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Covid-19: The role of palliative care had to be adapted to manage this "ultra-emergency"

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Raffaella Bertè and colleagues recount the experience of managing the covid-19 outbreak in a small town in Italy

One of the biggest emergencies of our times, the covid-19 pandemic, is spreading around the world as we write this, and it is striking Italy particularly hard. In the Emilian town of Piacenza, Italy, it all started on 21 February 2020. The first case was identified in nearby Codogno. There was the immediate search for the identity of patient zero. There was the minute-by-minute news, a good dose of panic, and many questions—for citizens and the authorities alike.

It was perhaps at the local hospital that the gravity of the situation was perceived more clearly, and the actions that were needed to reorganise happened quickly. Among the various interventions that were rapidly approved, was the conversion of almost all wards into "Covid Emergency Departments" and the creation of a dedicated ward aptly named the "End-of-life Department."

The health department in Piacenza took the difficult and perhaps controversial decision that one of its emergency departments be exclusively dedicated to the palliative care of the many patients who were rapidly succumbing from the infection. The hospital's palliative care team was asked to assist with the organization of the newly created structure and charged with providing guidelines for the support and assistance of patients destined for that department and their family.

End-of-life treatments are meant to improve the quality of life of dying patients and their families through the prevention and treatment of pain, but also address psychological, social, and spiritual issues related to the end of life. The hospitalization of elderly patients presenting with bilateral pneumonia and highly suspected or confirmed covid-19 infection, deemed to be at the end of life, had the purpose of addressing primarily their severe dyspnoea. For this highly morbid symptom, appropriate palliative therapeutic interventions involve the use of drugs such as morphine and benzodiazepines, providing symptomatic relief and alleviating suffering.

Organising the new department

The end-of-life department is equipped with 12 beds distributed over five rooms. All patients are treated as if they were covid-19 positive, even though many of them have presumed covid-19 and no confirmed infection. The medical team includes primarily surgeons, guided during the day by members of the palliative care team, while the night shift is covered by an "interdivisional" attending physician.

The non-physician team is comprised of six nurses and six nurse aids, aided by three palliative care team members (a nurse, a case manager, and a psychologist). The request for transfer to the end-of-life department typically starts already in the emergency department. The emergency department physician, after determining that a patient is terminally ill, refers the patient to the end-of-life department. This is based on clinical parameters, such as imaging, the presence of multiple comorbidities, or a decision that the patient would not benefit from aggressive measures. Some patients, however, are transferred from the regular floors or the intensive care unit when irreversible deterioration of their status occurs.

The movement of patients across departments is avoided, though, if it is deemed that their death is imminent. The palliative care team case manager is in charge of admissions, deaths certificates, liaison with the bed manager, pharmacy orders and shifts, and a palliative care team nurse gives daytime support to the shift workers. Attempts are made to work in pairs, so that one person can function as the "clean

worker". The general rule is that there are always two staff members present who collaborate, and that nothing can leave the room without it being decontaminated.

Visitors are not allowed to enter the hospital. This necessary rule is particularly devastating for the families of terminally ill patients. These patients, unfortunately, mostly die without the comfort of their family members. Hence, the issue of communicating with families is of the highest importance. Daily updates are provided to them on the status of their relatives. At the time of death, the physician personally communicates with the family. In the early days, brief operational instructions were issued to staff to guarantee a homogenous message in response to the ongoing tragedy.

The role of palliative care

The role of palliative care had to brutally be adapted to manage a situation of an "ultra-emergency"; in this situation the fundamental basis of palliative care is lacking: there is no relationship with the patient and his family, there is no typical palliation timing that allows sharing and planning the treatment path, all hospitalized patients die and these deaths are linked to a traumatic and startling psychological experience for the family and the members of the treating team.

Palliative care is, by definition, a combination of "chemistry" and "relationship". In an emergency situation like the one we found ourselves experiencing and managing, the palliative care team had to make a choice: putting chemistry before relationship, without forgetting its mandate. Still, the palliative care team provided daily contact with the family and the continuity of care was guaranteed by the palliative psychologist through telephone updates on the clinical status of the patients and monitoring of the emotional experiences and basic psychological needs of the family. We feel that the implementation of a dedicated end-of-life departments in the midst of the covid-19 crisis has allowed, on the one hand, the compassionate management of terminally ill patients, on the other hand it has made it possible for the hospital management to distribute resources appropriately, proportionately, and ethically in exceptional conditions of imbalance between needs and available resources.

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