and places of work. We may experience deep loneliness and distress when those aspects of our lives, which usually provide fulfillment and meaning, stop.
- This distress may be felt very deeply when someone we love, or when we are ill with COVID-19 and unable to be visited because they are in isolation. We may find we cannot visit elderly parents in aged care or at home, for fear of passing on the virus to them. Our usual human connectedness is obstructed.
- Our spiritual expression may need to move to a more interior and profound sense of connectedness, which provides courage and compassionate energy. Those who are health care responders need this courage to face the challenges and fears of being exposed to the virus in the workplace and being a source of calm and confidence for others. Those who cannot leave the home need this courage to resist panic and promotion of fear, to take stock and offer what is possible within the confines of the situation. Those who are ill need to find an inner comfort even when separated from those they love and this may come from within but also for some from a relationship with the transcendent. We know that difficult times in life can encourage us to review our priorities and purpose and can be a time of spiritual growth as well as struggle.
- Each person will have a different vehicle to find this sense of wholeness and courage. Devoting time to this dimension through acts of service, in simple and quiet reflection, in prayers of faith practices, is of great value personally and for those with whom you live and interact.

Questions often asked

• Why me? • What did I do to deserve this? • I have been good, then why? • What is the point of living like this? • What is the value of my achievements?	• Is there a God? • Why did God do this to me? • Why does God make me suffer like this? • Is this a punishment for any sins? • Is there life after death?

Some strategies are given below: These are mainly related to an individual's need, about presence, being non-judgmental, relational and intentional focusing on connectedness.

Connect Inwards

To Self:

- Spend time in quiet prayer/meditation/reflection/stillness each morning
- Look at your home and think about what you no longer need, or what changes you can make to simplify your life and surroundings
- Taking time to read, do craftwork, other home-based activities
- Think about what you want in terms of medical care, if you become very ill with COVID or other illness and write down your wishes, so that family and medical teams understand your values and priorities. This helps you to reflect on your life and values also.

Connect outwards

To Others:

- Using social media apps such as Whatsapp, zoom, facetime to connect to the people you love. An example might be reading a story to, or saying goodnight to your grandchildren every night, using one of these apps.
- Donating time, finances, and/or expertise to help people in need. There are many stories of people suffering due to the lockdown, lacking food or basic necessities. Identify an organization / group working to meet these needs and offer help.

To Nature:

- Spend time in a garden
- Planting and caring for indoor plants
- Putting out water for birds, feeding dogs and cats/ other pets or animals deprived of food and water
- Take time to feel the sun, feel the breeze in your terrace, balconies, courtyard

Connect upwards

- Relating to God and religion. Chanting, rituals, fasting are various ways in which one can re-establish the connectedness to God.
- Connecting back to one's values and beliefs, practicing compassion and altruism helps one to find meaning and purpose in life
- The universe, cosmos, larger dimension of life on earth

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Palliative Home Care in times of COVID-19 & Future Pandemics

Palliative Care during 'Normal Times':

Palliative Home Visits would be done by a team consisting of a Palliative Physician, Palliative Nurse, Nursing Assistant, Medical Social Workers, and Physiotherapist. Most Palliative Care Teams are supported to varying degrees by a team of volunteers who provide much needed voluntary support to not only the team but directly to the patients and their families. The constitution of the team may vary based on availability and need.

Patients are either financially or physically constrained which becomes a barrier to accessing regular medical consultations. They may also have an incurable chronic debilitating illness and do not derive any benefit from a continued hospital stay but still need continued care.

The usual cohort of patients seen during Palliative Home care would be:

1. Patients Terminally ill with End-stage cancers/ Organ Failure etc. End of Life Care as feasible in the home environment is provided.

2. Patients with distressing symptoms like Pain, Breathlessness, etc. (Cancers/ Organ Failures/ Post Trauma/ Post Surgery, etc.). Symptom relief is provided.

3. Patients Bedridden with Chronic illnesses/ injury (Traumatic Spine or Brain injury/ Neurological illness – CVD, MND, Dementia, etc./ Respiratory illness – COPD, ILD, etc./ Cardiac illness – CHF, etc.)

4. Elderly Patients Bedridden with debility of age and multiple co-morbidities.

Apart from symptom control, all patients and their families are also provided with psycho-socio-spiritual support as needed and as feasible by the team of professional Palliative Care providers and volunteers.

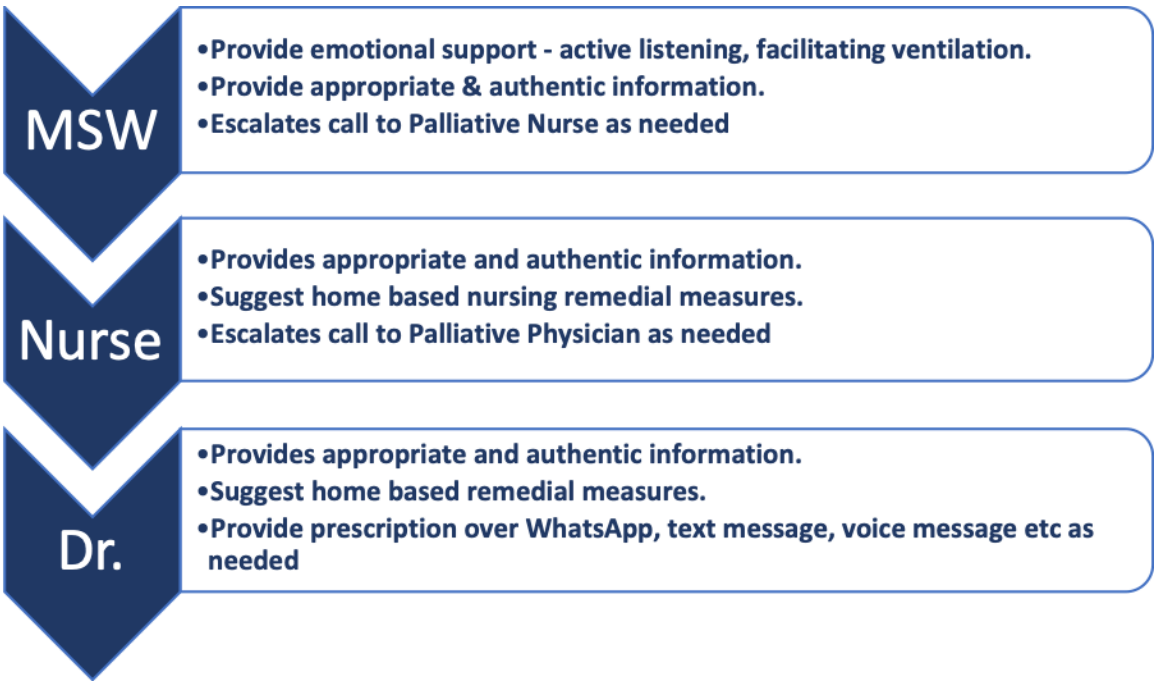
In view of the highly infectious nature of COVID-19, the National & State Governments have declared a National Lockdown & State Lockdown respectively. Considering the same, Palliative Home Care services (Govt., Pvt. & NGOs.) will have to consider making appropriate changes in the pattern of their services. This should be seen in the best interest of the patients, their families & the Palliative Care providers as well as their families.

'Virtual Home Visits': Minimizing the need for Physical Home Visits:

Phone consultation, messages, WhatsApp video chats, Zoom video chats & Telemedicine (where available) to be used for 'Virtual Home Visits'

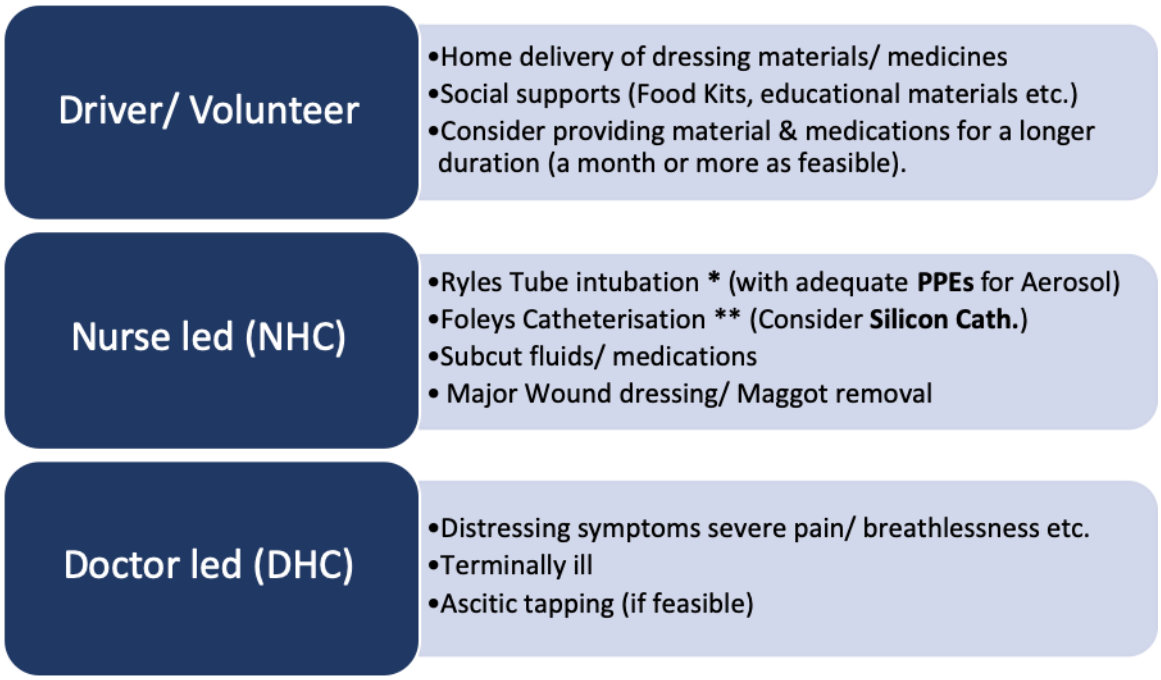
Make regular, periodic 'Virtual Home Visits' to all the registered Palliative Home Care patients.

New patient requests for registration into Palliative Home Care also to be managed by 'Virtual Home Visits' as much as possible.



Indications for Palliative Home Care 'Physical Visit':

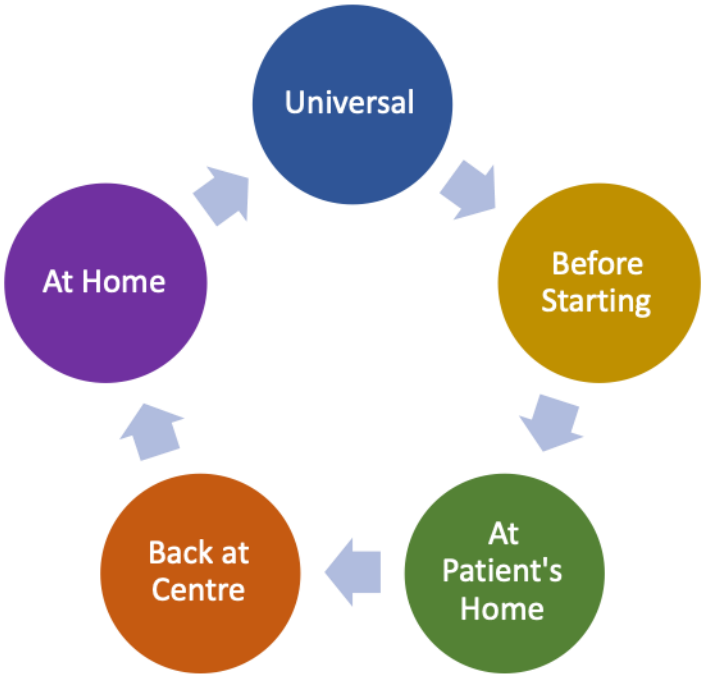
8) When access to Palliative Care IP services is not available or not accessible.
9) When access to a Hospital where Palliative Care phone consultation is also not possible



Ryles Tube intubation is expected to produce aerosol and it is advisable to don adequate PPEs for the same. In the absence of which patient should be taken to a hospital where facilities for the same are available.

** Silicon Catheters are expensive compared to regular Foleys Catheter, however as it needs to be changed only once in 3 months, it will be convenient to the patient and family as well as more protective to the Palliative Nurse because of less frequency of exposure.

Precautions to be adopted for Palliative Home Care 'Physical Visit'



1. Universal Precautions:

1. All team members should be familiar with universal precautions (handwashing, wearing and removing masks, gloves, donning & doffing PPEs, etc.)

2. A 'Spotter' to be designated among the team members who will help the other team members to sanitize, wear & remove PPEs (Gloves, Face Shield, Goggles, apron, etc.). The Spotter will spot any errors in maintain 'Universal Precautions' by any of the team members and help rectify if any. The spotter will not be coming in direct contact with the patient or family and hence will not be wearing PPE. The spotter should be trained in PPE guidelines.

3. The Home Care Vehicle should be fitted with spill-proof Bio-hazard Bins (Yellow & Red) to carry back bio-hazards back to the centre (Hospital/ Hospice) for proper disposal.

2. Before Starting:

a) Call the patient's home to confirm their presence.
b) Sanitize the interiors of the vehicle with Virex, Lysol or other available surface disinfectant sprays.
c) Use the vehicle only after a minimum 10 minutes to allow the disinfectant to act.
d) Home Care Kit (Bag, Bio-medical equipment) to be disinfected with Bacillol or similar alcohol-based quick-acting surface disinfectant Spray
e) Confirm adequate availability of hand sanitizers, surgical masks, gloves & other PPEs, etc. in the vehicle.
f) Confirm availability of spill-proof Biohazard Bins (Red & Yellow) & biohazard bags (Red & Yellow) to bring back biohazard materials to the hospital or Palliative Unit for the same prescribed disposal.
g) Puncture-proof container for Sharps.
h) Only essential team members to travel.
i) Only essential team members enter the patient's home.
j) All team members should empty their bowels and bladders before starting for home care.
k) Sanitize hands before entering the vehicle.
l) Since social distancing is not possible inside the vehicle, all team members wear a surgical mask.
m) Ensure all the team members have Photo ID proof as required by lockdown rules.
n) Carry drinking water and some snacks as having tea break on the way would not be possible.
o) A uniform for the team members is recommended for reasons of personal hygiene as well as the safety of family members of the team members.

3. At the Patient's Home:

a) Team leader to explain to patient & family about our need to wear masks, gloves, etc. Also to explain the need to maintain social distancing (6 feet/ 2 meter); before entering their home.
b) Spotter to help with sanitizing hands before entering the patient's home
c) Maintain social distancing when talking to patient & family (except on physical examination of patient).
d) Audio record documentation. File documentation can be done once back at Hospital/ Centre.
e) For any procedure - wear gloves & additional PPE (face shield, goggles, apron, etc.) as needed, with the help of the spotter.
f) Spend only absolutely essential time at the patient's home.
g) Remove PPEs slowly with the help of the spotter.
h) Put all biohazards in appropriate bags (Red & Yellow) and place the bags in spill-proof appropriate bins (Red & Yellow) in the vehicle.
i) Disinfect all bio-medical equipment (BP apparatus, pulse oximeter, thermometer, glucometer, etc.) with Bacillol or similar alcohol-based quick-acting surface disinfectant Spray.
j) Sanitize your hands before entering the vehicle.
k) The process to be repeated at each patient's home.

3. Back at Hospital/ Centre.

a) Remove the biohazards bags for safe and appropriate disposal.
b) Sanitize hands after getting out of the vehicle.
c) Sanitize the interiors of the vehicle with Virex, Lysol or available surface disinfectant sprays.
d) If you have a uniform, change back to personal civilian clothes before going home.
e) If possible, have a bath before going home

4. Back at Home/ Hostel

a) Remove footwear at the entrance. Do not bring it inside your home. Use the same pair daily for work.
b) Stand in a tub with a soap solution which at least covers your feet. Stay for 2 minutes. Then move inside your home.
c) Put non-electronic items (pen, keys, glasses, etc.) in a separate soap solution for 2 minutes. Then remove, rinse and place at designated places. Avoid mixing them with your other household items.
d) Electronic items (mobile phone) or other items which can't be put in soap solution should be wiped with sanitizer making sure not to damage the equipment.
e) Remove your clothes and put them in a separate soap solution/ Washing Machine. Wash your clothes separately. Do not mix with other family member's laundry.
f) Have a proper bath before interacting with your family members.
g) Sanitize with a sanitizer door-knobs, switches, and all possible surfaces that you are likely to come in contact with at home, at least ones a day.

End-of-life care at Home in the context of COVID-19

If there are no beds available at government facilities, end –of –life care could be done at home

How it can be done:

1. Except for the patient, all others need to vacate the house/ shifted to another room
2. The personnel trained in COVID-19 visits the home, and assess the sufferings. All the protective equipment should be provided and the person should be trained in using this equipment.
3. Start a subcutaneous line/ IV line
4. Manage the suffering as per the attached protocol for breathlessness/ agitation/ secretion.
5. Continuous infusion would be the preferred method to manage the suffering. A continuous infusion can be given by elastomeric pumps and if that is not available, mix the needed medication in 500 ml Normal Saline and given as a continuous infusion. Preferably infusion should last for 48 hours.
6. Loaded syringes of Morphine/ Haloperidol/ Midazolam are given to trained personnel.
7. Family members can also be trained to administer subcutaneous injections.
8. Phone number of the health care professionals to be given to the trained personnel & family member for any calcifications and titration of the infusion if required
9. The recruited volunteers who have training in COVID-19 can visit the family once in a day to provide psycho-social support
10. Food has to be provided to the family members from a community kitchen
11. When the patient dies, the dead body has to be buried as per WHO guidelines with the help of local health authorities.
12. The house needs to be disinfected as per the standard before the family can use it.

Requirements

- All the PHCs, CHC's and THQ's should be provided with Inj. Morphine, Inj. Haloperidol and Inj. Midazolam for this purpose.
- Personal protective equipment.
- Waste segregation bags and bins.
- Waste disposal system

References:

- Healy, S., Israel, F., Charles, M. and Reymond, L., 2018. Laycarers can confidently prepare and administer subcutaneous injections for palliative care patients at home: A randomized controlled trial. Palliative medicine, 32(7), pp.1208-1215.

List of Essential Medicines

List of essential medications for palliative care (adapted from IAHPC and WHO). The medications mentioned in the E-book in the context of COVID-19 for are in bold.

SlNo	Name	Formulation	Indication
1	**Amitriptyline**	**50-150 mg tablets**	**Depression** **Neuropathic pain**
2	**Bisacodyl**	**10 mg tablets** **10 mg rectal suppositories**	**Constipation**
3	Carbamazepine	100- 200 mg tablet	Neuropathic pain
4	**Citalopram**	**20 mg tablets** **10 mg/5ml oral solution** **20-40 mg injectable**	**Depression**
5	**Codeine**	**30 mg tablets**	**Diarrhea** **Pain - mild to moderate**
6	Dexamethasone	0.5-4 mg tablets 4 mg/ml injectable	Anorexia Nausea Neuropathic
7	Diazepam	2.5 -10 mg tablets 5 mg/ml injectable 10 mg rectal suppository	Anxiety
8	**Diclofenac**	**25-50 mg tablets** **50 and 75 mg/3ml injectable**	**Pain - mild to moderate**
9	Diphenhydramine	25 mg tablets 50 mg/ml injectable	Nausea Vomiting
10	**Fentanyl**	**25 micrograms/hr (transdermal patch)** **50 micrograms/hr**	**Pain - moderate to severe**
11	Gabapentin	tablets 300 mg or 400 mg	Neuropathic pain
12	**Haloperidol**	**0.5 - 5 mg tablets** **0.5 - 5 mg drops** **0.5 - 5 mg/ml injectable**	**Delirium** **Nausea** **Vomiting** **Terminal restlessness**
13	**Hyoscine butyl bromide**	**20 mg/1ml oral solution** **10 mg tablets** **10 mg/ml injectable**	**Nausea** **Terminal respiratory secretions** **Visceral pain** **Vomiting**

SlNo	Name	Formulation	Indication
14	**Ibuprofen**	**200 mg tablets** **400 mg tablets**	**Pain - mild to moderate**
15	Levomepromazine	5 - 50 mg tablets 25 mg/ml injectable	Delirium Terminal restlessness
16	Loperamide	2 mg tablets	Diarrhoea
17	**Lorazepam**	**0.5-2 mg tablets** **2 mg/ml liquid/drops** **2-4mg/ml injectable**	**Anxiety** **Insomnia**
18	Megestrol Acetate	160 mg tablets 40 mg/ml solution	Anorexia
19	Methadone	5mg tablets	Pain - moderate to severe Substance dependence
20	**Metoclopramide**	**10 mg tablets** **5 mg/ml injectable**	**Nausea** **Vomiting**
21	**Midazolam**	**1-5 mg/ml injectable**	**Anxiety** **Terminal restlessness**
22	Mineral oil enema		
23	**Mirtazapine**	**15-30 mg tablets** **7.5-15 mg injectable**	**Depression**
24	**Morphine** **Immediate release:** **Immediate release**	**Immediate release: 10-60 mg tablets 10mg/5ml oral solution, : 10 mg/ml injectable** **Sustained release: 10 mg tablets** **Sustained release: 30 mg tablets**	**Pain - moderate to severe** **Dyspnoea**
25	Octreotide	100 mcg/ml injectable	Diarrhoea Vomiting
26	Oral rehydration salts		Diarrhoea
27	Oxycodone	5 mg tablet	Pain - moderate to severe
28	**Paracetamol (Acetaminophen)**	**100-500 mg tablets** **500 mg rectal suppositories**	**Pain - mild to moderate**

SlNo	Name	Formulation	Indication
29	Prednisolone	5 mg tablet	Anorexia Anti-inflammatory agents
30	Senna	8.6mgtablets	Constipation
31	Tramadol	50 mg immediate release tablets/capsules 100mg/1ml oral solution 50mg/ml injectable	Pain - mild to moderate
32	Trazodone	25-75 mg tablets 50 mg injectable	Insomnia
33	Zolpidem	5-10 mg tablets	Insomnia

Links for FAQ's and Myth Busters

https://www.mohfw.gov.in/pdf/FAQ.pdf

http://people.iiti.ac.in/~medical/mythbusters.php

https://www.paho.org/en/health-emergencies/social-media-postcards-myth-busters-covid-19

https://www.who.int/emergencies/diseases/novel-coronavirus-2019/advice-for-public/myth-busters

http://dhs.kerala.gov.in/photo-gallery/

https://www.cdc.gov/coronavirus/2019-ncov/faq.html

https://www.fda.gov/emergency-preparedness-and-response/coronavirus-disease-2019-covid-19/coronavirus-disease-2019-covid-19-frequently-asked-questions

HELPLINES:

DISHA, 1056 (COMMON HELPLINE TO CONNECT YOU TO ALL THE OTHER GOVERNMENT SERVICES)
https://coronahelpdeskekm.deienami.com/

District control room numbers Ernakulam (COVID-19 HELPLINE)

Control Room Kakkanad - 0484 2368802

Other numbers:

0484- 2428077, 0484 2424077

0484 2426077

0484 2425077,0484 2422077

Guest Worker Helpline:

State Level Call Center Number (Toll Free-155214) and 1800 425 55214

Ernakulam district: 0484 2421277, 0484 2422277

De-addiction Services

Call for Counseling Toll-Free Number -14405

Southern Region- 9400022100, 9400033100

Central Region**-** 9188520198, 9188520199

Northern Region - 9188468494,

Tele Helpline for Medical Help

Ernakulam: IMA Control Room No:- 7593045730

Helpline for People with Hearing Impairment

Thiruvananthapuram, Kollam, Alappuzha, and Pathanamthitta Districts: 9249505723, Kottayam, Idukki, Ernakulam, Thrissur and Palakkad districts are: 7994548133, Malappuram, Kozhikode, Wayanad, Kannur, and Kasaragod Districts: 7025065488.

Helpline for Differently abled

Dr. P T Baburaj:-9495213248
Dr. N N Henna:- 9995582671

Helplines for Pregnant women:

Should call the consulting doctor or Disha helpline (1056) and should take advice.
For pregnant women or mothers of infants- 8884426444 (9 am to 4 pm)- Maternal and Infant Mental Health services, IMHANS, Kozhikode.

Community kitchens: http://kudumbashree.org/pages/826

Suicide helplines:

DISHA: 1056, Kerala Government-run Helpline, Available 24 hours

MAITHRI, Hotline: +91 (0)484 239 6272
Website: maithrikochi.org
Hours: Mon, Tues, Wed, Thurs, Fri, Sat, Sun: 10:00 - 20:00

SNEHA

Hotline: +91 (0) 44 2464 0050
Website: snehaindia.org
24 Hour service:

Helplines for vulnerable population:

Women Helpline (Including Domestic Violence): 1091 - For more details kindly visit: www.swd.kerala.gov.in

LGBTIQ community helpline - **1800 425 2147**

For schemes pensions etc related to specially-abled people: **Anuyatra helpline**, **1800 12**

Institute of Mental Health and Neurosciences (IMHANS), Kozhikode
(*An autonomous institution under the Government of Kerala*)
www.imhans.ac.in

കോവിഡ് 19 ബാധ നിലനിൽക്കുന്ന സാഹചര്യത്തിൽ രോഗികൾക്കും സമ്പർക്ക പട്ടികയിൽ ഉൾപ്പെട്ടവർക്കും, കുടുംബാഗങ്ങൾക്കും മറ്റ് പൊതുജനങ്ങൾക്കും സേവനങ്ങൾ നൽകുന്ന സന്നദ്ധ പ്രവർത്തകർ, ഡോക്ടർമാർ, നഴ്സുമാർ, കൗസിലർമാർ, മറ്റ് പാരാമെഡിക്കൽ, പാരാലീഗൽ വൊളൻറിയർമാർ, പോലീസുകാർ, ജേർണലിസ്റ്റുകൾ തുടങ്ങിയ ഏതൊരു സേവനദാതാക്കൾക്കും മാനസിക പിന്തുണ ലഭ്യമാക്കുന്നതിനു വേണ്ടി രാവിലെ 9 മുതൽ രാത്രി 9 വരെയുള്ള സമയത്തു 28 പേരടങ്ങിയ കൗൺസിലർമാരുടെ വിദഗ്ധ സംഘത്തിൻറെ സേവനം ലഭ്യമാക്കിയിട്ടുണ്ട്.

Morning (9am – 3pm)	Evening (3pm – 9pm)
9188042307 (Malayalam, English)	7034056654 (Malayalam, English)
8921627756 (Malayalam, English)	6282862727 (Malayalam, English, Tamil)
8086959631 (Malayalam, English, Tamil)	8138012320 (Malayalam, English)
9544165859 (Malayalam, English)	9544244890 (Malayalam, English)
9061964343 (Malayalam, English, Tamil)	8848287721 (Malayalam, English, Tamil)
6238802712 (Malayalam, English, Hindi)	9633808327 (Malayalam, English)
9847831560 (Malayalam, English, Hindi)	9400617732 (Malayalam, English)
9747833774 (Malayalam, Arabic)	9567181538 (Malayalam, English, Tamil)
9072442904 (Malayalam, English)	8281948946 (Malayalam, English, Tamil)
9496810113 (Malayalam, Hindi English)	9645835758 (Malayalam, English)
9496699220 (Malayalam, English, Kannada, Tamil)	8137901130 (Malayalam, English, Tamil)
6238996063 (Malayalam, English)	9746596677 (Malayalam, Tamil)
9446768602 (Malayalam, Tamil, Hindi, English)	8592959697(Malayalam, English)
9846202324 (Malayalam, English, Tamil)	9745454151 (Malayalam, Hindi, English)

ഇന്ത്യൻ അസോസിയേഷൻ ഓഫ് ക്ലിനിക്കൽ സൈക്കോളജിസ്റ്റ് (കേരള ഘടകം)
രജിസ്ട്രേഷൻ ട്രാവൻകൂർ കൊച്ചി സൈന്റിഫിക്ക് ലിറ്ററസി ആക്ട് 12–1955 പ്രകാരം
രജി.നമ്പർ. ഇ.ആർ 199/10
www.clinicalpsychologistkerala.com

പ്രിയപ്പെട്ടവരെ, 24/03/2020

കോവിഡ് 19 പടരുന്ന സാഹചര്യത്തിൽ ഇന്ത്യൻ അസോസിയേഷൻ ഓഫ് ക്ലിനിക്കൽ സൈക്കോളജിസ്റ്റ് (കേരളഘടകം) 24 മണിക്കൂർ പ്രവർത്തിക്കുന്ന ടെലി–സൈക്കോളജിക്കൽ സർവ്വീസ് തുടങ്ങിയിരിക്കുകയാണ്. 57 പേർ അടങ്ങുന്ന ക്ലിനിക്കൽ സൈക്കോളജിസ്റ്റുകളുടെ ഒരു സംഘം ഇതിനായി സജ്ജമായികഴിഞ്ഞു. കോവിഡ് 19 ന്റെ പശ്ചാത്തലത്തിൽ മാനസിക സമ്മർദ്ദം അനുഭവിക്കുന്ന എല്ലാവർക്കും ഞങ്ങളുടെ സംഘത്തിന്റെ സേവനം പ്രയോജനപ്പെടുത്താം. ഇതോടൊപ്പം ക്ലിനിക്കൽ സൈക്കോളജിസ്റ്റുകളുടെ ഫോൺ നമ്പറുകളും ലഭ്യമായ സമയവും ഇതോടൊപ്പം കൊടുക്കുന്നു. മലയാളത്തിനും ഇംഗ്ലീഷിനും പുറമെ ഏതാനും ചില ഭാഷകളിൽ കൂടി സേവനം ലഭ്യമാണ്.

ആദരവോടെ
ഡോ. ബിജി. വി.
ജനറൽ സെക്രട്ടറി

ഉച്ചയ്ക്ക് (AFTERNOON)		
9207288855	ഹിന്ദി, കന്നഡ, തമിഴ്	12pm – 2pm
+14163564280	For Keralites in Canada	10am – 5pm
9633687674		1pm – 2pm
9495683913		2pm – 4pm
8547131534		2pm – 4pm
9605067527		2pm – 4pm
9739060758		2pm – 4pm
8547281985		2pm – 5pm
9447970639		3pm – 4pm
9746592893	ഹിന്ദി,തമിഴ്	3pm – 5pm
9446502650		3pm – 5pm
9447172619		3pm – 5pm
9605477393	തമിഴ്, കന്നഡ	3pm – 5pm
9447991601	ഹിന്ദി	3pm – 6pm
9686188660	തമിഴ്	3pm– 7pm
9446308746		4pm – 6pm
8157002878		4pm – 6pm
9496115302		4pm – 6pm
9746939529		4pm – 7pm
+639369536148		5pm – 7pm
8547448055		5pm – 6pm
8547508641	ഹിന്ദി ,തമിഴ്	5pm – 6pm

ഈവിലെ (MORNING)		
9686568984		8am – 10am
9747900381		8am – 11am
9495422530		9am – 10am
9496613508	തമിഴ്, ഹിന്ദി	9am – 11am
9495626659		9am – 1pm
9447046768		10am – 11am
9847248898		10am – 11am
9495321687		10am – 11am
9745120411, +971508540630	(യു.എ.ഇ) തമിഴ്	10am – 1pm
9495245212		10am – 3pm
9539991643		11am – 1pm
9526838486		11am – 4pm

രാത്രി (NIGHT)	
9633702090	8pm – 9pm
9895477660	8pm – 10pm
9656422560	8pm – 10pm
9747001333	9pm – 11pm
9447664199	10pm – 11pm
9847704395	10pm – 12am

വൈകുന്നേരം (EVENING)		
9497254996		6pm – 8pm
9995189867	ഹിന്ദി, തമിഴ്	6pm – 8pm
9447782084		6pm – 8pm
9846411634	ഹിന്ദി	6pm – 8pm
9496187500		6pm – 8pm
9746014387	തമിഴ്,തെലുങ്ക്, ഹിന്ദി	6pm – 8pm
9895442089		6pm – 8pm
8943134909		7pm – 8pm
9847134970		7pm – 8pm
9880418128		7pm – 9pm

അർദ്ധരാത്രി/പുലർച്ച (LATE NIGHT/ EARLY MORNING)		
8547131534	ബംഗാളി	12am – 2am
+971528109474 (Zoom)	ഹിന്ദി കന്നഡ, തമിഴ്	12am – 2am
7559016729		2am – 4am
9495106704	ഹിന്ദി	4am – 6am
9560970324	ഹിന്ദി, കന്നഡ, തമിഴ്	4am – 6am
9447631325		4am – 6am
9288081680	ഹിന്ദി, കന്നഡ , തമിഴ്	6am – 8am

Links for Additional Reading

1) Integrating palliative care and symptom relief into responses to humanitarian emergencies and crises: a WHO guide https://apps.who.int/iris/handle/10665/274565

2) Home care for patients with COVID-19 presenting with mild symptoms and management of their contacts. https://www.who.int/publications-detail/home-care-for-patients-with-suspected-novel-coronavirus-(ncov)-infection-presenting-with-mild-symptoms-and-management-of-contacts

3) Recommendations for treatment of patients with COVID-19 from the palliative care perspective https://www.dgpalliativmedizin.de/images/DGP_Handlungsempfehlung_palliative_Therapie_bei_COVID18_V2.0_English_version.pdf

4) "COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care Role of the specialty and guidance to aid care" https://apmonline.org/wp-content/uploads/2020/03/COVID-19-and-Palliative-End-of-Life-and-Bereavement-Care-22-March-2020.pdf

5) COVID-19 rapid guideline: critical care in adults. https://www.nice.org.uk/guidance/ng159

6) National Hospice and Palliative Care Organisation, USA Communications on Coronavirus (COVID-19) https://www.nhpco.org/coronavirus

7) Cairdeas International Palliative Care Trust website has 11 symptom guidelines https://cairdeas.org.uk/resources/core-resources/core-textbooks

8) Worldwide Hospice Palliative Care Alliance https://www.thewhpca.org/covid-19/resources

9) International Association for Hospice and Palliative Care (IAHPC) http://globalpalliativecare.org/covid-19/

10) The British Medical Journal https://www.bmj.com/coronavirus

11) The Lancet https://www.thelancet.com/coronavirus

12) VitalTalk https://www.vitaltalk.org/guides/covid-19-communication-skills/

13) Social Media Facebook COVID-19 Palliative Care Providers https://www.facebook.com/groups/645971766160403/

14) And Twitter search with #Pallicovid

15) **Pallikare App** : https://play.google.com/store/apps/details?id=org.karunashraya.pallikare&hl=en_IN (Android) / https://apps.apple.com/in/app/pallikare/id1423074474 (iOS)