


BMJ Open Pandemic impact on patients with advanced non-COVID-19 illness and their family carers receiving specialised palliative home care: a qualitative study

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ABSTRACT

Objectives To investigate the experiential impact of the COVID-19 pandemic on patients with non-COVID, life-threatening disease and their family carers.

Design An interpretative qualitative design informed by phenomenological hermeneutics and based on data from in-depth interviews, performed between June and September 2020.

Setting Patients receiving specialised palliative home care and their family carers living in Sweden.

Participants 22 patients (male/female 11/11) and 17 carers (male/female 5/12) aged 50 years and older. All the patients received specialised palliative home care and most were diagnosed with cancer. Inclusion criteria: aged 18 years or older, diagnosed with an incurable life-threatening, non-COVID disease, sufficient strength to participate and capacity to provide informed consent. Participants were selected through a combination of convenient and consecutive sampling.

Results The significance of the pandemic for both patients and carers showed a continuum from being minimally affected in comparison to the severe underlying disease to living in isolation with constant fear of becoming infected and falling ill with COVID-19, which some likened to torture. The imposed restrictions on social contact due to the pandemic were particularly palpable for this group of people with a non-COVID-19, life-limiting condition, as it was said to steal valuable moments of time that had already been measured.

Most patients and carers found access to specialised palliative home care was maintained despite the pandemic. This care was of paramount importance for their sense of security and was often their sole visiting social contact.

Conclusions In the pandemic situation, highly accessible support from healthcare and social care at home is particularly important to create security for both patients and carers. Thus, to provide appropriate support, it is important for healthcare and social care personnel to be aware of the great diversity of reactions patients in palliative care and their carers may have to a pandemic threat.

INTRODUCTION

The COVID-19 pandemic has resulted in the development of national recommendations

STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ A strength of this study is the empirical anchorage through first-person narratives.
- ⇒ All interviews were performed by professionals trained in conversation methodology.
- ⇒ Demographic data were varied and showed a broad age range, although few men were represented among family carers.
- ⇒ Strategic sampling would have been stronger than the combined convenient and consecutive sampling applied.
- ⇒ The majority of patients were diagnosed with cancer and only a few participants had a migration background. Moreover, the study was performed in a country with tax-financed healthcare, comparably soft restrictions and no lockdown during the COVID-19 pandemic, which could limit transferability of the results.

for the care of infected patients, as well as for society as a whole. In this way, the pandemic is not only influencing those who are infected. In a review by Dubey *et al*, the psychosocial impact of COVID-19 is described as affecting the whole population, whether you are sick or healthy.¹ Numerous deaths caused by the pandemic have been reported daily, with excessive exposure in the media, resulting in death becoming unusually palpable in society. The resulting fear—that naturally arises when humans are faced with infectious disease—is present in the COVID-19 pandemic, and shows a positive correlation to anxiety and depression.² Patients admitted to palliative care with a non-COVID, life-threatening disease constitute a particularly vulnerable group, with a higher risk of adverse outcome from a COVID-19 infection.^{3,4} These patients are under life threat from both the underlying disease—most often cancer—and from impending pandemic infection. Moreover, the significant overlap of COVID-19 and

cancer-related symptoms can result in recurrent uncertainty whether the person is infected or not.^{5 6} We therefore found it important to explore the perspectives of these groups in the wake of the ongoing pandemic.

At the time of data collection (June to September 2020), the pandemic was classified under the Swedish *Communicable Diseases Act* but unlike many other countries worldwide restrictions in Sweden were soft, meaning no mandatory rules or lockdown, only recommendations (as compared with later during the pandemic). From an international perspective, this policy response to the COVID-19 pandemic in Sweden can be considered moderate according to a composite of response indicators (eg, workplace closure, travel bans), with restrictions proposed and recommended that build on the population's high confidence in the official authorities and personal responsibility.⁷ For healthcare personnel, protective equipment gradually became mandatory when working in close contact with patients. Regardless of the infection status of the patient or family, home visits were continued, although more often than before the pandemic these took the form of telephone or digital contact. No vaccines against COVID-19 were available at the time of data collection.

To our knowledge, the impact of the COVID-19 pandemic on patients with a non-COVID, end-stage disease receiving specialised palliative care at home has only been scarcely studied.^{6 8} We therefore conducted interviews with both patients and their family carers (in the following 'carers') in order to aid our understanding of how their needs can be met in clinical practice.

Aims and objectives

To investigate the experiential impact of the COVID-19 pandemic on patients and their carers receiving specialised palliative home care.

METHODS

Design

An interpretative qualitative design informed by phenomenological hermeneutics was chosen.^{9–11}

Setting and participants

Patients and their family carers were recruited for interview from a specialised palliative home care service (approximately 160 patients from a city with a diverse population) in western Sweden, which provided care at home until death. Visits by nurses and physicians were provided as often as needed, around the clock. Besides healthcare, patients often had help from social home care. This support allowed family carers (when present) to choose the extent to which they wanted to take part in the patient's daily care. The median period of time allocated to specialised palliative home care was 2 months.

Inclusion criteria were: aged 18 years or older, diagnosed with an incurable life-threatening disease, not previously or currently infected by the COVID-19 virus,

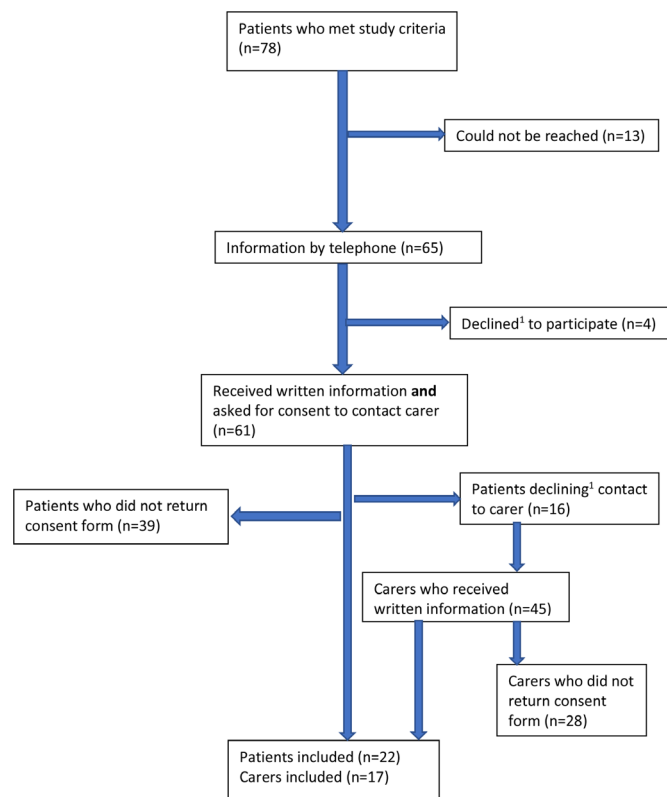


Figure 1 Inclusion of participants. First, physicians responsible for the patients were asked to evaluate them according to the study criteria. Eligible patients then orally received the first information about the study from a research nurse by telephone. Those expressing interest in participating were asked if they had a family carer who could be informed about the study. All written information, consent forms and prepaid envelopes were posted to the patients. Those who returned the consent form were contacted by telephone to agree on a time for a telephone interview. ¹Reasons for declining were not investigated.

sufficient strength to participate and capacity to provide informed consent. Participants were selected through a combination of convenient and consecutive sampling. Patients who were available at the service and scheduled for home visits were given written information about the study during the recruitment period. Details thereof are described in figure 1. Participants provided written consent by post to the researchers. For demographic and diagnostic data, see table 1.

Data collection

In-depth interviews with all the participants were conducted in Swedish over the telephone, and digitally recorded and transcribed verbatim. Due to the ongoing pandemic, the option of performing in-person interviews was omitted. The duration of the interviews was 9–33 min for patients and 7–54 min for carers. Transcripts were not returned to or commented on by the participants. Patients and their carers had the option of being interviewed separately or together, and three patient–carer pairs chose joint interview. All authors took part in the interviews, among them physicians, nurses and social workers. To ensure trustworthiness,

Table 1 Demographic and diagnostic data

	Patients (n=22)	Carers (n=17)
Gender		
Female	11	12
Male	11	5
Age (years)		
50–60	5	5
61–70	5	7
71–80	7	4
81–90	3	1
91	2	0
Employment status		
Employed	1	8
On sick leave	6	1
Retired	15	8
Living situation		
Living alone	10	2
Living together	10	15
No answer	2	0
Education		
Elementary school	4	1
High school	7	5
College/university	11	11
Country of birth		
Sweden	19	14
Other European	2	3
Outside of Europe	1	0
Patient's disease		
Cancer*	18	–
Heart failure	2	–
Lung fibrosis	1	–
No answer	1	–
Patient's disease duration (years)		
<1	2	–
1–2	3	–
2–5	6	–
5–10	7	–
>10	3	–
No answer	1	–
Relationship to patient		
Spouse/partner	–	12
Child	–	3
Sibling	–	2

*Colon, breast, prostate, ovarian, bile duct, lung and pancreas cancer and malignant melanoma.

all the researchers were professionals with long experience of conversations with patients in their daily work and were aware of differences in conversation strategy in interviews. None of the authors were involved in the care of any of the

participants they interviewed. Specific probing questions (see interview guide, online supplemental file 1) identified to clarify the narrative in relation to the research questions were:¹² Can you describe what it was like when the pandemic started? How is your daily life now? Has something become difficult for you now or is there anything you have been missing? Have you found something helpful? An additional question was used with carers: What are your thoughts about the (patient's) situation today?

Ethical considerations

Considering the potential vulnerability of the participants, no reminders were sent to potential participants who were provided with written information about the study. For the same reason, convenient and consecutive sampling was chosen, since a strategic sampling would have involved a selection process. All participants were invited to choose how to perform the interview.

Data analysis

Data were analysed in inter-related phases: first, naïve reading of the transcripts to acquire a general perception of the data and to generate analytical questions, then structural analyses based on the analytical questions, and finally an interpreted whole.^{10 11 13} For the naïve reading, all authors read transcripts from both patients and carers and met to discuss their reflections, both from the readings and from having performed the interviews. This resulted in the following analytical questions which guided the structural analyses: What are the meanings of the changed situation as a result of the pandemic? How has the changed situation been handled? What support has been received and/or wished for in the situation? For the structural analyses, all transcripts were scrutinised for text segments (meaning units) answering each of the questions, and subsequently, data related to each of these questions were analysed with a focus on experiential meanings. For the interpreted whole, the results of the naïve reading and meanings disclosed in the structural analyses were interwoven and discussed in the team to interpret the meaning of the studied phenomenon. All phases in the analysis were inter-related and repeated. The principle of data saturation is not applicable.^{10 11 13} All analyses were performed manually and supported by software for text only (Microsoft Office, Word).

Patient and public involvement

Patients' perspectives and topics of relevance were obtained through researchers' everyday clinical practice and previous research. There were no patient representatives involved in the research team.

RESULTS

Naïve reading

Both patients and carers described the impact of the COVID-19 pandemic in different ways related to the patient's underlying, non-COVID, life-threatening,

progressive disease and receiving palliative care. In this way, the participants' descriptions of the impact of the pandemic were explicitly or implicitly related to the advanced condition. This was especially emphasised by patients as a challenging living situation due to their life-limiting illness—a few labelled this 'a tough diagnosis', with all its implied restrictions in terms of limiting social activities, having to live day by day, and preparing for death and feeling increasingly vulnerable.

First structural analysis: meaning of the pandemic

The meaning of the impact of the pandemic was revealed as the themes 'worry' and 'fear'.

A worry and fear spectrum

The COVID-19 pandemic with its subsequent recommended and perceived restrictions was related to worry and fear among both patients and carers about how to adhere to restrictions and prevent getting infected. However, there was a wide spectrum of emotions among the participants, from almost no worry at all to a constant fear of getting infected, and/or infecting others, with profound consequences for everyday life. In addition to worry as related to risk of infection, some patients expressed fear there would be insufficient healthcare resources for themselves due to increased overall societal need, or they feared they would not get help from family, friends and other organisations outside healthcare due to their fear of infecting the patient or getting infected themselves. Moreover, what was perceived as an unnatural way of living during the pandemic caused some to worry about not dying normally.

Restrictions also made many social activities impossible, with some participants expressing fear of 'losing time' that was already limited, as emphasised by this patient: 'We're losing time we thought was our time—that we would do good things with—in this [situation]' (p 7).

The participants described distressing fear as a reason for isolating themselves in their homes, saying it was 'terrible' to have to cancel all non-essential services and support, including visits from carers. This was related to a considerable reduction in social contacts and in support, which over time also made patients feel depressed and lonely. Some individual participants described it as 'torture-like'. What remained was the perceived necessary support from healthcare personnel that consequently also gained importance as the sole source of social contact. For carers, distressing fear was related to the risk of infecting the patient, with emphasis on strictly adhering to recommendations and minimising interpersonal contacts with others. For carers living in the same household as the patient, this was described as living in joint isolation, with much anxiety about needing to leave the house. Significant others outside of the patient's household said they dare not visit. They described being torn between the risk of infecting the patient and their longing for a personal encounter, which was considered especially important due to the patient's need for support and the limited time

they had left. Some participants expressed this strongly, describing it as unbearable and bordering on torture.

At the other end of the spectrum there were descriptions of the pandemic having only minimal impact and vague indications of worry, largely related to an awareness of death being imminent regardless. As one patient said: 'Yes, but personally I wasn't that concerned that I would be affected because either I die of that or the other [illness]' (p 19). Carers also commented: 'Yes Corona would kill him but he's reaching the end anyway' (N5).

This was taken as a reason to put all focus on the present situation with advanced illness, but also to consider the situation proportionally: 'In our family, my illness is bigger than the pandemic, so to speak' (p 4).

Alternatively, daily life could already be very limited due to the advanced illness and severely reduced general condition. Consequently, the pandemic restrictions did not entail any change and had hardly been noticed. Some found that their previously limited lives were now common to many and that the pandemic may even have affected them less than others:

Perhaps the pandemic has affected us less than other people who are completely healthy, fully able to work and like, be in the thick of it—for those people the pandemic came like a smack in the face and we've already had ours—that meant we were at home more, well, for other reasons. (N14)

In between these opposite ends of the worry spectrum, examples were given in relation to weighing the risks against the benefits and trying to find creative solutions to problems while adhering to recommendations. This could still involve isolation, especially from peripheral contacts, but most often allowed personal meetings with family and friends. Such personal contact was motivated by efforts to maintain the practical as well as spiritual support said to be needed by both patients and carers. In these situations, the impact of the pandemic was expressed as very palpable, although bearable. Regardless of the individual's initial reaction to the pandemic, the amount of lived time was said to influence their worry in either directions. While some said the persistent threat of the pandemic gradually increased their fear, others became less fearful as they became accustomed to the situation.

When there was disparity in the fear felt by patients and their carers, deciding how to handle a situation could be problematic. For example, fearful patients described being stressed by less fearful carers who wanted to socialise and vice versa. Different expressions of fear and subsequent behaviour were perceived, leading to disputes between carers, which sometimes also affected the patient.

Second structural analysis: handling of the situation

The participants described a number of ways in which they handled the pandemic situation, with actions related to seeking information and knowledge in different ways, creating solutions to stay connected socially (primarily

through digital devices) and limiting their physical social contacts. Participants described their handling of the situation as governed by their degree of worry and fear (in relation to the spectrum presented above), as well as notions of responsibility.

Taking personal responsibility and being dependent on others acting responsibly

Carers explicitly described how, due to the pandemic and the patient's illness, they repeatedly needed to take responsibility in different ways in terms of caring for the patient and protecting him/her against COVID-19 infection. They also described how they personally could take action by refraining from certain activities to avoid infection and in order to take personal responsibility in the role of carers. Patients also often gave details about the measures they took and changes to their daily routines to avoid infection, but in this regard, taking responsibility was usually implicit in their narrative. Carers often re-emphasised their responsibility, for example: 'I'm probably more careful because of him than if it had only been about me, I really am' (N16).

At the same time, needing and wanting to take responsibility for oneself personally and as a carer was associated with uncertainty in several senses. Although the participants referred to the public health authority's guidelines regarding the pandemic, they were indecisive about how they should best be applied, especially in a family with a seriously ill person. This uncertainty also applied to the actual disease situation. Carers talked about a reduction in their necessary 'breathing space' in the care of the sick. Sometimes, participants confessed to telling a few 'white lies' in order to preserve their image of being a responsible carer and to avoid fuelling the sick person's anxiety:

So it's the same thing if I want to see the grandchildren a bit more and he thinks I shouldn't or if I want to use public transport, then it means you sometimes actually have to lie or not tell the whole truth, so I don't think that's good but it's very difficult to manage. Because you don't want the person who's worried to worry even more. (N6)

For most participants, keeping up to date with the latest information about the pandemic was included in taking responsibility. Some patients said their constant interest in media reports could annoy their carers, while others consciously chose to limit their exposure to information: 'I don't take it in. Today, now, I'm not reading anything—it's a strategy—barely read any news, don't watch hardly anything of any news on TV, kind of shut it out' (P9).

In the present situation, the value of relationships was often said to come to the fore as a core value. Changed and often creative ways of socialising were described to avoid risk of infection to the patient, for example, meeting outside or using digital devices. Relationships with health professionals and staff appeared to take on greater significance. In the carers' narratives, taking responsibility by being careful and avoiding risks was highlighted.

To protect the patient from infection, the carers also depended on and had to trust others to act responsibly. This became particularly obvious in the meetings with healthcare staff at home. Even though staff were perceived as demonstrating responsibility by not greeting with a handshake or close contact, patient care usually required body contact. Both patients and carers indicated that it was difficult not to worry and to be confident that the professionals were taking responsibility and not working if they were at risk of being infected. Several participants gave examples of how safety routines could vary between teams and units, which seemed incomprehensible, and for some, distressing and violating.

Third structural analysis: received or lack of support

All the participants described various types of support they received. Although the situation was framed by support related to the advanced illness, support as related to the pandemic was often interwoven with this. Many participants (both patients and carers) also mentioned support they were lacking or wished for, and were quite animated in describing this. Both received and lack of support were described in relation to a range of actors, including self, family members, friends, healthcare professionals/staff and a range of services, volunteers and organisations in civil society and public health authorities (see table 2).

Interpreted whole

Here, the interpretation is taken further. Living in a society with restrictions following the COVID-19 pandemic and receiving specialised palliative care was revealed as inter-related and not always possible to distinguish. The pandemic, implying a risk of life-threatening infection for both patients and carers, is framed by patients being aware of their mortality, with limited remaining life span due to their advanced life-limiting condition, and carers living with impending loss. The meaning of the pandemic's impact relates to a spectrum from mild indications of worry at one end to distressing fear at the other, leading to avoidance of personal encounters and resulting in isolation and loneliness. Individuals may hover between the two ends of the spectrum or move to either end over time. However, taking personal responsibility and managing the situation is at the same time dependent on how others do the same—hence, personal responsibility is interdependent on others. Taking action and handling the situation through various (in some cases creative) solutions seems to require being free from distressing fear. This underlines the importance of supportive actions, which could be provided in personal encounters with family, friends, volunteers and professionals. Such encounters were in place to various degrees but were also found lacking and wished for.

DISCUSSION

The impact of the pandemic on patients and carers in the context of specialised palliative home care was framed by

Table 2 Support: received, lacking or wished for

Support	Described by the patient		Described by the informal carer	
	Received	Lacking or wished for	Received	Lacking or wished for
Family and friends	Practical support. Personal support when meeting outdoors, calling by phone, FaceTime, etc.	In-person social contacts. Practical help.	Practical support adapted to current restrictions.	Spending time together. Understanding from bystanders. More support (not given due to health problems and fear of infection).
Palliative home care service	Support and safety at home through competent carers. Psychosocial/psychological support. Use of protective equipment creates security.	More visits from the home care team. More psychosocial support. Better use of technical solutions such as videoconferences. More consistent use of protective equipment.	Home care including holistic thinking, psychosocial support, problem solving and accessibility 24/7 creates security for both patient and carer and makes it possible to remain at home. Help at home also minimises the risk of getting infected when visiting, for example, the hospital with the patient. Good contacts with other forms of care. Consistent use of protective equipment creates security.	Better use of technical solutions such as videoconferences. More consistent use of protective equipment.
Other healthcare and social services	Hospital care and social services have been supportive. Use of protective equipment creates security.	In-person visits, for example, to hospital. Telephone calls make it harder to be spontaneous and harder for their next of kin to participate. More psychosocial support. More use of technical solutions such as videoconferences. More consistent use of protective equipment.	Being allowed to visit in the hospital despite restrictions. Use of protective equipment creates security.	Being able to take their ordinary supportive role (not possible due to restrictions for accompanying visitors in the hospital). More information and involvement in the care process/disease progression. Faster processing (the pandemic has made things take longer than promised). External support (eg, social services).
Society	Practical support from, for example, the Red Cross or churches.	More clarity in the official recommendations.	(Not mentioned.)	More practical support. More information from the authorities (has been insufficient and contradictory).

the patient's underlying non-COVID, end-stage disease. Most participants said they were aware of the patient's vulnerability, that their daily life was already limited to varying degrees and that death was inevitable. Despite the participants' similar circumstances, their reactions to the pandemic varied greatly. While some found the threat of the pandemic of little significance due to a reduced general condition and a life span that was already limited, others reacted with great fear for the same reason, as they were afraid of losing the little time they had left. Further, the value of social contacts became apparent. The loss of such contacts due to isolation was devastating for some, while others found creative solutions to maintain relationships. In many cases, visits from health professionals became the sole social contact and most participants found highly available palliative home care of utmost importance for their support and security.

During the pandemic, much interest has focused on palliative care needs for patients infected with COVID-19.^{14–17} A few studies have also explored how to practically perform and maintain high-quality palliative care for patients who were non-COVID during the pandemic.¹⁸ However, there is a lack of studies focusing on the experiential impact of the COVID-19 pandemic on patients receiving specialised palliative home care for reasons other than COVID-19. To our knowledge, this is the first study directly addressing patients with an end-stage, non-COVID disease receiving specialised palliative home care and their carers to investigate how they experience consequences of the COVID-19 pandemic.

Although some of our results are in line with the findings of other international studies, it must be noted that the present study was performed in a country with tax-financed healthcare, relatively soft restrictions and no

lockdown during the COVID-19 pandemic, which could limit transferability.

The impact of the pandemic on the participants in the present study varied greatly, with some participants describing great fear, that along with strict isolation, bordered on torture. A similar significant impact of the pandemic has been shown in populations worldwide. Already at the beginning of the pandemic, while death rates were low, polls found that about one-third of adults in Canada and the USA were very concerned about COVID-19¹⁹ and in China, fear of the disease was reported to cause a perceived moderate to severe impact on more than half of the respondents.²⁰ Research from previous pandemics suggests that perceived vulnerability to disease is an important factor inducing fear.²¹ As all the patients in the present study can be classified as vulnerable due to underlying life-threatening disease, most often cancer, an increased risk of adverse outcome of an infectious disease follows.^{4 22} Thus, their perceived fear is affected by the societal threat of the pandemic and has valid reason due to their condition, which is also recognised by their carers. The overhanging life threat from the patients' underlying disease might be one reason why many in this group of patients describe the pandemic as having a great impact on their lives.

Despite soft national recommendations for restrictions at the time of the study, all participants practised isolation to a greater or lesser degree. While having to abstain from visits to the gym, theatre and shopping mall was mentioned, there was an overwhelming consensus among the participants that the primary negative consequence of isolation was lack of social contact with close and significant others. This is consistent with the finding that increased mortality salience can enhance the value of the person's closest significant others.²³ It has also been shown that basic human conservation values, like favouring security and adhering to tradition, were endorsed during the COVID-19 pandemic,²⁴ which could contribute to the reported importance of close relations. Many patients, as well as carers, expressed regrets that fellowship with family and friends could not be maintained for the short time remaining of their lives, and for some this resulted in strong feelings of loneliness, blues and anxiety. From previous studies, it is known that isolation and quarantine can cause distressing problems, and that older people, like those in the present study, are more prone.^{1 25 26} Moreover, isolation adds to the distress already present among seriously ill patients receiving palliative care.

To relieve anxiety, many participants emphasised the importance of receiving continuous support from health-care professionals and official authorities in promoting their knowledge seeking and understanding in order to proactively manage their lives. However, some chose a different management tactic in completely abstaining from media, while others said they became addicted to media news. Participants with the latter behaviour expressed more anxiety, which could be due to exaggerated news reports and sensational headlines fuelling

anxiety and fear.²⁷ The great differences in participants' reactions to the pandemic threat, despite similar basic conditions, could speculatively be dependent on personality type, an important factor in determining stress.²⁸

To a large extent, patients with end-stage, life-threatening disease and their carers are already exposed to the type of threats and restrictions that a subsequently imposed pandemic entails. With this starting position, participants could find the COVID-19 pandemic to be of little significance to them, while at the other end of the spectrum, some participants were almost paralysed with fear. For health and social care professionals, awareness of these diverse reactions to a pandemic threat is important in order to provide appropriate support to patients in palliative care and their carers.

Major limitations of this study are related to the convenient and consecutive sampling from only one palliative care service. Although the number of participants is in line with suggestions in the literature for the chosen methodology, it should be recognised that the majority of the patients had cancer and were native born, thus limiting diversity. A further limitation is having the interviews performed over the telephone and that they varied in length. However, all of the participants shared sensitive issues and distressing experiences to a varying degree. In-person interviews could have opened up for further elaboration and thus generated richer data.

Implications and future directions

The participants' sometimes extreme emotions elicited by the pandemic (describing it as torture) emphasise the importance of the holistic view characterising palliative care and the need for the entire care team to practise person-centred competences as related to communication and care practice.²⁹ It also underlines the importance of maintaining high availability of specialised palliative care during future pandemics, and the need to further study other challenging societal situations involving major sections of populations. Further research in the field of patients with chronic non-cancer conditions and people who have migrated is suggested.

CONCLUSION

The double burden of chronic, non-COVID, life-threatening disease and the ongoing pandemic experienced by patients in specialised palliative home care, as well as by their carers, elicited a great variety of emotional and practical responses. This study reveals the pandemic's impact to be related to a spectrum from mild indications of worry to distressing and unbearable fear, where the latter hampers the opportunity to take action and find solutions to handle the situation.

For some, awareness of an already limited life span and reduced general condition meant they were minimally concerned about COVID-19 and could choose less isolation, while at the other end of the spectrum, participants said this awareness gave rise to extreme fear, with strict

isolation being perceived as torture like. This spectrum of reactions could be found among both patients and carers and provides a heuristic value. Tensions and stress could arise in cases where the level of concern for COVID-19 differed between the individual patient and his/her carers, adding to the already difficult situation.

Most patients and carers found access to specialised palliative home care was maintained despite the pandemic. Easy access to a competent palliative team was said to be supportive and instil a sense of security, which is of particular importance during a pandemic, and for some, it also took on importance as the sole social contact.

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