# Delivering holistic services to patients and residents who are imminently dying during the COVID-19 Pandemic

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## Our Mission and Vision

We strive to bring the healing ministry of Jesus to those who are sick, dying and in need through **'*being for others*'**:

- in the Spirit of Mary standing by her Son on Calvary;
- through the provision of quality, responsive and compassionate health, community and aged care services;
- based on Gospel values; and
- in celebration of the rich heritage and story of the Sisters of the Little Company of Mary.

"The whole purpose of our lives is to be for others what Mary was for her son on Calvary."

*from the writings of Venerable Mary Potter*

### *One of the mantras of the founding Sisters was that "no one dies alone".*

In ordinary circumstances, models of Palliative and End of Life Care across all our Calvary services, make every conceivable effort to connect our patients with the highest possible clinical care, to facilitate ongoing connections with their loved ones and to facilitate connection with their deepest spiritual aspirations and yearnings.

The latter two objectives are achieved through multiple means: Pastoral Care services, art and music therapy, biography programs, the organisation of special events and moments, ritual, prayer, Sacraments and Holy Communion. Most of these programs are delivered face-to-face, in cognizance of the deep importance of human connection at this crucial, never-to-be-repeated moment in the life journey of every person.

In an attempt to ensure the fullness of life up until each person's last breath, we actively pursue Goals of Care conversations, to enable patients to identify what is most important to them in their last days. In most instances, what is most important to them, is the opportunity to spend quality time with family and loved ones.

## Current risks and challenges

As the COVID-19 global pandemic has unfolded a number of cases have arisen that highlight the need for us to develop a clear protocol for fulfilling our non-negotiable Calvary mission objective to care for the dying in a manner that does not put other patients and our staff at risk.

Recent examples, such as the ones which follow and others, highlight the need for clarity.

- In the wake of the "one visitor only" policy which operated in a previous time, a 60+ year old male patient, about to undergo life-threatening open-heart surgery, begged to be able to see his children as well as his wife.
- A man flew home from Queensland to see his 70+ year old end-of-life father in ICU, arriving just after the

SA border closed, obliging him to spend 14 days in quarantine, at home with his mother. The relevant Manager was concerned that staff and other patients might be potentially compromised by visits from both the son and the wife, once they were domiciled together.

- A hospice patient who wanted to create legacy art with her grandchildren was not able to do this with them, as the children were not allowed into the hospice. As a compromise, the patient created her section of the art-work and the remainder was sent home for the children to complete. This readjustment, was sensitively made, and the following feedback was received: *“The support and encouragement was first rate. Lesley was wonderful working with Mum and guided her to make her plates. She quickly rearranged her day as Mum was worried two days’ time might be too late. She was caring and supportive and the finished plates will always be treasured by Mum’s grandchildren, just as she hoped. Thank you so much.”*
- If we experience a shortage of PPE , we need to preserve such equipment for urgent clinical needs. To what extent does unlimited or even of limiting visiting to end-of-life patients warrant the use of such resources to facilitate infection control in these circumstances?

How do we balance our mission imperative to meet people’s end-of-life life goal to spend as much time as possible with loved ones, with the need to protect others from the risk of infection with COVID-19?

## Ethical issues which arise

- How do we continue to meet dying patients’ and residents’ urgent end-of-life emotional/spiritual and psychosocial needs during this time?
- How do we mitigate the risk of what becomes long-term complex grief for people when they feel as though loved ones have been abandoned or died in physical or emotional pain?
- How do we balance this with our obligation to others in our care, and to our own staff?
- How do we rationalize the equitable distribution and use of scarce PPE resources?
- What are consistent criteria that can be employed to ensure equitable approaches to all patients, residents and their families?
- What additional expectations of staff are fair and reasonable in the implementation of potentially labour-intensive and emotionally distressing solutions?
- What co-contribution can we reasonably expect of families/carers during this time? (in terms of moderated expectations, personal inconvenience or additional expense)
- What are the processes by which we negotiate/communicate care decisions to patients, residents and their families/carers.

> *“I cannot but feel I have had a call from God to devote myself to help save souls in their last hour. I have been drawn so strongly to pray for the dying. ”*

Venerable Mary Potter

# Principles for delivering holistic services to patients and residents who are imminently dying during the COVID-19 Pandemic

- Wherever possible, patients and residents at imminent risk of dying (as a result of impending surgery, rapidly deteriorating condition, whether COVID-19 positive or not, or having been clinically identified as being, in the last days of life) should be given the opportunity to spend time with their loved ones.
- At the same time, Calvary needs to protect *all* patients, residents, staff and loved ones from potential exposure to the COVID-19 virus. Loved ones will need to make some compromises with respect to their expectations.
- All mandated rules of social distancing with respect to staff, other patients, other residents, and visitors MUST apply at all times, along with strict hand hygiene protocols. Visits may be limited in duration depending on the protocols of the individual facility and the requirements of each jurisdiction.
- ***When possible***, a different point of egress for visitors to end-of-life patients and residents should be provided. If possible, end-of-life patients/residents may need to be moved to areas where such egress is available.
- A a dying patient/resident should be given the opportunity to see *close* family/friends. Maximum numbers and access will be determined by the protocols of the individual facility and the requirements of each jurisdiction, negotiated on a case-by-case basis, dependent on family circumstances and the current restrictions in place, with the relevant Clinical Manager and/or Service GM/DCS).
- At least one nominated loved one should be permitted to remain with the dying person until they die, including overnight. Depending on the resources of the facility and the requirements of law, more than one nominated visitor may be allowed at this time, at the discretion of the facility Manager/GM/DCS.
- If the patient's next-of-kin or Substitute-Decision-Maker is screened and deemed eligible to be tested for COVID-19 or is awaiting results of COVID-19 testing (noting that the criteria is expanding regularly) and seeks permission to visit a patient or resident in the last days of life (e.g., a spouse, parent or child), the clinically recommended PPE protocols are mandated. Where PPE is in short supply, visits will need to be rationed accordingly, in fairness to other facility requirements as well as to other patients, residents and their visitors, who may require such PPE.
- Consistent with our core mission imperatives, the Sacrament of the Anointing of the Sick and Viaticum will be made available to identified end-of-life patients/residents who are Catholic and request this. Priests and visiting chaplains who are requested to attend patients/residents at end of life to administer these Sacraments will be provided with the clinically recommended PPE for each patient/resident if required. Where the clinically recommended PPE is not available, no visiting priest will be required to put themselves at risk to facilitate Sacrament of the Anointing of the Sick and Viaticum.
- We will adopt a similar approach to facilitate the important end of life rituals for dying patients and residents of other faiths.
- Priests, Ministers, Chaplains and Faith Representatives visiting Residential Aged Care Communities need to have and provide evidence of current, appropriate 'flu vaccination.
- Time needs to be taken to explain the rationale for these decisions as sensitively as possible, and to involve loved ones in problem-solving regarding how they are going to manage restrictions. Options like Facetime, Skype, emails, letters and cards should be suggested and facilitated. Pastoral Care staff can be involved to facilitate these conversations and assist with solutions.

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