Northamptonshire Healthcare
NHS Foundation Trust

Clinical guidance for the management of palliative care during the coronavirus pandemic

Version 7. 23rd April 2020

Adapted by Specialist Palliative Care Team, Northamptonshire Healthcare NHS Foundation Trust from: COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care, Association for Palliative Medicine and Northern Care Alliance NHS Group (22/3/20) and the Clinical guide for the management of palliative care in hospitals during the coronavirus pandemic, NHS England and NHS Improvement (27/3/20). COVID-19 rapid guidance: managing symptoms(including end of life) in the community. NICE guidance 163 (3/4/20)

Introduction

Within Northamptonshire we have access to specialist palliative care teams. These teams will be able to provide additional advice and guidance but it will not be possible for them to provide direct care to everybody who needs it, especially as the pandemic progresses. To seek specialist palliative care advice please telephone:

Cransley Hospice : 01536 452017
Cynthia Spencer Hospice 01604 678085

The following flowcharts relate to the care and relief of the common symptoms that may arise because of an infection with COVID-19 in adults, including how they should be managed if the patient is dying:

- breathlessness
- cough
- delirium
- fever
- pain
- respiratory secretions

These guidelines assume that the patient is receiving all appropriate supportive treatments and that correctable causes of the symptoms have been considered and managed appropriately. Examples include:

- antibiotic treatment for a superadded bacterial infection may improve fever, cough, breathlessness and delirium

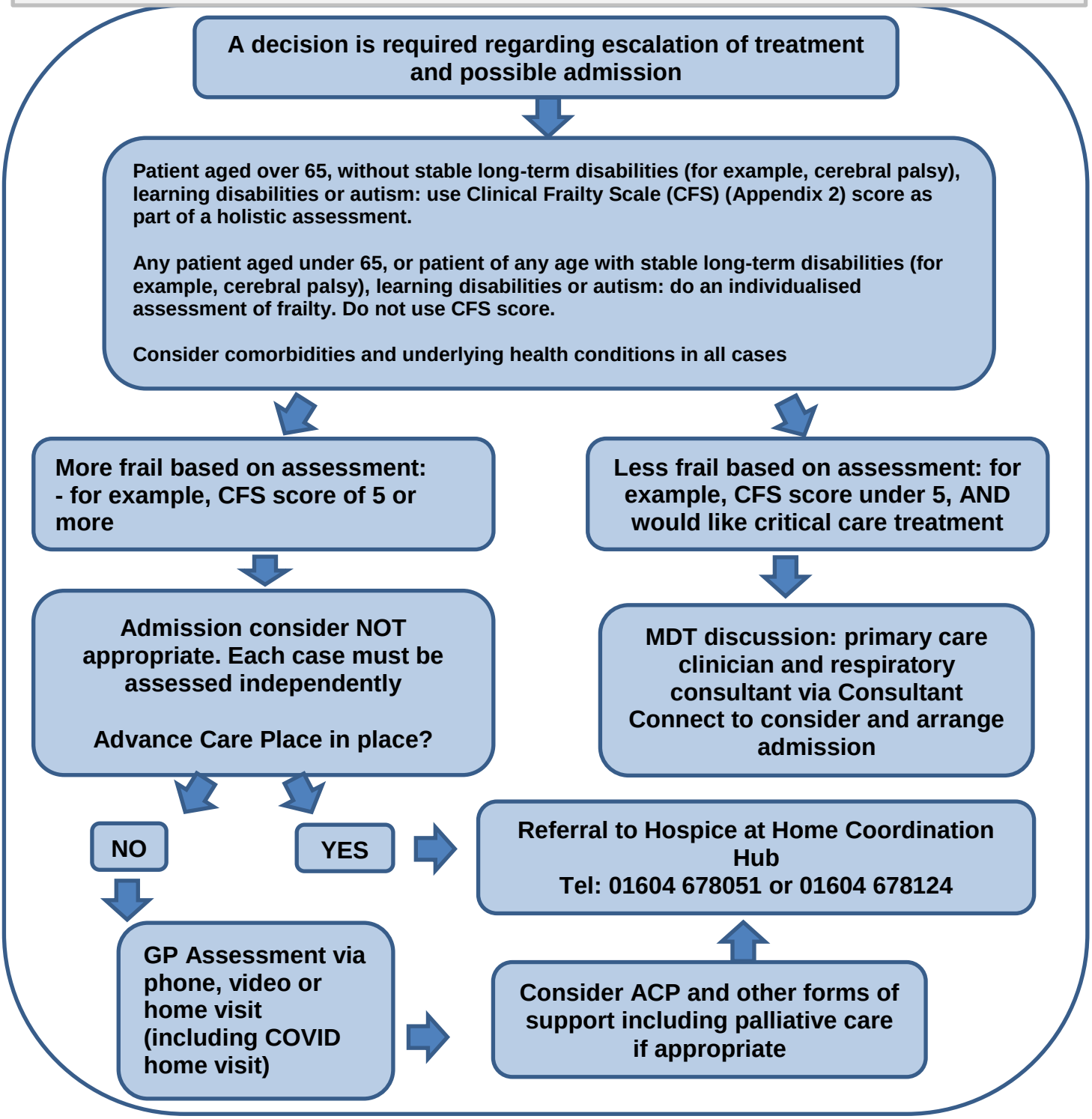
- optimising treatment of comorbidities (e.g. chronic obstructive airways disease, heart failure) may improve cough and breathlessness.

Typical starting dose of drugs are given. However, these may need to be adapted to specific patient circumstances, e.g. frail elderly (use even lower doses of morphine), or renal failure eGFR<30 seek advice from specialist palliative care (please contacts above).

Local palliative care guidelines already exist for the management of symptoms commonly experienced by people with advanced disease in the last days of life https://www.nhft.nhs.uk/download.cfm?ver=34844 , and should continue to be adhered to alongside this COVID-19 specific guidance. Both guidance, with their differences, incorporate current expert recommendations; this should not replace clinical judgement.

Clinical decision-making **in respiratory failure:** COVID-19 Outbreak

All emergency COVID positive and negative medical admissions to have Advance Care Plan (ACP) including decision regarding invasive ventilation discussed and recorded.
Refer to Lasting Power of Attorney, Advance Decision to Refuse treatment, Statement of Wishes if patient lacks capacity.



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.

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

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
- consider administering sodium chloride 0.9% via nebulizer

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 are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent
- consider administering sodium chloride 0.9% via nebulizer

Pharmacological measures

- humidified oxygen (no evidence of benefit in the absence of hypoxaemia)
- opioids may reduce the perception of breathlessness
    - morphine 2.5-5mg PO *prn (1-2mg SC if unable to swallow)
    - morphine modified release 5mg bd (titrate up to maximum 30mg daily)
    - midazolam 2.5-5mg SC *prn for associated agitation or distress

Anxiolytics for anxiety

- lorazepam 0.25mgs - 0.5mg SL *prn
- in the last days of life (if unable to swallow)
    - morphine 2.5-5mg SC *prn
    - midazolam 2.5mg SC *prn
    - if three or more prns required in 24 hours then consider morphine 10mg and / or midazolam 10mg over 24 hours via syringe pump, increasing to morphine 30mg / midazolam 60mg step-wise, as required

*PRN use indicated 2-4hrly

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 QDS
  if ineffective
- codeine linctus 15-60mg PO QDS
  or
- morphine sulphate immediate release solution 2.5mg PO 4 hourly
- carbocistiene 750mg PO TDS for viscous secretions

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)
- use of corticosteroids
- if severe / end of life: morphine sulphate 10mg over 24 hours via SC syringe pump,2.5–5mg SC *prn

*PRN use indicated 2-4hrly

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.

*Note the guidance given here differs from NHS England and NHS Improvement (27/3/20) due to local prescribing protocol and systems

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
- 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: first line

- lorazepam 0.5mgs to 1mg 4 times a day PO/SL* prn (maximum 4mgs in 24hrs). In elderly or debilitated patients 0.25mgs to 0.5mgs(maximum 2mgs in 24hrs)

or

- midazolam 2.5mg-5mg SC prn 1-2hourly

If three or more PRNs are given in 24 hours and are effective then consider pharmacological measures second line

Pharmacological measures: second line

Option 1
midazolam 10mg-30mg/24hr via a syringe pump)

and

haloperidol 2.5mg-5mg SC prn 1-2 hourly (1-5mg in the elderly).

Option 2
midazolam 10mg-30mg/24hr via a syringe pump)

and

levomepromazine 12.5-25mg SC prn 2-4 hourly (12.5mg in the elderly)

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

*PRN use indicated 2-4hrly

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:
  - 37.5°C or greater (oral)
  - 37.2°C or greater (axillary)
  - 37.8°C or greater (tympanic)
  - 38°C or greater (rectal)

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

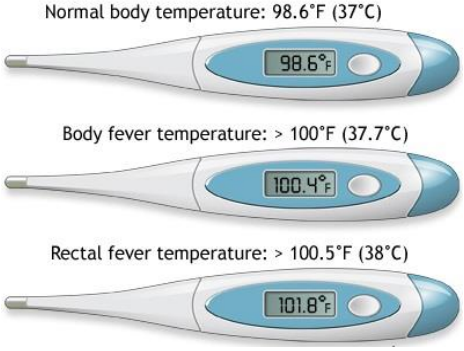
Non-pharmacological measures

- 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 patient is known or suspected to have an infectious agent

Pharmacological measures

- Paracetamol 1g PO / IV / PR QDS
- Ibuprofun 200/400mgs TDS or alternative NSAID

- if a patient is close to the end of life, it may be appropriate to consider use of NSAIDs via 24 hour SC syringe pump (e.g. parecoxib 40- 80mg in 24 hrs or diclofenac 75-150mgs in 24hrs)



Management of **pain:** COVID-19 Outbreak

Patients 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.

Patient 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 Paracetomol and start CoCodamol 30-60mg four times a day **regularly**
- Step 3:
  - Maximum CoCodamol, persistent or worsening pain: stop CoCodamol
  - Consider commencing strong opioid (e.g. oral morphine)

Commencing strong opioids

- start either an immediate-release (IR) or a modified-release (MR) preparation
- ALWAYS prescribe an immediate-release morphine preparation prn
- starting dose will depend on existing analgesia – calculate dose required
- monitor the patient 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)
- PRN dose calculation: one sixth of the 24 hour dose of morphine
- seek specialist advice if analgesia not effective

When the oral route is not available

- if opioid analgesic requirements are stable - consider transdermal patches (e.g. buprenorphine, fentanyl)
- if analgesic requirements are unstable consider initiating PRN subcutaneous opioids
- if constant pain and having more than three prns in 24hours consider prescribing a subcutaneous infusion via a syringe pump
- morphine is recommended as the first line strong opioid for subcutaneous use for patients, except for patients who have been taking oral oxycodone or those with severe renal impairment
- wide inter-individual variation exists and each patient should be assessed on an individual basis
- conversion from oral to SC morphine: oral morphine 5mg ≈ SC morphine 2.5mg
- seek specialist advice if necessary

Management of **Respiratory Tract Secretions:** COVID-19 Outbreak

- Noisy respiratory tract secretions can be a normal part of dying
- Consider whether they are troublesome or need treating at all
- Changing the patients position is the first step of management

Does the patient have troublesome respiratory tract secretions?

NO

Prescribe in anticipation of the symptom developing:

- Glycopyrronium 200mcgs by subcutaneous injection as required, up to every four hours

If symptoms develop, follow guidelines as for a patient who has respiratory tract secretions

YES

Consider:

- Patient positioning
- Stopping IV or subcutaneous fluids or PEG feed

Pharmacological measures

- If able to swallow consider carbocistiene 750mg PO TDS for viscous secretions
- Give Glycopyrronium 200 micrograms by subcutaneous injection as soon as symptom arises and as required, up to every four hours
- If two or more doses of Glycopyrronium have been given and are effective, consider prescribing a subcutaneous infusion of 800 micrograms Glycopyrronium via syringe pump over 24 hours.Review after 24 hours

If symptoms persist, increase the total daily dose to a maximum of 1.2mg Glycopyrronium over 24 hours

SUCTIONING: If felt to be helpful, AEROSOL GENERATING PPE REQUIRED

SUPPORTIVE INFORMATION

- In some patients, suction may be helpful
- This is a difficult symptom to treat and drugs may not be effective – remember to reassure relatives and friends
- Hyoscine hydrobromide is an alternative but is sedative and frequently causes confusion (400 micrograms stat and up to 2.4mg over 24 hours)

Discussions about goals of care (adapted from RCP, 2018)

Talking to patients 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 patients, often in emergency or urgent situations, and prioritise certain interventions and ceilings of treatment.

- 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

For GP/ANP discussion re inpatient referral to Cynthia Spencer Hospice call 01604 678085 or Cransley hospice 01536 452017

Patient in usual place of residence & in the last weeks/ days of life – appendix1

REFERRERS DECISION:
Critical Care not appropriate condition deteriorating:
Patient wishes to remain at home

Referral to Hospice at Home Coordination Hub
Tel: 01604 678051 or 01604 678124
7 Days a week 8am-6pm

Liaise with community nursing, Marie Curie Rapid Response & Age UK carers, as required

Triage and assessment undertaken if required by Community SPC Team and appropriate management organised

To discuss urgent needs if OOH: Please call Marie Curie Rapid Response Tel: 03301231014 24 hours/7 days/week

Care after death

Where coronavirus has been confirmed or, if the patient has been tested and no results are available yet, they will need to be treated as high risk when they die. Mementoes or keepsakes (for example, locks of hair, handprints, etc.) may be offered and taken at the time of care after death. These cannot be offered or undertaken at a later date. They must be placed in a sealed bag and the relatives must not open these before seven days. Full PPE should be worn for performing physical care after death.

An appropriately trained professional must complete the verification of death using PPE and maintaining infection control measures. As per national Covid guidance for primary care, the verification of death may be performed by a carer, relative or care home staff, it is not a requirement that a doctor should attend. Appropriate PPE should be worn. Support and guidance for verification of death is available. The appropriate doctor then completes the medical certificate of cause of death (MCCD) certificate as soon as possible.

COVID-19 is an acceptable direct or underlying cause of death for the purposes of completing the MCCD. It is not a reason on its own to refer a death to a coroner under the Coroners and Justice Act 2009. That COVID-19 is a notifiable disease under the Health Protection (Notification) Regulations 2010 does not mean referral to a coroner is required by virtue of its notifiable status

If referral to HM Coroner is required for another reason, a telephone conversation should take place as soon as possible with HM Coroner's Office and guidelines within Care after Death policy should be followed alongside this guidance

References

Association for Palliative Medicine and Northern Care Alliance NHS Group. COVID-19 and Palliative, End of Life and Bereavement Care in Secondary Care, https://apmonline.org/wp-content/uploads/2020/03/COVID-19-and-Palliative-End-of-Life-and-Bereavement-Care-27-March-2020.pdf [Accessed 27 March 2020]

Greater Manchester and Eastern Cheshire Strategic Clinical Network. Palliative Care Pain & Symptom Control Guidelines for Adults (5th edn). November 2019. https://www.england.nhs.uk/north-west/wp-content/uploads/sites/48/2020/01/Palliative-Care-Pain-and-Symptom-Control-Guidelines.pdf [Accessed 18 March 2020]

NHS England and NHS Improvement. Clinical guide for the management of palliative care in hospitals during the coronavirus pandemic https://www.england.nhs.uk/coronavirus/wp-content/uploads/sites/52/2020/03/C0081-Speciality-guide-Palliative-care-and-coronavirus.pdf [Accessed 27 March 2020]

National Institute for Health and Care Excellence. COVID-19 rapid guidance: managing symptoms(including end of life) in the community. NICE guidance 163 (3/4/20). https://www.nice.org.uk/guidance/ng163

Osborn M, Lucas S, Stuart R, Swift B, Youd E. Briefing on COVID-19: Autopsy practice relating to possible cases of COVID-19 (2019-nCov, novel coronavirus from China 2019/2020). Royal College of Pathologists, London. 2020. https://www.rcpath.org/uploads/assets/d5e28baf-5789-4b0f-acecfe370eee6223/fe8fa85a-f004-4a0c-81ee4b2b9cd12cbf/Briefing-on-COVID-19-autopsy-Feb-2020.pdf [Accessed 18 March 2020]

Royal College of Physicians. Talking about dying: How to begin honest Conversations about what lies ahead. RCP, London. 2018. https://www.rcplondon.ac.uk/projects/outputs/talking-about-dying-how-begin-honest-conversations-about-what-lies-ahead [Accessed 18 March 2020]

The Role of Palliative Care in a COVID-19 Pandemic. Shiley Institute for Palliative Care. 2020. https://csupalliativecare.org/palliative-care-and-covid-19 [Accessed 15 March 2020]

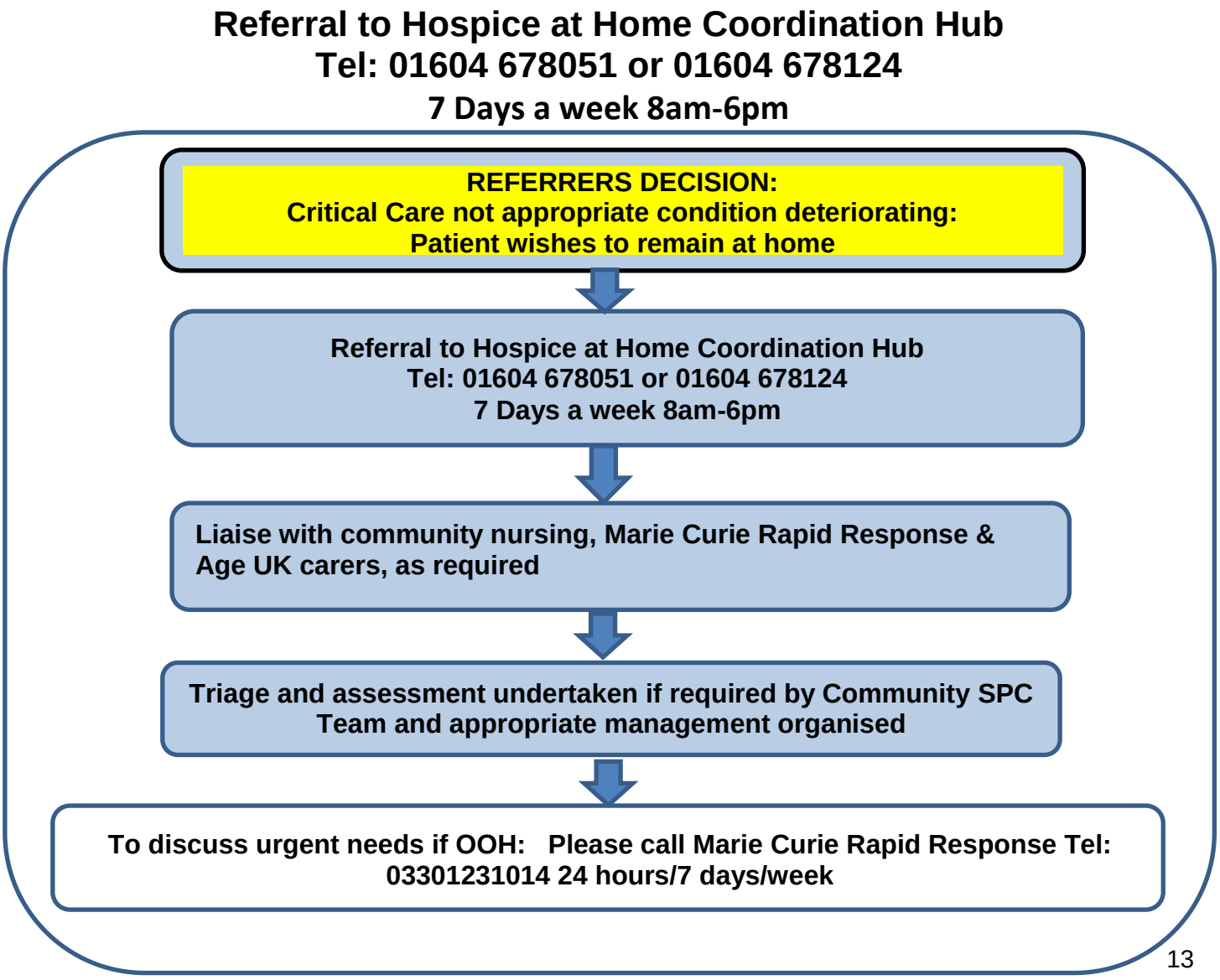
Appendix 1

Patient in usual place of residence & in the last weeks/ days of life and wants to die at home

HOSPICE @ HOME COORDINATION HUB has been set up by the Community Specialist Palliative Care Team during the Covid 19 crisis for **ALL** patients across Northamptonshire who are thought to be in the last weeks or days of life and wish to remain at home to die.

We will:

- Coordinate a patients care; involving all primary care teams, as appropriate
- Assess at home to review symptoms, equipment needed and social situation
- Ensure appropriate anticipatory medicines prescribed
- Ensure Special Patient Note completed, hence access to Marie Curie Rapid Response/Age UK carers
- As appropriate ensure DNACPR is requested and in place, alongside advance care planning
- Monitor situations through proactive telephone calls, providing advice and interventions and visits as necessary



Appendix 2

Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

The degree of frailty corresponds to the degree of dementia. Common symptoms in mild dementia include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In moderate dementia, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In severe dementia, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging. Revised 2008.
2. K Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495.

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