Community-based palliative care for COVID-19 disease

If you require medical advice about symptom management contact the Palliative Medicine consultants:

- For consultants based in Derby, in working hours call 01332 788794 and the secretary will locate an available consultant. Out of hours call RDH switchboard 01332 340131 and ask for the Palliative Medicine consultant on-call.
- For consultants based at Ashgate or Chesterfield contact the consultant on-call through the CRH switchboard 01246 568801 & 01246 277271

This guidance is collated from various recently produced resources about palliative care for patients with COVID-19. It is intended as a digest, not as a replacement for full documents, which can be found on websites listed at the end of the document.

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START HERE…

My patient does not have COVID-19 but is recognised to be dying

→ Usual symptom management guidance applies.
https://derbyshire.eolcare.uk/content/documents/uploads/toolkit-docs/Symptom-Management-EOL-Guidance-update-2020-1.pdf

My patient has COVID-19 or suspected COVID-19

→ They are recognised to be dying and they are distressed with agitation and breathlessness

→ They are recognised to be dying but they have no symptoms

→ Prescribe anticipatory prn medication

Go to Page 6 STEP 2

Or see alternative suggestions page 7-8

→ They are not recognised to be dying but they have symptoms related to COVID-19

→ Is my patient receiving appropriate supportive treatments?

Have correctable causes of symptoms been considered and managed appropriately?

Examples include:

- *Antibiotic treatment for a superadded bacterial infection which may improve fever, cough, breathlessness and delirium*
- *Optimising treatment of comorbidities (e.g. chronic obstructive airways disease, heart failure) which may improve cough and breathlessness.*

→ Go to Pages 3-8 **Management of common symptoms experienced in covid-19**

→ Go to Page 6

Guideline for the symptomatic management of actively dying patients with presumed COVID-19:

Severe breathlessness & agitation

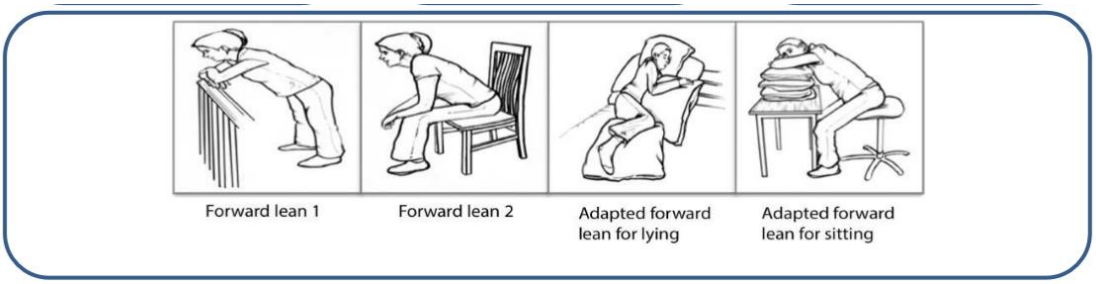
or see alternative suggestions page 7-8

Management of common symptoms experienced in COVID-19

Breathlessness

Non drug measures:

Different positions may be helpful



Reduce room temperature
Cool the face by using a cool flannel or cloth
Relaxation techniques, for example, quietly reading a favourite book to the patient, listening to preferred music
Portable fans are not recommended for use during outbreaks of infection; if a patient is at home you might open a window

Drug treatment:

If patient can manage oral medication:
Morphine modified release initially 5mg bd – usual maximum 30mg daily
AND
Morphine sulphate immediate release solution (Oramorph)2.5-5mg PO when necessary (prn); frequency 2 hourly
Consider adding lorazepam 0.5mg sublingual when necessary (prn) for anxiety/fear; frequency 2 hourly

If patient cannot manage oral medication use a parenteral opioid *and* a sedative anxiolytic:

- If opioid naïve:
  - give a stat dose of **morphine** 5mg SC OR **diamorphine** 5mg SC + **midazolam** 5mg SC (2.5mg in the elderly)
  - start **diamorphine** 10mg/24h + **midazolam** 10mg/24h by CSCI/syringe driver
  - prescribe **morphine** 5mg OR **diamorphine** 5mg + **midazolam** 5mg SC when necessary (prn); frequency 1 hourly (both 2.5mg in the elderly)
- Review regularly and titrate both prn and regular doses to obtain satisfactory relief – seek advice if your patient is distressed

If already taking PO **morphine** or another opioid convert to the equivalent parenteral 24h and prn doses: see https://derbyshire.eolcare.uk/content/documents/uploads/toolkit-docs/Symptom-Management-EOL-Guidance-update-2020-1.pdf
Consider a 25-33% increase in dose from baseline to manage current symptoms

- In renal or hepatic failure, alternate opioids may be preferable, contact the palliative care team
- Ensure patients receiving regular opiates are considered for laxatives e.g. senna and docusate

Cough (without significant breathlessness)

Non drug measures:

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

Drug treatment:

A strong opioid is the most effective cough suppressant. If already on **morphine** for breathlessness, this may suffice. Otherwise:
Morphine sulphate immediate release solution (Oramorph) 2.5mg PO 4 hourly
Sodium cromoglicate 10 mg inhaled 4 times a day (can improve cough in people with lung cancer within 36-48 hours)

If patient cannot manage oral medication use a parenteral opioid:

- If opioid naïve:
  - give a stat dose of **morphine** 5mg SC OR **diamorphine** 5mg SC (2.5mg in the elderly)
  - start **diamorphine** 10mg/24h by CSCI
  - prescribe **morphine** 5mg OR **diamorphine** 5mg SC when necessary (prn); frequency 1 hourly (both 2.5mg in the elderly)
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In renal or hepatic failure, alternate opioids may be preferable, contact the palliative care team
Ensure patients receiving regular opiates are considered for laxatives e.g. senna and docusate

Fever

Non drug measures:

Wear loose clothing
Reduce room temperature
Cool the face by using a cool flannel or cloth
Avoid alcohol
Portable fans are not recommended for use

Drug treatment:

Paracetamol 1G PO q.d.s. (500mg when ≤50kg)
Concerns about NSAIDs are irrelevant if the patient is believed to be dying.

Delirium (mild to moderate – if severe see p6)

Non drug measures:

Identify and manage possible reversible cause or combination of causes
Reorientate and reassure (for example explaining where the person is, who they are, and what your role is)
Ensure adequate lighting

Drug treatment:

Haloperidol 500mcg-1mg SC/PO and titrate in 500 microgram increments
Consider a higher starting dose if patient's distress is severe or there is a danger to self/others

RDH guideline for the symptomatic management of dying patients with presumed COVID-19: Severe breathlessness & agitation

**** All drugs are given subcutaneously****

Step 1:

Diamorphine 5mg **OR** Morphine 5mg
AND
Midazolam 5mg
AND
If severely agitated or delirious add: Levomepromazine 12.5mg **OR** Haloperidol 3mg

Step 2:

Prescribe anticipatory medication as follows, to be used at 30 minute intervals:
Diamorphine 5mg **OR** Morphine 5mg
Midazolam 5mg
Levomepromazine 12.5mg **OR** Haloperidol 3mg

If no effect after 30 minutes they should be repeated
If patient remains unsettled after 1 hour in spite of repeated dosing call for advice

Step 3:

Prescribe a CSCI/syringe driver as the patient may survive long enough to benefit:
Over 24hrs:
Diamorphine 10mg, Midazolam 30mg, Levomepromazine 50mg
OR
Diamorphine 10mg, Midazolam 30mg, Haloperidol 10mg

Notes:

- Experience has shown that, when death from COVID-19 occurs, it happens quickly
- This guideline (page 6) is for patients who are **dying (believed to be in their last hours of life)** of COVID-19 irrespective of age, frailty or co-morbidities **who are overtly symptomatic.**
- Some patients die of COVID-19 without symptoms. Use clinical judgement to determine what is necessary. Guidance for mild/moderate symptoms, or if survival is anticipated, is given in the first part of this document.
- The on-call palliative medicine consultant is contacted via switchboard for advice 24/7

Advice for Lay Carers

Hospice UK have produced excellent COVID specific advice for carers available at https://www.hospiceuk.org/docs/default-source/echo/covid-19-echo/covid-19_care-at-home_guide_final.pdf

A 2-sided leaflet with practical advice for carers has been created; an image is shown below. This leaflet can be downloaded for free from:
https://helixcentre.com/project-end-of-life-toolkit
Practical care for a dying person

What you can do to practically care for someone who is in their last days and hours of life

NHS

It is important to be aware of what to expect and how to make the experience as comfortable as possible.

Your health team will advise you on the medications that can help with controlling symptoms experienced at the end of life.

Communication and environment

When approaching the end of life, people often sleep more than they are awake and may drift in and out of consciousness.

Try to imagine what the person you are caring for would want. Provide familiar sounds and sensations, a favourite blanket for example, or piece of music. Keep the environment calm by not having too many people in the room at once and avoid bright lighting. This can reduce anxiety even when someone is unconscious. Even when they cannot respond, it is important to keep talking to them as they can most probably hear right up until they die.

Pain

Some people may be in pain when they are dying. If they are less conscious they may grimace or groan to show this. There are medicines that can be given to ease pain.

Always check their positioning in bed to see if this can also help. They may be too weak to move and this can cause discomfort. Consider if they have any areas that are known to hurt, for example a bad back, and remember this when positioning them.

Feeling sick

Sometimes people can feel nauseated or sick when they are dying.

If vomiting, and unable to sit up, turn the person on their side to protect their airway. There are medicines that can be given to help relieve this.

Going to the toilet

Towards the end of life, a person may lose control of their bladder and bowel. Even though we expect someone to go to the toilet less as they eat and drink less, contact the health care team that is looking after them if they have not passed any urine for 12 hours or more as it can be uncomfortable.

Keep the person comfortable by regularly washing them and changing pads if they are wet or soiled.

Moving

The person will require washing at least once a day and regular turning every 2-4 hours to protect their skin from developing pressure sores.

Alternate their position from lying on their back to each side. You can use pillows or rolled up towels to support them and also to support under their arms and between and under their legs. When you are washing the person, look for signs of redness, or changes in the colour or appearance of their skin. Check the back of the head and ears, the shoulder blades and elbows and the base of the spine, hips and buttocks, ankles, heels and between the knees.

Mouth care

While people rarely complain of thirst at the end of life, a dry mouth can be a problem due to breathing mostly through their mouth.

It's important to keep lips moist with a small amount of un-perfumed lip balm to prevent cracking. Regularly wet inside their mouth and around their teeth with a moistened toothbrush whether he or she is awake or has lost consciousness. Check for sore areas and white patches on the tongue, gums and inside the cheek which can be sore. If this happens tell the person's healthcare professionals as it can be treated easily.

Breathlessness and cough

Breathlessness and cough can be another cause of agitation and distress and it can make it difficult to communicate. Don't expect the person to talk and give them time and space to respond. Reassure them that the unpleasant feeling will pass.

You can offer reassurance by talking calmly and opening a window to allow fresh air in. If possible, sit the person up with pillows rather than lying flat as this can help the sensation of not being able to breathe.

Before someone dies their breathing often becomes noisy. Some people call this the 'death rattle'. Try not to be alarmed by this, it is normal. It is due to an accumulation of secretions and the muscles at the back of the throat relaxing. There are medicines that can be given to help dry up secretions if it is a problem.

Agitation or restlessness

Some people can become agitated and appear distressed when they are dying. It can be frightening to look after someone who is restless. It's important to check if the cause is reversible like having a full bladder or bowel which can be reversed by using a catheter to drain the urine or medicines to open the bowels. Your health team can assess if this is necessary.

Check if their pad is wet to see if they are passing urine or if they are opening their bowels. If it's not either of these things, there are things you can do and give to help. Try to reassure the person by talking to them calmly and sitting with them. Touch can be effective in doing this too. There are also medicines that can be given to help settle and relax someone.

Looking after yourself

Caring for a dying person can be exhausting both physically and emotionally. Take time out to eat and rest. Try to share the care with other people when possible and remember it is OK to leave the person's side to have a break.

Washing

Sometimes it may be too disruptive for the person to have a full wash. Just washing their hands and face and bottom can feel refreshing.

To give a bed bath, use two separate flannels, one for the face and top half of the body and one for the bottom half. Start at the top of the body, washing their face, arms, back, chest, and tummy. Next, wash their feet and legs. Finally, wash the area between their legs and their bottom. Rinse off soap completely to stop their skin feeling itchy. Dry their skin gently but thoroughly. Only expose the parts of the person's body that are being washed at the time – you can cover the rest of their body with a towel. This helps to keep them warm and maintains their dignity.

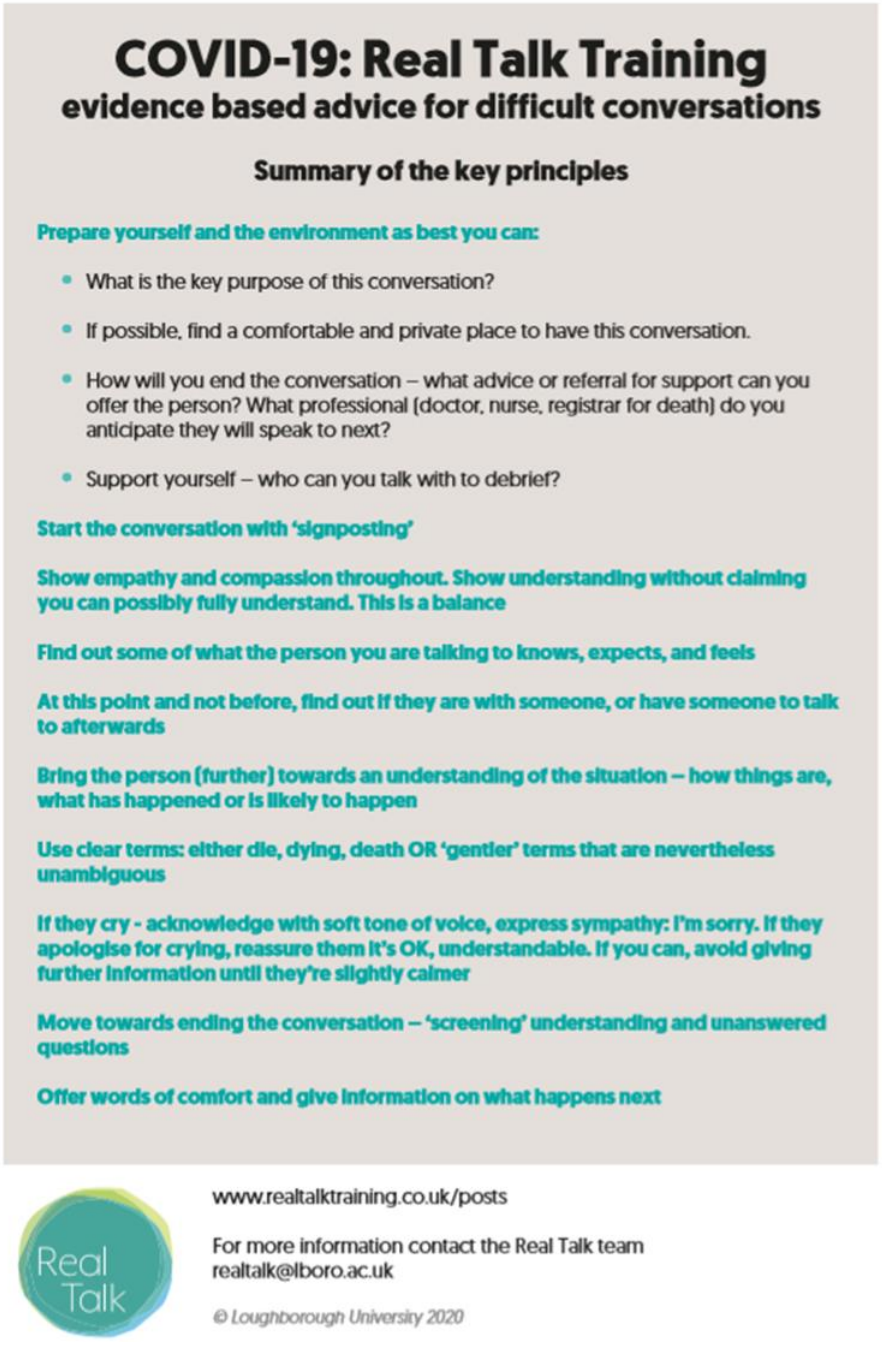
Eating

As the body shuts down it no longer needs food and fluid to keep it going. When a person is dying they often lose their desire to eat or drink and finally their ability to swallow. They can lose weight rapidly.

This is often difficult to accept because we often equate food with health and feeding people as an act of love. However, hunger and thirst are rarely a problem at the end of life.

Continue to offer a variety of soft foods and sips of water with a teaspoon or straw for as long as the person is conscious (but allow them to refuse it). It's important not to force food or drink onto someone who no longer wants it. Remember to sit them up when offering food and fluids to avoid choking.

When a person is no longer able to swallow some people want them to have fluids via other routes like a drip, but at the end of life this offers little, if any, benefit. The body cannot process the fluid like a healthy body can and it can be harmful to artificially feed and hydrate. Risks include infection at the insertion site or in the blood, and fluid overload resulting in swelling or even breathing problems.



COVID-19: Real Talk Training

evidence based advice for difficult conversations

Summary of the key principles

Prepare yourself and the environment as best you can:

- What is the key purpose of this conversation?
- If possible, find a comfortable and private place to have this conversation.
- How will you end the conversation – what advice or referral for support can you offer the person? What professional (doctor, nurse, registrar for death) do you anticipate they will speak to next?
- Support yourself – who can you talk with to debrief?

Start the conversation with 'signposting'

Show empathy and compassion throughout. Show understanding without claiming you can possibly fully understand. This is a balance

Find out some of what the person you are talking to knows, expects, and feels

At this point and not before, find out if they are with someone, or have someone to talk to afterwards

Bring the person (further) towards an understanding of the situation – how things are, what has happened or is likely to happen

Use clear terms: either die, dying, death OR 'gentler' terms that are nevertheless unambiguous

If they cry - acknowledge with soft tone of voice, express sympathy: I'm sorry. If they apologise for crying, reassure them it's OK, understandable. If you can, avoid giving further information until they're slightly calmer

Move towards ending the conversation – 'screening' understanding and unanswered questions

Offer words of comfort and give information on what happens next

Real Talk

www.realtalktraining.co.uk/posts

For more information contact the Real Talk team
realtalk@lboro.ac.uk

https://www.realtalktraining.co.uk/app/uploads/2020/03/COVID-19-Real-Talk-Summary-sheet-1.pdf

Additional educational resources including video teaching clips is available at
https://portal.e-lfh.org.uk/Catalogue/Index?HierarchyId=0_45016&programmeId=450

Other useful websites

NHS England specialty guidance Palliative Care and Coronavirus:

https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0081-Speciality-guide-Palliative-care-and-coronavirus.pdf

RCGP guidance for End of Life Care with Coronavirus, including care after death, death certification

https://elearning.rcgp.org.uk/mod/page/view.php?id=10537

For general advice regarding managing COVID-19 in care homes see also:
https://www.bgs.org.uk/resources/covid-19-managing-the-covid-19-pandemic-in-care-homes

Guidance for care after death:

https://www.gov.uk/government/publications/covid-19-guidance-for-care-of-the-deceased/guidance-for-care-of-the-deceased-with-suspected-or-confirmed-coronavirus-covid-19