Publications approval reference: 001559

Specialty guides for patient management during the coronavirus pandemic

Clinical guide for the management of palliative care in hospital during the coronavirus pandemic

Keeping the care in healthcare

22 April 2020, Version 2 Updated 22 April with updates highlighted in yellow.

As clinicians, we all have responsibilities in relation to coronavirus and we should seek and act on national and local guidelines. We have a specific responsibility to institute best practice palliative care for all patients who require this, either with pre-existing palliative care needs or because of coronavirus infection. We may need to work outside our specific areas of training and expertise, and the General Medical Council (GMC) has already indicated its support for this in the exceptional circumstances we may face.

All hospitals have access to specialist palliative care teams, whether as in-house hospital palliative care teams or in-reach teams from local palliative care services. These teams will be able to provide advice and support, but it will not be possible for them to provide direct care to everybody who needs it, especially as the pandemic progresses.

This guidance is aimed at all professionals looking after patients with coronavirus, and their families, in the hospital setting.

This guidance does not replace evidence based local guidelines for palliative care. It is intended to support practice where local guidance does not already exist.

Goals of care

The treatment of patients suffering from coronavirus may be orientated towards:

- Supportive measures – for example, provision of fluids and/or oxygen.
- Targeted treatment – for example, provision of antibiotics to treat pneumonia.
- Organ support – for example, ventilator support, renal replacement therapy, etc.

These are aimed at preserving and prolonging life. It is important to remember that most people with coronavirus will survive and recover.

For those who are dying as a consequence of coronavirus and/or who do not wish to have active or invasive treatments, the switch in focus to high quality, compassionate, palliative care at the end of their life is equally important.

Treatment escalation planning

In the context of the coronavirus pandemic, decisions about further treatment escalation or shifting the focus to palliative care will need to take place rapidly. It may not be possible to have joint discussions involving the patient, those close to them and the clinicians because:

- the patient may have become ill and deteriorated very quickly, so they may not be able to fully participate in the decision-making.
- the patient's family and those closest to them may not be able to be present because of hospital infection control procedures, or they may be in self-isolation or looking after family members who are ill.

Conversations with the patient's family may well have to take place remotely. They are likely to be anxious and shocked by what has happened. These are not easy conversations to have but it is important that honest and timely conversations do take place. Senior clinicians should role model these conversations and support their teams to do so. Palliative care teams are skilled at these conversations and will do their best to support colleagues in doing so, but there will not be enough capacity for palliative care teams to undertake all conversations themselves.

See Appendix 2 for 'three talk' model for shared decision making.

Potential triggers for contacting specialist palliative care

- Patient already known to specialist palliative care.
- Symptoms not responding to clinical guidelines, including when a patient is imminently dying.
- Complex symptoms that require specialist advice.
- Decision not to escalate treatment in the face of deterioration or uncertain prognosis.
- Other complexities, for example, young children or other dependents who rely on the patient.

Role of Specialist Palliative Care teams

Specialist palliative care teams can provide:

- Advice, guidance and support to health care teams.
- Remote assessment, via window, if indicated and possible.
- Face-to-face assessment, if it is not possible to help remotely, for example, due to complexity, refractory symptoms or severe distress.
- Additional support for family and those close to the patient.
- Training and support for ward staff, for example, syringe drivers, prescribing, conversations to plan treatment escalation.
- Help to facilitate rapid discharge out of hospital using established connections with hospices, community palliative care teams and primary and community health care services.

Symptom management

Even though many patients will survive and recover from coronavirus, managing their symptoms during this period remains important. This guidance assumes that a patient has received all appropriate supportive treatments and management of their comorbidities has been optimised.

The good practice approach to symptom management is as follows:

- Correct the correctable, for example, give the patient antibiotics for a bacterial infection.
- Non-drug approaches, especially in mild to moderate disease – see Appendix 1.

- Drug approaches – see Appendix 1.

The most common symptoms of coronavirus that require attention are:

- breathlessness
- cough
- fever
- delirium

A synopsis of **the approach to these symptoms is set out in Appendix A** – originally published by the Association for Palliative Medicine and Northern Care Alliance NHS Group. Local guidelines may be used instead, provided these have been ratified appropriately within local governance structures.

Management of other symptoms, including pain, should be treated in accordance with local guidelines and policies.

Care of the dying patient

Despite the challenging circumstances of the coronavirus pandemic, it is important not to lose sight of the important elements of holistic care of the dying person. This includes:

- Effective communication including clear decision-making.
- Adequate pain and symptom management.
- Opportunity to prepare for death, including emotional and spiritual support (chaplains and faith leaders may play an important role here).
- Support for those close to the dying person, including the ability to keep in touch via phone or virtual communication (for example, Skype, WhatsApp)

Personal protective equipment (PPE) will need to be used by those visiting or attending to the dying person. As far as possible, try to make the immediate environment as conducive as possible to a peaceful and dignified death.

At the time of 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 for at least 72 hours. 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. 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

Coordination of support for the bereaved family and those close to the patient should be managed by the hospital's bereavement services, signposting them to locally and nationally available support services, including those provided by the voluntary sector. National guidance on the use of PPE, verification of death and medical certification should be followed.

Appendix 1

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 (for example, advanced lung cancer, lymphangitis carcinomatosis, SVCO, etc) **may** cause severe breathlessness/distress toward end of life.

Reversible causes

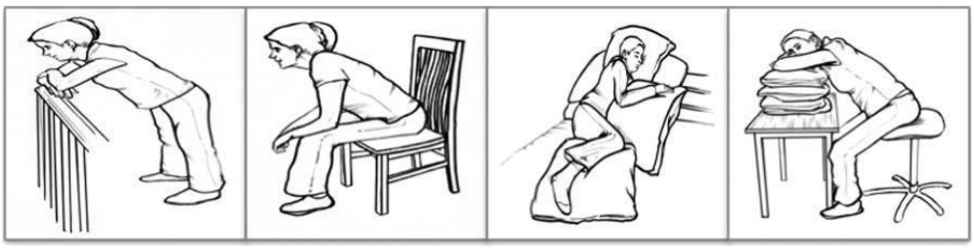
- both COVID-19 and non-COVID-19 conditions (advanced lung cancer, SVCO, lymphangitis carcinomatosis, etc) **may** cause severe distress or breathlessness towards the end of life
- check blood oxygen levels

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
- cool 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

Pharmacological measures

- humidified oxygen (no evidence of benefit in the absence of hypoxaemia)
- opioids may reduce the perception of breathlessness
  - morphine modified release 5mg bd (titrate up to maximum 30mg daily)
  - morphine 1-2mg SC prn 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 2.5mg 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



Forward lean 1 | Forward lean 2 | Adapted forward lean for lying | Adapted forward lean for sitting

Management of cough during a 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 and 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 and 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 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 during a 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 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. People with dementia are more prone to becoming delirious.

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: mild to moderate to severe

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

- start with 500 microgram / 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 patient's distress is severe and/or immediate danger to self or others

If the patient 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 (patients are usually unaware of what they are doing at this time) can be troublesome. Through use of the medications above, 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
- Adoption of daily screening, using Single Question in Delirium (SQiD) and / or 4AT rapid test for delirium (https://www.the4at.com/) to detect early and treat cause

Management of fever during a 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^{o}C or greater (oral)
  - 37.2^{o}C or greater (axillary)
  - 37.8^{o}C or greater (tympanic)
  - 38^{o}C or greater (rectal)
- associated signs and symptoms:
  - shivering
  - shaking
  - chills
  - aching muscles and joints
  - other body aches

Non-pharmacological measures

- reduce room temperature
- wear loose clothing
- cool the face by using a cool flannel or cloth
- oral fluids
- avoid alcohol
- portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

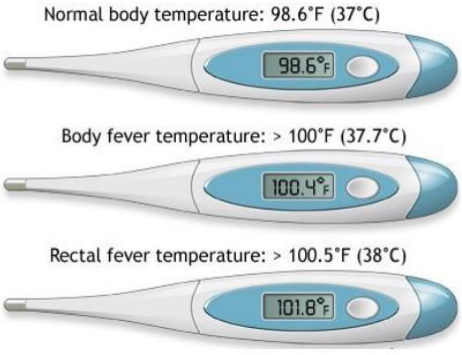
Pharmacological measures

- paracetamol 1g PO / IV / PR QDS

Or

- ibuprofen 200-400 mg tds (use lowest dose that works)

- if a patient 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)**



Source: https://apmonline.org/wp-content/uploads/2020/03/COVID-19-and-Palliative-End-of-Life-and-Bereavement-Care-22-March-2020.pdf

** Patients can take paracetamol or ibuprofen when self-medicating for symptoms of COVID-19, such as fever and headache, and should follow NHS advice if they have any questions or if symptoms get worse, as advised in the latest CAS alert. The policy statement on the use of non-steroidal anti-inflammatory drugs (NSAIDs) can be found here. **

Appendix 2

'Three talk' model for shared decision making can be used to guide the decision-making process:

1. **Team talk**

Clarify the diagnosis, establish that a decision needs to be made regarding the next steps and reinforce partnership

For example, 'You have coronavirus infection that has severely affected your breathing. ***We*** *need to decide on the next steps'*

2. **Option talk**

Check prior knowledge, then outline options along with what is known of the pros and cons of the options, then check understanding

3. **Decision talk**

Further establish that a decision needs to be made, reinforce empathy and partnership, check for information gaps

The decision

If possible, defer closure and give time for discussion with relatives, carers, advocates.

If not possible, '*What thoughts do you have about the best way forward?'*

If low confidence/high anxiety, empathy

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