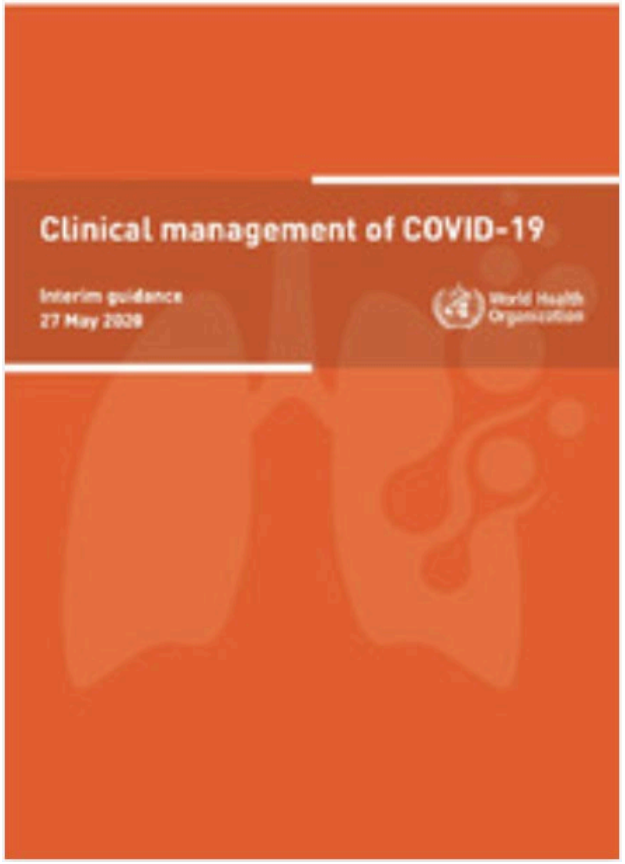

- **We recommend to identify, in all patients with COVID-19, if they have an advance care plan for COVID-19 (such as desires for intensive care support) and respect their priorities and preferences to tailor the care plan and provide the best care irrespective of treatment choice.**
- **Palliative care interventions should be made accessible at each institution that provides care for persons with COVID-19.**

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SPES BONA

Purposeful, Planned, Positive

PALLIATIVE CARE

PALPRAC

Palliative Care

Dr Rene Krause and the Palliative Care Team Groote Schuur Hospital

Indications for Palliative Care

South African Supportive and Palliative Care Indicator Tool

The aim of the indicator tool is to identify adult patients who have serious health related suffering due to a life-limiting or life-threatening illness and whose condition is deteriorating. It is likely that the patient's death will be a consequence of this illness. This is a generic tool for the South African setting to identify patients who will benefit from a palliative care approach in conjunction with usual care by the treating clinician. This patient may need to be referred to a palliative care team to optimize care.

Specific Disease Indicators

This tool is for deteriorating patients with an advanced life-limiting illness where all available and appropriate management has been offered:

Solid-organ Cancer

- Malignancies not amenable to curative surgery or radical oncological interventions
- Metastatic cancer with symptoms
- Progressive metastatic cancer
- Too frail for oncological interventions

Dementia / Frailty

- Unable to dress, walk or eat without help
- Swallowing difficulties resulting in a significant reduction in oral intake.
- Fractured femur
- Recurrent febrile episodes or infections

Hepatic Disease

Cirrhosis with one or more complication in the past year:

- Diuretic resistant ascites
- Hepatic encephalopathy complication
- Hepatorenal syndrome complications
- Bacterial peritonitis
- Recurrent variceal bleeds

Neurological Disease

- Progressive deterioration decline in physical and/ cognitive function.
- Swallowing difficulties resulting in a significant reduction in oral intake.
- Recurrent pneumonia, breathlessness or respiratory failure.

Respiratory Disease

- Patients on continuous oxygen.
- Breathlessness at rest or on minimal effort between exacerbations.

Heart / Vascular Disease

- Heart failure or extensive, untreatable coronary artery disease with breathlessness or chest pain at rest or on minimal exertion.
- Severe, inoperable peripheral vascular disease.

Trauma

- Severe burns (ABSI score >10)
- Brain injury with clinical deterioration where further interventional treatment is futile.

Renal Disease

- Stage 4 or 5 chronic kidney disease
- Patients stopping or not for dialysis.
- Kidney disease complicating other life-limiting conditions or treatments.

Infectious Disease

- HIV
  HIV with deteriorating clinical condition and failing the best available treatment.
- TB
  TB with deteriorating clinical condition and failing the best available treatment.

Hematological Disease

- Haematological cancer with recurrent admissions for transfusions, infections and/ bleeding.
- Haematological condition or cancer with deteriorating clinical condition and failing the best available treatment.

Look for two or more general indicators of deteriorating health

- The patient with 2 or more unplanned health care facility visits within a period of 3 months with deteriorating life-limiting illness despite optimal treatment.
- Performance status is poor or deteriorating, with limited reversibility e.g. the person stays in bed or in a chair for more than half the day.
- Depends on others for care due to increasing physical and/or emotional and/or mental health problems.
- The person's carer needs more help and support in caring for the patient.
- The person has had significant weight loss (10%) over the last few months or remains underweight.
- Persistent symptoms despite optimal treatment of the underlying condition(s).
- The person (or family) ask for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Review supportive, palliative care and care planning

- Review current treatment and medication so the patient receives optimal care.
- Consider referral for specialist assessment if symptoms or needs are complex and difficult to manage.
- Agree current and future care goals, and a care plan with the patient and family.
- Plan ahead if the patient is at risk of loss of capacity.
- Record, communicate and coordinate the care plan.

Mild to moderate COVID-19 cases	Less likely to need oxygen	Will need medical care and symptom control if required and psycho-social support.
Severe COVID-19 cases	Less likely to need mechanical ventilation. Likely needs oxygen	Symptom control and psycho-social support of patient and family are needed
Critical COVID-19 cases	Probably needs mechanical ventilation.	Palliative care should be integrated with life sustaining treatment. Psycho-social support of patient and family are needed
Expectant of not surviving COVID-19	Survival not possible with care available	Urgent palliative care is required

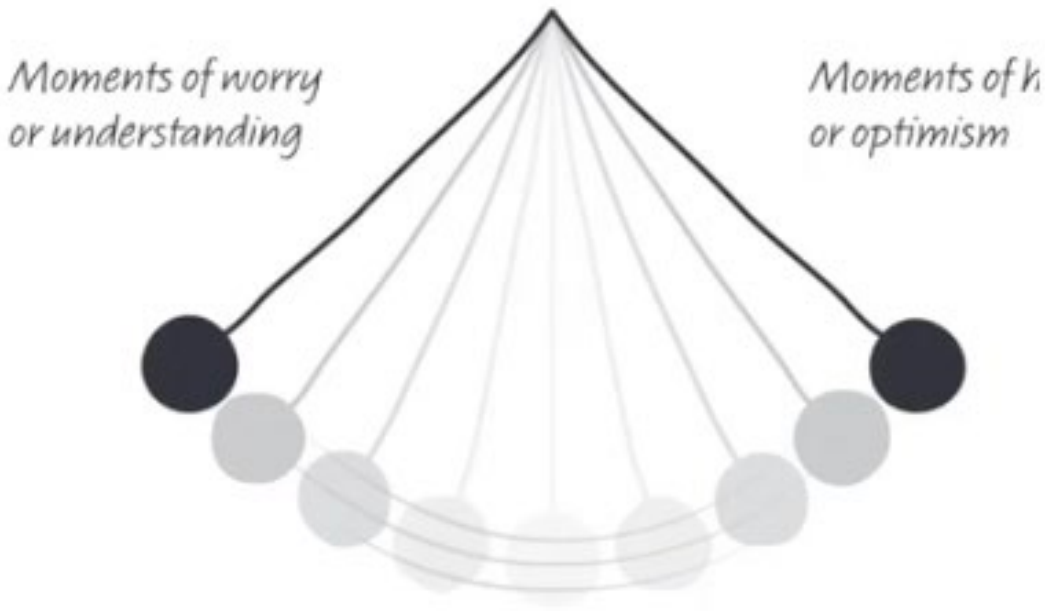

Image from Juliet Jacobsen EAPC Research Conference 2021

Communication

- Requires teamwork
- You are not dealing with just patients, there are families behind these patients
- Multiple losses
- Poor communication has negative impact the patient, the family and the health care team.
- Key point about communication
  - Regular
  - Structured
  - Documented (especially who you spoke to)
  - Identify people at risk
  - Clear indication when the family can expect the next phone call or how to contact the ward.

PALPRAC

The Association of Palliative Care Practitioners of SA
215-486 NPO
https://palprac.org/

Palliative Care in the COVID19 Wards (May 2020)

All Patients

- Document category status and any relevant conversations with patient and/or family
- Communicate decisions with whole team
- Include non-pharmacological management and give medication orally where possible
- Wear appropriate PPE at all times.

"To care and note to harm"

- Stay calm and use PPE
- Communicate clearly & compassionately
- Your presence means a lot
- Don't forget the family

Specific Symptom Management

Relevant to all symptomatic COVID patients, no matter the expected outcomes

Fever

- No fans
- Wet cloth, remove some bedding

Paracetamol 1g 6hrly orally or IV if unable to swallow

Anxiety

- Be calm, reassuring and present

Lorasepam 1-2mg q2 prn until settled, then 6-12h prn OR
Alprazolam 0.5–1mg 8h prn
Midazolam 2,5mg-5mg SC q1h until symptoms settle OR
Diazepam 2,5mg orally. Can repeat as needed until sedated - then divide needed dose by 2 and give q12h (long acting)

Dyspnoea

- No Nebulizing
- Correct positioning
- Breathing techniques- 'smell the roses, blow out the candles'
- O2 if sats <90% (ensure correct settings)

Oral morphine 2,5-5mg q 1h until settled, then q4h; OR
Morphine 1-2mg SC/IV q 1h until settled, then q4h OR
Fentanyl patch 12.5mcg-25mcg/h q72h (may take up to 8-12h to be effective; give morphine po/sc to start)
Note:
Increase dose by 25% if patient is struggling, until comfortable
Use lower doses and bigger dosage intervals in elderly
Add metoclopramide 10mg 8gpo/iv/sc for nausea side effect

Dosing

Dosing will also depend on treatment intent i.e. Palliation vs end-of-life care.
Higher doses of midazolam may be used if the patient is terminal.
COVID symptoms might advance rapidly, needing dose escalation; reassess!

Agitation/Delirium

- Exclude reversible causes like hypoxia, urinary retention, constipation
- Use medication only if patient is distressed, hallucinating, danger to self or others

Haloperidol 0,5mg orally q1h prn OR
2.5-5mg IV/SC stat
Can add Haloperidol 5mg in syringe driver over 24hrs

If syringe driver is available:
Initial stat oral/sc doses of morphine and midazolam will be required.
Calculate oral morphin
total dose by 2-3 and
ous sc infusion.
Suggested starting dos
Morphine 15mg + Met
10mg.
Check specifications o
Note on subcutaneous
Can use a 23G butterfl
down with clear dressi

Short Report

PALLIATIVE MEDICINE

Palliative Medicine
1–6

DOI: 10.1177/0269216320935361
journals.sagepub.com/home/pmj
SAGE

End-of-life care in COVID-19: An audit of pharmacological management in hospital inpatients

Timothy Jackson, Katie Hobson, Hannah Clare, Daniel Weegmann, Catherine Moloughney and Sally McManus

Clinical guidelines

Availability of Internationally Controlled Essential Medicines in the COVID-19 Pandemic

Katherine Pettus, PhD,[a,*] James F. Cleary, MB, BS, FAChPM,[b] Liliana de Lima, MHA,[a] Ebtesam Ahmed, PharmD,[c] and Lukas Radbruch, MD[d]

Medication to contain the delirious patient

- Very distressing to observe and negatively affects therapeutic intervention like oxygen delivery.
- Be vigilant to diagnose delirium and document it.
- Reverse the reversible, if possible
- Non-pharmacological interventions have repeatedly demonstrated to be superior to any drug.
- Physical restraint is not recommended and may worsen the agitation.
- Assess on daily basis by doing a 360-degree assessment
- Start with haloperidol 0,5mg every 12hourly. Can increase the dose and the can be given subcutaneously
- Second line Olanzapine 2,5mg 12 hourly orally.

- Terminal agitation
  - Midazolam 2,5 mg subcutaneously and increase or provide continuously through a syringe driver. (See Palprac guidelines)
  - If a patients is actively dying the need for an oxygen mask that can further agitate a patient must be reviewed.

Dyspnea

- Subjective experience not depending on the level of oxygen saturation
- Oral morphine 2,5mg stat and then depending on response and can be increased

OR

- Morphine sulphate 1mg subcutaneous and can be converted to a continues subcutaneous infusion.
- Remember the anti-emetics whenever prescribing an opioids.

Bereavement requires a team

- ‘it is not easy saying goodbye over the telephone’
- Families are isolated
- Talk to the right family members and if possible, have collateral information from the treating team.
- The treating team need to be available if complex questions arise about the treatment
- Multiple losses in families
- Families need facts
  - Funerals
  - Contact details
- Children can be referred for specialist bereavement (Paeds Pal)
- Community referrals
- Some family members may need to be referred for further counselling
- Need to follow up.