COVID 19 Palliative Care and Anticipatory Care Planning

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Topics

• Experience so far
• Where are people dying from COVID 19 in Glasgow?
• Symptom control and anticipatory prescribing
• Syringe drivers and contingency plans for alternatives
• Communication – tc and vc
• ACP in care homes
• Oxygen
• Support available
# COVID Deaths GG&C NRS 3/6/20

<table>
<thead>
<tr>
<th></th>
<th>COVID</th>
<th>All cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home</td>
<td>57</td>
<td>2005</td>
</tr>
<tr>
<td>Care Home</td>
<td>589</td>
<td>2103</td>
</tr>
<tr>
<td>Hospital</td>
<td>612</td>
<td>2828</td>
</tr>
<tr>
<td>Other institution</td>
<td>4</td>
<td>17</td>
</tr>
</tbody>
</table>
End of Life Care Guidance when a Person is Imminently Dying from COVID-19 Lung Disease

The focus of this guideline is to reduce the suffering for those dying from COVID-19 lung disease.

• A proportion of patients dying of COVID-19 lung disease could have severe symptoms with rapid decline. In this situation it is important to deliver effective medications, at effective doses, from the outset. Early management of symptoms will be the most effective way to reduce suffering.

• The clinical profile of COVID-19 lung disease driven dying is likely to include:
  • High breathlessness / ‘air hunger’
  • High distress
  • High delirium / agitation
  • High fever
  • Risk of cessation of life over a short number of hours.

This guideline should only be used when reversible causes for deterioration have been addressed and there is consensus that the patient is dying.
Atypical presentations

- Less likely to present with cough, breathlessness or temperature
- Delirium
- Anorexia, fatigue, malaise
- GI symptoms
- Deterioration in function
- Falls/ syncope
- Day to day variability
Anticipatory Prescribing in COVID

Breathlessness

Consider whether the patient is benefiting from any oxygen prescribed. If not, consider discontinuing non-beneficial oxygen and using medication and non-pharmacological measures for symptom control. Patients who are receiving medication via nebulisers may continue to do so in the context of COVID-19 lung disease. Currently corticosteroids are not recommended for managing the symptoms of dying of COVID-19 lung disease.

Non-pharmacological measures to manage breathlessness should also be considered, these include positioning, relaxation techniques, wiping the face with cool wipes. **Fans must not be used in the context of COVID-19 infection as they increase aerosol spread of the virus.**
<table>
<thead>
<tr>
<th>Medicine</th>
<th>Administered as</th>
<th>Dosage</th>
<th>Titration Frequency and Considerations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morphine sulfate</td>
<td>Subcutaneous or slow intravenous</td>
<td>Start with 2 to 5mg as required; can be titrated to resolution of symptoms.</td>
<td>• Titration frequency: subcutaneous 10-15mins; intravenous 3-5mins.</td>
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<td></td>
<td></td>
<td>• In patients who are already receiving regular opioid, use 1/6 of total daily opioid dose for as required dose.</td>
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Early commencement of syringe pump, if available, is strongly recommended.

**Morphine sulfate**

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<th>Dose</th>
<th>Titration frequency</th>
<th>Notes</th>
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<tbody>
<tr>
<td>Oral</td>
<td></td>
<td>5mg every hour as required</td>
<td></td>
<td>Consider using lower doses in elderly patients.</td>
</tr>
<tr>
<td>Subcut injection</td>
<td></td>
<td>2mg every hour as required</td>
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• In patients who are already receiving regular opioid, use 1/6 of total daily opioid dose for as required dose.

If the patient has known renal impairment (eGFR <30), consider using equivalent and equipotent doses of oxycodone, if immediately available, as required and alfentanil or oxycodone in an infusion. Refer to: [https://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain/choosing-and-changing-opioids.aspx](https://www.palliativecareguidelines.scot.nhs.uk/guidelines/pain/choosing-and-changing-opioids.aspx) for conversions. If only one opioid is available, this should be used to relieve suffering in the setting of COVID-19 lung disease rapid dying.

**Codeine linctus**

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<td>Oral</td>
<td></td>
<td>60mg every 6 hours as required</td>
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Cough

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### Respiratory secretions

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dose</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hyoscine Butylbromide</td>
<td>Subcutaneous injection</td>
<td>20mg every hour as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>Up to 180mg over 24h</td>
<td></td>
</tr>
<tr>
<td>Glycopyrronium</td>
<td>Subcutaneous injection</td>
<td>200micrograms every hour as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>1.2mg over 24h</td>
<td></td>
</tr>
<tr>
<td>Hyoscine Hydrobromide</td>
<td>Subcutaneous injection</td>
<td>400micrograms every hour as required</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>2.4mg over 24h</td>
<td></td>
</tr>
</tbody>
</table>

*Alternative drugs and routes of administration are also available – Refer to: [https://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/alternatives-to-regular-medication-normally-given-via-a-syringe-pump-when-this-is-not-available.aspx](https://www.palliativecareguidelines.scot.nhs.uk/guidelines/symptom-control/alternatives-to-regular-medication-normally-given-via-a-syringe-pump-when-this-is-not-available.aspx)*
## Terminal delirium / Terminal agitation / Terminal restlessness

A combination of midazolam and levomepromazine should be considered in terminal agitation/restlessness/delirium.

Early commencement of syringe pump, if available, is strongly recommended.

<table>
<thead>
<tr>
<th>Drug</th>
<th>Route</th>
<th>Dosage during initial agitation/restlessness/delirium</th>
<th>Titration frequency:</th>
<th>Maximum dose</th>
<th>Indications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Midazolam</td>
<td>Subcutaneous or slow intravenous injection</td>
<td>Start with 2 to 5mg as required; can be titrated to resolution of symptoms.</td>
<td>subcutaneous 10-15mins; intravenous 3-5mins.</td>
<td>100mg over 24h</td>
<td>- Better for agitation due to distress and anxiety.</td>
</tr>
<tr>
<td></td>
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<td></td>
<td></td>
<td>• Consider using lower doses in elderly patients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• High doses may be required in patients who have severe agitation.</td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>Start with 10 to 20mg over 24h</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Levomepromazine</td>
<td>Subcutaneous injection</td>
<td>Start with 10 to 25mg every hour as required</td>
<td></td>
<td>Over 100mg/day may be given under specialist advice.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Better for agitation due to delirium.</td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>Start with 50mg over 24h (can be given as bd injections)</td>
<td></td>
<td></td>
<td>• Consider using lower doses in elderly patients.</td>
</tr>
<tr>
<td>Haloperidol</td>
<td>Subcutaneous injection</td>
<td>1mg every 2 hours as required.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Subcutaneous infusion</td>
<td>Start with 5 to 10mg over 24h</td>
<td></td>
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</tr>
</tbody>
</table>

Haloperidol Use where levomepromazine is not available.
Palliative Care Toolkit

Syringe drivers and alternatives during COVID

1. **WE WILL HAVE TO TALK ABOUT DYING: COVID-19**

   - **All clinicians, some working outside usual areas**

   - **How can we do this with confidence and empathy?**

   - **Openness, compassion, dignity**

   - **How do we have difficult conversations?**

   - **Have we done this often?**

   - **...and have to do on the front line!**

   - **Out of comfort zone**

2. **WHY IS THIS SO HARD?**

   - **Before**

   - **Cycle of life**

   - **Sleep more**

   - **Awake less**

   - **Become unconscious**

   - **Stay unconscious**

   - **Breathing stops**

3. **SUPPORT + PREPARATION**

   - **You are not alone**

   - **We don’t get it right every time**

   - **Emotions**

4. **REDMAP FRAMEWORK**

   - **Ready**

   - **Expect**

   - **Diagnosis**

   - **Matters**

   - **Action**

   - **Plan**

   - **CPR**

   - **Listening**

   - **Anxious, fearful**

   - **Power of silence**

5. **THINGS YOU MIGHT SAY...**

   - **What am I saying is hard to hear?**

   - **It’s important to be honest with you**

   - **That didn’t come out right.**

   - **Sick enough to die.**

   - **Can I start again?**

   - **We are in a different place now.**

   - **This is your final journey.**

   - **Check-in with yourself.**

   - **Check-in with a colleague.**

   - **Let’s play good care for you + your family.**
Difficult conversations phone or vc

- Undisturbed
- Check they are able to speak, who is there
- Warning shot
- Check understanding
- What will you do now? Shall we make a plan together? Are there other people you need to tell? Who is there to support you?
- Acknowledge sadness and difficulty of the situation
Video-consultations in Palliative Care

- Increased use for outpatient/ CNS follow up
- Family meetings
- Loss of doorstep conversations
- Still need for FTF assessment - elderly no one to assist with technology/ hard of hearing/ need to see what is going on in home
- Hospices developing virtual services e.g. breathlessness management, counselling, bereavement support
Case History

- 79 metastatic breast cancer
- Fungating breast cancer
- Increased pain
- Admitted for symptom control - deteriorated over admission
- AF with reduced saturations, treated for wound infection
• Recognition she was approaching end of life wished home for end of life care
• ‘Nothing you will say will change my mind’
• Complex discharge planning short time frame
• Oxygen (husband smoker)
• Hospital bed, single level living, POC, DN for syringe driver, catheter and wound care

• Lived with husband, son and daughter in law self isolating ? COVID
Discharge delayed as tested for COVID

- Febrile 24 hrs prior to discharge
- Tested positive COVID 19 (Friday)
- Husband distressed ‘I just want my wife back’
- HSCP, DN, GP informed
- Syringe driver medication, just in case meds. Community Kardex, VOED form
- Discharged home
Disaster!

- Carers refused to visit because of COVID positive status
- Support from DN and Marie Curie Fast Track over weekend
- Family not leaving room
- House crowded with relatives
- Difficulty complying with social distancing
- Pain uncontrolled
- Emergency readmission following the weekend
Re-admitted for end of life care

- Husband unable to visit on readmission
- Staff with her when she died
- Distressing for everyone
Learning

• Early in pandemic-first COVID positive patient for community staff involved
• Less control over family behaviour in community setting (social distancing/handwashing)
• Moral distress re visiting restrictions
• No PPE available for informal carers at that point
Useful links informal carers

- Scottish Government Website – Coronavirus (COVID-19) unpaid carers providing personal care. Information on this website of where to get PPE and who would require it. Social Care PPE Support Centre on 0300 303 3020
- Just in case medication
- Caring for patients in last days of life
- NHSGGC Booklet - What can happen when someone is dying
- NHS Inform – Palliative Care
- NHSGGC Palliative Care Symptom Control
- NHSGGC Bereavement Information and Support


Questions?

• How can we support end of life care at home for COVID positive patients who do not wish hospital admission

• How do we support those dying following delayed diagnosis or who have not been able to receive treatment e.g. palliative chemotherapy due to COVID

• Bereavement support for families who have not been able to be with loved ones, experience usual rituals around funerals etc