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Research Question

Is there an emerging international best practice for the approach to palliative care in long term residential care (LTRC) settings in the context of COVID-19?

In particular, what are the emerging issues and actions and are there commonalities of approach? Furthermore, what are the considerations for:

- palliative care in the context of a resident of a LTRC setting that develops COVID-19; and
- palliative care in the context of a resident of a LTRC setting that has palliative care needs unrelated to COVID 19, but who now requires critical care (hospitalisation)?

Summary findings

The present review was guided by six themes which emerged during the course of our investigations into the research question: is there an emerging international best practice for the approach to palliative care in long term residential care (LTRC) settings in the context of COVID-19?

1. Communication
2. Visitation
3. Stuff (equipment and supplies)
Four of the preceding themes were taken from the Journal of Pain and Symptom Management medical journal article entitled *Palliating a Pandemic*, published in 2010 to discuss the lessons learned by clinicians and regulators during and following the SARS epidemic in 2003. The additional thematic elements emerged as common themes during the course of the review of guidance and literature.

The following jurisdictions were considered as part of the review:

- Australia
- Canada
- England
- Ireland
- Italy
- New Zealand
- North America
- Northern Ireland
- Scotland
- Switzerland

An interesting and wide variety of guidance was published by the ten chosen comparable jurisdictions in the early part of March (see Palliative Care Comparable Jurisdictions Matrix, attached hereto as Appendix 3). In the latter part of March and early April, any newly published guidance tended to become uniform, reflecting the guidance that has been proven most effective. This may be due to the palliative care research community performing reviews similar to the one being undertaken here, whereby pertinent information from comparable jurisdictions was incorporated into further guidance.

International best practice appears to have developed very quickly, due to the requirement for each comparable jurisdiction to coordinate their response to the provision of palliative care to LTRC facilities during the COVID-19 outbreak as efficiently and effectively as possible.

An issue faced by the researchers during this review was the initial lack of guidance specifically relating to the research question posed. Ample guidance was sourced relating to either palliative care in the context of COVID-19, or relating to long-term care facilities in the context of COVID-19, but little official guidance was published relating to both topics.

Across the jurisdictions and themes, there were a number of issues, considerations and practices which stood out. One of the key learnings from this review was the need for healthcare systems and providers to be flexible and adaptive. The two themes which stood out most prominently, where international best practice appeared to be the most uniform and coherent, were those of visitation and staffing. Although discussed more fully in the Themed Findings section to follow, please see below a brief summary of the findings from each theme:
• **Communication:** One of the key findings under this theme was the importance of advance care planning for palliative and end-of-life care patients, whether they had contracted COVID-19 or were simply resident in a LTRC setting during the pandemic. Additionally, all of the comparable jurisdictions had produced guidance in relation to the implementation of telecommunication as a way to replace regular in-person conversation.

• **Visitation:** Visits to LTRC facilities have for the most part been reduced to the minimum amount possible. In many cases, this means that family or next-of-kin visits may only be permitted at the end of a resident’s life, and at that, the visitor may be required to go alone, wearing personal protective equipment (PPE), or staying at a distance of 2 metres from the resident.

• **Stuff:** Services have typically been recommended to maintain a stock of PPE, medications required for adequate and sufficient palliative care, and any equipment required for the administration of those medications.

• **Staffing:** The two most significant findings under the Staffing theme was the importance of staff education and training during the course of the COVID-19 emergency, to include providing the best possible palliative and end-of-life care, as well as symptom management, in order to meet the predicted increase in demand. Staff cohorting also emerged across the documents reviewed, whereby staff would be segregated into teams so as to avoid cross-infection if one of the members of one of the teams contracted COVID-19.

• **Space:** As the COVID-19 epidemic intensifies, the efficient use of space will become increasingly important, and the maximisation of LTRC units so as to facilitate the care of the greatest possible number of patients in need. The jurisdictions also indicated the potential of not transferring end-of-life patients to hospital, as would commonly be the case, so as to minimise the spread of the virus.

• **Systems:** Triaging, symptom management and acute palliation were the most common elements to emerge under the Systems theme, along with the examination of services’ existing environments, processes and practices to consider how they might amend and improve the delivery of palliative care in the context of COVID-19.
Themed findings

Theme 1 - Communication in long-term residential care facilities (COVID-19) - Considerations for end of life care

Of the guidance and articles reviewed, the following jurisdictions issued guidance in respect of communication in long-term residential care (LTRC) facilities:

- Scotland
- England
- New Zealand
- Australia
- North America
- Northern Ireland
- Italy
- Canada

The following issues emerged as common themes during the course of this review:

- The use of telecommunication, including telephone and video calls, as a proxy for in-person communication;
- Communication by healthcare staff of difficult decisions to be made, emanating primarily from resource-based triaging, and of choices to be made by the resident as a result;
- The importance of advanced care planning for end-of-life and palliative care patients in LTRC settings; and
- Additional considerations.

Telecommunication

All of the jurisdictions reviewed included a provision in their guidance for the implementation of telecommunications, either by telephone call, text message (where appropriate and possible), or internet-based video call (suggestions included the use of Skype and FaceTime).

Advance care planning

The communication of a LTRC facility resident’s wishes, expectations and values through advance care planning has emerged as one of the most important elements of end-of-life care in the context of COVID-19. As outlined in the Journal of the American Medical Association (JAMA) article concerning advanced care planning, documenting a dying patient’s will and preference to avoid intensive treatments that they do not want is something clinicians should strive for, even where the time to do so may not be as ample as usual. In addition, avoiding non-beneficial care and treatment, with no goal or possibility of eventual recovery, becomes increasingly important during a public health emergency where resources are scarce.

Communication of difficult decisions and choices to be made

The challenge faced by clinicians addressing and communicating difficult decisions having to be made on foot of triaging was addressed; a number of the jurisdictions reviewed addressed communication of decisions in the context of shortages of resources.

The Italian organisation Societa Italiana di Cure Palliative (SICP) produced a toolkit for doctors, including examples of appropriate and inappropriate statements to make to both patients and their families and
next of kin. These statements were designed for use by medical practitioners heavily occupied with the COVID-19 emergency, aimed at families and patients who may be rapidly deteriorating, and who will not be provided with any further lifesaving treatment, but rather with accelerated palliative care.

Each of the jurisdictions that provided guidance on the communication of difficult decisions (namely, England and Italy) reinforced the importance of including residents’ family and next of kin in decision making where appropriate.

**Additional considerations**

Additional considerations emanating from this review included:

- Ensuring that open and honest conversations continue to occur between medical staff and LTRC facility residents about end of life care, whether this is required to happen behind PPE or, for family members not permitted to visit, using technology.
- Encouraging meaningful and frequent contact between the resident and family members and friends.
- Communicating important information about service provision in the LTRC facility to residents and their next of kin in accessible formats, such as fact sheets.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Organisation</th>
<th>Telecommunication</th>
<th>Communicating Difficult Decisions and Choices to be made</th>
<th>Advance Care Planning</th>
<th>Additional Considerations</th>
</tr>
</thead>
</table>
| Scotland     | NHS Scotland/Health Protection Scotland | Consider alternative measures of communication including telephone or video calls | • Difficulty of decision-making during time of crisis, management of patients not expected to survive, and of communicating with those patients and those close to them.  
• Timely and honest conversations about the person’s preferences and priorities, including advance decisions to refuse treatment, is part of advance care planning for anyone who has a progressive life-limiting illness. Families and those close to the person should be involved in these discussions as far as possible. | | Being kept honestly informed helps to reduce anxiety, even if the health care professionals do not have all the answers and even if the conversations need to be conducted behind PPE, or, in the case of families who are self-isolating, by telephone or by using other technology solutions. |
<p>| England      | Association for Palliative Medicine of Great Britain and Ireland/NHS | Decisions may have to be made when health professionals have not had the opportunity to get to know their patient as well as they would usually like, or may involve discussions with those close to the patient over the telephone or via internet-based communication facilities. |  |  |  |
| New Zealand  | Hospital Palliative Care New Zealand/Hospice New Zealand/ANZSPM | Explore how to support communication, i.e. through mobile devices, through video calling, or putting the phone on speaker so that the caller may speak to the patient, even if they are unable to respond. |  |  | Explore how the patient’s next of kin can best support them with timely communication. |
|             | Ministry of Health | Providers to monitor home and community support service users by phone/using digital platforms. |  |  |  |</p>
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<thead>
<tr>
<th>Jurisdiction</th>
<th>Organisation</th>
<th>Telecommunication</th>
<th>Communicating Difficult Decisions and Choices to be made</th>
<th>Advance Care Planning</th>
<th>Additional Considerations</th>
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</thead>
<tbody>
<tr>
<td>Australia</td>
<td>Palliative Care Australia</td>
<td>Optimising telehealth capacity will support the provision of palliative care across the whole community, including improved access to smart phones to community palliative care nurses and increased use of telehealth items by doctors and nurse practitioners seeing palliative care patients.</td>
<td>Developing clear goals of care and helping patients undertake advance care planning is an important role of specialist palliative care services.</td>
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<td></td>
<td>Department of Health</td>
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<td>Signage and other forms of communication (i.e. information and factsheets) must be used to convey key messages including what actions the facility is taking to protect them and explaining what they can do to protect themselves and residents.</td>
</tr>
<tr>
<td>North America</td>
<td>Journal of Pain and Symptom Management (JPSM)</td>
<td>Managing most outpatient palliative issues by phone or video chat and for enrolment in hospice earlier than would be the norm.</td>
<td></td>
<td>Advance care planning is important because: 1. Clinicians should always strive to avoid intensive life-sustaining treatments when unwanted by patients; 2. Avoiding non-beneficial or unwanted high-intensity care becomes especially important in times of stress on health care capacity;</td>
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<td>Jurisdiction</td>
<td>Organisation</td>
<td>Telecommunication</td>
<td>Communicating Difficult Decisions and Choices to be made</td>
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<tr>
<td>Northern Ireland</td>
<td>Department of Health</td>
<td>Homes should seek to facilitate and increase other forms of contact - telephone or video calls</td>
<td>and 3. provision of non-beneficial or unwanted high-intensity care may put other patients, family members and health care workers at higher risk of transmission of COVID.</td>
<td></td>
<td>Good communication with families and friends on restrictions; ensure ongoing communication about the quality of care and wellbeing of residents.</td>
</tr>
<tr>
<td>Italy</td>
<td>European Association of Palliative Care (EACP)</td>
<td>24-hour hotline which provided advice for all people reaching end of life and their families, hospitals and LTC providers.</td>
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<td></td>
<td>Societa Italiana di Cure Palliative (SICP)</td>
<td>A toolkit was developed by the SICP giving examples of appropriate and inappropriate statements to make to: (i) a conscious patient; and (ii) the family of a patient, whether conscious or unconscious. These statements are to be used by medical practitioners heavily occupied with the COVID-19 emergency, aimed at families and patients who are rapidly deteriorating, and who will not be provided with any further lifesaving treatment.</td>
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<td>Jurisdiction</td>
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<td>Telecommunication</td>
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<td>Advance Care Planning</td>
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<td></td>
<td>Constantini, Sleeman, Peruselli, Higginson</td>
<td>One hospice implemented daily telephone calls to relatives who were unable to visit, which might mitigate against the disruption in connectedness described following the 2003 SARS epidemic in Singapore.</td>
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<tr>
<td>Canada</td>
<td>Canadian Medical Association Journal (CMAJ)</td>
<td>Enable video calling to connect patients with family members who are separated because of visitor restrictions.</td>
<td></td>
<td></td>
<td>One of the key domains of palliative care is the communication of a patient's wishes, expectations and values via advance care planning and articulation of goals of care.</td>
</tr>
</tbody>
</table>
Theme 2 - Visitors to long-term residential care facilities (Covid-19) –
Considerations for end of life care

Of the guidance and articles reviewed, the following jurisdictions issued guidance in respect of visitors to long-term residential care facilities:

- Northern Ireland
- Scotland
- England
- Australia
- New Zealand
- Canada
- USA

The following issues were considered:

- General restrictions on visits in long-term care facilities
- Exceptions for end-of-life care
- Guidance for an non-COVID positive visitor for a non-COVID positive resident
- Guidance for an non-COVID positive visitor for a COVID positive resident
- Guidance for a visitor potentially infected with COVID
- Guidance for child visitors
- Additional considerations

General restrictions on visitors to long-term care facilities

Nearly all of the jurisdictions reviewed either recommended or ordered the restriction of visitors to essential visitors only, and that those essential visitors should practice good hand hygiene and personal distancing from the patient.

Jurisdictions such as Scotland recommended visits be limited to essential visitors only. However, in the case of a cluster or outbreak no visitors should be admitted. Those jurisdictions that have not recommended a blanket ban on visits have at the very least implemented significant restrictions.

Non-urgent professional visits, such as allied health professionals and hairdressers, should be postponed until such a time as the pandemic has concluded.

Exceptions for end-of-life care

Of the seven jurisdictions reviewed, four made specific reference to exceptions to visiting restrictions in relation to end-of-life care. The recommendations tended to be general, advising services to act compassionately and make special allowances for palliative care recipients at the end of their lives.

The Canadian province of Alberta stated that dying patients may be permitted visitors, so long as only one visitor at a time was present.

The United Kingdom’s guidance asserted that, if the patient was COVID-19 negative, end of life visitation, and care practice should continue as normal.

No jurisdictions reviewed explicitly banned visits in the event of a resident in receipt of end-of-life care, apart from the case where the visitor had a suspected/confirmed case of COVID-19.
Guidance for a non-COVID-19 positive visitor for a non-COVID-19 positive resident

For visitors and families of residents who do not have a suspected or confirmed case of COVID-19, the general restrictions to visiting tend to apply, i.e. limiting visits to the minimum necessary, and only when absolutely essential.

Guidance for a non-COVID-19 positive visitor for a confirmed or suspected COVID-19 resident

Where a resident has been diagnosed with COVID-19, the protection of the visitor is paramount, and as such visitation is not generally recommended. Several jurisdictions have implemented policies relating to the use of electronic communication, either by telephone or video call as an alternative.

If the resident is in receipt of end of life care, exceptions should be considered, however visits should be limited i.e. to one person at a time. Appropriate PPE will need to be available to visitors. Risks should be explained to visitors who are in high-risk cohorts i.e. >70 years of age or with underlying medical conditions. However, such persons should be allowed to visit in the case of a resident in receipt of end of life care.

Guidance for a visitor with a suspected or confirmed case of COVID-19

The relevant guidance generally asks that anyone who is unwell or who is suspected to have COVID-19 should not visit a resident of a LTCF, whether they themselves have the virus or not, as it is an untenable risk to staff and other residents.

The Canadian province of Alberta goes so far as to require each visitor to undergo a health screening before being permitted access to visit a resident, including a temperature check and a medical questionnaire.

Guidance for child visitors

None of the jurisdictions reviewed permit child visitors to LTCF, as they are generally less able to comply with hygiene measures.

However, both Australia and the United Kingdom assert that an informed decision may be made by the service if it is a visit at the end of a resident’s life, and that exemptions may be made on a case-by-case basis.

Additional considerations

Additional considerations emanating from this review:

- The use of good hand hygiene by all visitors; information and education may need to be provided.
- Visiting healthcare professionals and care workers should continue to have access to residents where they need to carry out necessary assessments or provide care.
- Where possible, visits should not be conducted in common areas, to mitigate risk of transmission to other residents.
- Visits providing care and companionship would be permitted under special circumstances, in particular where the patient is dying.
### Table 2: Visitation in LTRC settings: a summary of guidance and articles

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<tbody>
<tr>
<td>Scotland</td>
<td>Review their visiting policy, by asking no one to visit who is suspected to have COVID-19 or is generally unwell and emphasising good hand hygiene for visitors. The review should take into consideration advice for the whole population to practice social distancing and remain in their home.</td>
<td></td>
<td></td>
<td>Asking no one to visit who is suspected to have COVID-19 or is generally unwell.</td>
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<td></td>
<td>Promote hand hygiene by making sure that staff, contractors, service users and visitors have access to hand washing facilities and where available alcohol-based hand sanitiser in prominent places where it is safe to do so. If there is a cluster or outbreak, no visitors should be admitted to the facility</td>
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<tr>
<td>United Kingdom</td>
<td>Consideration regarding the number of visitors should be guided by the individual situation, the facility and appropriate risk assessments.</td>
<td>For COVID-19 negative patients, end of life visiting and care continues as normal practice, including performance of religious rituals in care after death</td>
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<td>Children under 12 should not visit without previous permission, but considered, informed decision-making should be the rule of thumb.</td>
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<tr>
<td>New Zealand</td>
<td>Non-urgent professional visits, those not related to statutory requirements, should cease. During visits, people should stay 2 metres apart.</td>
<td>Make special arrangement for end-of-life patients.</td>
<td>Issues are protection of an uninfected visitor, and protection of staff from a potentially infectious visitor.</td>
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<td></td>
<td>Health professionals and care workers continue to have access to residents where they need to carry out necessary assessments or care.</td>
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<tr>
<td>Australia</td>
<td>Suspend all group activities, particularly those that involve visitors. Postpone visits from non-essential external providers (hairdressers and allied health professionals). RCF should advise all regular visitors to be vigilant with hygiene measures including social distancing, and to monitor for symptoms of COVID-19, specifically fever and acute respiratory illness. Visits will be limited to a short duration.</td>
<td>Care providers understand the difficulty that these new arrangements will pose for families and should manage cases compassionately especially when it relates to end-of-life situations, palliative care and dementia units.</td>
<td>Inform regular visitors and families of residents of the outbreak, and request that they only undertake essential visits.</td>
<td>They should be instructed to stay away when unwell, for their own and residents’ protection, and to observe any self-quarantine requirements. Aged care facilities should advise all visitors and staff to monitor themselves for symptoms of respiratory illness and to stay away from the facility while they are unwell. Visitors and staff must not enter the facility if they have been diagnosed with COVID-19 until they have recovered.</td>
<td>Children should not be allowed in at all. Visits by children 16 years and under are not permitted except in special circumstances, as they are generally unable to comply with hygiene measures. Exemptions can be assessed on a case-by-case basis when the resident is in palliative care.</td>
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<td>Visits will be conducted in a resident’s room, outdoors, or in a specific area designated by the facility, rather than communal areas where the risk of transmission to residents is greater.</td>
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<tr>
<td>Northern Ireland</td>
<td>Visits will be limited to a maximum of two visitors at a time.</td>
<td>Exceptions to these essential visitor rules can be made by the designated visitor for the resident’s family, their religious leader(s), and their friends to visit a person who is dying, so long as only one visitor enters the facility at a time.</td>
<td>have ended their isolation.</td>
<td>No visits if visitor unwell; utilise good hand hygiene techniques; limit to one adult visitor per day. Each essential visitor must be verified and undergo a health screening prior to entering the facility. This includes a temperature check and a questionnaire</td>
<td></td>
<td></td>
<td>Non-urgent professional visits, those not related to statutory requirements, should cease. Visits from the designated essential visitor are limited to visits meeting either of the following two criteria: (1) visits which provide care and companionship for the well-being of the resident; or (2) visits in circumstances where the resident is dying.</td>
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<tr>
<td>Canada</td>
<td>Visitors to any continuing care facility in Alberta are limited to a single individual designated by the resident or guardian</td>
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Theme 3: ‘Stuff’ (equipment and supplies) in long-term residential care facilities (COVID-19) - Considerations for end of life care

The concept of the theme of ‘stuff’ (herein referring to supplies and equipment being used in long-term residential care facilities during the COVID-19 pandemic) was taken from the Journal of Pain and Symptom Management (JPSM) paper entitled Palliating a Pandemic, published in 2010 to document the most important learnings reached from the SARS pandemic. That paper in particular recommended that services: (i) stockpile medicines for common symptoms; (ii) stockpile equipment to deliver those medications; and (iii) prepare kits including medications and equipment to deliver medications for long-term care facilities and home care services. This theme was subsequently included in the Institute of Medicine’s 2012 Crisis Standards of Care: A Systems Framework for Catastrophic Disaster Response.

Of the guidance and articles reviewed, the following jurisdictions issued guidance in respect of visitors to long-term residential care facilities:

- Scotland
- England
- New Zealand
- Australia
- North America
- Italy
- Canada

The following issues emerged as common themes during the course of this review:

- Personal protective equipment (PPE);
- Medication; and
- Additional considerations.

**Personal protective equipment (PPE)**

A common recommendation evidenced in the guidance reviewed was the provision and use of personal protective equipment ("PPE") during the COVID-19 pandemic. Certain organisations, for instance the Australian Department of Health, provided more detailed details of the PPE to be provided: Personal protective equipment (gloves, gowns, masks, eyewear); hand hygiene products (alcohol-based hand rub, liquid soap, hand towel); diagnostic materials (swabs) cleaning supplies (detergent and disinfectant products).

Generally, the term PPE was used to encompass anything that may be used for the protection of clinical staff in particular, as well as for residents and their visitors. NHS Scotland and Health Protection Scotland recommended using dedicated care equipment in each individual room, in the case that single use PPE was not available due to scarcity of resources.

**Medication**

A common recommendation seen during the course of the review was the stockpiling of medications, and equipment to administer those medications, for all palliative care requirements.

Certain organisations made specific recommendations, such as Hospital Palliative Care New Zealand, Hospice New Zealand, Australia and New Zealand Society of Palliative Medicine (ANZSPM), who gave an explicit list of the equipment care homes should be in possession of.
In relation to scarcity of resources, in particular, time available to clinicians, Hospice New Zealand recommended the application of slightly higher than normal doses of appropriate medications for residents experiencing distress and breathlessness where they may not be available to provide timely titration.

Additional considerations

Additional considerations emanating from this review:

- Several jurisdictions recommended the preparation of palliative care drug kits by palliative care specialist services, where a long-term care facility does not have one in-house, including medications and equipment, for long-term care facilities to administer to any patients in need.
- It was further recommended that LTRC staff would be supported by the palliative care specialist service by telephone, who would assist them in the management of all eventualities.
- Supportive brochure resources for families whose relative is at the end of their life.
Table 3: ‘Stuff’ (equipment) in LTRC settings: a summary of guidance and articles

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Organisation</th>
<th>PPE</th>
<th>Medication</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>NHS Scotland/Health Protection Scotland</td>
<td>Use dedicated care equipment in each individual room, if single use PPE is not available.</td>
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<tr>
<td>England</td>
<td>Public Health England</td>
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<td>Plans to share resources locally.</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Hospice New Zealand</td>
<td></td>
<td>Where regular assessment of distress and breathlessness is curtailed because of staff shortage, it might be appropriate to use slightly higher than normal doses in the absence of the ability to titrate in a timely manner.</td>
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<td></td>
<td>Hospital Palliative Care New Zealand, Hospice New Zealand, ANZSPM</td>
<td>PPE worn for all patient interactions.</td>
<td>Blunt fill filter needles, syringes, Saf-t intima cannula, Niki T34 syringe drivers</td>
<td>Supportive brochure resource for family of those at the end of life.</td>
</tr>
<tr>
<td>Australia</td>
<td>Palliative Care Australia</td>
<td></td>
<td>Access to - and stock of - the appropriate prescription medicines, will allow palliative care services to continue to care for people outside hospital. We need to ensure palliative care patients are able to access health professionals who can prescribe necessary medications for symptom control and then have rapid access to these medications.</td>
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<td></td>
<td>Department of Health</td>
<td>Personal protective equipment (gloves, gowns, masks, eyewear); hand hygiene products (alcohol-based hand rub, liquid soap, hand towel); diagnostic materials (swabs) cleaning supplies (detergent and disinfectant products).</td>
<td></td>
<td>Facilities should ensure that they hold adequate stock levels of all consumable materials required during an outbreak.</td>
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<tr>
<td></td>
<td>University of Sydney</td>
<td>Personal and protective equipment being used.</td>
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<td>Jurisdiction</td>
<td>Organisation</td>
<td>PPE</td>
<td>Medication</td>
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<tr>
<td>North America</td>
<td>Hastings Center</td>
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<td>Triage decisions may need to be made concerning shortages of supplies.</td>
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<td></td>
<td>Journal of Pain and Symptom Management</td>
<td></td>
<td>Stockpile medicines for common symptoms.</td>
<td>Prepare kits including medications and equipment to deliver medications for long-term care facilities and home care services.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Stockpile equipment to deliver medications.</td>
<td></td>
</tr>
<tr>
<td>Italy</td>
<td>European Association of Palliative Care</td>
<td>Supply of PPE</td>
<td></td>
<td>Produce a palliative care drug kit to leave in the home. This will enable management of all eventualities and should be supported by telephone.</td>
</tr>
<tr>
<td>Canada</td>
<td>Canadian Medical Association Journal</td>
<td></td>
<td>Advise stockpiling medication and supplied used in palliative care.</td>
<td></td>
</tr>
</tbody>
</table>
Theme 4 - Staffing in long-term residential care facilities (COVID-19) - Considerations for end of life care

Of the guidance and articles reviewed, the following jurisdictions issued guidance in respect of visitors to long-term residential care facilities:

- Scotland
- England
- New Zealand
- Australia
- North America
- Canada
- Northern Ireland

The following issues emerged as common themes during the course of the review:

- Staff training and education
- Staff cohorting
- Additional considerations

Staff training and education

The training and education of staff in the context of the provision of palliative and end-of-life care emerged as the most common theme across the guidance reviewed.

All but three of the jurisdictions included an explicit provision in their guidance that each LTRC facility had a responsibility to ensure that its staff were adequately trained to manage the potential of ongoing transmission of COVID-19. This would include focused education for symptom management and end-of-life care, and in order to meet the predicted increase in demand for palliative care needs.

Staff cohorting

The concept of staff cohorting refers to care facility staff being separated into two or more teams, to help prevent the onward spread of infection if one of the members of a team fell sick. In this case, the uninfected team would be able to step up to take on the responsibilities of the other team, and to ensure that no further members of staff or residents became infected. This is particularly important in respect of staff with palliative care expertise. Where previously palliative care teams may visit and treat a resident as a team, consideration may need to be given to a single point of contact.

Staff cohorting also relates to the necessity for facilities to have a contingency plan, whereby designated staff members are allocated the role of planning, coordinating and managing logistics in the context of an outbreak in the facility.

Additional considerations

Additional considerations relating to staffing of long-term residential care facilities varied between jurisdictions, with useful information to be gleaned from each (see table below).

The US journal article published in 2010 in the aftermath of the SARS pandemic, Palliating a Pandemic, asserted that it would be beneficial for facilities to remove the need for members of staff to undertake case-by-case triaging of patients by instead developing standardised protocols for symptom management and end-of-life care. The Journal of Pain and Symptom Management added to this, saying that palliative
care teams, who by their very nature tend to be the bearers of bad news relating to the deteriorating state of a patient, should not participate in creating those guidelines or in making decisions about the value of life-sustaining therapies for individual patients.

The security and comfort of staff was also raised by Palliative Care Australia, who said that staff must be confident that everything possible is being done to ensure their safety in the workplace.
Table 4: Staffing in LTRC settings: a summary of guidance and articles

<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Organisation</th>
<th>Staff training and education</th>
<th>Staff cohorting</th>
<th>Additional considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>NHS Scotland/ Health Protection Scotland</td>
<td></td>
<td>Staff cohorting (working in dedicated teams) can help prevent onward spread of infection.</td>
<td></td>
</tr>
<tr>
<td>England</td>
<td>Public Health England</td>
<td></td>
<td>Workforce, including deployment of volunteers, should be shared between services where necessary.</td>
<td></td>
</tr>
<tr>
<td>New Zealand</td>
<td>Hospice New Zealand</td>
<td></td>
<td></td>
<td>Staff shortages will result in the need to palliate patients sooner than usual, where no further life-saving treatment can be provided due to time and resource constraints.</td>
</tr>
<tr>
<td>Australia</td>
<td>Department of Health</td>
<td>Each residential care facility is responsible for ensuring their staff are adequately trained and competent in all aspects of outbreak management prior to an outbreak. Education for staff, residents and their families is vital to inform their behavior and help manage the potential occurrence for ongoing transmission in an outbreak setting.</td>
<td>Facilities should have a staff contingency plan in the event of an outbreak where unwell staff members need to be excluded from work for a prolonged period until cleared to return to work. Facilities must identify a dedicated staff member to plan, co-ordinate and manage logistics in an outbreak setting as well as communicate and liaise with the state/territory health department.</td>
<td>For suspected or confirmed cases of COVID-19 it is preferable that only staff who have been designated to care for patients with COVID-19 provide care for these residents.</td>
</tr>
<tr>
<td>Australia</td>
<td>Palliative Care Australia</td>
<td></td>
<td></td>
<td>In order to continue the normal work of palliative care in the environment of the COVID-19 pandemic, those who are working in palliative care must also be confident that everything possible is being done to ensure their safety in the workplace, whether that be in a hospital, hospice, residential aged care facility or someone’s home.</td>
</tr>
<tr>
<td>Country</td>
<td>Journal/Source</td>
<td>Recommendations</td>
<td>Notes</td>
<td></td>
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<tr>
<td>--------------</td>
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<td></td>
</tr>
<tr>
<td>USA</td>
<td>Journal of Pain and Symptom Management</td>
<td>Palliative care teams to coach primary care teams through issues relating to seriously ill COVID-19 patients.</td>
<td>Palliative care teams, being by their nature the bearers of bad news, should not participate in creating guidelines to ration care or in clinical decision-making about the value of life-sustaining therapies for individual patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hastings Center</td>
<td></td>
<td>Triage decisions may need to be made concerning shortages of supplies.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Journal of Pain and Symptom Management</td>
<td>Provide focused education sessions to frontline staff for symptom management and end-of-life care</td>
<td>Identify all clinicians with palliative care expertise (physicians, nurse specialists)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Rather than case-by-case triaging, develop standardised order sheets and protocols for symptom management and end-of-life care.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Involve specialist allied health care workers to provide psychosocial support and grief and bereavement counselling (social care workers, spiritual care workers).</td>
<td></td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>Department of Health</td>
<td>All staff should receive fresh training on infection prevention and control, and on the use of PPE equipment.</td>
<td>Make best use of assets available to the community - include voluntary, community and social enterprise sectors. How to use existing contracts with these sectors to support work related to COVID-19</td>
<td></td>
</tr>
<tr>
<td>Canada</td>
<td>CMAJ</td>
<td>Train staff to meet palliative care needs.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Theme 5: Space in long-term residential care facilities (COVID-19) - Considerations for end of life care

The theme of ‘Space’ refers to considerations for the physical environment within the long-term residential care (LTRC) facility. This was the theme with the least amount of useful information obtained from the recently published literature concerning the provision of palliative and end-of-life care in LTRC facilities. There seemed to be minimal cohesion between jurisdictions, or indeed between organisations within those jurisdictions, in relation to the utilisation of space in long-term LTRCs during the COVID-19 pandemic.

Of the guidance and articles reviewed, the following jurisdictions issued guidance in respect of visitors to long-term residential care facilities:

- Ireland
- Australia
- North America
- Northern Ireland
- Canada

The Irish guidance published by the HSE on 21 March 2020, *Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facility (RCF) and Similar Units*, provided that if a resident’s clinical condition does not require hospitalisation, they should not be transferred from the RCF on infection control grounds. This was echoed in most of the other jurisdictions which provided guidance on space reviewed (see below Table).

The Hastings Centre (North America) made the salient point that triage decisions may need to be made concerning shortages of space, which would not necessarily be in the interest of end-of-life patients. Northern Ireland gave specific details in relation to the isolation of care home residents who become infected with COVID-19, in that there need not necessarily be dedicated isolation facilities, but that ideally each infected patient should be housed in a single bedroom with en-suite facilities in the interest of not spreading infection to the wider community.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Organisation</th>
<th>Space</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ireland</td>
<td>HSE</td>
<td>If a resident’s clinical condition does not require hospitalisation, they should not be transferred from the residential care facility on infection prevention and control grounds.</td>
</tr>
<tr>
<td>Australia</td>
<td>University of Sydney</td>
<td>Residents on lockdown, but not locked into rooms, sometimes forget that they should be in their rooms; finding 'the ongoing isolation extremely difficult'.</td>
</tr>
<tr>
<td>North America</td>
<td>Journal of Pain and Symptom Management</td>
<td>Discourage existing palliative care and hospice patients from coming to hospital. If epidemic intensifies, older patients with pre-existing serious illness will be first to be denied life-sustaining care in the event of scarcity. Hospitalisation would provide no benefits above and beyond care occurring at home.</td>
</tr>
<tr>
<td>Hastings Center</td>
<td></td>
<td>Triage decisions may need to be made concerning shortages of space.</td>
</tr>
</tbody>
</table>
| North America     | Journal of Pain and Symptom Management | • Identify wards and non-clinical areas in all health care facilities that would be appropriate to accommodate large numbers of patients expected to die.  
• Maximise the use of identified palliative care units, hospice, and ward beds. |
| Northern Ireland  | Department of Health                  | Not expected to have dedicated isolation facilities for people living in the home, but should implement isolation precautions when someone displays COVID-19 symptoms.  
Ideally room should be a single bedroom with en-suite facilities. |
| Canada            | CMAJ                                  | • Optimise space  
• People with frailty or comorbid illness should update their advance care plans and indicate if they wish to avoid hospital transfers or critical care in the event of serious illness. |
Theme 6: Systems in long-term residential care facilities (COVID-19) - Considerations for end of life care

Each of the chosen jurisdictions provided disparate advice in relation to the implementation and alteration of existing systems in long-term residential care facilities. These recommendations tended to be highly useful, but it is interesting to consider the lack of overlap between organisations.

Of the guidance and articles reviewed, the following jurisdictions issued guidance in respect of systems and processes to long-term residential care facilities:

- England
- Switzerland
- New Zealand
- Australia
- North America
- Northern Ireland
- Italy
- Canada

The following issues emerged as common themes during the course of the review:

- Triaging;
- Symptom management/acute palliation; and
- Additional considerations

Triaging

Of the jurisdictions reviewed, five included provisions relating to the necessity for triaging in long-term residential care facilities in the context of the COVID-19 pandemic. These recommendations ranged from triaging as it relates to identifying patients in need of specialist palliative care management, creating a triaging system for transfers to dedicated palliative care units, hospices etc., to the development of clinical and care pathways to ensure access for all needing palliative care.

Symptom management / acute palliation

In New Zealand and North America, systems have been recommended to be put in place in order to ensure and prioritise comfort-focused care during the present public health emergency. Life-saving treatment will not always be able to be provided to those who may, under normal circumstances, be ventilated with the goal of stabilisation and recovery, due to resource constraints.

Additional considerations

This final theme encompasses the disparate recommendations provided by certain of the comparable jurisdictions considered during the course of this review. These recommendations are provided more fully in the table below but include:

- Best practice on financial resilience;
- The coordination of rapid discharge to a dying patient’s home or to a hospice, rather than remaining in the long-term care facility without the possibility of being visited by family;
- Examining a service’s existing environment, processes and practices to consider how they may be amended to improve the delivery of care in the context of COVID-19;
- Creating guidelines for the management of typical symptoms for those who have become infected with the virus;
- Updating the care plans of all LTRC facility residents; and
- The refinement of care homes’ systems in a general sense.
<table>
<thead>
<tr>
<th>Jurisdiction</th>
<th>Organisation</th>
<th>Triaging</th>
<th>Symptom Management/Acute Palliation</th>
<th>Additional Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>England</td>
<td>Public Health England</td>
<td>Triaging of patients and ceilings of treatment may have to be considered in these circumstances. This is to ensure that those with significant potential to recover receive appropriate care, but also that those who are very unlikely to survive receive appropriate palliative or end-of-life care.</td>
<td></td>
<td>Best practice on financial resilience to be provided to LTCF</td>
</tr>
<tr>
<td>Switzerland</td>
<td>Swiss Medical Weekly</td>
<td>Triaging performed on admission to determine the extent and duration of treatment and the determination of a pathway (the final being palliative care); after 2-3 days, assessment is made as to whether to continue treatment, limit the treatment’s intensity or duration, modify goals, or initiate palliative care.</td>
<td></td>
<td>For care home residents identified as being in their last days or weeks of life, care teams can help coordinate rapid discharge to home or hospice. This supersedes the current fast track end of life process.</td>
</tr>
<tr>
<td>New Zealand</td>
<td>Hospice New Zealand</td>
<td>Management of acute respiratory failure can be challenging, especially in a pandemic situation. It may necessitate proportional use of medication at life’s end with a view to sedation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hospital Palliative Care New Zealand, Hospice New Zealand, ANZSPM</td>
<td>People who may under normal circumstances be ventilated with a goal of stabilisation and recovery, may instead need acute palliation.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>Palliative Care Australia</td>
<td></td>
<td></td>
<td>Undertaking immediate contributions in planning critical care for those with life-</td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Organisation</td>
<td>Triaging</td>
<td>Symptom Management/Acute Palliation</td>
<td>Additional Considerations</td>
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<td>------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td></td>
<td>Department of Health</td>
<td></td>
<td>limiting illnesses, and proactively considering future clinical issues or risks in those plans.</td>
<td>Examining the RCF’s service environment, equipment, workforce training, systems, processes or practices that affect any aspect of how they deliver personal and clinical care.</td>
</tr>
<tr>
<td></td>
<td>University of Sydney</td>
<td>Caring for residents who would usually be managed in the hospital setting (putting immense pressure on residential aged care providers, many of whom would not have the workforce, expertise, protective equipment or systems to manage an outbreak).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hastings Center</td>
<td>Processes and practices should be put in place for palliative care services in hospitals.</td>
<td>Services should put processes in place concerning access to palliative care for symptom relief and comfort-focused care during a public health emergency and potential limitations on life-sustaining treatment, including oversight of palliative care safety under these conditions.</td>
<td>Ethics services should collaborate with multi-disciplinary palliative care services concerning practice under contingency and crisis conditions, in view of their frequent collaboration under normal conditions and the likelihood that these services will be short-staffed.</td>
</tr>
<tr>
<td></td>
<td>Journal of Pain and Symptom Management</td>
<td>Create triage system to identify patients in need of specialist palliative care management.</td>
<td>Ensure that all patients currently admitted have updated advance care plans.</td>
<td></td>
</tr>
<tr>
<td>Jurisdiction</td>
<td>Organisation</td>
<td>Triaging</td>
<td>Symptom Management/Acute Palliation</td>
<td>Additional Considerations</td>
</tr>
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<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Northern Ireland</td>
<td>Department of Health</td>
<td>Create a triaging system for intrafacility, interfacility, and community transfers to dedicated palliative care units, hospices and wards.</td>
<td>Create a system for direct consultation support for staff.</td>
<td>Care Home Transformation to develop and improve practice, to support homes in how they manage COVID-19 outbreaks and minimise the likelihood of infection.</td>
</tr>
<tr>
<td>Italy</td>
<td>EACP</td>
<td>Developed clinical and care pathways and referral forms ensuring access to palliative care.</td>
<td></td>
<td>Due to the risk of harm to patients, home palliative care visits must be limited to those who actually need care.</td>
</tr>
<tr>
<td></td>
<td>Constantini, Sleeman, Peruselli, Higginson</td>
<td></td>
<td></td>
<td>Hospices responded to this challenge through rapid changes to service provision.</td>
</tr>
<tr>
<td>Canada</td>
<td>CMAJ</td>
<td></td>
<td></td>
<td>Refine systems.</td>
</tr>
</tbody>
</table>

29
Appendix 1: Resources and references

Note: List of references updated as at 1 May 2020.

Australia (22 April 2020), Coronavirus (COVID-19) - Restrictions on entry into and visitors to aged care facilities (CDNA) (Department of Health).

Australia (13 March 2020) CDNA National Guidelines for the Prevention, Control and Public Health Management of COVID-19 Outbreaks in Residential Care Facilities in Australia (Department of Health).

Australia (13 March 2020), Guidelines for outbreaks in residential care facilities (CDNA) (Department of Health).

Australia (18 March 2020), Information for health care and residential care workers (CDNA) (Department of Health).

Australia (19 March 2020), Information for workers in residential aged care facilities (CDNA) (Department of Health).


Australia (26 March 2020), Palliative Care Australia Statement (Palliative Care Australia).

Canada (17 March 2020), COVID-19 Guidance: Long-Term Care Homes (Ontario Ministry of Health).

Canada (28 April 2020), Guidance Visitation Restrictions (Alberta Ministry of Health).

Canada (14 April 2020), Pandemic palliative care: beyond ventilators and saving lives (Canadian Medical Association Journal). Online, available at: https://www.cmaj.ca/content/192/15/E400


England (22 March 2020), COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care: Role of the speciality and guidance to aid care (Association for Palliative Medicine of Great Britain and Ireland & NHS England).


Ireland (22 April 2020), Interim Public Health and Infection Prevention Control Guidelines on the Prevention and Management of COVID-19 Cases and Outbreaks in Residential Care Facilities and Similar Units (HSE).

Italy (22 March 2020), Palliative care in Bologna during the COVID-19 crisis (European Association of Palliative Care).

Italy (March 2020), *Response and role of palliative care during the COVID-19 pandemic: a national telephone survey of hospices in Italy* (Constantini, Sleeman, Peruselli & Higginson).

New Zealand (5 April 2020) *Update for Disability and Aged Care Providers on Alert Level 4* (Ministry of Health).

New Zealand (27 March 2020) *Palliative Care in a Pandemic* (Hospice New Zealand).

New Zealand (17 April 2020), *End of Life Nursing Considerations – COVID-19 Patients* (Hospital Palliative Care New Zealand, Hospice New Zealand & ANZSPM).

North America (16 March 2020), *Ethical Framework for Health Care Institutions & Guidelines for Institutional Ethics Services Responding to the Coronavirus Pandemic* (Hastings Center).


Switzerland (24 March 2020), *COVID-19 pandemic triage for intensive care treatment under resource scarcity* (Swiss Medical Weekly).
Appendix 2: Methodology

Introduction

The purpose of this review is to retrieve and document recently published evidence in relation to the provision of palliative care in long-term residential care settings in the context of the COVID-19 pandemic. The following themes (see Table 1) emerged during the course of the review as being common to the guidance produced by the comparable jurisdictions reviewed.

<table>
<thead>
<tr>
<th>EMERGING THEMES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communication</td>
</tr>
<tr>
<td>Visitation</td>
</tr>
<tr>
<td>Stuff</td>
</tr>
<tr>
<td>Staff</td>
</tr>
<tr>
<td>Space</td>
</tr>
<tr>
<td>Systems</td>
</tr>
</tbody>
</table>

Scope of this review

This systematic review will examine materials published by the health and social scientific communities relating to guidance produced by the following comparable jurisdictions: Scotland, Italy, United Kingdom, Australia, New Zealand.

The chosen six themes will be used to partition results, and to categorically inform the development of guidance.

Review objectives

Objectives of this review include:

1. To use online search databases to conduct a systematic review of the latest published health and social science material supporting the development of guidance, toolkits, and best practice in relation to the provision of palliative and end-of-life care in long-term residential care (LTRC) facilities.
2. To group retrieved results under the six themes pertaining to emerging best evidence, to help guide the subsequent development of national guidance.

Search Strategy Methodology

Building the research question

Systematic reviews collate evidence without bias and should be reproducible, thorough and transparent. Formulating the appropriate research question from the outset is an essential part of producing an effective systematic review. The following research questions was posed:

*Is there an emerging international best practice for the approach to palliative care in long term residential care (LTRC) settings in the context of COVID-19?*
This research question can be broken down into three key elements: the ‘T’ (topic) element, addressing the selected terms being used as part of the search, outlined below (see Table 2); the ‘S’ (setting) element, addressing the types of location considered, namely long-term care facilities, nursing homes, and disability care facilities; and the ‘LQ’ (limiting query) element, addressing ---. Findings from the review were thematically analysed using a deductive approach in the ‘O’ (outcome) element, which deals with the six Emerging Themes. These elements were combined to formulate search queries, and were used in conjunction with search filters, limiters and qualifiers to mine major online long-term care facility and palliative care resources. The resources searched for papers are listed in Appendix I: Resources and references above.

**Search strategy in practice**

The following were researched to inform the completion of the present systematic review: guidance or policies published by the department of health (or similar) of each of the chosen comparable jurisdictions; high quality meta-analyses; systematic reviews; case control or cohort studies; non-analytic studies; and expert opinions. All relevant publications of new and updated documents during the period January 2010 to April 2020 were considered.

The key elements of this phase of the review included:

- A comprehensive review of international literature published, research carried out, and guidance and policy developments during the period January 2010 to April 2020 inclusive; leading to
- The identification of national and international areas of best practice; and
- A comparative analysis of international guidance based on the chosen themes.

**Identification of Subject Terms to build Search Queries**

**Generation of keywords**

Keywords were generated by consulting available literature, policy and guidance documents, and internal consultation (see Table 3 for keywords). These keywords informed the subject headings used with the --- databases.

<table>
<thead>
<tr>
<th>SEARCH TERMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative</td>
</tr>
<tr>
<td>Community</td>
</tr>
<tr>
<td>Nursing</td>
</tr>
<tr>
<td>Disability</td>
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<tr>
<td>Residential</td>
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<tr>
<td>Long-term</td>
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<tr>
<td>Communication</td>
</tr>
<tr>
<td>Visit</td>
</tr>
</tbody>
</table>

**Restrictive search criteria**

In order to uncover the most applicable results using the identified subject terms and search queries, our search was restricted to documents in the date range of January 2010 to April 2020, in the
English language, and belonging to one of the following categories of documents: guidance or policies published by the department of health (or similar) of each of the chosen comparable jurisdictions; high quality meta-analyses; systematic reviews; case control or cohort studies; non-analytic studies; and expert opinions.