South Tees Hospitals NHS
NHS Foundation Trust

PALLIATIVE CARE IN HOSPITAL FOR PATIENTS WITH COVID-19 (V2_02APRIL2020)

GENERAL GUIDANCE – DO NOT BE AFRAID TO ASK FOR HELP

Decision making

- Severe illness is more likely in the over 80s with comorbidities especially cardiovascular, respiratory & diabetes.
- Those ill enough to be in hospital may deteriorate rapidly to severe/critical status (organ failure) and die.
- Understanding patient's wishes regarding treatment is important.
- Observe all usual provisions of MCA. Document Mental Capacity Assessment if in doubt. Establish Best Interests.
- Find out if any sort of Advance Care Plan (Advance Statement, ADRT, EHCP) already exists and observe it.
- Seek advice from Specialist Palliative Care Team (SPCT) in complex situations.

Communication

- Patients, carers & families will be frightened. Speak calmly, clearly and honestly.
- Reassure them you will do your best to help them feel comfortable and will get specialist advice as needed.
- Be honest that the patient is ill enough to die but all possible supportive treatment will be given and symptom management will not shorten life. Explain that when a patient is dying, treating symptoms is a major priority.
- Explain plan to patient/family/clinical team. Document clearly in notes. Complete DNACPR and STEP form.

Rapid discharge home to die of patients from hospital

- **THINK!** Narrow window of opportunity if rapid deterioration? Available community nursing and carers?
- NEAS& YAS have confirmed they will transfer patients with COVID-19 home to preferred place of death.
- NEAS ring 0191 414 3144. YAS ring 0300 130 3512. Give full clinical handover observing usual guidance.
- Guidance **Intranet>Services A-Z>End of life care>End of life discharge**. Seek SPCT advice if necessary.

Prescribing

- Symptoms may start and progress rapidly. DO NOT DELAY in prescribing anticipatory ("just in case") medication.
- Give anticipatory medication at the first sign of symptom distress (but only to patients with symptoms).
- If a second dose of anticipatory treatment is needed in a 24hr period, start regular treatment.
- Continue to prescribe "as required" medication alongside regular for symptoms that still persist.
- For additional symptom management consult the normal NECN Palliative & End of Life Care Guidelines **(Intranet > Services A-Z > Palliative care** – link on front page).
- If in doubt contact SPCT on mobiles/ext 54938 (M-F 8.30-4.30) or Pall Med Consultant on call OOH via switch.

Supplementary oxygen at end of life

- If tolerated and clearly providing benefit then continue supplementary oxygen.
- If benefit in doubt/not tolerated/worsening symptoms, use opioids and benzodiazepines for symptom management as per chart. Continuing oxygen therapy will not change the outcome at this stage.
- In this situation stop monitoring oxygen saturations – the goal is symptom control and comfort.
- Give careful clear explanations to patient and family about focus of treatment.

Withdrawal of ventilatory support – general points – seek advice if you are in any way unsure

SEE SEPARATE CHECKLIST & FLOWCHART FOR WITHDRAWAL OF WARD-BASED VENTILATORY SUPPORT

- Patients with severe COVID-19 infection not responding may require withdrawal of ventilatory support.
- Discontinuing ventilation that fails to improve health is not euthanasia or physician-assisted suicide.
- Ensure ongoing, sensitive and honest communication with patient and family (who may not be present).
- Life expectancy after discontinuation of ventilation in non-COVID-19 illness is unpredictable.
- Base decisions on team consensus with second opinions if needed and observing MCA2005 guidance.
- Patients may be very symptomatic – use the flowchart guidance for PREMEDICATION and this guideline for ONGOING treatment of BREATHLESSNESS AND DELIRIUM/AGITATION.

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SYMPTOM MANAGEMENT AT A GLANCE DON'T FORGET Palliative Care Guidelines (Services A-Z > Palliative Care)

<table>
<tr><th>Symptom</th><th>NB dose guidance in (brackets and italics) is for elderly/frail</th></tr>
<tr><td>Breathlessness

POTENTIALLY SEVERE SO TREAT PROMPTLY</td><td>• Sit upright, cool room, cool face. Use oxygen if hypoxaemia, tolerated and provides relief
<u>Opioids reduce awareness of breathlessness; Anxiolytics treat associated anxiety</u>
• PRN Morphine oral solution 5mg (2.5mg) 1-hourly OR injection 2.5mg slow IV/SC 1-hourly
• PRN Lorazepam 500 micrograms SL 1-hourly OR Midazolam 5mg (2.5mg) slow IV/SC 1-hourly
IF NEED 2nd dose of either in 24hr start regular treatment AND continue to allow PRNs
• Start syringe driver with Morphine 10mg/24hr & Midazolam 10mg/24hr
RENAL IMPAIRMENT? Use OXYCODONE at HALF the stated Morphine doses
NO SYRINGE DRIVER? Lorazepam 1mg SL QDS SL & Fentanyl 12microg/hr patch PLUS PRNs & ask SPCT for further guidance</td></tr>
<tr><td>Agitation and delirium

POTENTIALLY SEVERE SO TREAT PROMPTLY</td><td>• Identify and manage cause if possible. Calm clear communication and familiar environment.
• First Haloperidol 500 microgram PO/SC once daily AND 2-hourly PRN
• If <u>severe</u> start Haloperidol 1.5mg PO/SC once daily; low threshold to increase to 3mg. PRN as before. Max 10mg/24hrs. If partly helps add next step. If not helpful replace with next step.
• If <u>persists</u> add Lorazepam 500microgram SL BD & 1-hourly PRN OR Midazolam 5mg (2.5mg) slow IV/SC 1-hourly
• END OF LIFE: Levomepromazine 25mg (12.5mg) stat and 25mg SC BD OR 50mg/24hrs via syringe driver. Also 12.5mg SC 1-hourly PRN. Get SPCT advice on titration.
• <u>Persisting</u> symptoms: Midazolam 5mg(2.5mg) SC 1-hourly and advice from SPCT
NO SYRINGE DRIVER? Give Levomepromazine SC BD and PRN as above.</td></tr>
<tr><td>Cough</td><td>• Oral fluids; honey and lemon in warm water. Suck hard sweets if able. Avoid smoking.
• First: Simple linctus 10mg PO qds. Second: oral Morphine solution 2.5-5mg (2mg) 4 hourly</td></tr>
<tr><td>Pyrexia (fever)</td><td>• Cool room, loose clothing, cool face, oral fluids.
• Paracetamol 1g PO/PR/IV QDS (Reduce dose if weight <50kg, severe renal impairment, frail).
• Avoid NSAIDS in COVID-19 infection.</td></tr>
<tr><td>Pain (due to pre-existing condition, cough or immobility)</td><td>PRE-EXISTING PAIN
If a dying patient has a previous pain management plan and is unable to take medication by mouth, see pages 22 and 23 of the normal Palliative Care Guidelines (Services A-Z > Palliative Care)
Convert regular oral medication to equivalent dose of appropriate opioid/24hr by SC infusion
Also prescribe PRN opioid by SC route 1/6th-1/10th of the 24hr regular dose 1-hourly max 6 doses/24hr.
NEW PAIN
Mild pain: Paracetamol 1g qds (or usual dose reduction) AND Morphine oral solution 5mg(2.5mg) 2-hourly PRN max 6 doses/24hr
Moderate/severe pain: oral Morphine solution 5mg 2-hourly and establish regular daily dose of MR form (total PRN dose divided by 2 given q2-hourly) after 24hours
If on regular MR morphine also prescribe PRN oral morphine solution 1/6th -1/10th of 24hr regular dose for use. Will need conversion to SC meds if dying.
OTHER POINTS
NO SYRINGE DRIVER? Get SPCT advice on dose & initiation of buprenorphine or fentanyl patch.
Renal impairment? Consider oxycodone reduced dose/extended interval, or fentanyl/alfentanil.
Remember antiemetic PRN (metoclopramide 10mg 6-hourly unless contraindicated) and laxative regularly (senna 15mg at night) to counteract common side effects.
Seek SPCT advice if symptoms persist, opioid doses escalate or opioid intolerance occurs.</td></tr>
<tr><td>Secretions</td><td>• Reposition patient. Reduce/stop parenteral fluids. Start medication at earliest sign.
• PRN Hyoscine butylbromide 20mg SC 1-hourly (max 6 doses in 24hr).
• Low threshold to start hyoscine butylbromide 80mg/24hr via syringe driver. Continue PRN
NO SYRINGE DRIVER? Seek SPCT advice and consider 2 x Hyoscine hydrobromide patches/72hr.</td></tr>
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IF SYRINGE DRIVER SHORTAGE, THREE DRUGS IN ONE DRIVER MAY BE POSSIBLE – ASK SPCT!

STeesSPCT with CDDFT SPCT; Association for Palliative Medicine; Field manual for palliative care in humanitarian crises (Waldman&Glass 2019)