Basic management of palliative patients:

Correct the correctable (Antibiotics for infection, fluids & bisphosphonates for ↑Ca2+ in cancer) → **Non-drug approaches** → **Drug approaches**

Try to connect patient & relatives by phone / video if visiting not possible

Palliative management of patients during COVID-19 Pandemic

NHS North Cumbria Integrated Care NHS Foundation Trust

Addressing patient's wishes:

DNACPR

EHCP (Emergency healthcare plan) – agreed plan inc. escalation plans (eg ↑symptoms, infection)

Advanced care planning – record of patients wishes for their end of life care

Preferred place of care – options may be limited

Some only active in event of loss of capacity:

ADRT (Advanced decision to refuse treatment) – can include refusals of treatments eg ventilation – legally binding

LPA (Lasting Power of Attorney for Health) – named attorney to make medical decisions on patients behalf

Dyspnoea / breathlessness:

Subjective sensation of discomfort with breathing. Dyspnoea both causes and is exacerbated by severe anxiety.

- Patient often hypoxic – oxygen may help if available

Check for **reversible causes** – treat / optimise what is possible

- COVID-19: hypoxia, bacterial infection, ARDS
- Non-COVID-19: lung cancer, SVCO, effusion, PE, CCF, COPD

Adapted forward lean for lying

Positioning: upright, cool room (avoid fan), lean forwards, support with relaxation

COVID-19 at EoL: two main patterns observed – 'gentle' hypoxia with little warning of death & a much more distressed picture with severe ARDS & hypoxia

Communication

Good symptom management

Opportunity to prepare for death
Address patients priorities.
Emotional & spiritual support

Support those close to the patient

Dyspnoea in COVID-19 with ARDS:

Can be severe with significant distress. May need rapid titration of drug doses or frequency - titrated to resolution of symptoms & repeated as symptoms recur. NB subcut doses take minimum 20mins to have effect. [Consider IV if in extremis]

Cough: Protective reflex response to airway irritation, triggered by stimulation of airway cough receptors by irritants or airway distortion.

- Maintain cough hygiene, humidify room air (if safe), elevate head when sleeping, avoid smoking. Honey & lemon in water, cough linctus / sweets

Delirium: Acute confusional state – sudden change over hours / days. Intermittent & variable with lucid periods. Can present as agitation, drowsiness / withdrawal. Increased incidence with dementia / structural cerebral changes

- Assess & treat ?underlying causes: hypoxia, infection, organ failure, drugs, fluid/electrolyte imbalance [↓Na+, ↑Ca2+), constipation, urinary retention
- Effective communication & reorientation (where they are, who you are)
- Involve family / friends –via video link / telephone if needed
- Minimise changes – familiar staff, minimise moving between wards / rooms
- Ensure adequate day / night changes (light in day and quiet, dark at night)

Delirium prevention essential: orientation, prevent constipation, treat hypoxia

Daily screening: Single Question in Delirium (SQiD) and / or 4AT rapid test

Practical management of opioids & benzodiazepines towards the end of life

Start with PRN doses. Use oral / sublingual where possible.

If >3 PRN doses in 24hrs – add in continuous background dose (oral or patch, or CSCI)

Increase background & PRN doses by 30-50% max if >3 PRNs /24hrs

Long-acting oral opioid – onset within hours, can titrate after 24hrs

Patches: Buprenorphine onset 5-7 days; Fentanyl onset 24-72hrs – don't titrate till effective

CSCI: effective in 4hrs, can titrate after 12hrs

In last days of life:

Use subcut PRNs when unable to swallow

Consider continuous subcutaneous infusion via syringe driver (CSCI)

– start at 2-3x the patients current PRN dose

– if on long-acting oral opioid – stop & convert to CSCI (Zomorph 10mg bd = 10mg /24hrs CSCI)

– if on opioid patch – leave in place and titrate CSCI in addition to patch (change patches as usual)

Symptom severity	Prognosis		
	Hours	**>6 hours - days**	**Weeks - months**
Mild	**PRNs**	**PRNs**	**PRNs**
Moderate	**PRNs** + Increase dose if needed	**PRNs** + consider background syringe driver	**PRNs** + background oral long acting medication or patch
Severe	**Titrate PRN dose to needs**	**Titrate PRN dose** + Syringe driver	**Titrate PRN dose +** Oral long acting medication or patch

Severe symptoms but prognosis in hours – will not be time to establish syringe driver (takes 4hrs)

Use PRNs – titrating up dose and / or frequency to meet needs.

Consider combining drugs (eg morphine + midazolam)

Supporting patients & those close to them:

Fundamental to palliative care is the ability to communicate sensitively and offer support to patients & those close to them.

Specific concerns in COVID-19 positive patients:

Tips in planning conversations →

- Deterioration may be rapid
- Decisions re treatment escalation / initiating palliation may need to occur rapidly
- Patient may not be able to participate fully in decision making & may be very distressed
- Family may be remote – increasing anxiety, shock & distress

This can make conversations difficult. It is **important that honest & timely conversations do take place**, and that **plans are agreed with patient & those close to them** as much as is practically possible. Senior clinicians should role model conversations & support team with this.

Three talk model for shared decision making:

1. **Team talk:** clarify diagnosis, establish decision to be made, reinforce partnership

'You have coronavirus that has severely affected your breathing, we need to decide on the next steps'

2. **Option talk:** check prior knowledge, outline options (pros/cons), check understanding
3. **Decision talk:** establish decision to be made, reinforce empathy & partnership, check for information gaps

If possible, allow time for decision making & the option for relatives to support this process.
If not possible,

'What thoughts do you have about the best way forward?'

'This is so difficult, but I'm here…' 'What else can I do /tell you to help us come to the right decision?'

Rhetorical 'testing' question:

Patient or those close to them may ask a rhetorical question reflecting their worst fears eg **'but I won't die, will I?'**

Reply sensitively but honestly, eg:

'I can see this is very frightening. I don't want to upset you, but it is important to be honest with you.'

' You asked whether you might die, is that something you want to talk about further?'……

…….'I'm afraid it is possible / likely that you may not get better from this illness. Which means that you may die.'

Care around & after death:

Aim for an environment to support a peaceful & dignified death. May need to be a decision whether dying patients would rather be at home with family, or admitted possibly without family

After death: it may be possible to offer personal effects &/or keepsakes (hand print, lock of hair). Use PPE & place in sealed bag – instruct relatives not to open for 7 days. Ask if your location supports this.

COVID-19 = notifiable (not automatically for referral to coroner on its own)

Spiritual support – personal & subjective

Finding meaning, inner hope / strength

Triggers for palliative referral:

- Patient already known to service
- Symptoms complex / not responding
- Challenging escalation decisions
- High risk dependents eg children

Significant risk of patients **deteriorating rapidly.** Can be without warning, or with distress. ↓SpO2 can herald a decline.

In ANY patient deemed NOT for escalation to ITU – DNACPR should be considered (this can be revoked if patient recovers).

Sensitive communication is vital to both patient & relatives.

Be calm, reassuring and comforting - leave pauses for time to process

Listen for & respond to patient cues (eg 'I am scared I'm not getting better…')

Try to reflect their own words / language back to them

Ask: what the patient / relatives **understand**

Opening: 'I need to talk to you because **we are worried about your condition.'**

Warning shot**: 'I am sorry**, but what I need to say **will be upsetting to hear**. How much do you want to know?'

Patients should not be forced to have these conversations

Explain: **'While we will continue to look after you**, we are concerned that your condition may (is) deteriorate (ing).'

Priorities: **'If your illness continues to get worse, what things would be most important to you?'**

This may be enough to begin conversations regarding goals of care / escalation plan / DNACPR / priorities re end of life care – if not, you may need to be more direct & focused in your approach, while continuing to check it is ok to do so

Refocus: 'We will continue to look after you and to ensure you are comfortable, but **other treatments such as life support would not help you to recover**. Unfortunately this means that **if your illness worsens, you are likely to die.**'

DNACPR: 'In this situation, it will **not be possible to re-start your heart or your breathing**.'

You may need to explain why these treatments (ICU / CPR) would not help

You may need to explain re DNACPR form (eg in community) – 'to ensure you have a peaceful & natural death.'

Priorities: '**I want to ensure we address those things that matter most to you**. Given what we have discussed, do you feel able to share with me **what things are most important to you now?.'**

Reassure: 'No matter what happens, **we will continue to look after you**. We will **do everything we can to make sure you are comfortable**.'

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Symptoms	Simple measures	Initial medication strategy	PRN options – start at lowest doses Use oral / sublingual where possible		Longer acting (background) options		
					Oral	**Patch**	**Syringe driver (CSCI)**
Dyspnoea (shortness of breath – may be associated with & worsened by anxiety)	Positioning (sit up) Cool flannel (face / neck) Cool room (open window - do NOT use a fan)	Both an **opioid** (eg morphine) & an **anxiolytic** (midazolam / lorazepam) are useful – **in combination if symptoms severe / not responding**	**Morphine** 2.5-5mg PO PRN max 1 hourly OR **Morphine** 2.5-5mg Subcut PRN /1 hour *And / or* **Lorazepam** 500mcg – 1mg **sublingually** up to hourly (max 4mg / 24 hours) OR **Midazolam** 2.5-5mg PRN subcut 1 hourly *Prescribe laxative & antiemetic with opioid*	**If not responding to PRNs alone** **Increase PRN dose / frequency (titrate to need)** If patient rapidly deteriorating & prognosis in hours – concentrate on PRNs, may need significant titration of doses / frequency if very distressed If prognosis >12 hours – add in longer acting background medication via **1.** Oral / patch if prognosis in weeks **2.** Syringe driver if prognosis days	***For pain & dyspnoea:*** **Morphine modified release 12 hour preparation** **5-10mg PO BD** *Zomorph M/R for ≥10mg doses (MST for 5mg doses only)* **Titrate up to max 30mg bd** Alternatives are oxycodone M/R If on regular opioids - increase dose	***For pain & dyspnoea:*** **Buprenorphine 5micrograms/hr transdermal patch** = 10mg oral morphine / 24 hours (NB takes up to 7 days for full effect therefore ONLY if symptoms mild & prognosis in weeks) **Fentanyl patch 12micrograms/hr** is equivalent to 30-45mg oral morphine in 24 hrs therefore **only for patients tolerating at least 30-40mg oral morphine/24 hours**	**Morphine 10mg / 24 hours CSCI** *and / or* **Midazolam 10mg / 24 hours CSCI** *Adjust dose as per PRN needs up to morphine 30mg/24hrs **and/or** midazolam 60mg/24 hrs*
For opioids in both dyspnoea & pain		NB Do NOT stop patients usual long acting opioid (eg modified release oral drug or patch)	*In patients already on opioids (eg oxycodone) – give usual PRN opioid at their normal dose*				If unable to swallow and on long acting oral opioid – factor this into CSCI doses (see above**)
Pain	**Paracetamol** 1gram PO/PR/IV QDS (adjust for weight)		**Codeine** 30-60mg PO 4-6 hourly PRN *If ineffective – switch to strong opioid* **Morphine** 2.5-5mg PO PRN max 1 hourly (1.25-5mg Subcut PRN max 1 hourly)				**Morphine** 10mg / 24 hours CSCI
Agitation / anxiety not controlled by above measures	Reassure Re-orientate Link with family ↓disruption	If not responsive to anxiolytic, consider ADDITION of one of the following	**Haloperidol** 1-2.5mg PO / Subcut 4 hourly (max 5mg / 24 hours) or **Levomepromazine** 5mg PO / subcut 6 hourly (max 25mg / 24 hours)		→	→	**Haloperidol** 3-5mg / 24 hours via CSCI or **Levomepromazine** 6.25-12.5mg / 24 hours via CSCI
Cough	Oral fluids Lemon/honey Cough drop Raise head	Start with **Simple linctus** 5-10mls QDS – if ineffective →	**Codeine linctus** 30-60mg PRN PO QDS *or* **Morphine** 2.5-5mg PRN PO max 1 hourly (1.25-5mg S/C PRN max 1 hourly)		**Long-acting Morphine M/R** 5-10mg PO BD	→	**Morphine** 10mg / 24 hours via syringe driver *+ PRN subcut morphine 2.5-5mg 1 hourly*
Nausea / vomiting	Sips of cool fluids Mouth care	Use single option from list See alternatives in case of contra-indications**	**Metoclopramide** 10mg 8 hourly PO / SC** **Haloperidol** 1-2.5mg 4 hourly PO / SC** **Levomepromazine** 5mg 6 hourly PO / SC**		** do NOT use metoclopramide, haloperidol or levomepromazine in **Parkinson's disease** or if patient has experienced **dystonia / extra-pyramidal movements** – instead try: **Cyclizine** 50mg 8 hourly PRN PO/SC or 150mg / 24 hour via CSCI **Ondansetron** 4mg BD PO / IV or **Domperidone** 10mg PO TDS		**Metoclopramide** 30-60mg / 24 hours** **Haloperidol** 3-5mg / 24 hours** **Levomepromazine** 12.5mg / 24 hours**
Resp secretions	**1. Glycopyrronium bromide:** 200micrograms Subcut 4 hourly PRN (max 1.2mg / 24 hours) if >1 PRN dose per 24hrs add 400micrograms – 1.2mg / 24 hrs via CSCI **Or 2. Hyoscine hydrobromide*:** 400micrograms Subcut / 4 hours PRM (max 2.4mg / 24 hours) if >1 PRN dose per 24hrs add 1.2-2.4mg / 24 hrs via CSCI Consider **Hyoscine patch*** 1mg/72 hours (apply 1-2 patches) – this can be used in addition to glycopyrronium if symptoms severe **Or 3. Hyoscine butylbromide:** 20-40mg Subcut / 4 hours PRN (max 120mg / 24 hours) if >1 dose per 24hrs add 40-120mg / 24 hrs via CSCI						*Hyoscine hydrobromide & Hyoscine patch can cause agitation – if affected switch drug

Anticipatory prescribing:

For an opiate / benzodiazepine naive patient, typical first line subcutaneous anticipatory drugs are below which should cover the majority of a patients symptoms at end of life. If a patient is already established on an alternative drug such as oxycodone, these should continue to be prescribed wherever available. During the crisis, some medications may not be available – alternatives are in the tables above and right.

- **Morphine 10mg/1ml solution for injection**. 10x 10mg/1ml vials – for pain / dyspnoea
- **Midazolam 10mg/2ml solution for injection**. 10x 10mg/2ml vials – for dyspnoea / agitation
- **Haloperidol 5mg/1ml solution for injection**. 10x 5mg/1ml vials – nausea / agitation
- **Glycopyrronium bromide: 200microgram/1ml**. 10x 200mcg/1ml vials – resp secretions

There may be some **'anticipatory packs'** available for patients being discharged for end of life care direct from A&E / assessment areas. Will include a small supply of morphine (oral & subcut), sublingual lorazepam & midazolam for the initial hours at home. Depending on prognosis, prescribe additional drugs in community. [Drugs may change with availability]

For patients on long-acting background oral opioids, please consider a switch to a patch if swallowing is likely to be limited in the coming days / weeks, provided there is time to establish this (see above / right).

If patient is already on specific medications for symptom control (due to COVID-19 or underlying illness), these should only be altered prior to discharge where route of administration is no longer viable (eg oral medication). However, all patients expected to deteriorate in coming weeks, should have anticipatory medications prescribed on discharge.

Alternatives end of life care medications during COVID-19 Crisis:

Medications may be very difficult to obtain during the crisis. Specific supplies are likely to fluctuate and means alternatives may be needed.

	Opioid
1st option	Morphine as above
2nd option	Oxycodone 2.5-5mg PO PRN max 1 hourly; 1-3mg Subcut PRN max 1 hourly Long-acting: 5-15mg PO BD; Syringe driver: 5-15mg / 24 hours If switch needed from morphine to oxycodone, reduce dose by 50% (10mg oral morphine = 5mg oral oxycodone)
Alternative to syringe driver	Analgesic patch if time to establish & baseline opioid requirements sufficient (see above) - Buprenorphine: 5mcg/hr = 10mg oral morphine / 24 hours. Takes 5-7 days to reach maximum - Fentanyl: 12mcg/hr = 30-45mg oral morphine / 24 hours. Takes 3 days to reach maximum
Alternatives to subcut PRNs	Oral morphine 20mg/1ml concentrated strength – 0.5mls (10mg) rubbed into the gums

Anxiolytic: if no availability of lorazepam or midazolam, consider Diazepam PO / PR

Respiratory secretions: if provision of syringe driver difficult, look at hyoscine patch (as over), subcutaneous PRNs can be delivered in addition to this if needed.

Process on discharge to community:

Rapid discharge can be facilitated to get a patient discharged home within hours if not for escalation of treatment in a patient felt to be dying. Palliative care can assist with this planning if needed.

Considerations:

- **Feasability** – will patient & relatives / carers cope post discharge home? Are there alternatives?
- **Symptoms** – can symptoms be managed at home?
  - If PRNs ineffective – follow chart above & establish on continuous subcut infusion via syringe driver (CSCI) or long-acting (oral / patch) medications. Alternatives are above – these will vary depending on CSCI & DN availability.
- **Community support** – availability will vary through crisis, specific issues will be updated locally
  - **District nurses** – support end of life care & management of subcutaneous PRNs / syringe drivers
  - **Hospice at Home** (Charity) – offer some overnight care – contact directly
  - **Eden Valley Hospice** – both advice line for professionals & inpatient beds (not COVID positive patients at present)
  - **Specialist Palliative Care Team** – if complex symptom control issues or already known to team
- **Equipment** - hospital bed, commode etc. Order **via stores** – confirm for rapid discharge via telephone. CRS open till 8pm. OT / physio can support re: equipment needs / facilitation. On discharge, nurse patient in own bed till equipment arrives.

Contacts:

Specialist Palliative Care Team

Hospital **CIC:** 01228 814178 **WCH:** 01946 523512

Contact switch if urgent

Community **East:** 01228 602098 **West:** 01900 705200

Hospice at Home East Cumbria: 01228 603208

Hospice at Home West Cumbria: 01900 705200

Eden Valley Hospice: 01228 810801

Bereavement team: via CIC for both sites 01228 616878

Hospital chaplain / Spiritual support (via switch)

CIC: switch 01228 523444 **WCH:** switch 01946 693181