

The Impact of COVID-19 on Palliative Care Services in a Tertiary Hospital in Brunei Darussalam

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Abstract

The wake of the novel coronavirus (COVID-19) pandemic had caused substantial disruptions to the usual delivery of healthcare services. This is because of restrictive orders that were put in place to curb the spread of the infection. Palliative care services in Brunei also face challenges to deliver effective services during this period. However, the impact of advanced illnesses on patients' health and end-of-life care are issues that cannot be planned, postponed or cancelled. Hence, the palliative care team needs to continue to deliver effective palliative care services. As Brunei faced its second pandemic wave in August 2021, crucial adaptations were made to ensure palliative care service was not disrupted. This reflective case study aims to discuss the adaptations made in providing palliative care during this era of disruptions.

Keywords: COVID-19; RIPAS; Palliative care; Brunei

Introduction

The COVID-19 pandemic is far from being just a health crisis. It also posed unprecedented challenges to various aspects of life. While the impact may vary in different countries, the pandemic has profound socio-economic effects on societies (World Bank, 2020) as a result of measures taken by governments such as lockdowns and stay-at-home orders. Apart from the economic impact of the pandemic, many essential healthcare services are disrupted, affecting the health, well-being and quality of life of societies in many countries (World Health Organisation (WHO), 2021a).

Brunei reported its COVID-19 second wave/community spread on 7th of August 2021, 17 months from its first reported wave of imported cases on 9th of March 2020. Following the successful containment of the first wave with only three deaths, Brunei reopened and loosened its strict economic and social activities before the second wave hit the Sultanate. By then, only 9.2% of its population had completed their COVID-19 vaccination, and 24% were partly vaccinated (Ritchie et al., 2021). The Brunei government quickly implemented stricter levels of lockdowns in all areas of services in response to the second wave, which has undoubtedly led to changes in the healthcare landscape. Hence, adaptations have to be made on delivering healthcare services safely without compromising the quality of patients' care.

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The significance of this study

This case study highlighted the adversity of the COVID-19 pandemic to the usual standard palliative care deliveries in Brunei. It has disrupted healthcare services and has also affected how healthcare professionals provide care. In the discussion above, the authors have highlighted the improvisations and adaptations made in the services in order to address the challenges. What has been learnt from the critical analysis of this case study is that the changes implemented will not and cannot be a temporary or a reactive solution to the state the world is in at the moment. The authors suggest that the experiences made during this period should be taken as an opportunity to foresee and prepare ourselves to 'living in the new normal'.

The catchphrase 'living in the new norm' has frequently been heard throughout the duration of the COVID-19 pandemic. To healthcare professionals, the term equates to embracing novel strategies in providing care and treatment to their patients while also realising that the coronavirus is still 'alive' amongst the community. Although social restrictions may be relaxed as the number of infected people reduces, 'living in the new norm' in the healthcare domain means continuing to prioritise strict health protocols (Chen, Tan, and Chan, 2020).

Palliative care services around the world have been observed to adapt to the COVID-19 challenges equally. The utilisation of technology in palliative care will be the 'new norm' for the long run. An investigation on specialist palliative care services across a few countries in Europe found that prior to the COVID-19 pandemic, only 21.6% of palliative services used telehealth/video support/e-learning for clinical care. The number now stands at 83.7% (Dunleavy et al. 2021). The same study also reported that 84.4% of the services use virtual technologies to communicate with fellow healthcare professionals, a substantial increase from the pre-pandemic era. A telehealth study in Taiwan (Wu et al., 2020) was conducted on the use of smartphones for family conferences in palliative care decision-making. Out of the 12 families who were using videoconferences for family meetings for the first time, ten families reported their willingness to use the video conferencing facility again. Though some of the families indicated their preference for face-to-face consultations (citing a lack of satisfaction with communication done virtually), having no negative feedback on telehealth shows that the use of technology in communication in the palliative care setting is a new norm many are now embracing.

Similar to the situation in Brunei, the pandemic has also impacted palliative care at home and across the community setting in many countries across the globe. Brunei's palliative care team's strategies of providing a helpline to their patients as well as of triaging telephone assessment before any home visits were also observed in other countries. For example, during the period when the government tightened its restriction policy, the palliative care teams in Singapore had to discontinue home visits to stable home care patients. In its stead, support was provided via phone or videoconferencing. This increased the number of phone calls made for assessments and advice and a decrease of home visits from January to May 2020 (Kumar Radha

Krishna et al., 2020a). Many palliative care services across the European countries reported similar findings, with 40.6% of the respondents in Dunleavy et al. (2021) claiming that there is an increase in the number of patients needing support at home.

There are advantages and disadvantages of providing palliative care support via telehealth and video conferencing. A rapid literature review carried out by Sutherland, Stickland, and Wee (2020) to aid their decision-making on using telehealth in palliative care found that there is global evidence to support video consultation as an effective, accessible, acceptable and cost-effective method of service delivery; telehealth can radically reduce the spread of COVID-19 while maintaining the standard of palliative care.

These transformational changes may be exciting, but the use of technology, especially smartphones or tablets, can cause issues pertaining to the boundaries of space and time when going about one's professional activities. Before the pandemic, teleworking was seen as a means to improve work-life balance, but it is now seen as one of the preventive measures to protect health during the pandemic. The International Labour Organisation (ILO) (2021) reveals that, in general, there is no accepted approach yet for ensuring health and safety during teleworking. One example, however, can be seen in Chile, where new teleworking legislation was introduced, which requires employers to respect their workers' right to 'disconnect' for at least 12 consecutive hours in any given 24-hour period. During this 'disconnection' period, teleworkers are not obliged to respond to any communication (International Labour Organisation, 2021).

While remote video consultations may offer a huge benefit to healthcare delivery during the pandemic, the WHO cautioned against its rapid implementation without a full assessment of an evidence-based model of care, taking into account patients' safety. The WHO guidance includes establishing a standard operating procedure, clinical protocols for when video consultations can or cannot be used, policies to ensure the equity of access in disadvantaged populations, adequate staff training, and administrative support (World Health Organisation, 2021b).

The authors posit that, in establishing an evidence-based model of telehealth in palliative care in Brunei, the use of telehealth as supplemental palliative care and support to the patients and their families at home is the 'new norm' that is here to stay. The WHO recognises that the virus will be with us for a long time, and that is a call for the world's governments to take the opportunity to invest in robust health systems which can benefit the population beyond COVID-19, as well as to prepare for future public health emergencies (World Health Organisation, 2021a).

There is a need for a long-term investment in training the healthcare staff to improve their use of information technology and enhance their clinical skills, such as patient assessment and triaging skills. The upgrading of skills can assist in building the confidence of the healthcare professionals in adapting to the new way of working. More studies need to be carried out to provide evidence-based telehealth provision for palliative care patients. A proper working environment and well-articulated standard

operating procedures need to be established that are befitting with the 'new norm'. All these strategies certainly need major funding and investments. Greater collaborations between the stakeholders, such as between the government and the private organizations, are much needed as we transition to this life in the new normal. These collaborations could come in the form of driving forward innovations, minimising duplications of efforts, and the optimising of resource use.

The pandemic has clearly affected the well-being and morale of the working population. Proactive innovations should be implemented to help ease these burdens. Healthcare leaders need to be more creative and innovative in establishing strategies that provide a balance between costs, the services provided, and employees' well-being. Not only should there be a provision to ensure enough supplies of personal protective equipment and adequate training on clinical safety and competency, but there is also a need to allocate time and to provide a safe space for open communication and debriefings as an approach to keep healthcare professionals' mental health in check (Dunleavy et al., 2021; International Labour Organisation, 2021). Instituting clear yet responsive guidelines and protocols is also paramount in alleviating doubts and confusion as healthcare workers swiftly adjust to their changing environment (Kumar Radha Krishna et al., 2020). These guidelines need to be developed with the cooperation of other services that are also affected by the crisis of COVID-19 (Powell and Silveira, 2020). These strategies should not be considered as mere reactive solutions towards the pandemic, but rather a proactive approach in the transition towards living with COVID-19 as an endemic era.

Aim of study

COVID-19 pandemic posed many challenges to various aspects of life, including to healthcare services. There is limited published literature on how the palliative care services in Brunei continue to strive to deliver the best possible quality of care to their patients and families. This case study is developed based on two of the authors' personal experiences and the clinical observations of the third. Personal experiences were critically discussed and reflected based on current health issues regarding palliative care provided during the COVID-19 pandemic.

This case study aims to reflect on the challenges facing palliative care service worldwide and how it has affected the services in a palliative care unit of a tertiary hospital in Brunei Darussalam. Strategies, improvisations and adaptations to the challenges so as not to compromise the quality of the service deliveries will be discussed. It will also discuss the opportunities that COVID-19 has brought to the palliative care realm of the healthcare services in Brunei.

Brief background on Palliative care

Palliative care is crucial for any integrated healthcare service (World Health Organisation 2021c). The WHO defines palliative care as care that;

"...improves the quality of life of patients and that of their families who are facing challenges associated with life-threatening illness, whether physical, psychological, social or spiritual. The quality of life of caregivers improves as well" (World Health Organisation 2021c)

Palliative care as a medical discipline has evolved rapidly since the 1970s. It originated from the modern hospice movement that stemmed from the work of Dame Cicely Saunders, who drew that attention to the quality of end-of-life care of patients with cancer in the United Kingdom. Palliative care continued to progress as a medical specialty in its own right that provides physical, social, psychological and spiritual support for patients with a life-limiting illness. Such a specialty is delivered by a multidisciplinary team (MDT), which often consists of doctors, nurses, physiotherapists, occupational therapists, medical social workers and in some cases, chaplains or religious leaders (Clark, 2007).

Unlike many elective or planned health activities and treatments in healthcare, critical life events such as childbirth and death cannot be scheduled, cancelled or postponed. High-quality palliative care must continue despite the main agenda imposed by the Ministry of Health Brunei, which focusses on controlling the spread of the pandemic (Cairns and Coghlan, 2021). At present, there is no evidence to support any specific model of palliative care during national healthcare emergencies (Nouvet et al., 2018). WHO has issued guidance on maintaining essential health services during the pandemic, highlighting immunisation, maternal care, emergency care, and chronic diseases, among others. However, there was no mention of palliative care.

Challenges of Palliative Care globally during the pandemic

Pandemic posed unique challenges to the delivery of palliative services everywhere in the world. The demand is expected to increase, where at the peak of a crisis, medical consults for palliative care increased by four- to sevenfold for both long-term and acutely patients. At the height of the pandemic, palliative patients and families often face symptoms, emotional distress in decision-making that is full of uncertainty (Powell and Silveira, 2020). These needs often surpass the capacity of the palliative care team (Blinderman et al., 2021).

Access to palliative care services is one of the key challenges many patients face during the pandemic where human and medical resources are scarce, and rationing needs to be made. Many typical patterns of referral and occupancy in hospitals and palliative care units have changed due to COVID-19 (Blinderman et al., 2021). The directives designed to prevent the spread of COVID-19 had caused limited access to health care settings such as hospitals and primary health care clinics, leading to an increased demand for home care services. Therefore, many health and palliative care bodies have created mechanisms to deliver more efficient palliative care services at home.

The issue of access to medications and healthcare equipment also needs to be dealt with. Throughout the pandemic, it is essential to plan for the possibility of constraints

on the supply chain for medications and equipment such as medical beds for immobile patients and oxygen assistance devices for palliative patients with difficulty in breathing. These issues are most notable in community settings. Palliative care teams need to plan and consider conserving some key medications or providing reasonable alternatives by assessing and prioritising the urgency of patients' needs (Blinderman et al., 2021)

Clinical workloads are expected to increase due to the rapid restructuring of healthcare services to meet the pandemic crisis needs. As a result, healthcare workers are more prone to illnesses, fatigue and burnouts from the demand for direct involvement in screening and treating COVID-19 positive patients. Fatigue and exhaustion have also been reported to be the main symptoms experienced by healthcare workers for having to cope with the adversities experienced during the pandemic (Roslan et al., 2021). Coupled with the challenges described above, ensuring that the palliative care providers' safety and support needs are met is also a challenge in its own right. The most palliative care team cannot afford to lose their team members due to prolonged illness. Protection of limited resources is thus essential to keep the palliative care team provider well and healthy to serve society (Powell and Silveira, 2020).

Palliative care services in Brunei have certainly faced similar challenges outlined above. Palliative care clinicians are deployed as frontliners at the Tutong isolation centres and swab centres all over the country. In light of limited staffing, the palliative care team has to make use of the available resources most efficiently and safely. The strategies used to deal with these challenges during the pandemic will be discussed following a brief introduction on the palliative care services available in Brunei.

Palliative care services in RIPAS Hospital

The Ministry of Health Brunei Darussalam puts in a considerable effort to implement an integrated healthcare service to its population by providing health care to patients and clients on a continuum of preventive and curative care and treatment across different levels of its system. The palliative care unit at the Raja Isteri Pengiran Anak Saleha Hospital (RIPASH) is a specialist unit established in 2008 to manage patients with advanced diseases' health and well-being and improve their quality of life we; as those of their families. The team consists of a multidisciplinary team (MDT) that comprises four doctors and five nurses supported by allied healthcare providers that include physiotherapists, occupational therapists, dieticians, and medical social workers. The team provides care and treatment for patients in inpatient (hospital) and outpatient (community) settings.

Inpatients services refer to patients being admitted to wards. The MDT sees them of the palliative care team address acute medical issues experienced by chronically ill patients to optimise their quality of life. Outpatient services involve routine clinic appointments made for palliative patients discharged from the hospital and newly referred patients from other medical specialties who feel that their patients require palliative care inputs and support. The palliative care team also provides home visits and telephone follow-ups to patients who are too ill or too weak to travel to the

hospital. Our palliative inpatient services oversee between 20 to 30 patients a day on average. In contrast, our outpatient services have between 40 to 50 clinic patients seen monthly. On top of that, our home visit team organised about 20 visits each month, overseeing those who are bedbound or have difficulties attending outpatient clinic appointments.

Palliative Inpatient services during the pandemic

Similar to the global phenomenon in palliative care described earlier, palliative care resources in terms of the workforce are finite in Brunei. Hence, in light of the pandemic, it is crucial to managing the human resources appropriately so that patients affected by the pandemic and patients who make up the 'usual palliative population' are being cared for effectively and appropriately. At the same time, it is prudent to balance out the fluidity of the clinical situation, given the progress of the spread of the pandemic and the safety of healthcare workers.

A few measures have been made to address the management of human resources and their well-being. Firstly, by ensuring social distancing and minimising physical contact between healthcare providers and patients. The clinical staff in the palliative care unit at the RIPASH are divided into two sub-teams referred to as the '*Clean Team*' and the '*Dirty Team*'. The '*Clean Team*' also acts as the standby team if the '*Dirty Team*' members fall ill or are required to serve quarantine/isolation orders. In this way, any interruptions to the palliative care services are minimised. The '*Dirty team*' is at a higher risk of being exposed to the infection due to the high risk of COVID-19 positive cases being admitted to the inpatient settings of the RIPASH. Thus, 'quarantine/isolation order' is a situation that the palliative care team aims to avoid as much as possible due to the already limited human resources. Depending on whether the healthcare worker (HCW) is a positive case or a direct contact of a positive case, the 'quarantine/isolation order' would involve doctors and nurses undergoing the COVID-19 swab test, followed by a self-isolation for at least seven days or up to 14 days.

The '*Dirty Team*' is a ward-based team led by a consultant stationed at specific, designated wards. The team will manage all types of general medical patients admitted to that particular ward, regardless of the patients' health issues. As a result, the '*Dirty Team*' will consult both palliative and non-palliative care patients. The aim is to avoid unnecessary bed movements and physical contact among patients and healthcare team members in the hospital. Inputs from specific specialities will be consulted as needed. Currently, the RIPASH does not have its palliative care wards for palliative patients. During the pre-pandemic era, all palliative care patients were admitted to any of the four of nine medical wards available (two female and two male medical wards). However, during this challenging period, all newly admitted patients who are expected to be under the care of the palliative team are assigned to just one specific ward. As a result, the number of palliative care patients admitted to the hospital for support and treatment is limited and triaged according to those who need urgent attention.

As the palliative care team anticipated an overwhelming demand from the healthcare system, the focus of the inpatient palliative care services is to expedite the early but safe discharge of patients whenever possible. Safe discharge of patients here refers to the patients being holistically stable to continue their treatment at home. To ensure this holistic stability, care and treatment referrals must be made to the MDT to ensure the patients' smooth transition from the ward to their homes.

The allied healthcare team of the MDT comprising several physiotherapists, occupational therapists, medical social workers, and dieticians, are also limited in numbers. Referrals for treatment to these professionals need to be made early and strategically. In normal circumstances, this would involve a weekly MDT meeting where the palliative care and allied healthcare teams develop a treatment and care plan for the patients and their carers at home in preparation for their discharge. However, this weekly meeting has been replaced with a daily e-platform group discussion on the pandemic-imposed changes. A few days following a patient's discharge from the hospital, a follow-up check will then be carried out by the '*Clean Team*' through phone calls from the palliative care clinic. If needed, this will also be followed up by a video call conference with the patient and the patient's family to address more complex matters such as pain management or end of life care issues faced by the patient and his/her family at home.

The '*Clean Team*' is led by a team of senior clinicians who work remotely from the clinic at RIPASH. The main role of this team is to deal with all inquiries and concerns pertaining to palliative care management of patients under the care and treatment of other wards, departments, and specialities, including the Intensive Care Unit (ICU) of RIPASH well as other smaller hospitals in Brunei. To aid these palliative care consults and inputs, patients' clinical details and progress can be assessed via the hospital e-health platform, the BruHims, and appropriate advice is made via phone consults with the respective clinicians. If there is a need, video conferences will be scheduled with the patients and/or their family members.

The '*Dirty*' and '*Clean Teams*' switch roles every four weeks to reduce any risks of burnout and of being infected with the COVID-19. Switching positions will also ensure the safety of the patients and the other healthcare professionals that the palliative care team interacts with daily. This protocol has helped maintain the fluidity of the palliative care services. Every second of interruptions to the care and treatment will have an impact on the quality of life of these patients.

'The Muleh Care bundle'

Even with the designated '*dirty*' and '*clean*' teams in place, there have been instances when palliative care patients with urgent support needs were admitted to wards that are not designated for the palliative care team. A non-palliative care specialist would carry out the medical consult for the palliative care team when this happens.

To ensure patients are assessed appropriately from the 'lens' of the palliative care specialty, the palliative care team has developed a care tool called the '*Muleh Care*

Bundle' for terminally ill patients (Figure 1). The bundle aims to guide the non-palliative care specialists on the holistic approach to ensure that patients do not suffer at the end of life and that close family members are constantly updated on the latest development of the patients' journey. Non-palliative care specialists may have limited knowledge and practice on the palliative care approach. The *'Muleh Care Bundle'* is based on the principles of the Liverpool care pathway (LCP)(Seymour and Clark, 2018), which was developed in the United Kingdom as a pathway covering care options for patients in their final days or hours of life. The LCP is also intended to help and doctors provide end-of-life care. *The 'Muleh Care Bundle'* consists of seven sections of simple tick boxes that the clinician needs to go through daily. It ensures effective communication with the patients and their family members and serves as a tool to check that the patients' symptoms are well controlled with medications. Religious rights of the patients are also taken into account for a more holistic approach.

| 'Muleh' Care bundle- DDIL (DNACPR status) | | |
|--|--|---------------------|
| Date | | Ward |
| Day of Admission | | Bed |
| Communication | | |
| Relay to patient/family members that patient is dying | Done | Not Done |
| Discuss with patient/ family members re plan for symptom control | Done | Not Done |
| Review of symptoms which may develop in the last hours or days of life | | |
| Pain | | |
| Agitation | | |
| Respiratory tract secretion | | |
| Nausea / Vomiting | | |
| Dyspnoea | | |
| Medications | | |
| Current Medication reviewed and non-essential medication discontinued | | |
| Start medications to control above symptoms--See appendix | | |
| Anticipatory PRN medications--See appendix | | |
| Access for drug administration | | |
| IV access | | Subcutaneous access |
| Review monitoring and current intervention | | |
| Routine vitals | Per shift | |
| D stick monitoring | Discontinue | Frequency |
| | Continue | |
| IV Antibiotics | Discontinue | |
| | Continue | Capped at |
| O2 therapy | If SpO2 < 92% but capped O2 at | |
| Inotropes if started prior | Capped at | |
| IV/SC hydration | Discontinue | |
| | Continue | |
| Artificial nutrition | Discontinue | |
| | Continue | |
| Central Line/ Catheter | Remove if deemed medically appropriate. Otherwise keep | |
| Religious Beliefs | | |
| Offer Ustaz/Cleric to rectify prayers/patients last rights | Done | Not Done |
| Daily review | | |
| Above symptoms | | |
| Oral care | | |
| Bowel care | | |
| Skin care | | |

Figure 1. The Muleh Care Bundle

Palliative outpatient services during the pandemic

Many outpatients' services are currently reduced to enhance the physical distancing protocol mandated by the Ministry of Health during this period. The nurse clinicians contact all patients under the team's follow-up care to stratify the cases that need early or urgent tele-consults. Non-urgent clinical appointments are deferred with advice, and medications are prescribed for a more extended duration of use.

To ensure continuous palliative care support, a helpline palliative service is offered to the patients and their

families as a means for them to directly contact the palliative care nurses and to reduce the need for them to visit the healthcare facilities. The palliative care team is also in regular communication with the home-based nursing services to ensure that the patients' long-term care needs, such as clinical procedures for maintaining long-term urinary catheters and nasogastric feeding tubes, are effectively managed. The home-based nursing services continue to deliver their care in patients' homes with extra caution against the transmission of COVID-19. For this type of clinical care to be carried out, pre-visit telephone consultations enquiring COVID-19 risk factors are made prior to each home visit. If the concerned patients or any household members

are COVID-19 positive or on quarantine order or an isolation notice, the home visit will be postponed or even, cancelled; thereby leading to further delay in their care.

Communication challenges

As the Ministry of Health has imposed a no visitor policy during this pandemic period, one of the palliative care team's biggest challenges is effective communication with the patients and the patients' family members. Pre-COVID-19, with the patients' consent, the team would occasionally gather the family members in order to discuss the patients' diagnosis, expected trajectory, and the treatment plan. All healthcare and treatment issues would be discussed in depth. For people who suffer from advanced diseases, their primary carers would often be their family members. These individuals often find it challenging to care for their loved ones at the advanced stage of their illnesses. This is particularly true of the patients who have difficulty coping with symptoms such as pain, breathlessness and fatigue (Potter et al., 2003). It has been documented that the patients' families often struggle without the support of the palliative care team (Greer et al., 2020).

Advance care planning (ACP)

Another vital role of the palliative care team is to initiate 'advanced care planning (ACP) with patients and their families. ACP offers patients the opportunity to plan for their future care and support, including medical support, while they have the capacity to do so. As Brunei is a close-knit, family-orientated society, patient care is often discussed with family members. In many other global palliative healthcare settings, these discussions would typically be carried out mainly with the individuals afflicted with the advancefamily members often discuss patient careir families' wishes (National Institute of Clinical Excellence, 2021).

Initiating ACP is often a delicate matter that requires ample training and adequate experience in palliative care communication skills, and the conversation should only commence when the timing is appropriate. Based on their rapport and the relationship they have built with their patients, the palliative care team will be able to gauge which patient is ready to discuss ACP. However, there have been occasions when patients were identified and deemed ready to discuss ACP by the palliative care team, but who later on expressed their non-readiness to discuss the matter. In such an event, the palliative care team will respect their wishes and continue to provide support to the patients until the time comes when they are undoubtedly ready to discuss ACP.

Though it is a sensitive aspect of care, ACP remains the gold standard for palliative care practitioners to institute because studies have shown that people with advanced care planning experience better end of life quality of care (National Institute of Clinical Excellence, 2021). ACP requires the palliative care practitioners to discuss the advantages and challenges of making a plan about the type of treatments the patients wish to have when they no longer have the capacity to decide on their own (National Institute of Clinical Excellence, 2021). During normal circumstances, facilitating advanced care planning is already challenged by barriers such as a lack of

time during patient visits, patients' discomfort, and the lack of resources (Bender, Huang, and Raetz 2021). Now, communication challenges such as not being able to talk in person and to engage with patients and their families due to the COVID-19 restrictive measures further hinder this critical discussion from being carried out, thereby risking the quality of care in patients at the end of life.

The use of technology

The COVID-19 pandemic certainly has created many restrictions to communication-in-practice. Effective and empathic communication is challenged by the limited engagements medical practitioners have with the patients and their families. The palliative care team has no other choice but to embrace technology as a means of communication, particularly the use of telephone calls and video conferencing facilities with the patients' family members. Several systematic reviews have examined home-based telehealth in palliative care settings and have reported improved quality of life or symptom management (Steindal et al. 2020). Kidd et al. (2010) found that telehealth applications, including the use of videoconferencing in consultations, symptom assessments, and providing advice for patients, relatives, and health care professionals, were deemed usable and acceptable for patients and health care professionals.

In light of the pandemic, it is clear that quick adaptation and utilisation of technologies such as e-platform are vital for the efficacious delivery of palliative care. As the COVID-19 pandemic looms, no doubt it is high time to further amplify the deliveries of palliative care services through telehealth. Some healthcare workers are of thinking that empathic communication cannot be achieved through the telehealth approach because of its limitation in enabling one to express the correct body language, facial expression and tone of voice when speaking. These nonverbal communication skills are essential in breaking bad news and updating patients' progress.

Though rigorous studies in the use of videoconferencing for clinical purposes are limited to draw a generalised conclusion about its effectiveness, a review on psychotherapy using videoconferencing carried out by Simpson (2009) found that its use is generally acceptable by both patients and clinicians. However, the findings of studies on patients' and clinicians' satisfaction with the use of videoconference lack clarity due to multiple aspects of the technology that contributes to users' satisfaction (Orlando, Beard, and Kumar, 2019). Some patients preferred videoconferencing to face-to-face treatment due to the sense of being in control of their session. This may be partly because videoconferencing was carried out in their own space and comfort (Allen, Roman, and Cardwell 1996). On the other hand, those who were unfamiliar with technology were subject to anxiety and confusion (Omodei and McClennan, 1998).

The novel use of technology is necessary to facilitate communication with the patients and their families and for consultation and assessment. However, we realised that many health care providers and patients have little experience in using technology, particularly videoconferencing. Such inexperience has raised some concerns on the

effectiveness of communication, especially when dealing with complex psychosocial and clinical issues. It is essential to acknowledge these concerns and to continuously upskill healthcare workers while educating the patients and their family members on its usage (McConnochie, 2019).

Other barriers for effective telehealth and technology usage involve security measures to protect patient's confidential data and internet access connections, especially when almost all sectors of life, such as education and businesses, will continue to rely on the same technology even more now (Okereafor and Manny, 2020). Nonetheless, some locations in the rural areas have no adequate access to the resources that enable telehealth technology to be carried out. All stakeholders must tackle these challenges hand-in-hand, including the government and the telecommunication service providers.

Communication with a non-palliative care specialist

Due to the measures taken to limit movements between healthcare professionals and patients in the hospital setting (described above), some of the palliative inpatients' care is managed by a non-palliative care speciality team. The *'Muleh Care Bundle'* was introduced to guide non-palliative care specialists in providing palliative patients with appropriate care. However, the palliative care team found that some non-palliative care specialists are not comfortable with specific palliative care interventions, for example, the prescribing of opioids. Dzierzanowski and Kozlowski (2021) found that insufficient experience and vexatious opioid prescribing regulations are some of the reasons why non-palliative care physicians discourage prescribing opioids. Similarly, (Gardiner et al., 2012) found that many generalists expressed serious concerns about giving high doses of, and having insufficient training in opioids.

It is fundamental to build palliative care capacity among non-palliative healthcare specialists to provide more responsive and sustainable palliative care in the long run. However, embedding palliative care principles early in the patients' disease trajectories is often challenging. Evidence on the experiences of those providing non-specialist palliative care in hospitals is limited. The organisation of acute care, clinicians' attitudes, poor communication structures, and the lack of education and training in palliative care principles exacerbates the poor implementation of this care earlier for patients in hospitals and has been cited as among the challenges faced by the palliative care team in Brunei (Nevin, Hynes and Smith, 2020).

The COVID-19 pandemic has called attention to the need of providing continuous professional training on the discipline of palliative care and has also shed some light on the importance of working in collaboration between the generalists and palliative care specialists. The palliative care team currently encourages non-palliative physicians to communicate with the palliative team members to ensure clarity without compromising patients' care. Nonetheless, it is high time that educational opportunities for generalists be enhanced and for effective interprofessional working models to be developed so that palliative care delivery can be optimised.

Well-being of human resources

Finally, as COVID-19 continues to evolve, it poses a heightened risk to personal safety and increasing workloads to healthcare workers. Deployed staff working outside their 'comfort zone' were observed to experience isolation, anxiety and stress. A review carried out by Braquehais et al. (2020) on the impact of the COVID-19 pandemic on the mental health of healthcare professionals showed a high prevalence of anxiety and depressive symptoms, most of which were associated with epidemiological issues, human and material resources, and also personal factors. The deployment of hospital staff members to the isolation centres also resulted in an increased workload for those who remain in the hospital setting, leading to burnout and physical exhaustion, two factors which been known to reduce the quality of care. A high prevalence of burnout was recorded among physicians with high emotional exhaustion, depersonalisation and low personal accomplishment reported as burnout symptoms in a study carried out by Elghazally et al., 2021. A self-reported study on nurses carried out by Kakemam et al. (2021) found that the nurses admitted to providing poor care quality in an Accident and Emergency department during the COVID-19 pandemic as a result of feeling burnout.

The urgent need to contain and manage the pandemic also means healthcare professionals' annual leave is subject to restriction and cancellations. Stress, anxiety and depression-related disorders may be considered normal emotional reactions to a pandemic; however, it is necessary to understand burnout syndrome as a potential problem among healthcare professionals (Dimitriu et al., 2020). Ensuring proper mental health care of the healthcare workers is important as their mental well-being have direct bearing towards the care provided to the patients. To alleviate distress and fatigue, it is necessary to offer opportunities for reflection, advice and reprieve through increased access to in-house counsellors as well as scheduling regular team meetings.

Discussions

Palliative care is a specialty that looks into the needs of terminally ill patients and their families, which also utilises a holistic approach. It requires an in-depth assessment of the patients' and their families' health needs from various life dimensions to maintain the patients' quality of life. Effective communication is at the heart of the palliative care discipline (Liao and Arnold 2007).

Communication with patients and families ensures understanding of the care plan when the patients are at home and ensures their needs are dealt with as their illness continues to progress. Each level of progression of incurable illness brings the patients closer to the inevitable death. The role of the palliative care team in this instance is to support the concerned patients and their families throughout the dying and death process. Often patients and families are confronted with bad and challenging news regarding the progress of the illness. This is referred to as 'breaking bad news' in the healthcare realm. From the palliative care perspective, breaking bad news is not a one-

off procedure. It is a continuous process of reinforcing and reexplaining the patient's condition and situation until they reach a level of acceptance and throughout the process of grief of loss (Miller, Porter, and Barbagallo, 2021). Effective communication serves the purpose of informing and educating the patients and their families about their illness and condition but is also an approach to support the patients in articulating the changes they are facing. Effective communication also plays a vital role in supporting the family carers by confronting the complexity of caring for their loved ones and helping them understand the emotions that come with living with and losing their loved ones at the same time.

The essence of communication in palliative care is to communicate with individuals with empathy, which involves deep human engagement over time (Sinclair et al., 2017). Empathy in palliative care is a response given to patients by acknowledging their experience of suffering and trying to understand them from their point of view or by "feeling with" the patient (Hein and Singer 2008: p. XX). Palliative care professionals praise themselves with this skill because the only way to understand patients' care needs and concerns is with a trusting therapeutic relationship. A therapeutic relationship allows the patients, their families and the healthcare professionals to discuss an individual care plan when all the three parties meet. Reaching this point requires a long-term development of trust between them, and the single most effective way is through therapeutic communication and empathy.

Conclusion

The widespread COVID-19 pandemic has posed new challenges in all areas of healthcare. In palliative care, communication issues and palliative care management by non-palliative care specialists, for example, their hesitancy in the use of opioids for pain management, appear to be among the substantial challenges that need to be overcome by the team. However, the team also learnt that the current crisis also opens doors to several professional development opportunities and innovative approaches to treatment and care. The palliative care team is currently adapting to the utilisation of technology in optimising care. The team was also given the opportunity to raise awareness through encouragements of the non-palliative care specialists to adapt some of the principles of palliative in their day-to-day care and treatment. Evaluative studies need to be carried out on the viewpoints and level of satisfaction of the patients, their families and the non-palliative care specialists with the changes made on the palliative care service during the pandemic. The findings could then be adapted to develop a systematic guideline on the continuous provision of palliative care during crisis.

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