

The Key Role of Nurses and Social Workers in Launching End of Life Communication in the Focus of the Covid – 19 Pandemic.

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ABSTRACT:

The new COVID – 19 pandemic broad scale and rapid spread has changed the way hospitals and other health facilities function. Patient – centred end of life decision making opportunities are risked by a scarcity of resources in the health system. The conventional physician initiated advanced care planning for critical disease may also need to be rejected as a response. We propose Nurse led and allied health led ACP discussions to ensure patient and family inclusion and understanding of the prognosis of disease, overtreatment prevention, and potential outcomes in times of crisis. We highlight recognized problems and list enablers, long-term and short term opportunities for helping with the shift in culture.

KEY WORDS: COVID – 19, Health, Nurse, Social workers, Pandemic, advanced care planning's

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I. INTRODUCTION:

Medical science and advances in therapy have allowed us to enjoy an extended life expectancy. However, prolonging the suffering and impairing the quality of the remaining life can be questionable in older people with advanced irreversible multi disease. The benefits of advanced care planning (ACP) are well known among physicians in avoiding overly invasive and unnecessary end-of - life treatments. Paradoxically, advanced care planning's acceptance remains weak, and is a global challenge.

Awareness of the need for documentation of patients' wishes has been heightened recently due to the coronavirus 2019 (COVID-19) pandemic, with high infection rates and mortality risk among older people and/or those with underlying chronic conditions. This rapid spread of COVID-19 is placing a strain on existing resources and limiting universal healthcare access in some health systems.

Role's and responsibility of COVID – 19:

The unprecedented transmissibility of COVID-19 and the potential for high mortality are removing opportunities for patients and families to plan for future health care. The pandemic presents a challenge of time pressure for decisions because of the sudden increase in patient workload, resulting in the need to ration stretched resources to people with the best chances of survival. While the concurrent economic crisis unfolds, the ethical dilemma of health care allocation requires urgent attention so that end-of-life care discussions including withholding life-sustaining treatments are not delayed. With the extensive media coverage and online information on the diagnosis, prognosis, and global spread of COVID-19 and the shortage of health personnel and medical supplies, the public is becoming aware of the possibility that restricted access to ideal healthcare is

imminent. However, there is still a chance to preserve dignity and provide supportive palliative care if end-of-life discussions are streamlined and widespread.

Challenge of decision making:

A strategy for the health system to adequately respond to the challenge of urgent decision-making is warranted. Delegating some of the responsibility of end-of-life discussions in the transition from curative to palliative care to other health professionals who feel ready and competent may be one option. Non-medical clinicians, specifically nurses, can play a supportive role for patients and their families due to their on-going interactions with patients and families at the bedside, which builds trust and rapport. Nurses have a unique perspective of the personalized disease trajectory, which strengthens their credibility in end-of-life conversations. Nurses currently play three roles in end-of-life communication, including information broker, supporter, and advocate. Their role spans from translating technical medical details to advocating the patient and family’s goals with the wider healthcare team through to navigating across the intricacies of the health system, and clarifying the need to prevent futile overtreatment. Barriers, from level of competency through to system level legislation, can have an impact on effective engagement of end-of-life discussions and in turn they can negatively affect the quality of end-of-life care for patients.



Barriers and Opportunities:

Current barriers and opportunities for non-medical staff engagement in initiating end-of-life discussions

Barriers	Short-term opportunities
<ul style="list-style-type: none"> - A culture in healthcare that works against any change in role delineation fueled by the social expectation that doctors take the lead on prognostic disclosure and offers of treatment options - Inadequate training and skills for initiation of such complex end-of-life discussions - Feeling that their input to the conversation is vague and somewhat meaningless - Lack of support, as a profession, in having end-of-life responsibility within their scope of practice - Discomfort about implications due to the uncertainty of whether taking a leading role in end-of-life discussions could result in potential legal action by patients’ families 	<ul style="list-style-type: none"> - Accelerated refresher training on communication of bad news and ACP - Internal service policies to enable an expanded scope of practice for non-medical clinicians and work through the ability for a nurse practitioner to sign off an advanced resuscitation plan (including in end of life) - Greater protection through broader legislation, expedited law amendments to be authorized and protection to deliver these activities - Public campaign to enhance support for prognostic disclosure, open discussions on ACP by any health professional, and awareness regarding the harms of life-sustaining treatments when potentially futile

Advanced care planning's nurse-led models of care implemented and evaluated in urban and rural settings have shown promising results with good patient acceptability and understanding of its benefits. An expanded role for allied health professionals including social workers in advanced care planning's has also been proposed due to their involvement in conflict resolution and advocacy duties and advanced communication skills necessary to support this process. Given the chaotic hospital atmosphere, resource scarcity and doctor fatigue, and the burnout and isolation of those infected during the COVID-19 pandemic, the opportunity exists globally for end-of-life communication to be initiated by nurses and social workers if they are coupled with rapid educational updates and legal safeguards in routine practice. With additional training, expanding the role of dedicated social workers into becoming effective initiators of end-of-life discussions during this pandemic may also alleviate the pressure of doctors when facing the need to limit ICU admission or resuscitation. Importantly, consideration must be taken to not overburden specific individuals within occupational groups such as frontline workers who may be overwhelmed with direct clinical management. These subgroups should not be charged with the new role or responsibility in the current environment as their levels of distress, anxiety, depression, and insomnia are already known to be high during the pandemic.



The final action moving forward is to have patients and families, hospital executives, and residential aged care be supportive of this cultural shift, recognizing the value of nurses and allied health workers' potential role in timely engagement of end-of-life discussions.

II. CONCLUSION:

The **COVID-19 epidemic** has placed an extraordinary burden on health systems worldwide and it has reignited awareness of the need for hastier decision-making near the end of life. This unprecedented high level of demand for intensive care services which cannot be satisfied may be an opportunity to explore an expanded scope of practice for key members of the broader healthcare team, i.e., **Nurses and Social Workers**. They are suitably qualified and intimately familiar with the social and clinical circumstances to take on the role of initiators and facilitators of end-of-life discussions with patients and families. With targeted education, legislative support, and public awareness, it may be possible to implement a change to the healthcare culture that improves the understanding of quality end of life care, accepts the role of palliative care, and normalizes the need to withhold or withdraw futile life-sustaining therapies for people who do not have prospects of survival. Concurrent evaluation of the effectiveness of this model of care is encouraged.

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