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COVID-19 and ‘conversations not had’ with people with frailty in acute settings

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COVID-19 has had a devastating impact on communities globally. In the United Kingdom and elsewhere, the pandemic has led to sharp increases in hospital admissions and deaths, with a disproportionate effect on older people with frailty. This surge of individuals experiencing rapid health decline and being ‘sick enough to die’ has put a spotlight on the need to ensure professionals in acute hospitals are supported to talk openly about end of life care with people with frailty, and their families.

Preparedness to engage in sensitive conversations about nearness to end of life with people with frailty and their families is essential during an acute admission to hospital. Older people living with frailty are, by definition, at greater risk of morbidity and mortality from infection with COVID-19. Timely and compassionate communication between professionals, people with frailty, and their families about goals and preferences for care, including end of life care, is an essential part of a person-centred approach.¹ When part of a process of advance care planning, these conversations can increase the likelihood of people receiving care that is in line with their preferences, and improve bereaved relatives’ satisfaction with end of life care.²

Challenges faced by professionals in talking about serious illness and increasing risk of end of life with patients and families are well-documented. Difficulties around prognostication and identifying the ‘best time’ to discuss end of life care, fear of causing distress, and feelings of being inadequately skilled for these conversations, are commonly reported.³ Perhaps as a result, a recent audit in the United Kingdom found that during unscheduled hospital admissions, fewer than 10% of people aged 80 and over had an advance care plan that was available to the admitting medical team. Even when people had a previous hospital admission within the last 30 days, availability of advance care plans was still only 15%.⁴ This suggests that some of those most at risk of morbidity and mortality for COVID-19 will likely enter the acute care setting with little documented evidence of their goals and preferences for life-sustaining treatments and end of life care, and those later discharged may rarely have these conversations recorded on route.

In this issue, Redwood et al.⁵ present the experiences of doctors and nurses who are responsible for discharging older people living with frailty from hospital. They note how important conversations about end of life care, treatment limits, and cardiopulmonary resuscitation were avoided by staff throughout the person’s journey through the hospital, with examples of harmful consequences including prolonged hospitalisation and inappropriate investigations and treatment. Two key contributors to these ‘conversations not had’ were cited: lack of adequate ‘collateral information’ to aid prognostication and planning (e.g. level of function before the admission, social circumstances), and a perception that the acute setting was not appropriate for conversations about the end of life.

In the context of COVID-19, we can expect that these existing issues will be exacerbated. However, the actions needed to address them have not changed; it is just clearer how sorely they are needed. With the COVID-19 pandemic we have witnessed stark increases in hospital admissions, excess deaths and significant workforce reorganisation. This means that many health care professionals are working under increased strain and potentially outside of their usual roles. Uncertainty around the impact of a new virus and risk of rapid deterioration means that there is often only a brief window in which discussions

about 'being sick enough to die' and preferences for care can occur with the person (when able) and their family. When communication does occur, the impact of personal protective equipment or having to rely on virtual methods may further impede conversations by limiting non-verbal communication and family presence to support decision making. In some cases, these conversations may also occur on a background of wariness of staff's ability to uphold the person's best interests due to discussions in the media around care rationing, and fears of treatments being inappropriately withheld.⁶

Going forward, a stronger commitment to evidence-based initiatives to support professionals in acute settings to start, and continue, conversations about end of life preferences and care should be a priority. Approaches of parallel planning are essential: where we can hope for the best supporting recovery, while preparing for the worst of deterioration and end of life.⁷ It is important to reassure professionals that what is often most valued by people in hospital and their families is feeling listened to, and being treated with compassion.³ Evidence-based communication skills training programmes can then play an important part in enhancing professionals' confidence and skills further.⁸ Models that integrate such training alongside daily clinical practice may be particularly promising.⁹ Importantly, these should be supplemented with opportunities for emotional support and reflection to acknowledge and ameliorate the impact of the emotional labour these conversations can involve.¹⁰

However, strategies that rely on individual support alone will not address cultural and system barriers. Evidence highlights the importance of developing policy and guidelines to support these conversations as part of usual practice, and strong engaged leadership to help implement this at an organisational level.¹¹ Within hospitals, Redwood et al.'s study suggests a role for promoting a culture of joint responsibility to obtain and record non-medical history, and to see hospitalisation as a trigger for (rather than place to avoid) conversations about the future with older people with frailty. Across systems, the need for cross-sectoral capability to store and retrieve documentation about preferences and priorities at the end of life is an important next step,¹¹ so that conversations started and continued in acute settings can be shared as appropriate.

Among all the devastating impacts of COVID-19, it has also been suggested that the pandemic may result in more openness to discuss goals and preferences for end of life care.⁶ We must do better to support professionals with the practical and emotional labour of these conversations in the acute settings, and address the organisational cultures and system barriers that continue to limit their impact.

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