Nationally Approved Palliative Care Symptom Management Medications for the COVID-19 Pandemic

All palliative patients should have at least 1 PRNs written for each of the symptoms below. Engage with your team to ensure comfort is the priority as patients approach end of life. CONSIDER SUBLINGUAL (SL) IF PATIENT AT HOME FOR EASE OF ADMINISTRATION BY WHANAU. THIS IS A GENERALIZED GUIDE, PLEASE USE CLINICAL JUDGEMENT OR CALL FOR ADVICE. More detailed references linked below.

PAIN
BREATHLESSNESS

- **Opioids** are the mainstay of treatment; can also help with cough; primarily use morphine unless GFR <30, then use fentanyl ; usually best and safest to start low and go slow with opioids but if condition advancing quickly and/or patient severely distressed, may require rapid dose titration
- Opioid naïve Patient
- **MORPHINE** - 2.5 - 5mg PO/ SL Q1 hour or 2.5mg-5mg SC Q1 hour PRN - Morphine is the best choice for breathlessness, unless GFR <30. 2.5-5mg Morphine elixir 10MG/ML can be given sublingual (SL)
- **OXYCODONE** 2.5mg PO Q1 hour or 1mg - 2.5mg SC Q1 hour PRN
- **FENTANYL** (if GFR < 30) – 12.5 - 25 mcg SC/ SL Q1hr PRN. Note: Can be given sublingually (SL)
- Patients already taking Opioids
- Continue previous opioid, consider increasing by 25% if in distress
- PRN dosing = Calculate total amount opiate and start opioid PRN at 10-15% of total daily opioid dose
- Example – On oxycontin 20mg PO BD; total oxycodone in 24hrs is 40mg; PRN dose is 4-6mg Q1hr PRN
- Give PRN: Q1h PRN ; always review/re-evaluate if patient needs 3 consecutive doses
- Common Opioid Conversions:
- 1mg oxycodone = 1.5mg - 2mg morphine
- SC dose is equal to half the oral dose (example M-Eslon 20mg BD = 40mg oral morphine in 24hrs = 20mg morphine in a 24hr pump)

ANXIETY
BREATHLESSNESS
RESTLESSNESS
ACUTE EVENT

- **MIDAZOLAM** 2.5-5mg SC or SL Q1 hour PRN anxiety
- **MIDAZOLAM** 5-10mg SC or SL Q1 hour PRN acute events (seizure, massive bleed)
- Remember breathlessness often leads to anxiety and both need treating

AGITATED DELIRIUM
NAUSEA / VOMITING

Delirium	LEVOMEPROMAZINE	HALOPERIDOL
Mild:	6.25mg SC Q1hrs	0.5-1mg SC Q1hrs
Moderate:	12.5mg SC Q1hr	1-2mg SC Q1hrs
Severe	25mg SC Q1hrs	2.5mg SC Q1hrs

- Nausea/vomiting - Use levo or haloperidol at mild dosing levels
- Haloperidol 2mg/ml elixir can be given SL
- Levomepromazine 25mg tablets can be crushed and given SL; 25mg/ml ampoules can be given SL
- SL DOSE SAME AS SC DOSE LISTED ABOVE

RESPIRATORY SECRETIONS

- FOR USE ONLY IN THE DYING PATIENT- Advise family & bedside staff: not usually uncomfortable, just noisy, due to patient weakness / not able to clear secretions; changing positions can be even more helpful then medications
- **HYOSCINE BUTYLBROMIDE** 20mg SC/ SL Q2hrs PRN (non-sedating)

Other Notes:

- DO NOT USE NEBULISERS IN COVID POSITIVE PATIENTS (MAY SPREAD INFECTION)
- Review patients regularly – assess if treatment effective in 1-2 hours; if patient needs 3 consecutive doses of opioid or midazolam in less than 4 hours, needs re-evaluation and possible titration of medications.
- If signs of opiate toxicity (myoclonus, hallucinations or opioid-induced hyperalgesia) a dose reduction or switch may be required
- Consider a subcut pump when a patient is using >4-5 PRNS in a 24hr period.
- **Example starting dose of a pump**: morphine 10mg, midazolam 10mg and levomepromazine 6.25mg over 24hrs. Each medication should be increased or decreased depending on use of PRNs in previous 24hrs. ***However***, do not always include all PRNs used in previous 24hrs to calculate pump as a patient requires more meds in PRN form than in a pump as they are "playing catch up" when only receiving PRN meds.
  Call Hospice doctor on-call if questions about dosage of a pump. It is helpful to have the past 24 hours of medications given and their effectiveness when calling.
- If subcut pump not available, then may give opiate and/or benzodiazepine SC/ SL Q4hours regularly. For example: patient using 30mg morphine SC over 24hr period – instead of pump, give morphine 5mg SC/ SL Q4hrs and continue PRN morphine in addition.
- **SL MAY BE EASIER FOR FAMILIES TO USE AT HOME THAN SUBCUTANEOUS**

Example Comfort Cares PRN order set for an opioid naïve patient

Morphine 2.5-5mg SC/ SL Q1hr PRN pain or breathlessness
Midazolam 2.5-5mg SC/ SL Q1hr PRN breathlessness, anxiety or acute event
Levomepromazine 6.25mg SC/ SL Q1hr PRN nausea/agitated delirium
Hyoscine Butylbromide 20mg SC/ SL Q1hr PRN respiratory secretions

This document is rapidly assembled in response to the pandemic and is continuing to evolve as we receive feedback. Feedback to rachel@hospice.org.nz. Document originally developed by Hospice Taranaki from National Guidelines.

Nationally Approved Palliative Care Symptom Management Non-Drug Measures for the COVID-19 Pandemic

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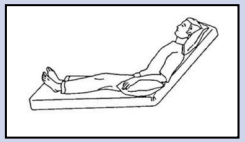
BREATHLESSNESS

- **Breathing techniques to ease breathlessness**
- 'Smell the roses, blow out the candles'
- Focus on slow breathing from the tummy – rise the tummy with the in-breath Focus on long relaxed breaths out
- Pursed lip breathing for those with COPD

- **Positioning**
- Sit upright, legs uncrossed, let shoulders droop, keep head up; lean forward
- See illustration for if ambulant/ in bed



- **Distraction**
- Turn on the radio/ TV, or some music
- Chat about hobbies or interests if able to talk
- Phone a family member

- **Anxiety reduction**
- Actively explore and address and fears or concerns
- Fear of suffocation or choking is commonly described, but in practice almost never seen. Provide reassurance

AGITATED DELIRIUM

- Look for a reversible cause and treat if possible– medications/ infection (although in the case of COVID-19 this may not be reversible)/pain/dehydration/hypoxia. Constipation will aggravate a delirium.

- Speak quietly and reassuringly to the patient. They will often be very frightened. Frequently re-orientate them as to where they are, who you are, what is happening to them. Explain what you are going to do before doing any cares or touching the patient. Try and approach them from in front so they do not get a fright.
- Keep familiar things around them and try and keep them in a familiar environment.
- Ensure adequate lighting – a night light may be helpful.
- Try and keep those who are caring for them as people who they are familiar with – family members are particularly useful.
- Try not to move a patient with delirium out of their usual environment – if at all possible.
- Explain to the family what is going on as this can be very distressing to watch. If the patient is paranoid or altered personality reassure the family that this is not the patient's fault. Explain that the brain's usual filters are not working, and the patient is getting a very distorted view of reality.

PYREXIA

- Cool the room temperature
- Light, loose pyjamas only. Cool flannels and appropriate bedding

ANXIETY

- **Relaxation**
- Focus on relaxing each individual muscle. Ask the person to close their eyes, or choose a spot in front of them to focus on
- Visualise a relaxing scene or colour
- See also distraction and anxiety reduction techniques above

Mouth cares: Continue to offer sips of drinks/ice-chips/ice-blocks as patient is able to tolerate for comfort

For dry mouth – use lubricating mouth gels where available, brushing of teeth where able/appropriate - Moistened mouth swabs, or gentle brushing of the teeth/tongue/inner cheeks

Use moistening lip balm/creams (ie: Vitamin A cream or similar) to prevent dry/chapped lips.

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Nationally Approved Palliative Care Communication Essentials for COVID-19

- **Communication is very important at this time. It is better for patients and families to receive bad news than no news at all.**
- **Remember: 'the smallest kindness can make all the difference'. Your communication can be very powerful.**

Focus on using phrases such as "I wish" "I'm concerned" "I hope" "May I suggest"
"We want to make sure you have the best care possible"

Goals of Care Discussions

Medical preparation

Check for ACP/ Advance directives

Which medical interventions will help if he /she deteriorates?

Develop a medical opinion before seeing the patient

Start to think in terms of shared goals of care

This is the outcome of a decision-making process between the patient, family, whānau and the clinical team(s)

Try to identify the overall direction for an episode of care (eg. curative, restorative, focused on improving quality of life or providing end-of-life care) and any limitations on medical treatment.

Check understanding

"I am so sorry you are feeling so unwell"

"Can I start with what you understand so far?"

Elicit discussion preferences

Do you like to talk about what is happening?" "Or not?"

"Is there someone else we should talk to?"

Discuss serious news & prognosis

Tell them the information they need and want in small chunks

"I'm afraid the news is not good" "severe pneumonia I am not sure you will pull through"

"I know this is not what you wanted to hear"

Values goals hopes fears

"If you were to get sicker despite everything we are doing, what would be most important to you?"

"What things worry you the most?"

Make a recommendation

"In the light of your illness and what you have told me, may I make a recommendation?"

"My recommendation is to do everything we can with the resources we have to get you through this"

"Do all we can with what we have to help you recover and if things are not going well, we will keep you comfortable"

"I'm worried that you won't pull through and we should focus on your comfort'

Giving Bad News

PREPARATION

- Before you call, what can you find out about the patient?
- What do you need?
- Ground yourself so you can be present with the person you are calling- try to find a private space to call from (or a personal ritual such as touching a greenstone around your neck)

INTRODUCTION

- Can I check I am speaking with the daughter of [___]
- My name is [___]; I am one of the nurses/doctors at [___] facility. Are you the right person for me to talk to about [___].

GIVE THE SERIOUS / BAD NEWS

- Give the news in short 'chunks' and stop: they are very likely to be overwhelmed and will most likely not hear anything else.
- I am afraid that I have some serious news. *Pause*. Your grandmother has a severe pneumonia.
- OR I am worried that time is now short. *Pause. S*he may die very soon.
- OR I am afraid I have some very sad news. *Pause.* Your grandmother died in the early hours this morning.

EXPECT AN EMOTIONAL RESPONSE OR SILENCE

- Leave silence. They may want to speak. If not and you feel you need to say something:
- "I am so sorry that this is happening / has happened"
- OR "I can't imagine how this is for you."
- Leave silence again.

THEY START ASKING QUESTIONS

- Answer slowly as best as you can.
- "She was very comfortable when the nurse checked in on her, and died around 4am this morning."
- "The virus unfortunately caused a serious pneumonia."

SUPPORTS AND NEXT STEPS

- "Right now, is there someone you can talk to about this?"
- "Is there someone else you would like me to call?"
- Explain the process from here with regard to burial / cremation / funeral arrangements
- Explain that someone will notify their GP to inform of death – may be another support for family.

Resources for palliative symptom management and communication:

Hospice NZ COVID resources - https://www.hospice.org.nz/resources/covid-19-response
BC Centre for Palliative Care - https://bc-cpc.ca/cpc/publications/symptom-management-guidelines/
Health Quality and Safety Commission NZ – Serious Illness Conversation Guide
Feedback to rachel@hospice.org.nz

Te Ara Whakapiri – Care of the dying leaflet
https://www.health.govt.nz/publication/te-ara-whakapiri-principles-and-guidance-last-days-life
Goals of Care: Developed by Jonathan Adler and Anne O'Callaghan
Contact your local hospice or palliative care service for input as needed