Filip Lebiedziński[1], Leszek Pawłowski[2], Joanna Jastrzębska[1], Alicja Świątek[3],
Monika Lichodziejewska-Niemierko[2]

[1]Medical University of Gdańsk, Poland
[2]Department of Palliative Medicine, Medical University of Gdańsk, Poland
[3]University Hospital of Karol Marcinkowski in Zielona Góra, Poland

Website information on visiting policies at specialist in-patient palliative care settings during COVID-19 pandemic across Central and Eastern Europe: a quantitative and qualitative study

Abstract

Introduction: Since the COVID-19 pandemic, visiting policies in various healthcare centres across the world have changed. Visiting patients by relatives and friends have been stopped or significantly limited. New conditions and legal constraints for family visits had to be implemented also at in-patient palliative care settings, even though accompanying a dying person is crucial for the quality of the end of life. The study aimed to identify and review the visiting policies at in-patient specialist palliative care settings across Central and Eastern Europe.

Patients and methods: The study was conducted one year after the COVID-19 pandemic outbreak from May to October 2021. Information about visiting policies, published on official websites of the in-patient specialised palliative care settings (stationary hospices and hospital-based palliative care units) from Central and Eastern European countries, were identified and categorised. The websites which lacked information about visiting policy during the COVID-19 pandemic were excluded. Qualitative and quantitative analysis of the obtained data was conducted by using content analysis techniques and descriptive analysis. The content from websites was translated into Polish with the usage of the Google Translate machine tool.

Results: Data from 55 in-patient palliative care settings from 8 countries were collected and analysed (83.6% from Poland, and the other from Bulgaria, Czech Republic, Estonia, Lithuania, Romania, Slovakia and Ukraine). In 43.6% of the organisations, visits were stopped and 56.4% of settings published information about the special requirements for visiting arrangements. In 32.7% of all examined units upfront approval from a physician or the head of a department for visiting a patient was required, and 29.1% published information about personal protective equipment. 32.7% of organizations recommended telephone contact with the patient, and 12.7% provided video calls.

Address for correspondence:
Filip Lebiedziński
Gdański Uniwersytet Medyczny, Marii Skłodowskiej 3a, 80–210 Gdańsk, Poland
e-mail: flebiedzinski@gumed.edu.pl

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Conclusions: Web information regarding visiting patients in in-patient palliative care settings is limited. There is a need to establish detailed requirements for the visits with better access to the website for the visitors, in case of a global disease outbreak.

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Key words: COVID-19 pandemic, palliative care, palliative care unit, stationary hospice, visiting policies

Introduction

The COVID-19 pandemic outbreak has impacted every aspect of life and has caused changes on the individual, local and international levels. The activity of healthcare systems has been particularly affected by this situation. Some healthcare systems had been facing challenges even before the pandemic and had been struggling to operate efficiently and provide appropriate health service to all patients on time [1, 2]. The need to act against the spread of SARS-CoV-2 poses an additional challenge, requiring the reorganisation of the functioning of facilities, including the introduction of restrictions on visiting patients by their relatives. There are fields of medicine, such as palliative care, where the closeness of the family is an extremely important component of patient care. It has also been proven that accompanying a dying patient allows the family to go through the mourning process more easily, reducing the frequency of depressive episodes [3, 4].

Patients' families at in-patient palliative care settings are usually involved in the physical, emotional and practical care of the patient as well as in decision-making. Their participation in palliative care is beneficial for patients' well-being and improves the quality of care [5, 6]. It alleviates the fear of death and also reduces the prevalence of anxiety and depression both in patients and family members [7–9]. Taking part in patient care may also play a role in family members' well-being, decreasing physical and emotional distress [10]. The study aimed to identify and review the visiting policies at in-patient specialist palliative care settings across Central and Eastern Europe.

Patients and methods

The study was conducted one year after the COVID-19 pandemic outbreak from May to October 2021. Internet search was limited to 11 Central and Eastern European countries: Belarus, Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania, Slovakia, and Ukraine. The websites which lacked information about the visiting policy during the COVID-19 pandemic were excluded. Qualitative and quantitative analysis of the obtained data was conducted by using content analysis techniques and descriptive analysis. Information about visiting policy at in-patient palliative care settings (stationary hospices and hospital-based palliative care units) was searched via an internet search tool with phrases translated into the languages of the studied countries: "family visits hospice COVID-19"; "family visits palliative care COVID-19"; "visitor restrictions in hospice COVID-19", "visitor restrictions in palliative care COVID-19". The search results were translated into Polish if needed and the content was analysed. The content from websites was translated into Polish by the usage of the Google Translate machine tool. Ethical approval was not required because the study was based only on freely available information published on palliative care centres' websites.

Results

Web information regarding visiting patients at 55 out of 85 in-patient palliative care settings from 8 Central and Eastern European countries was identified and analysed (Poland 83.6%, Romania 5.5%, Bulgaria 1.8%, Czech Republic 1.8%, Estonia 1.8%, Lithuania 1.8%, Slovakia 1.8% and Ukraine 1.8%). 30 were excluded because of the lack of information about the visiting policy on the unit's website.

At 24 (43.6%) of examined units visitors were not allowed ("no visitor policy"), and 31 (56.4%) allowed visits under special requirements. 10 (18.2%) implemented the "no visitor policy" with exceptions. At 18 (32.7%) of all examined units, upfront approval from a physician or the head of a department was required for visiting a patient, but in most cases, no decision criteria were published on the website. 1/3 of in-patient palliative care centres recommended telephone contact with the patient and only 7 (13%) provided access to video calls. 16 (29.1%) of examined settings published information about personal protective equipment (PPE) on the website (Fig. 1). As a result of qualitative analysis, the most common web information about restrictions for visitors, special rules and requirements for the visitors were identified (Table 1).

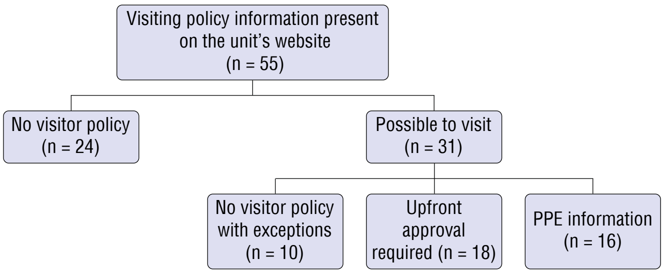

Figure 1. Main visiting policies shared on palliative care units' websites; PPE — personal protective equipment

Table 1. Examples of the most common requirements for visiting arrangements

Restrictions for the visitors	Special requirements for the visitors	Special rules for the visits
• Mask wearing • Hand disinfection • Social distancing	• COVID-19 vaccination • Negative COVID-19 test	• Limited number of visitors (in most cases 1 visitor per patient) • Limited duration of the visit (in most cases from 15 to 30 minutes)

Discussion

As the number of new SARS-CoV-2 infections varies between different geographic regions, the visiting policies in palliative care settings in different areas of the world are regulated mostly at the regional level, as well as by the decisions made within the facilities [6, 8–11]. The changes include, among others, limiting the number of visitors and the time of visits, the obligation to wear masks and protective gloves and the need to obtain consent from the staff to visit a patient [9, 11]. In some cases, visiting patients is completely prohibited [12]. Visitor restrictions in palliative care settings should vary depending on the population risk associated with the pandemic, as well as whether the COVID-19 outbreak was present in the unit. Multi-bed patient rooms could also have an impact on visiting policy. Hugelius et al. [13] suggested in their work that the visiting restrictions in palliative care settings during the COVID-19 pandemic might have negatively affected the patients' "quality of dying" as well as the mourning process of the family members.

In addition to modifying the rules of visits, the necessity to enable family contact with the patient while maintaining safety has become a significant problem. The use of technology has made it possible to replace direct contact to some extent. Many centres have introduced systems to facilitate video calling [14]. Nonetheless, taking measures to prevent the spread of SARS-CoV-2 is an absolute necessity. COVID-19 infection has worse outcomes in patients at late stages of chronic diseases such as cancer or heart failure and is associated with more severe symptoms and higher mortality [15, 16]. In addition, an infected hospice patient or medical professional can spread the virus to others in the hospice, which may potentially impair the palliative care provided by the facility. Taking all the above into consideration, the most important challenge seems to be balancing safety and compassion, i.e. maintaining epidemiological safety while ensuring that most aspects of efficient palliative care can be provided to the patients [17]. Ethical and psychological aspects should be taken into account when deciding on visiting policies in hospices, and embracing strictly biomedical logic in this situation is a limited approach [18].

Of the analysed centres, almost half (43.6%) decided to suspend visits completely until further notice. As scientific data from other countries are limited and the visiting policies are constantly adjusting to local epidemiological situations, it is hard to compare the present study results to other countries. However, some studies on this topic which were performed in western countries i.e. the USA, UK, Germany and Italy, suggest that no visitor policy was not a commonly introduced solution in palliative care during the pandemic. More often, visiting policies were based on conditional visiting and families were allowed to see patients near the end of life [19–23]. It must be considered that the decision to stop visits entirely may also have some economic basis because when the possibility of ensuring safety by constant testing of patients and visitors is limited, preventing direct contact is one of the most effective solutions in terms of infection prophylaxis. With the analysis tools available for the authors of the study, it was not possible to precisely assess whether the reason for stopping visits was associated with the detection of the SARS-CoV-2 virus in the facility, or the primary prevention based on the local epidemiological situation.

The study indicates that 53.4% of the analysed facilities, which published their visiting policy on their websites, allowed patients to visit. In all cases, special conditions for visiting patients were present. In 32.7% of all examined units upfront approval from the physician or the head of the department was required. This approach allows staff to be able to decide whether or not to admit a visitor, based on an assessment of the risk of infection in the department and, potentially, based on the clinical evaluation of the visitor himself. 29.1% reported information on PPE such as masks, gloves and hand disinfection. It is worth noting that in addition to monitoring compliance with the PPE rules, it could be helpful to provide visitors with these PPE measures. The necessity of both screening for symptoms and PPE provision for visitors is mentioned in many recommendations, i.e. in Pragmatic Recommendations for Infection Prevention and Control Practices for Healthcare Facilities in Low- and Middle-Income Countries during the COVID-19 Pandemic [24]. 32.7% of organizations recommend telephone contact with the patient.

Noteworthy is the low percentage (12.7%) of centres that published information on their websites about the provision of video calls between patients and their relatives. According to studies from other countries, it could be assumed that providing video calls has constituted a new way of support for patients and families in times of COVID-19 and it has become a common practice in palliative care [22, 25–27]. Models of telehealth response to the pandemic were developed such as a safety-net healthcare delivery system called NYC Health + Hospitals. This system is based on volunteers who support tele-visits and family-patient video calls for thousands of patients, including palliative care patients with COVID-19 [28, 29].

Despite the obvious limitations of video calling when compared to direct contact (the lack of closeness, no possibility of holding hands or taking care of personal care activities such as shaving/brushing), it is a solution that can provide a substitute for a meeting, allowing for a conversation between relatives and patients while maintaining eye contact. Hence, in a pandemic situation when direct contact is not possible, the provision of video calling seems to be an important element of palliative care. However, it must be noted that, as a lot of palliative care patients suffer from various degrees of cognitive decline which potentially impede the operation of electronic devices, the assistance of a third party during a video call may often be required. Although most palliative care centres have used telehealth/video during the COVID-19 pandemic (83.7%), according to the multinational observational survey (CovPall), the information about the use of phone calls and video calls for communication between patients and their families was published only on a part of units websites [25].

The data obtained in the study are limited because only a part of hospice and palliative care settings published information about visiting policy on the website. The percentage of units from Poland is significantly higher than from the other Central or Eastern European countries because Poland has the highest number of in-patient palliative care settings in this region [30]. Moreover, the information was published in native languages, which caused difficulties in identifying them by the research team.

Conclusions

Visitor restrictions caused by the COVID-19 pandemic outbreak significantly limited communication between palliative care patients and their families. It can be assumed that most in-patient palliative care settings somehow adapted to the epidemiological recommendations and took measures to minimize the risk of SARS-CoV-2 infection, with most of them trying to maintain the possibility of patient–family meetings either by conditional permission or by providing video calls or telephone calls. Adjusting the visiting policy at in-patient palliative care centres to both the epidemiological situation and the needs of patients and their families is a difficult challenge for palliative care teams, hospice managers, as well as people responsible for creating recommendations and legal regulations. More studies are needed to develop guidelines and recommendations for visiting policies in palliative care in-patient settings for extraordinary situations such as pandemics, including the provision of good-quality information about access to alternative means of communication for patients and their families.

Declaration of conflict of interest

The authors declare that there is no conflict of interest.

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