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Indications for the prevention of SARS-CoV-2 infections in hospices and home palliative care

Version of December 15, 2020

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This document proposes indications for the prevention and management of SARS-CoV-2 infections in hospices and home-based palliative care. These are part of the services provided by the National Health System and it is necessary to provide organizational measures capable of coping with the COVID-19 emergency. The document provides information on how to regulate the access of visitors to hospice facilities, on the management of patients, on management of health personnel, on communication between the patient and the family and on the overall organization and management of hospice facilities during a pandemic. Specific guidelines are provided for pediatric hospice facilities and for home-based palliative care.

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Introduction and rationale

Palliative care is the treatment and assistance given to patients (adults and children) suffering from complex chronic life-threatening disorders. The key elements of its action are the discussion on the expectations and values of the patients (and in the case of children also of those who exercise parental responsibility) through shared care planning, management of the psychophysical symptoms and support for the family (Italian Law no. 38, 15 March 2010). Palliative care may be necessary in the various developmental stages of the disease, from diagnosis to the final stage of life and can therefore be delivered in the different settings of the patient's care plan (outpatient, home, hospital or hospice). In general, hospice / paediatric hospice facilities receive both patients who require specialized palliative care which, being particularly complex, is not practicable at home, and terminally ill patients who autonomously choose the hospice as the place where they wish to spend the last moments of their life.

Palliative care delivered at home and in hospices is part of the local tier of the socio-health care structure and as such the hospices are healthcare facilities which must be provided with organizational measures capable of coping with the COVID-19 emergency[1]. Like all the facilities that provide health care on an ongoing basis and at various levels of intensity of care, structural reorganization is required as well as a rearrangement of the work of the healthcare staff. The approach to the patient must be characterized by very special attention to the measures for the prevention and control of the infection so as to protect individual and collective health while ensuring that the patients live in conditions of dignity and that their suffering is alleviated as much as possible. During this pandemic, the management of children receiving palliative care has special characteristics. Indeed, whatever the facility that hosts them, the essential factors are the presence of the parents and / or caregivers as well as a socio-healthcare setting that is appropriate for the children in terms of their age and condition, and therefore these factors are to be carefully considered when planning the prevention and safety measures for the children, the families and the workers.

[1] Costantini M, Sleeman KE, Peruselli C, Higginson IJ. Response and role of palliative care during the COVID-19 pandemic: A national telephone survey of hospices in Italy. *Palliat Med* 2020;34(7):889-895. doi: 10.1177/0269216320920780.

Palliative care in hospices and at home during the pandemic

In this emergency phase, hospices and paediatric hospices have not only the objective of ensuring the best possible care and quality of life for their patients and of supporting the "families", but they also need to protect the safety of all those who provide care to the patients (including the healthcare professionals), endeavouring to maintain an environment that is as hospitable and serene as possible which, regardless of age and clinical situation, ensures the clinical, psychological and relational well-being of the patients and of their families.

It is necessary to consider that the current pandemic is causing a decisive increase in the number of patients with complex needs who may need palliative care[2]. Among the effects that the current pandemic has produced in the Italian population, there has also been an increase in the pressure on palliative care facilities (which provide hospice care, home palliative care and in-hospital care) because the pandemic has caused a significant deterioration in the health conditions of seriously ill patients. During the first wave of the pandemic in many hospitals in northern Italy there was an increase in consultations on palliative care aimed at assessing the proportionality of the objectives of care, at controlling the symptoms of patients on life-support treatment and at managing the end-of-life period of COVID-19 patients[3].

Where counselling was not an appropriate response, and depending on local emergency situations, sections in hospitals were designated for the end-of-life period of COVID-19 patients managed by palliative care professionals. Similarly, some hospice facilities and several services providing palliative care at home also managed patients dying "because of" or "with" a SARS-CoV-2 infection / illness. Finally, with regard to the role of palliative care, it must be emphasized that in the course of the pandemic, the delivery of palliative care in hospices and at home continued without interruption for traditionally assisted patients, i.e., patients who are terminally ill for oncological or other diseases.[4] [5] [6].

In October 2020, the SICP (Società Italiana Cure Palliative/Italian Palliative Care Society) and the FCP (Federazione Cure Palliative/Palliative Care Federation) published a joint document which analyses the role of palliative care at the time of the SARS-CoV-2 pandemic as reported in the international and national scientific literature; the document also proposes a series of recommendations and guidelines aimed at integrating palliative care into a wider national plan on pandemics[7].

While falling within the scope of the local socio-health facilities, hospices have characteristics that are substantially different from the latter: Hospices admit patients who, by choice or out of necessity, opt for

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2 Nouvet E, Sivaram M, Bezanson K, Krishnaraj G, Hunt M, DeLaat S, Sanger S, Banfield L, Escobio F, Schwartz L. Palliative care in humanitarian crises: a review of the literature. *Journal of International Humanitarian Actio*n 2018;3:article 5. doi.org/10.1186/s41018-018-0033-8.

3 Riva L, Caraceni A, Vigorita F, Berti J, Martinelli MP, Crippa M, Pellegrini G, Scaccabarozzi G. COVID-19 emergency and palliative medicine: an intervention model'. *BMJ Support Palliat Care*. 2020 Nov 23:bmjspcare-2020-002561. doi: 10.1136/bmjspcare-2020-002561.

4 De Angelis M, *et al.* Le cure palliative nella pandemia da SARS-CoV-2: esperienze italiane e internazionali a confronto. *RICP* 2020;22:54-63

5 Bertè R, *et al.* Creare e gestire un reparto "end stage" per malati COVID-19 positivi. *RICP* 2020 22: 64-9.

6 Pizzuto M, *et al.* Hospice-COVID: cinque settimane di trasformazione per rispondere ad uno tsunami. *RICP* 2020; 22: 70-6

7 Gruppo di lavoro SICP-FCP. *Ruolo delle cure palliative durante una pandemia*. Ottobre 2020. https://www.sicp.it/wp-content/uploads/2020/10/FCP-SICP-Covid_def_con-immagine-1.pdf

protected hospitalization that generally lasts just under 20 days (11 days on average[8]). For these reasons, the rules on the prevention and control of the SARS-CoV-2 infection in hospices differ in part from those proposed for other socio-health facilities.

The literature and available data confirm that, compared to the adult population, the SARS-CoV-2 infection has a much smaller impact on the paediatric population both in terms of number of infected individuals and severity of symptoms and prognosis. However, as for the adult population, even in the paediatric setting, children with previous comorbidities are at higher risk of developing severe forms of the disease. Consequently, for these children and their families, the infection is an additional criticality both in terms of the direct impact on the patient and for the higher number of close contacts involved in providing care to the child and the family for the routine management of their needs.

For the reasons set out above, specific strategies need to be implemented in order to prevent and control the SARS-CoV-2 infection in the places where palliative care is provided, namely hospices and in the home. It should be emphasized that, even at home, it may be complicated to operate safely due to a number of factors such as, for example, the promiscuity of the living environment and some objective difficulties in ensuring that the procedures for the prevention and control of the infection normally adopted in a hospital can also be implemented in the home.

[8] Rapporto al Parlamento sullo stato di attuazione della Legge 30/2010; Disposizioni per garantire l'accesso alle cure palliative e alla terapia del dolore – anni 2015-2017

Prevention measures for hospices

Access to hospices by visitors

Access to hospices by visitors is regulated by the legislation in force based on the current epidemiological situation associated with COVID-19[9]. In residential facilities, visits may be authorized in end-of-life situations also for patients with COVID-19 (see paragraph "Management of COVID-19patients in hospices and of new patients") by the Medical Director of the facility, who decides after an appropriate risk-benefit assessment and after the adoption of the prevention measures described for residential structures[10]. Considering the characteristics of the patients admitted to hospices, visits must be allowed as much as possible. However, authorized persons need to be limited in number and are to comply with all the recommended precautions for preventing the transmission of the SARS-CoV-2 infection. In end-of-life situations, at the request of the patient or of family members, face-to-face spiritual assistance should be authorized where this is not feasible through virtual media, with all the recommended precautions for preventing the transmission of the SARS-CoV-2 infection.

The Medical Director of the hospice, in pursuance of the regulatory provisions, is required to facilitate and provide for the access of family members and visitors, taking into account the importance of relationships in such a delicate phase of life, and making sure that safety measures are adopted. In particular, it is recommended that the following indications be complied with:

- adopt a system for booking visits to avoid crowding both in the facility and in the waiting areas. At the time of booking, provide all the information for ensuring safety when accessing the facility;
- do not admit people in isolation or home quarantine or who have been in close contact with a confirmed or probable case of COVID-19 in the previous 14 days, unless the visitor has a negative antigen test or a negative molecular test carried out after the tenth day from the last close contact with a case;
- prevent access to people who have a cough, cold or sore throat or, in any case, symptoms attributable to COVID-19;
- prevent access to visitors with a body temperature of 37.5 ° C; Management will make arrangements to have visitors' body temperature measured at the entrance of the facility;
- admit a limited number of visitors per patient in order to avoid excessive crowding of the premises; in the case of situations where end of life is imminent, we invite you to develop rotation strategies among the visitors of the dying patient;
- visitors' access should be restricted to the hospital room only, prohibiting access to common areas; it would be advisable to identify an area in the facility, if possible, where direct interviews with visitors can be held;

[9] Circular of the Ministry of Health of 30/11/2020 Provisions for the access of visitors to healthcare and sociohealthcare facilities and hospices and guidance on new admissions in case infected patients are present in the facility

[10] Gruppo di lavoro ISS Prevenzione e controllo delle Infezioni – COVID-19. *Indicazioni ad interim per la prevenzione e il controllo dell'infezione da SARS-COV-2 in strutture residenziali sociosanitarie e socioassistenziali. Versione del 24 agosto 2020*. Roma: Istituto Superiore di Sanità; 2020 (Rapporto ISS COVID-19, n.4/ 2020 Rev 2.).

- visitors must necessarily be equipped with a surgical mask or other appropriate PPE in accordance with the risk assessment made by the facility (otherwise the facility will provide the protection equipment);
- before accessing the room of a patient, visitors must use hand gel; the facility is responsible for providing hydroalcoholic solution dispensers and for providing access to rest rooms dedicated only to visitors.

Access to paediatric hospices by visitors

In the case of paediatric hospices, given the characteristics of the patients and the complexity and peculiarity of their conditions, while adhering to the current legislation, the Medical Director must allow safe access not only to parents, but also to visitors who may be of critical importance for the quality of life of the patient (such as siblings, friends, teachers), and where necessary to caregivers who are temporarily replacing the parents.

Before being admitted to the hospice, a molecular swab should be taken of the patient and of his/her parents and caregiver, and on the day prior to admission, information should be gathered over the phone about the health status of the patient, family members and / or the caregiver.

During hospitalization, parents and caregivers must comply with all the rules regarding PPEs, social distancing, hand disinfection and the use of common areas.

During the time spent in a paediatric hospice, the children can go for small walks or errands with their parents or caregivers: in this case also, all individuals are expected to comply with the rules on wearing masks, social distancing and disinfection of their hands.

During hospitalization, the children can receive visitors who must book a time slot in order to avoid excessive crowding of the premises of the facilities: hospice staff need to be informed of the arrival of the visitors and they are to collect information about their state of health before allowing admittance. The hospice staff shall take visitors' temperature and make sure they are wearing PPE and have used hand gel.

Visitors can stay for limited amounts of time and cannot come into close contact with the patients, family members and/or caregivers. It is advisable for visitors to have a rapid antigen test performed every time they go to the paediatric hospice (unless they have had a test with negative outcome during the previous 72 hours).

The paediatric hospice staff are to explain how to properly use the PPE to patients, parents and visitors and provide them will illustrated leaflets designed to educate and remind them of the rules on how to behave safely when they are inside the paediatric hospice.

Rapid antigen tests for visitors of residential facilities authorized by the Medical Director of the facility

In order to re-establish and facilitate visitor access in all safety, as has already been done in some Regions, immediate screening strategies could be implemented by carrying out rapid antigen tests on visitors upon each access. Visitors with a negative rapid antigen test performed within the past 72 hours are allowed access. These tests can be carried out directly on site and, in the event of a negative result, visitors are authorized to access the facility and are to comply with the rules laid down by the facility's Medical Director. The facility must take all precautions to avoid the crowding of visitors on site while waiting to be

tested. This strategy is a precious tool that combines health protection with the need to be close to loved ones.

In the current epidemiological context, characterized by a high circulation of the virus, finding SARS-CoV-2 positive individuals capable of transmitting the infection is highly probable and, therefore, it is extremely useful to adopt validated screening methods as reported in the Circular of the Ministry of Health no. 35324 of 30 October "Laboratory Tests for SARS-CoV-2 and their Use in Public Health". The use of rapid antigen tests, repeated at short intervals, is now internationally recognized as a tool of proven usefulness, especially for screening purposes and for identifying early SARS-CoV-2 positive cases so as to implement strategies to contrast and contain the infection[11].

The use of this screening measure does not mean that visitors are relieved of the obligation to comply with the standard indications and precautions contained in the ISS COVID-19 Report no. 4/2020 Rev. 2. Authorized visitors are expected to adhere to such indications in order to prevent and reduce the risk of spreading the SARS-CoV-2 virus. In particular, it is necessary to ensure that visitors scrupulously comply with the indications on the behaviour to be adopted during the entire duration of the time spent on the premises (for further information, see ISS COVID-19 Report no. 2).

Molecular tests for the screening of new patients and for the staff of the facility

The rapid antigen test is currently recommended in contexts where the rapid identification and isolation of COVID-19 positive individuals is necessary to protect fragile patients at risk of complications and to protect large closed communities. The prompt identification of cases avoids the risk of spreading the virus. However, the rapid antigen tests currently available have low sensitivity (i.e. the ability to correctly detect all positive subjects) and the document of the Ministry of Health - Istituto Superiore di Sanità "Laboratory tests for SARS-CoV-2 and their use in public health" included in the Circular of the Ministry of Health no. 35324 of 30 October 2020, specifies that molecular tests have high sensitivity in identifying positive cases and hence are capable of protecting patients at risk of complications and large communities at risk of clusters. Molecular tests are therefore recommended for patients accessing the hospice (to be performed during the 2 hours prior to admission) and for the screening, at set intervals, of healthcare professionals / staff operating in high-risk contexts.

In agreement with the Department of Prevention, which has competence at the local level, it is suggested that hospice staff and healthcare workers who provide home care should have molecular swabs taken every two weeks.

Informal caregivers (family) and formal caregivers who are not members of the staff but provide care to patients in the hospice, are to undergo a rapid antigen test upon their entry like any resident and the test should be repeated at least every week thereafter.

Finally, it is recommended that all patients in the hospice be subjected to a rapid antigen test periodically, possibly at least once every fortnight.

[11] European Centre for Disease Prevention and Control. *Options for the use of rapid antigen tests for COVID-19 in the EU/EEA and the UK. 19 November 2020*. ECDC: Stockholm: European Centre for Disease Prevention and Control. Stockholm; 2020

Communication

When it is not possible or not allowed to give visitors access to the hospice (because, for example, they themselves are in quarantine or in isolation), it is nevertheless essential that the patient maintain contact with family and friends. It is therefore necessary to provide and encourage the use of smartphones, tablets or laptops, and an internet connection is to be made available to patients. Furthermore, it is essential to assist the patients who are unable to use the modern technological tools.

If it is impossible to establish direct communication between the patient and the family, it is the responsibility of the staff of the facility to contact the family members, both to update them on the clinical situation of their loved ones, and to provide psychological support.

For patients in hospices who are in isolation for a SARS-CoV-2 infection, it is absolutely necessary for there to be a "virtual" contact between them and their families as well as between the families and the care team. This approach should be multidisciplinary, involving the doctor, the psychologist and the other health professionals who provide care to the patient, in order to provide updates on the clinical evolution of the patient, but also and above all to welcome, contain and deal with manifestations of anger, anxiety and reactive depression caused by the state of isolation. Communication through a video call is preferable to a telephone call and should be accompanied and mediated before, during and after the contact, offering support, as far as possible, enabling active participation and providing access to religious or family rites. In these situations, often characterized by rapid clinical deterioration, video calls accompanied by this type of support should become an integral part of the daily care provided in hospices when patients are "isolated", since such calls are the patient's only opportunity for contact with family members and significant others.

In particular, communication between the healthcare personnel working in the hospices and the relatives of hospitalized patients has the purpose of:

- providing information about the patient's disease in a simple and understandable manner[12], ensuring a periodic update, possibly on a daily basis;
- obtaining information about the expectations of family members regarding the evolution of the disease and respect for the choices made by the patient and family members;
- demonstrating participation and empathy for the family members, allowing for the expression of emotions and, if necessary, offering specific psychological support, also with a view to preparing for bereavement;
- preventing misunderstandings and conflicts.

It would be desirable to:

- organize communications in such a manner as to ensure that the information is provided always by the same member of the staff to the family member of reference, possibly within the same time-slot, in order to build a relationship of trust, facilitate communication, help out with the technical aspects of video calls / phone calls, and avoid anxiety and misunderstandings;
- periodically review the availability and emotional conditions of the staff in charge of communicating with the families.

[12] *COMUNICoViD - Position Paper. Come comunicare con i familiari in condizioni di completo isolamento.* SIAARTI, Aniarti, SICP, SIMEU; 2020. https://www.sicp.it/wp-content/uploads/2020/04/ComuniCoViD_ita-18apr20.pdf

- use a short operational checklist to make the video call[12] [13] if the patient is conscious and cooperating. If the patient is not conscious it is advisable that the video call should be appropriately introduced and mediated by a healthcare professional of the hospice. Communication with family members must take place even without the consent of the unconscious patient.

This method of communication applies also in the case of children, when a family member or other significant contacts of the patient are unable to be physically present in the paediatric hospice for other reasons (such as SARS-CoV-2 infections).

Management of COVID-19 patients in hospices and new patients

Admission of new patients to a Hospice should be preceded by carrying out a molecular test within 72 hours prior to admission; given the high rate at which the virus spreads in peak periods of the SARS-CoV-2 pandemic, the Medical Director of the facility may decide to have the molecular test repeated upon admission of the patient. In cases of urgent hospitalization, a rapid antigen test can alternatively be performed, followed by a molecular test as soon as possible for confirmation.

In addition, the Medical Director may consider the possibility of allowing admittance of new patients with a positive test to the Hospice if there already are SARS-CoV-2 positive patients in the facility; likewise, the Medical Director may consider the hospitalization of patients who are SARS-CoV-2 positive who would not receive adequate treatment in other care settings (home palliative care or palliative counselling in a hospital or other healthcare facility). If healthcare bodies cannot reserve a hospice for the exclusive hospitalization of SARS-CoV-2 positive patients, the presence in the hospice of terminal patients infected with SARS-CoV-2 must be accompanied by measures ensuring maximum safety and capable of containing the spread of the virus both among the staff of the facility and among patients. Strict organizational procedures need to be adopted and in particular:

- in facilities where a clear structural division between the COVID-19 section ("dirty") and the no-COVID-19 section ("clean") is not possible, the two sections need to be kept distinctly apart with clear signage and symbols;
- define clean / dirty routes both for staff and for visitors who are given access;
- define sites for putting on and removing the disposable gowns dedicated to the sections having different levels of risk with separate routes and special filter areas that are separate from the dirty area;
- reschedule and reorganize daily activities to reduce risks of contagion by SARS-CoV-2;
- reorganize work schedules and activities to comply with the requirements for preventing contagion from SARS-CoV-2;
- train all staff on the proper handling of personal protective equipment and on the adoption of standard precautions and isolation procedures.

[13] Mistraletti G, Gristina G, Mascarin S, Iacobone E, Giubbilo I, Bonfanti S, Fiocca F, Fullin G, Fuselli E, Bocci MG, Mazzon D, Giusti GD, Galazzi A, Negro A, De Iaco F, Gandolfo E, Lamiani G, Del Negro S, Monti L, Salvago F, Di Leo S, Gribaudi MN, Piccinni M, Riccioni L, Giannini A, Livigni S, Maglione C, Vergano M, Marinangeli F, Lovato L, Mezzetti A, Drigo E, Vegni E, Calva S, Aprile A, Losi G, Fontanella L, Calegari G, Ansaloni C, Pugliese FR, Manca S, Orsi L, Moggia F, Scelsi S, Corcione A, Petrini F. How to communicate with families living in complete isolation. *BMJ Support Palliat Care.* 2020 Oct 15:bmjspcare-2020-002633. doi: 10.1136/bmjspcare-2020-002633.

Regardless of whether admission to the hospice of a SARS-CoV-2 infected patient was a choice or a fortuitous event, it is necessary for all hospices to establish procedures to manage suspected / probable / confirmed cases of SARS-CoV-2 infection in the facility. In these cases, it is recommended to:

- reduce the frequency of delivering care that requires close and prolonged contact with the patient, naturally without detriment to the quality of the care provided;
- simplify, where possible, treatment dosage regimens and consider continuous multi-drug infusions in order to reduce nurses' access to hospital rooms;
- where the facility has created a separate section for SARS-CoV-2 cases, organize separate care teams dedicated to each section so that they are autonomous. The aim of this is to avoid or reduce as much as possible the crossing over of workers from one section to the other; night shifts should be organized in this way as well; where this is not possible for lack of staff, set up a workflow of the various activities (visits, bed hygiene, administration of therapies) where the staff begin in the wards where there are SARS-CoV-2 negative patients and then moving on to the wards with SARS-CoV-2 positive patients; in any case, the protective devices used when going into the rooms of SARS-CoV-2 positive patients must not leave the COVID-19 area. They are to be removed in the appropriate filter areas for doffing the PPE that are to be equipped with containers for the disposal of the used PPE;
- make sure that patients do not leave their sections, avoid transfers and the inter-mingling of patients in the common areas of the hospice;
- ensure that the hospital rooms of COVID-19 patients are cleaned daily using an authorized disinfectant, or a sodium hypochlorite solution containing 0.1% active chlorine;
- ensure adequate and specific training for the staff in charge of cleaning the rooms, so that the cleaning operation proceeds from top to bottom, with the surfaces having low contact frequency being cleaned before the high contact surfaces (handles, remote controls, chairs and armrests, tables, light switches, handrails, water taps, elevator buttons / vending machines, etc.); have the non-COVID-19 sections cleaned before moving on to the COVID-19 sections, using separate cleaning equipment and materials for the areas frequented by the public and those reserved for the staff of the facility; in COVID-19 environments cleaners must wear PPE during cleaning activities;
- hospital rooms previously occupied by patients with SARS-CoV-2 infection are to be properly sanitized; in addition, the functional areas of the facility must be sanitized at regular intervals;
- take measures against airborne diseases in COVID-19 rooms where high flow oxygen is used;
- regulate the access of suppliers (for example: canteen, pharmacy, warehouse, maintenance workers).

If the hospice is not in a position to adopt structural and organizational measures designed to contain the risk of spreading the infection, the Medical Director should consider the possibility of transferring a COVID-19 patient to another facility where infected patients can be isolated (for example, a hospital or facility dedicated to COVID-19 residents) based on the indications described in the 'Facility Preparation and Management of Suspected or Probable / Confirmed Cases of COVID-19' of the Report 'Interim Guidance on the Prevention and Control of SARS-CoV-2 Infection in Residential, Socio-health, and Social Care Facilities'. In any case, since in general these are patients whose clinical conditions are seriously impaired, palliative counselling is to be available in the new healthcare setting.

In residential facilities, visits can be authorized in end-of-life situations for patients affected by COVID-19, by the Medical Director of the facility, subject to an appropriate risk-benefit assessment. Visits by family members to SARS-CoV-2 positive patients in the facility may be allowed, provided they comply with the

procedures designed to ensure their safety: only one family member at a time is allowed, the family member must wear full PPE (filtering face piece, FFP2 / 3, water-repellent gown, goggles with side protection / visor, footwear, gloves, cap), the time spent in the hospital room must be limited, family members must be accompanied by a member of staff). However, the presence of SARS-CoV-2 positive patients is not an absolute contraindication to visits to other patients in the facility. In such circumstances, visits to SARS-CoV-2 negative patients may be allowed in accordance with the evaluation and authorization of the Medical Director of the facility, based on the facility's ability to keep the sections with COVID-19 patients totally separate from the wards with non-COVID-19 patients. The indications presented in the paragraph "Access to hospices by visitors" are valid.

In paediatric hospices, if the pre-admittance COVID-19 swab of a child is positive or becomes positive during hospitalization, the Medical Director will have to decide whether the child can remain in the facility or be sent home and be entrusted to the regional paediatric palliative care network. In the event that this is not possible due to the severity of the child's clinical situation or because the home setting is not adequate, the Medical Director must consider the possibility of transferring the child to the closest hospital endowed with a paediatric ward dedicated to COVID-19 positive children, where care for the child and his/her family will be shared by the hospital team and the regional paediatric palliative care team.

In the event of a positive swab, parents, caregivers, family members and / or visitors will not be able to access the paediatric hospice, and other members of the family / network of friends identified by the parents, will have to ensure their presence with the minor during hospitalization.

Different prevention measures for home-based palliative care

Precautions in providing home care

Home Palliative Care Units provide multidisciplinary palliative care at home for oncological and non-oncological patients in an advanced stage of the disease, if the patient's conditions allow this and the presence of a caregiver is guaranteed.

In the case of children, specialized palliative care is provided in their homes by the Regional Network of Paediatric Palliative Care (PPC). The Network is coordinated by the Regional Reference Centre which runs a multi-specialist team that works in close interaction with all the local and hospital services in the area, responding continuously and competently to the health needs of children and families.

Due to the SARS-CoV-2 pandemic, the Home Care Units / Regional Paediatric Palliative Care Network should reorganize their care delivery activities in such a way as to reduce the risk of exposure for workers and patients.

Before taking on a new case of home care, it is advisable to check whether the patient and / or his/her household are subjected to quarantine / isolation measures. If so, before going to the patient's home, a careful telephone triage is required. The triage has the dual purpose of ascertaining the patient's needs and at the same time verifying whether any new symptoms potentially attributable to the SARS-CoV-2 infection have appeared in the patient or in any other member of the household; finally, it is advisable to ascertain whether the patient or any member of the family are subjected to quarantine / isolation measures or not.

When possible and if recommended, teleconsultation should be used for providing both clinical care/treatment and psychological support.

The palliative care worker accessing the patient's home must be equipped with PPE (FFP2 mask, water-repellent coat, gloves, goggles with side protection or visor. Footwear and caps are optional) and must adhere to the correct procedures for the prevention and control of the SARS-CoV-2 virus. In particular, it is recommended to:

- ensure that the rooms where palliative care is delivered are adequately aired before and after the visit;
- remain in the patient's home only for the time required to provide adequate care;
- encourage the patient and family members present during the visit to wear a mask (preferably no more than one family member should be present to avoid crowding);

Home care of patients with suspected or confirmed SARS-CoV-2 infection

The home management of suspected or confirmed COVID-19 patients, both adults and children, requires special organizational measures given the fact that, unlike the conditions of a hospital, in people's homes the elements for the transmission of a virus are not completely and directly governable by the health workers who access the home. It is not uncommon that, in addition to the patient, both the caregiver and other family members also test positive for SARS-CoV-2. And finally, the structure of the house may sometimes

complicate the procedures for putting on and taking off the Personal Protective Equipment. For these reasons it is recommended to:

- envisage, in case of suspected infection, the possibility of carrying out a diagnostic test for SARS-CoV-2 at home or address other competent bodies to have the test performed;
- where possible, to have two healthcare workers make the house calls so that they can help each other to avoid mistakes in putting on and taking off the Personal Protective Equipment (FFP2 / 3 filtering face piece, water-repellent gown, goggles with side protection or visor, single pair of gloves, boots and cap). As in the hospital, also at home, the PPE is to be disposed of at the end of the visit by placing it in bags and containers for special waste;
- set up a unit of totally healthcare workers dedicated to these patients so that the absence of any single worker can be covered by the other members of the team;
- set up, where possible, a totally dedicated team to provide care simultaneously to several SARS-CoV-2 patients (at least for weekly routine activities);
- simplify, where possible, the treatment dosage regimens and consider continuous multi-drug infusions;
- leave a kit containing drugs commonly used in palliative care and infusion devices for emergencies at the patient's home, instructing the caregiver, where possible, to use them independently if needed;
- envisage the possibility of reaching the patient's home already wearing the PPE or of dressing immediately before entering the house, taking care to disinfect all surfaces touched by the equipment;
- check that a hydroalcoholic solution dispenser is present at the patient's home and, if not available, provide one;
- undress upon leaving the home making sure there are specific containers for special waste (for transporting the containers by car, place them in a double bag to curb the risk of environmental contamination);
- thoroughly disinfect all the instruments used during the visit with a hydroalcoholic solution;
- immediately report suspected and ascertained cases and any other useful information for patient management to the entire team of the Home Care Palliative Care Unit / Regional Paediatric Palliative Care (CPP) Network;
- the health care personnel assigned to home care should NOT be considered as cases of "contact" if they scrupulously adhere to the individual protection measures.

Regarding the means of transport, adhere to the following recommendations:

- provide for the possibility of using company means of transport;
- sanitize the vehicle before boarding;
- in the event that it is essential to host another healthcare worker on board a vehicle, he/she must sit in the right back seat, wearing a surgical mask or a filtering face mask (FFP2 / 3);
- whenever possible, travel with the windows open;
- avoid as much as possible the use of car ventilation and air conditioning systems;
- keep a hydroalcoholic solution dispenser in the car;
- at the end of the work shift, sanitize the car with appropriate disinfectants using a reusable manual sprayer, or a disposable microfiber cloth soaked in an alcohol-based disinfectant; minimum contact

time: 30-90 seconds. Clean and disinfect the door handles as well as the immediate surrounding bodywork; open the doors of the car to make sure it is aired properly; clean and disinfect the car keys and controls (levers, buttons, seat belts, steering wheel, gearbox, parking brake, controls, indicators, buttons, keyboards, touch screens, interior handles, rear-view mirror, etc.) and, if the vehicle is equipped with a load compartment, clean and disinfect its door handles, then open the door and air the compartment.

Rapporti ISS COVID-19 (ISS COVID-19 Reports)

ISS COVID-19 Reports are mainly addressed to healthcare professionals to cope with different aspects of the COVID pandemic. They provide essential and urgent directions for emergency management and are subject to updates. All reports have an English abstract.

The complete list is available at **https://www.iss.it/rapporti-COVID-19**.

Some reports (highlighted below) are also translated in English and are available at **https://www.iss.it/rapporti-iss-COVID-19-in-english**

1. Gruppo di lavoro ISS Prevenzione e controllo delle Infezioni. *Indicazioni ad interim per l'effettuazione dell'isolamento e della assistenza sanitaria domiciliare nell'attuale contesto COVID-19.* Versione del 24 luglio 2020. Roma: Istituto Superiore di Sanità; 2020 (Rapporto ISS COVID-19, n. 1/2020 Rev.)
2. Gruppo di lavoro ISS Prevenzione e controllo delle Infezioni. *Indicazioni* ad interim *per un utilizzo razionale delle protezioni per infezione da SARS-CoV-2 nelle attività sanitarie e sociosanitarie (assistenza a soggetti affetti da COVID-19) nell'attuale scenario emergenziale SARS-CoV-2.* Versione del 10 maggio 2020. Roma: Istituto Superiore di Sanità; 2020 (Rapporto ISS COVID-19, n. 2/2020 Rev. 2)
3. Gruppo di lavoro ISS Ambiente e Gestione dei Rifiuti. *Indicazioni* ad interim *per la gestione dei rifiuti urbani in relazione alla trasmissione dell'infezione da virus SARS-CoV-2.* Versione del 31 maggio 2020. Roma: Istituto Superiore di Sanità; 2020 (Rapporto ISS COVID-19, n. 3/2020 Rev. 2)
4. Gruppo di lavoro ISS Prevenzione e controllo delle Infezioni. *Indicazioni ad interim per la prevenzione e il controllo dell'infezione da SARS-CoV-2 in strutture residenziali sociosanitarie.* Versione del 17 aprile 2020. Roma: Istituto Superiore di Sanità; 2020 (Rapporto ISS COVID-19, n. 4/2020 Rev.) Available also in English.
5. Gruppo di lavoro ISS Ambiente e Qualità dell'aria *indoor*. *Indicazioni ad per la prevenzione e gestione degli ambienti indoor in relazione alla trasmissione dell'infezione da virus SARS-CoV-2.* Versione del 25 maggio 2020. Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 5/2020 Rev. 2). Available also in English.
6. Gruppo di lavoro ISS Cause di morte COVID-19. *Procedura per l'esecuzione di riscontri diagnostici in pazienti deceduti con infezione da SARS-CoV-2.* Versione del 23 marzo 2020. Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 6/2020).
7. Gruppo di lavoro ISS Biocidi COVID-19 e Gruppo di lavoro ISS Ambiente e Rifiuti COVID-19. *Raccomandazioni per la disinfezione di ambienti esterni e superfici stradali per la prevenzione della trasmissione dell'infezione da SARS-CoV-2.* Versione del 29 marzo 2020. Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 7/2020).
8. Osservatorio Nazionale Autismo ISS. *Indicazioni ad interim per un appropriato sostegno delle persone nello spettro autistico nell'attuale scenario emergenziale SARS-CoV-2.* Versione del 30 aprile 2020. Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 8/2020 Rev.).
9. Gruppo di Lavoro ISS Ambiente – Rifiuti COVID-19. *Indicazioni ad interim sulla gestione dei fanghi di depurazione per la prevenzione della diffusione del virus SARS-CoV-2. Versione del 3 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 9/2020).
10. Gruppo di Lavoro ISS Ambiente-Rifiuti COVID-19. *Indicazioni ad interim su acqua e servizi igienici in relazione alla diffusione del virus SARS-CoV-2 Versione del 7 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 10/2020).
11. Gruppo di Lavoro ISS Diagnostica e sorveglianza microbiologica COVID-19: aspetti di analisi molecolare e sierologica *Raccomandazioni per il corretto prelievo, conservazione e analisi sul tampone oro/rino-faringeo per la diagnosi di COVID-19. Versione del 17 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 11/2020).

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13. Gruppo di lavoro ISS Ricerca traslazionale COVID-19. *Raccomandazioni per raccolta, trasporto e conservazione di campioni biologici COVID-19. Versione del 15 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 13/2020). Available also in English.

14. Gruppo di lavoro ISS Malattie Rare COVID-19. *Indicazioni ad interim per un appropriato sostegno delle persone con enzimopenia G6PD (favismo) nell'attuale scenario emergenziale SARS-CoV-2. Versione del 14 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 14/2020). Available also in English.

15. Gruppo di lavoro ISS Farmaci COVID-19. *Indicazioni relative ai rischi di acquisto online di farmaci per la prevenzione e terapia dell'infezione COVID-19 e alla diffusione sui social network di informazioni false sulle terapie. Versione del 16 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 15/2020). Available also in English.

16. Gruppo di lavoro ISS Sanità Pubblica Veterinaria e Sicurezza Alimentare COVID-19. *Animali da compagnia e SARS-CoV-2: cosa occorre sapere, come occorre comportarsi. Versione del 19 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 16/2020). Available also in English.

17. Gruppo di lavoro ISS Sanità Pubblica Veterinaria e Sicurezza Alimentare COVID-19. *Indicazioni ad interim sull'igiene degli alimenti durante l'epidemia da virus SARS-CoV-2. Versione del 19 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 17/2020). Available also in English.

18. Gruppo di lavoro ISS Ricerca traslazionale COVID-19. *Raccomandazioni per la raccolta e analisi dei dati disaggregati per sesso relativi a incidenza, manifestazioni, risposta alle terapie e outcome dei pazienti COVID-19. Versione del 26 aprile 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 18/2020). Available also in English.

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20. Gruppo di Lavoro ISS Prevenzione e Controllo delle Infezioni. *Indicazioni ad interim per la sanificazione degli ambienti interni nel contesto sanitario e assistenziale per prevenire la trasmissione di SARS-CoV 2. Versione del 14 maggio 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 20/2020 Rev.).

21. Ricci ML, Rota MC, Scaturro M, Veschetti E, Lucentini L, Bonadonna L, La Mura S. *Guida per la prevenzione della contaminazione da Legionella negli impianti idrici di strutture turistico recettive e altri edifici ad uso civile e industriale, non utilizzati durante la pandemia COVID-19. Versione del 3 maggio 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 21/2020).

22. Gruppo di lavoro ISS Salute mentale ed emergenza COVID-19 *Indicazioni ad interim per un appropriato supporto degli operatori sanitari e sociosanitari durante lo scenario emergenziale SARS-CoV-2. Versione del 28 maggio.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 22/2020 Rev.) Available also in English.

23. Gruppo di lavoro ISS Salute mentale ed emergenza COVID-19 *Indicazioni di un programma di intervento dei Dipartimenti di Salute Mentale per la gestione dell'impatto dell'epidemia COVID-19 sulla salute mentale. Versione del 6 maggio 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 23/2020).

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25. Gruppo di Lavoro ISS Biocidi COVID-19. *Raccomandazioni ad interim sulla sanificazione di strutture non sanitarie nell'attuale emergenza COVID-19: superfici, ambienti interni e abbigliamento. Versione del 15 maggio 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19 n. 25/2020)

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32. Gruppo di lavoro ISS Sanità Pubblica Veterinaria e Sicurezza Alimentare COVID-19. *Indicazioni ad interim sul contenimento del contagio da SARS-CoV-2 e sull'igiene degli alimenti nell'ambito della ristorazione e somministrazione di alimenti. Versione del 27 maggio 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 32/2020).

33. Gruppo di Lavoro ISS Ambiente-Rifiuti COVID-19. *Indicazioni sugli impianti di ventilazione/climatizzazione in strutture comunitarie non sanitarie e in ambienti domestici in relazione alla diffusione del virus SARS-CoV-2. Versione del 25 maggio 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 33/2020).

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37. Gruppo di Lavoro ISS Ambiente-Rifiuti COVID-19. *Indicazioni per le piscine, di cui all'Accordo 16/1/2003 tra il Ministro della salute, le Regioni e le Province Autonome di Trento e Bolzano, in relazione alla diffusione del virus SARS-CoV-2. Versione del 31 maggio 2020.* Roma: Istituto Superiore di Sanità; 2020. (Rapporto ISS COVID-19, n. 37/2020).

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