Clinics 77 (2022) 100050

CLINICS
OFFICIAL SCIENTIFIC JOURNAL OF FACULDADE DE MEDICINA AND HOSPITAL DAS CLÍNICAS
UNIVERSIDADE DE SÃO PAULO – SÃO PAULO, BRAZIL

CLINICS

journal homepage: https://www.journals.elsevier.com/clinics

Comments

Palliative care in the COVID-19 pandemic: Strategy of HCFMUSP

In January 2020, the Hospital das Clínicas da Faculdade de Medicina da Universidade de São Paulo – HCFMUSP set up a Crisis Committee (CC) to organize the actions to fight the COVID-19 pandemic. The focus was to organize itself to receive severely ill patients from the city of São Paulo and the metropolitan region.

On March 30th, the largest patient relocation operation in its history was unleashed, with the objective of allocating the Central Institute (CI), with 900 beds, exclusively for COVID-19 cases.

From there, an action plan was elaborated and submitted to the CC, proposing specific actions of the Palliative Care Team (PCT) based on the World Health Organization (WHO) document, which describes the role of Palliative Care (PC) in humanitarian crisis.[1]

Some actions were approved by the CC and are described below:

a) Triage Protocol

A triage protocol for patients who might need help from the PCT. Three patient profiles were identified by colors[2] according to two main criteria: the presence of terminal disease (according to the SPICT-BR tool)[3] and clinical criteria that predict poor evolution facing an acute and potentially severe complication. In this sense, three profiles were defined:

Red: patients without terminality criteria and without general predictors of poor evolution according to the National Hospice Organization-NHO.[4] It was oriented to consider calling the PCT for joint follow-up if there were factors of poor prognosis listed by the WHO.[5]

Yellow: patients with criteria for terminality but without predictors of bad evolution. Call the PCT if have difficulties in symptom control, communication with families, discuss advance directives, or need to make complex decisions.

Green: Patients with terminality criteria and with clinical predictors of poor outcome (death). Call the PCT to transfer the patient to the PC Inpatient Unit (PC-IU).

The flowchart (Fig. 1) also indicated the methodology for making complex decisions and ethical and legal rules in force in Brazil.[6-8]

a) The "Hot Line"

A telephone was made available by the institution as a way to establish a communication channel with the PCT. This enabled the CI care teams to receive quick help to solve doubts regarding the control of difficult symptoms, aspects related to communication or interaction difficulties with the families, as well as help for complex decisions from the PC technical, ethical, and legal point of view.

Also, was possible to provide quick access to the vacancy's regulation center of the HCFMUSP, speeding up the referral and admission process of cases indicated for the PC-IU.

a) Communication

With a donation, specifically made to enable this communication through telepresence, it was possible to deploy 50 cell phones, 40 tablets, and 4G chips for all this equipment. The action plan included the distribution, to each CI unit, of a tablet and a cell phone with the WhatsApp application, for convenience, already installed.

A booklet was created with instructions and flowcharts involving the main communication modalities in this context: notice of worsening of the clinical picture, death news, family meetings for shared decision making[9] besides virtual visits from the families to the patients. A partnership was also made with technology companies from INOVAHC. This also made possible a lending contract for three robots with remote control and steering for communication actions.

In all this context, the PC-IU organized the pilot actions, developed the action plans, and made possible the expansion of the communication project to the other CI. This was done with the help of volunteers, including FMUSP students, trained to give access to the equipment to hospitalized patients.

The devices could also be used for family orientation at the time of hospital discharge.

a) Palliative Care Inpatient Unit (PC-IU)

On 04/08/2020 the PC-IU was opened at CI specifically to care for patients who were assigned to the green group after triage protocol. The PC-IU had 24 beds that were managed in such a way as to keep suspected and confirmed cases isolated separately.

The PC-IU operated with a local assistance team added to 2/3 of the PCT, medical and multi professional staff, and residents besides volunteer doctors from other areas and hospitals, with 24-h coverage.

Between 04/08/2020 and 07/31/2020, 186 patients were admitted to the PC-IU, with a median (IQR) age of 76 (65–86) years. The overall rate of discharge or transfer to a non-COVID area after treatment during this period was 32%, of which 62% had a confirmed diagnosis. Symptoms in the end-of-life phase were palliated appropriately, and palliative sedation therapy was used in 13% of cases, a rate consistent with the experience of literature in PC units.[10]

All patients had their advanced directives registered in their medical records and were not referred to the ICU.

In parallel, in the same period, 310 inter-consultations were attended by the same team, of which 65% generated transference of the patient to the PC-IU within 72-h, contributing to greater mobility of beds in critical areas.

a) Post-death care and bereavement follow-up

A professional from the PCT was assigned to be part of the team that welcomed the families after the notification of death by telephone. The families were instructed to go to the hospital to proceed with the legal

https://doi.org/10.1016/j.clinsp.2022.100050
Received 15 March 2022; Accepted 6 May 2022

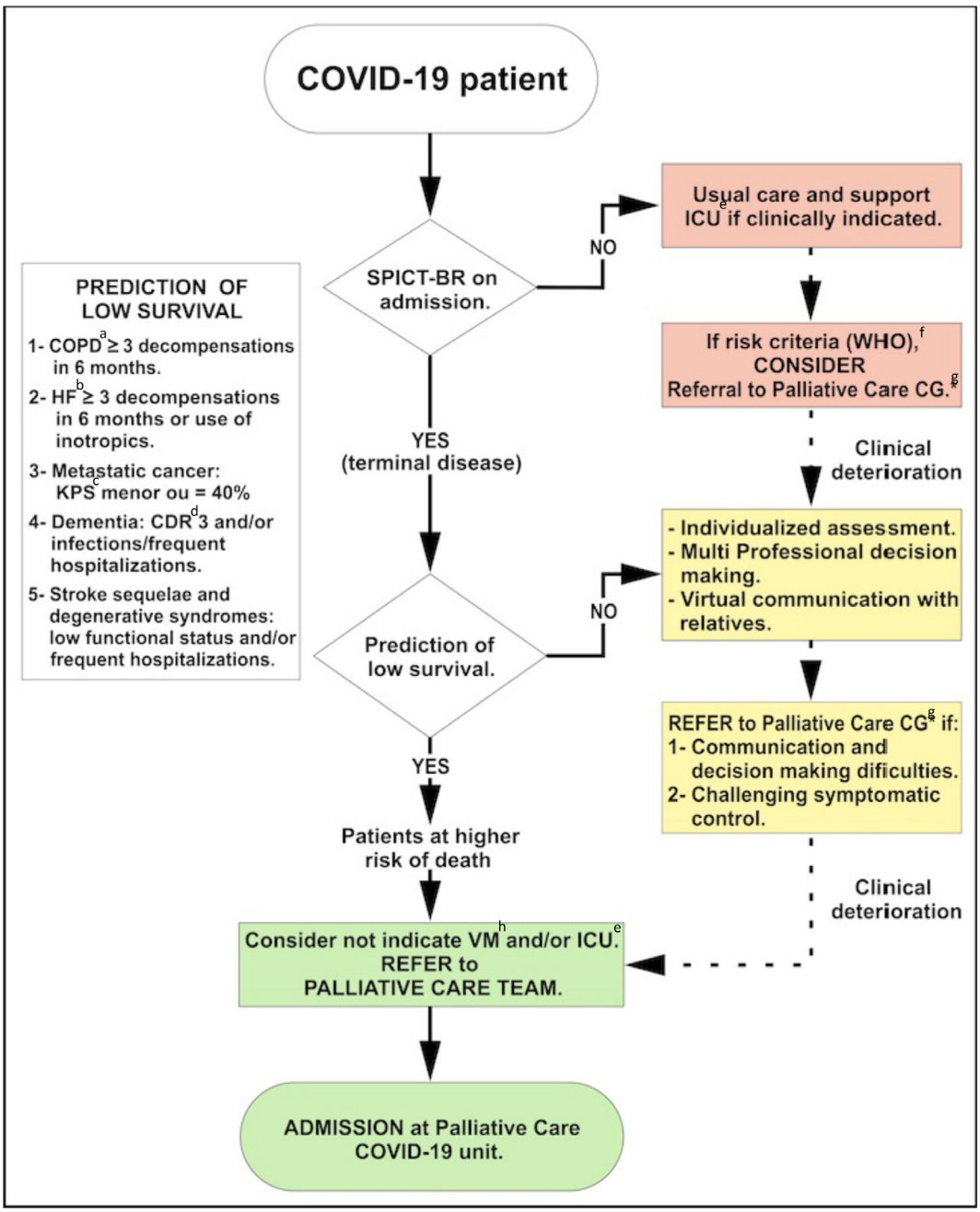

Fig. 1. Triage protocol for COVID-19 patients and Palliative Care needs. [a] Chronic Obstrutive Pulmonary Disease; [b] Heart Failure; [c] Karnofsky Performance Scale; [d] Clinical Dementia Rating; [e] Intensive Care Unit; [f] World Health Organization; [g] Consultant Group; [h] Mecanical Ventilation.

issues related to the burial. On this occasion, they had the opportunity to be welcomed by a team assigned for this purpose.

The families of patients who died in the PC-IU were screened for further outpatient follow-up based on markers indicating the possibility of complicated grief. About 50% of the triages performed led to a referral to the outpatient clinic.

As final considerations, the planning of strategic actions in PC in the context of the pandemic brought positive aspects that included the dissemination of the work and the perception of the teams about the importance of PC in this context. This assistance brought visibility to the PCT and great interaction with the CI teams, previously unaccustomed to this practice. It is important to say that the PCT decided to share their experiences in PC-IU and with inter-consultations write a book about Palliative Care during the COVID-19 pandemic.

Declaration of Competing Interest

The authors declare no conflicts of interest.

Funding Sources Declaration

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

References

[1]. World Health Organization. Integrating Palliative Care and Symptom Relief into the Response to Humanitarian Emergencies and Crises: a WHO Guide, Geneva: World Health Organization; 2018. Available from https://www.who.int/publications/i/item/9789241514460 [Last Accessed March 9th, 2022].

[2]. Azeredo TRM, Guedes HM, Almeida RAR, Chianca TCM, Martins JCA. Efficacy of manchester triage system: a systematic review. Int Emerg Nurs 2015;**23**(2):47–52.
[3]. University of Edinburgh. Supportive and Palliative Care Indicators Tool. SPICT-Br™. (Brazilian version), 2016. Available from: https://www.spict.org.uk/the-spict/spict-br/ [Last Accessed March 9th, 2022].
[4]. Stuart B. The NHO medical guidelines for non-cancer disease and local medical review policy: hospice access for patients with diseases other than cancer. Hosp J. 1999;**14**(3-4):139–54.
[5]. World Health Organization. UN Inter-Agency Task Force on NCDs and Covid-19. Geneva: World Health Organization; 2020. Available from https://www.who.int/teams/ncds/Covid-19/unitaf [Last Accessed March 9th, 2022].
[6]. Brazil. Conselho Federal de Medicina. Resolução CFM n° 1.805/2006. Available from: https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2006/1805 [Last Accessed March 9th, 2022].
[7]. Brazil. Conselho Federal de Medicina. Código de Ética Médica. Resolução CFM n° 2217/2018, modificada pelas Resoluções n° 2.222/2018 e 2.226/2019. Available from: https://portal.cfm.org.br/images/PDF/cem2019.pdf [Last Accessed March 9th, 2022].
[8]. Brazil. Conselho Federal de Medicina. Resolução CFM n° 1995/2012. Available from: https://sistemas.cfm.org.br/normas/visualizar/resolucoes/BR/2012/1995 [Last Accessed March 9th, 2022].
[9]. Crispim DH, Silva MJP, Cedotti W, Câmara M, Gomes AS. Comunicação difícil e COVID-19: recomendações práticas para a comunicação e acolhimento em diferentes cenários da pandemia. 2020. Available from: https://ammg.org.br/wp-content/uploads/comunica%C3%A7%C3%A3o-COVID-19.pdf.pdf [Last Accessed March 9th, 2022].
[10]. Caraceni A, Speranza R, Spoli E, Ambrose CS, Canestri S, Marinari M, et al. Palliative sedation in terminal cancer patients admitted to hospice or home care programs: does the setting matter? results from a National Multicenter Observational Study. J Pain Symptom Manag 2018;**56**(1):33–43.

Ricardo Tavares de Carvalho [a], Douglas Henrique Crispim [b], Ednalda Maria Franck [b,*], Daniel Battacini Dei Santi [b], Sergio Seiki Anagusko [b], Márcio Veronesi Fukuda [b], Luciana Suelly Barros Cavalcante [b], Sumatra Melo da Costa Pereira Jales [b], Mônica Estuque Garcia de Queiroz [b], Eloisa Silva Dutra de Oliveira Bonfá [c,*]

[a] *Coordinator of Department of Palliative Care, Hospital das Clínicas, Universidade de São Paulo, Faculdade de Medicina, São Paulo, SP, Brazil*
[b] *Department of Palliative Care, Hospital das Clínicas, Universidade de São Paulo, Faculdade de Medicina, São Paulo, SP, Brazil*
[c] *Clinical Director of the Hospital das Clínicas, Universidade de São Paulo, Faculdade de Medicina, São Paulo, SP, Brazil*
*Corresponding authors.
E-mail address: ednalda.franck@hc.fm.usp.br (E.M. Franck).