Northern Care Alliance NHS Group

Association for Palliative Medicine Of Great Britain and Ireland

Adapted from

COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care

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Discussions about goals of care
(COVID-19 Outbreak)

Talking to residents and those close to them about prognosis, ceilings of treatment and possible end of life care is often challenging but, in the current COVID-19 outbreak, such conversations with the population described may become even more difficult, as health professionals may have to triage residents, often in emergency or urgent situations, and prioritise certain interventions and ceilings of treatment.

Background

Our population is ageing, and many more people are living with chronic illness and multiple co-morbidities. Despite this, few have ever had discussions about ceilings of treatment or resuscitation.

Such conversations, which constitute advance care planning, are useful during normal times, but even more so during the COVID-19 outbreak. Open, honest discussions regarding ceilings of treatment and overall goals of care are not only essential to ensure that those with significant potential to recover receive appropriate care, but also that those who are very unlikely to survive also receive appropriate, end of life care.

Such decisions may have to be made when health professionals have not had the opportunity to get to know their resident as well as they would usually like or may involve discussion with those close to the resident over the telephone or via internet-based communication facilities. While this is less than ideal, honest conversations are often what residents and those close to them actually want.

Consider

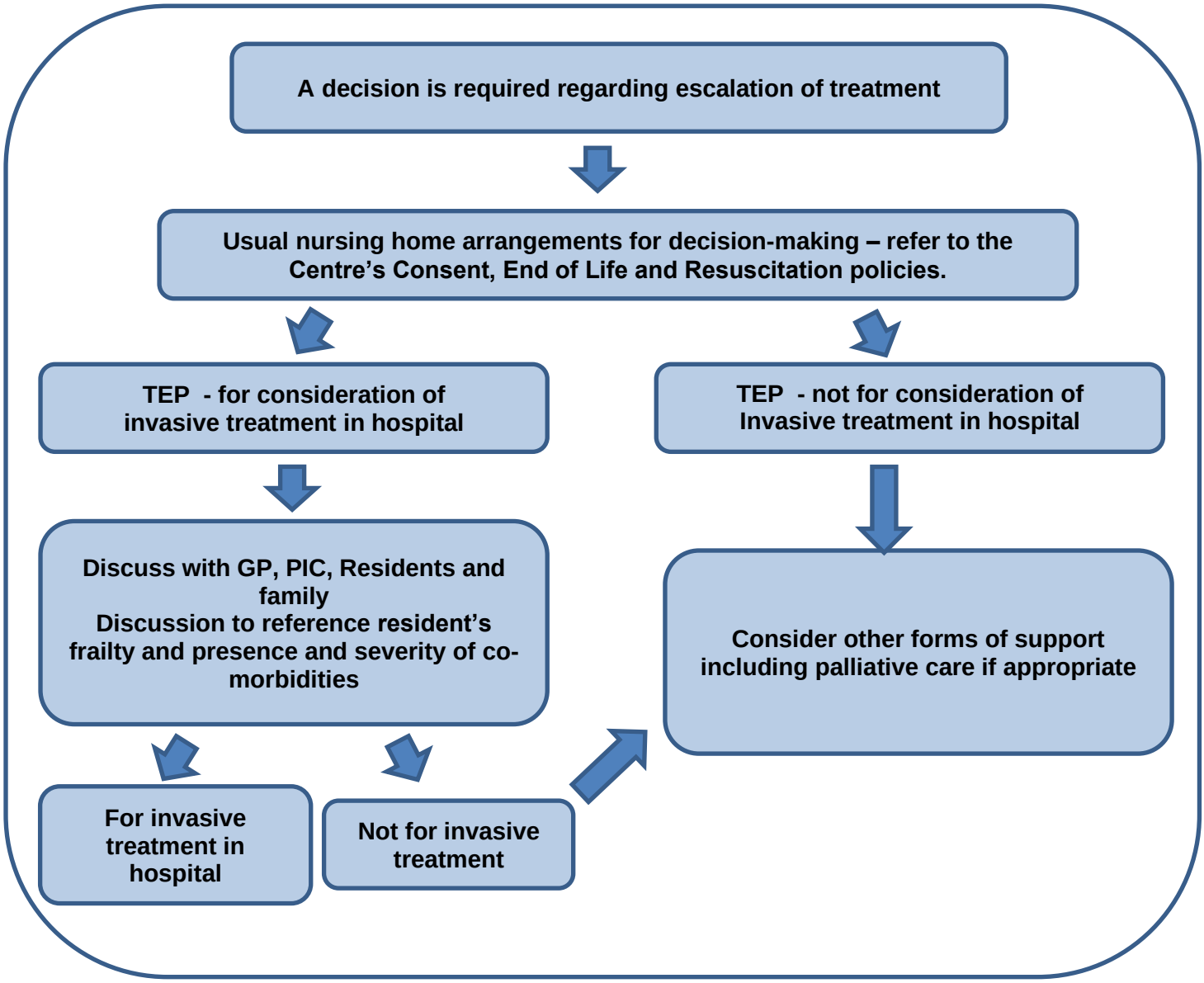
- Don't make things more complicated than they need to be - use a framework such as SPIKES:
  - **S**etting / situation
    read clinical records, ensure privacy, no interruptions
  - **P**erception
    what do they know already?; no assumptions
  - **I**nvitation
    how much do they want to know?
  - **K**nowledge
    explain the situation; avoid jargon; take it slow
  - **E**mpathy
    even if busy, show that you care
  - **S**ummary / strategy
    summarise what you've said: explain next steps

- Should ceilings of treatment conversations include ethical issues, for example where escalation to invasive treatment is thought not to be appropriate due to frailty, comorbidity or other reasons, health professionals should be prepared for anger / upset / questions
  - these are usually not aimed directly at you, but you may have to absorb these emotions and react professionally, even if they are upsetting / difficult at the time
  - residents or those close to them may request a 'second opinion' – this should be facilitated wherever possible
- Be honest and clear
  - don't use jargon; use words residents and those close to them will understand
  - sit down; take time; measured pace and tone; use silences to allow people to process information
  - avoid using phrases such as "very poorly" on their own – is the resident "sick enough that they may die"? If they are – say it

Clinical decision-making in respiratory failure
COVID-19 Outbreak

All COVID suspected / positive residents should have a Treatment Escalation Plan (TEP) including decision regarding invasive ventilation discussed and recorded.

Refer to any previous wishes and preferences expressed by the residents, Any current DNAR order in place or an Advanced Healthcare Directive.



The National Institute for Health and Care Excellence (NICE) has produced a more comprehensive rapid guideline for critical care, published on 20 March 2020. It is available on their website at https://www.nice.org.uk/guidance/ng159.

Communication with Residents Family / Representatives
COVID-19 Outbreak

Significant conversations should be conducted by a senior member of staff with the necessary knowledge and skills, with relatives in an appropriate safe environment or via teleconferencing (either video or telephone). These include, but are not limited to:

- limitation of treatment
- withdrawal of life-sustaining treatment
- resident death

The residents Treatment Escalation Plan / DNAR status must be recorded in the residents care plan and communicated to all those providing care to the residents.

On a day to day basis, where a resident is suspected or confirmed as having COVID-19, communication with residents' relatives will be underpinned by clinical staff documentation and categorisation of each resident with suspected or confirmed COVID-19. The clinical team will categorise each COVID-19 resident as:

- Improving
- Progressing
- Stable
- Concern
- Deteriorating

Where nursing staff are busy caring for residents, a nominated person can provide information to relatives based on a **'script'**. The following page provides guidance on a script that can be communicated.

Once the communication update has been conveyed to the nominated relative, this should be recorded in the resident's records or a communications diary.

Script for Communication with Family / Representative

- confirm identity of relative
- confirm identify of the resident with relative with **two** of three identifiers:
  - name
  - date of birth
  - address

Give background statement

"This is a 12 hourly update on your relative's condition. I am contacting you because the clinical staff are extremely busy looking after all the residents. The information I will give you has been provided by the nurses looking after your relative. I cannot answer specific questions about their condition"

Then provide the appropriate update according to the resident's current category

Improving

……is improving.

Progressing

……is making some progress and is requiring oxygen support. We hope that they continue to improve.

Stable

…….. is stable at the moment. They still need a high amount of oxygen support. We hope that they improve but are concerned that they may get worse.

Concern

…… is causing the nurses to be very concerned because they are not making the progress that was hoped for. They are receiving all possible treatment and will be reviewed regularly.

Deteriorating and being transferred to Hospital

……is requiring high levels of oxygen and is being transferred to Hospital. The nurses are extremely concerned and will try to contact you to discuss this; it may be some time before they are able to do so due to they are extremely busy caring for your relative.

Deteriorating

Residents with DNAR

…… is requiring high levels of oxygen and the nurses are extremely concerned and are worried that your relative may deteriorate further. The nurses will try and contact you to discuss this; it may be some time before they are able to do so due to they are extremely busy caring for your relative.

Management of breathlessness
COVID-19 Outbreak

Breathlessness is the subjective sensation of discomfort with breathing and is a common cause of major suffering in people with acute, advanced and terminal disease. Treatment of underlying causes of dyspnoea should be considered and optimised where possible.

Reversible causes

- Both COVID-19 and non-COVID-19 conditions (advanced lung cancer, SVCO, lymphangitis carcinomatosis, etc) ***may*** cause severe distress / breathlessness toward end of life
- Check blood oxygen levels

Non-pharmacological measures

- Positioning (various advice depending on position: sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward)
- Relaxation techniques
- Reduce room temperature
- Cooling the face by using a cool flannel or cloth
- Portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
- Portable fans are not recommended for use during outbreaks of infection or when a resident is known or suspected to have an infectious agent

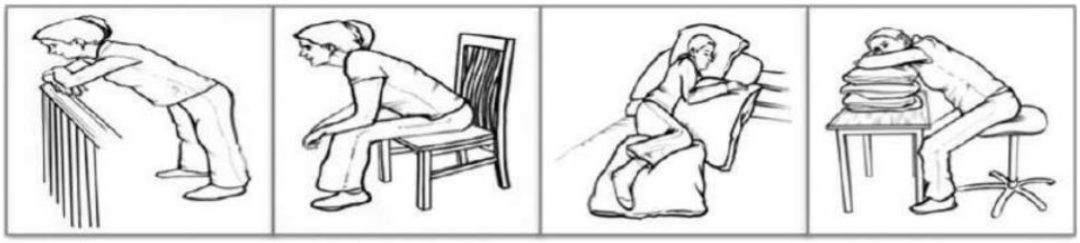
Pharmacological measures (mild to moderate)

- Opioids for breathlessness
  - morphine MR 5mg po bd (titrate to max 30mg daily then seek advice)
  - morphine 2.5-5mg po prn (1-2mg sc if unable to swallow)
  - midazolam 2.5-5mg sc prn for associated agitation or distress
- Anxiolytics for anxiety
  - lorazepam 0.5mg sl prn
- In the last days of life
  - morphine 2.5-5mg sc prn
  - midazolam 2.5-5mg sc prn
  - consider morphine 10mg and / or midazolam 10mg over 24 hours via syringe driver, increasing to morphine 30mg / midazolam 60mg step-wise as required

Pharmacological measures – severe breathlessness (akin to ARDS scenarios)

Residents with severe COVID-19 symptoms, especially severe breathlessness, who are not expected to survive their illness often deteriorate quickly over a short period of time. As a result, they may need higher starting and maintenance doses of opioids / anxiolytics than suggested previously for breathlessness and associated anxiety.

- morphine 5-10mg SC prn 2 hourly (oxycodone 2.5-5mg SC prn 2 hourly if low eGFR)
- midazolam 5-10mg SC prn 2-4 hourly (may need in some cases to be hourly)
- consider morphine 10-20mg and / or midazolam 10-20mg over 24 hours via syringe driver
- syringe driver dosing may need to be reviewed 8-hourly rather than every 24 hours if the resident's prn requirements are escalating rapidly without control of their symptoms
- dosing requirements may not 'fit' with established practice and may have to be determined on a case by case basis – always prescribe safely, but don't be afraid to prescribe in line with your residents' requirements
- the bottom line is that, if a resident is going to die, we need to ensure they die without distress
- syringe drivers may be in short supply or needed for non-COVID-19 residents requiring palliative care support. Where possible, use 'as required' dosing for COVID-19 residents



Management of cough
COVID-19 Outbreak

Cough is a protective reflex response to airway irritation and is triggered by stimulation of airway cough receptors by either irritants or by conditions that cause airway distortion.

Cough hygiene

To minimise the risk of cross-transmission:

- Cover the nose and mouth with a disposable tissue when sneezing, coughing, wiping & blowing the nose
- Dispose of used tissues promptly into clinical waste bin used for infectious or contaminated waste
- Clean hands with soap and water, alcohol hand rub or hand wipes after coughing, sneezing, using tissues, or after contact with respiratory secretions or objects contaminated by these secretions

Non-pharmacological measures

- Humidify room air
- Oral fluids
- Honey & lemon in warm water
- Suck cough drops / hard sweets
- Elevate the head when sleeping
- Avoid smoking

Pharmacological measures

- Simple linctus 5-10mg po q.d.s.
  if ineffective
- Codeine linctus 30-60mg po qds
  or
- Morphine sulphate immediate release solution 2.5mg PO 4 hourly

If all these measures fail, seek specialist advice, to discuss:

- Use of sodium cromoglicate 10 mg inhaled 4 times a day (can improve cough in people with lung cancer within 36-48 hours)
- If severe / end of life: morphine sulphate injection 10mg CSCI over 24 hours and 2.5-5mg SC 4 hourly prn

Management of delirium
COVID-19 Outbreak

Delirium is an acute confusional state that can happen when someone is ill. It is a SUDDEN change over a few hours or days, and tends to vary at different times of day. People may be confused at some times and then seem their normal selves at other times. People who become delirious may start behaving in ways that are unusual for them- they may become more agitated than normal or feel more sleepy and withdrawn.

Non-pharmaceutical measures

- Identify and manage the possible underlying cause or combination of causes
- Ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- Consider involving family, friends and carers to help with this (Skype/ phone)
- Ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk
- Avoid moving people within and between wards or rooms unless absolutely necessary
- Ensure adequate lighting

Pharmacological measures: mild to moderate to severe

Haloperidol is generally the drug of choice for both hyper- and hypo-active delirium:

- start with 500 micrograms / 24h CSCI or PO/SC at bedtime and q2h prn
- if necessary, increase in 0.5−1mg increments
- median effective dose 2.5mg/24h (range 250 microgram - 10mg / 24h
- consider a higher starting dose (1.5-3mg PO/SC) when a resident's distress is severe and / or immediate danger to self or others

If the resident remains agitated, it may become necessary to add a benzodiazepine, e.g.

- lorazepam 500 micrograms-1mg PO bd and prn
  or
- midazolam 2.5-5mg SC prn 1-2 hourly

Pharmacological measures: end of life (last days / hours)

Use a combination of levomepromazine and midazolam in a syringe driver

Levomepromazine (helpful for delirium)

- start 25mg SC stat and q1h prn (12.5mg in the elderly)
- if necessary, titrate dose according to response
- maintain with 50-200mg / 24h CSCI
- alternatively, smaller doses given as an SC bolus at bedtime, bd and prn

Midazolam (helpful for anxiety)

- start with 2.5-5mg SC/IV stat and q1h prn
- if necessary, increase progressively to 10mg SC/IV q1h prn
- maintain with 10-60mg / 24h CSCI

If the above is ineffective, seek specialist palliative care advice

Management of this symptom, which is distressing for both relatives and staff (residents are usually unaware of what they are doing at this time) can be troublesome. Through use of the medications below, titrated appropriately, this can usually be managed effectively.

- Prevention of delirium better than cure, so meticulous adherence to delirium prevention strategies (orientation, prevention of constipation, management of hypoxia, etc) is essential.

Management of fever
COVID-19 Outbreak

Fever is when a human's body temperature goes above the normal range of 36–37° Centigrade (98–100° Fahrenheit). It is a common medical sign. Other terms for a fever include pyrexia and controlled hyperthermia. As the body temperature goes up, the person may feel cold until it levels off and stops rising.

Is it fever?

- Significant fever is defined as a body temperature of:
  - 37.5ºC or greater (oral)
  - 37.2ºC or greater (axillary)
  - 37.8ºC or greater (tympanic)
  - 38ºC or greater (rectal)

- Associated signs & symptoms:
  - shivering
  - shaking
  - chills
  - aching muscles and joints
  - other body aches

Non-pharmacological measures

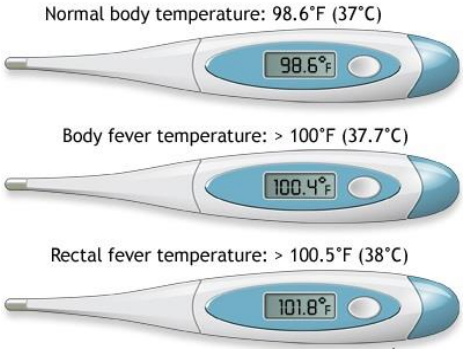
- Reduce room temperature
- Wear loose clothing
- Cooling the face by using a cool flannel or cloth
- Oral fluids
- Avoid alcohol
- Portable fans used in clinical areas have been linked to cross infection in health and social care facilities, although there is no strong evidence yet
- Portable fans are not recommended for use during outbreaks of infection or when a resident is known or suspected to have an infectious agent

Pharmacological measures

- Paracetamol 1g PO / PR Q.D.S.

NSAIDS cannot currently be recommended in COVID-19
(March 2020)

- If a resident is close to the end of life, it may be appropriate to consider use of NSAIDs (e.g. parecoxib 40mg SC OD-BD; maximum 80mg in 24 hours)



Management of pain
COVID-19 Outbreak

Residents may experience pain due to existing co-morbidities but may also develop pain as a result of excessive coughing or immobility. Such symptoms should be addressed using existing approaches to pain management.

Resident on no analgesics - mild pain

- Step 1:
  - start **regular** paracetamol (usual dose 1g four times a day)
  - dose reduction is advisable in old age, renal impairment, weight <50kg, etc
- Step 2:
  - persistent or worsening pain: stop paracetamol if not helping pain
  - start codeine 30-60mg four times a day **regularly**
- Step 3:
  - maximum paracetamol and codeine, persistent or worsening pain: stop paracetamol if not helping pain
  - stop codeine
  - commence strong opioid (e.g. oral morphine)

NSAIDS not currently recommended in COVID-19 (March 2020)

Commencing strong opioids

- start either an immediate-release (IR) or a modified-release (MR) preparation
- ALWAYS prescribe an immediate-release morphine preparation p.r.n.
- starting dose will depend on existing analgesia – calculate dose required
- monitor the resident closely for effectiveness and side effects
- always prescribe laxatives alongside strong opioids
- always prescribe an antiemetic regularly or prn

Suggested starting doses

- opioid-naïve/frail/elderly
  - morphine 2.5-5mg PO IR 4 hourly
- previously using regular weak opioid (e.g. codeine 240mg/24h)
  - morphine 5mg PO IR 4 hourly or MR 20-30mg BD
  - frail/elderly: use lower starting dose of 2.5mg PO IR 4 hourly or MR 10-15mg BD
- eGFR <30
  - seek advice

Titrating oral opioid dose

- if adjusting the dose of opioid, take prn doses into account
- check that the opioid is effective before increasing the dose
- increments should not exceed 33-50% every 24 hours
- titration of the dose of opioid should stop when either the pain is relieved or unacceptable side effects occur
- if pain control achieved on IR consider conversion to MR opioid (same 24-hour total dose)
- seek specialist advice if analgesia titrated 3 times without achieving pain control / 3 or more prn doses per day / total daily dose of oral morphine over 120mg / day unacceptable side effects

When the oral route is not available

- If analgesic requirements are stable - consider transdermal patches (e.g. buprenorphine, fentanyl)
- If analgesic requirements are unstable consider initiating subcutaneous opioids
- Seek specialist advice if necessary
- Morphine is recommended as the first line strong opioid for subcutaneous use for residents, except for residents who have been taking oral oxycodone or those with severe renal impairment
- If constant pain, prescribe morphine 4 hourly SC injections or as 24-hour continuous infusion via a syringe driver (McKinley T34)
- Conversion from oral to SC morphine: oral morphine 5mg ≈ SC morphine 2.5mg
- Wide inter-individual variation exists, and each resident should be assessed on an individual basis
- Prn doses of 1/10 to 1/6 of regular 24-hour opioid dose should be prescribed 2-4 hourly SC prn

Important considerations for care immediately before and after death
COVID-19 Outbreak

This advice is for cases where a COVID-19 is suspected or confirmed.

The utmost consideration and care must be given to the safety of other residents, visitors and staff by maintaining infection control procedures at all times. The HSE and HSPC websites can provide additional support and guidance.

Clear and complete documentation

Open, honest and clear communication with colleagues and the deceased residentss family / significant others

Before death

Decisions regarding treatment plan made on a case by case basis

If death is imminent one family member may wish to visit their loved one (maximum one hour per day); they should wear PPE

Provide appropriate religious / spiritual care in keeping with residents Faith

After death

Inform and support family and /or Next of Kin

Appropriately trained professional completes Verification of Death process wearing required PPE and maintaining infection control measures

Mementoes / keepsakes (e.g. locks of hair, handprints, etc) should be offered and taken <u>at the time of care after death.</u> These <u>cannot be offered or undertaken at a later date</u>

- mementoes in care after death can be provided, on the ward
  - mementoes should be placed in a sealed bag and the relatives must not open these before 7 days

Full PPE should be worn for performing physical care after death

- The deceased resident's property should be handled with care as per policy by staff using PPE and items that can be safely wiped down such as jewellery should be cleaned with a detergent & disinfectant.
- Clothing, blankets, etc., should ideally be disposed of. If they must be returned to families they should be double bagged and securely tied and families informed of the risks.
- Any nursing home linen should be treated as risk laundry and be placed in a water soluble / alginate bag.

Property bags should still be used for property that has been properly cleaned / bagged

Consideration of emotional/spiritual/religious needs of the deceased resident & their family/significant others

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