

End-Of-Life Care Innovations Due to the COVID-19 Pandemic

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Palliative and end-of-life care are essential components to critical nursing care practice. Palliative care refers to the management of acute symptoms and distress resulting from illness or injury, and end-of-life care is concerned with the nursing care and interventions provided to patients in their last hours of life (Delgado, 2020). The Coronavirus Disease 2019 (COVID-19) pandemic presented a new and unique challenge to delivering this palliative care to patients who were near the end of their life. COVID-19 demanded innovation and change in response to these arising challenges.

Role of the Critical Care Nurse

According to the World Health Organization (WHO) (2022), the total number of deaths related to COVID-19 has reached 6,286,057. Many COVID-19 patients spend the last moments of their life in an Intensive Care Unit (ICU), where nurses make up the majority of the care team. Before the pandemic, although death was common in the ICU, providing palliative end-of-life care in addition to their normal critical care interventions was not something nurses frequently associated the ICU with. However, due to the COVID-19 pandemic and other health crisis worldwide, increasing numbers of dying patients will receive care from a critical care nurse. This change has resulted in a shift to care that consists of critical care, palliative care, and care that advocates for the rights of the patient and their loved ones (Rosa et al., 2020).

Nurses spend about 86% of their time at work in direct contact with their patient, which is much greater than the amount of time that any other member of the critical health care staff spends at the bedside with the patient (Rosa et al. 2020). The communicable nature of COVID-19 offers new and significant challenges, and because they are present so often at the bedside, nurses have recently taken on the responsibility of providing interventions and cares in a way that promotes their own safety, as well as the safety and emotional well-being of the patient and their family. Because of the widespread and exhaustive scope of the pandemic, there have been reports of inadequate palliative care being provided to patients because of the lack of supplies, inadequate staff, equipment, and beds available (Chapman et al., 2020). Therefore, it is important for nurses to rapidly adapt and change to this uncertain environment, and tailor their nursing interventions to provide the best holistic, palliative end-of-life interventions for those in their care.

Nursing Interventions

Prior to the COVID-19 pandemic, nurses were able to spend a significant amount of time getting to know their patient and the patient's family members. Because of the strict policies that were enacted to limit communicable spread of the disease, it became difficult for critical care nurses to meet the emotional and spiritual needs and desires of their patient and their patient's family. It became apparent that it was necessary for nurses to find new ways of connecting with patients and their families, and often had to find ways to connect patients *to* their families.

Nurses would be required to don full Personal Protective Equipment (PPE) before visiting and performing cares for patients, and they found it improved patient experience when they would attach a picture of the nurse to the front of the PPE and draw smiling faces on their

masks in an attempt to provide a sense of human connection and engagement (Castaldo et al., 2022).

Nurses faced the task of ensuring that a patient's physical and emotional pain was managed while acting under crisis standards of care, and often the nurse would have to arrange which patients received what care according to a triage system. Nurses were required to learn how to prioritize certain patients, as well as learn how to provide palliative care, as in many cases these nurses were working in unfamiliar situations. It is evident that it was necessary for nurses to be creative and innovative, as even nurses who had extensive experience with palliative, end-of-life care, and critical care were overwhelmed with the crisis that was COVID-19. Nurses were faced with the ethical dilemmas of deciding which patients would have the greatest chance for a successful recovery, and providing care accordingly. For patients which there could not be much done, nurses could simply only be a therapeutic presence for said patients while they passed, and provided final cares and communicated with the patient's family, due to the fact that patients dying from COVID-19 were severely, if not completely, restricted from having visitors (American Association of Critical Care Nurses, 2021). This limitation of visitation is just part of the numerous limitations that have become prevalent due to this critical period. Limitations on the amount of care that can be performed because of limited contact polices have also impacted nursing practice. Nurses have to be careful to cluster their cares to conserve PPE, a consideration that was rare before the pandemic occurred. Nurses also have to be careful with certain procedures wherein droplet spread occurs because of the communicable nature of the disease. These limitations can make it difficult for nurses to provide the same care that would normally be performed for dying patients under usual circumstances (Hospice & Palliative Nurses Association, n.d.). Palliative and end-of-life care used to be characterized by

therapeutic touch and presence, and now nurses must adapt the way they perform their cares and the way they manage emotional distress with their patients as they pass away.

The utilization of technology to facilitate telehealth meetings as well as meetings with family was extremely vital during the pandemic. While the technology used to make the video calls was not new, the mass utilization and fast adoption of technology as a primary means of communication required a lot of change and adaptation by the critical care nurse (Ritchey et al., 2020). Nurses were at the forefront of ‘humanizing’ the experience for patients and their families, and performed special interventions intended to limit the distressing nature of isolation so many COVID-19 patients faced.

The nurse handled the technological troubleshooting, and made sure to explain to both the patient and their family the limitations of technology. The nurse would manage expectations and provide therapeutic communication when technology failed, or when family became frustrated that the quality of communication was not the same as being in the room. The nurse also prepared the patient’s family for how the patient might look, and explained the purpose of the medical equipment and machinery. It was essential that the patient’s family knew that the patient’s symptoms were being managed and that comfort measures were being utilized. The process of explaining the interventions being performed was a much different process compared to an in-person explanation, because the family was unable to be physically present, and so this was a new consideration for the nurse. The nurse also made sure that the family witnessed the small comfort acts of palliative care in the last moments of life, such as medication administration, oral care, and therapeutic touch, to assure the family that the patient was comfortable and well-cared for (Ritchey et al., 2020). Extra reassurance was needed for the members of the families who could not be in the room with their loved ones while they passed,

and it was the nurse's responsibility to effectively communicate that the patient was in good hands and being treated like a human being.

Nurses also gauged the emotional status of the patient's family, and at times determined that the utilization of non-visual communication might be best. Nurses would advise family members to speak to their loved ones via audio telephone call in their last moments in order to facilitate closure and ensure a sense that the patient was not alone (AACN, 2021). Some loved ones might find seeing their relatives pass away traumatic, and it is a responsibility for the nurse providing care in this unprecedented time to ensure the least traumatic outcome for the patient and their family. It was unheard of in normal times for patient's families to have their last goodbyes over video chat, and this is a new adaptation that had to be made by nurses (Castaldo et al., 2022).

Patient and Family Education

Educating the family about what to expect with their loved one at the end of their life has always been a part of nursing care, but during the pandemic, it became increasingly distressing for the patient because of the fact that they would not be able to see their loved ones. It was likewise distressing for the patient's family to not be present at the bedside for the patient's final moments. The patient's family might find the patient's condition distressing, due to the nature of the disease, and it is important to educate the family of the symptoms the patient is experiencing as it might be a new and traumatic experience to see a loved one on a ventilation system, gasping for air, or actively dying.

Because patients with COVID-19 have an unpredictable timeline of symptom progression, it is important to pay close attention and recognize when death is imminent, and to provide this information to the family members (Hospice & Palliative Nurses Association, 2020). This allows

the family time to know what to watch for, and prepares them for what happens when a patient passes. The nurse will also give special attention to educate the patient's family about what will happen to the patient after death, as they might not be there to witness the post-mortem care, and might want to ensure spiritual and cultural concerns are met.

If a patient's family is allowed to visit for the patient's final moments, it is important that they are educated on the purpose and importance of PPE, handwashing, airborne precautions, and visitor limits. It is the nurse's responsibility to ensure that the family is properly educated, and that emotional needs are managed, especially because of the distressing nature of limited visitor interaction (Hospice & Palliative Nurses Association, 2020).

Effect on Patient Goals/Outcomes

The research performed on this topic has shown that palliative management of symptoms of COVID-19, as well as providing emotional support is essential to improving patient experience in these unprecedented times (Lovell et al., 2020). The nursing interventions outlined above (such as utilizing therapeutic communication and providing atraumatic care for patients and their families while adapting to the unique stipulations of the COVID-19 pandemic) has the potential to result in positive outcomes for the patient's family. If the nurse allows the patient to communicate with their family members and thoroughly explains and provides education on the end-of-life care process, then the family has a decreased chance of experiencing anxiety, depression, and post-traumatic stress disorder. As a result of the pandemic, we know that existing concepts regarding end-of-life care must be combined with new, innovative nursing concepts and interventions in order to ensure a dignified and comfortable death for a patient suffering from COVID-19 in an ICU (Jeitziner et al., 2021).

Conclusion

It is evident that more research is urgently needed on how best to treat symptoms and provide palliative and end-of-life care (Lovell et al., 2020). Nurses are critical in managing end-of-life care for patients with COVID-19 by providing humane care for suffering patients, and have had to adapt their process to fit in with the new guidelines related to caring for dying patients with COVID-19. Innovation and creativity are constantly necessary in this new situation, and nurses have had to take on the responsibility of adapting the care they perform to tailor to each individual patient's needs, all while following standards of care in a crisis and adapting to new policies.

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