SESLHD GUIDELINE COVER SHEET

NAME OF DOCUMENT	COVID-19 – End of Life Symptom Management
TYPE OF DOCUMENT	Guideline
DOCUMENT NUMBER	SESLHDGL/101
DATE OF PUBLICATION	November 2021
RISK RATING	Medium
LEVEL OF EVIDENCE	National Safety and Quality Health Service Standards: Standard 1 – Clinical Governance Standard 4 – Medication Management Standard 5 – Comprehensive Care
REVIEW DATE	November 2024
FORMER REFERENCE(S)	SGH-TSH CLIN590 Clinical Business Rule COVID-19 – END OF LIFE SYMPTOM MANAGEMENT
EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Clinical Stream Director, Palliative Care and End of Life Care
AUTHOR	Palliative Care Service
POSITION RESPONSIBLE FOR DOCUMENT	Nurse Manager Cancer Services SESLHD Kim.rigg@health.nsw.gov.au
FUNCTIONAL GROUP(S)	Cancer and Palliative Care Services
KEY TERMS	COVID-19, End of Life, Symptom Management
SUMMARY	A district document to provide guidance to staff when managing end of life symptoms in patients diagnosed with COVID-19.

Feedback about this document can be sent to SESLHD-Policy@health.nsw.gov.au

COVID-19 End of Life Symptom Management

Section 1 - Background

This Guideline is to support clinicians who are caring for patients with COVID-19 at the end of life. It provides a summary and flowchart of symptoms, and relevant prescribing and administration of medications for end of life care (EOLC). The aim is to ensure standardised care across all clinical groups, in order to achieve safe, high quality end of life symptom management.

**To be used as an adjunct to:*

SESLHDPD/308 - Terminal Care / End of Life Plan

SESLHDPR/666 - Administration of Subcutaneous Medications in Palliative Care using a NIPRO Surefuser™

SESLHDPR/175 - Administration of subcutaneous medications in Palliative Care: a) Intermittent b) via a syringe driver

Section 2 – Principles

- Elderly people and people with chronic and /or life limiting illnesses are more susceptible to being infected and becoming seriously ill and symptomatic from COVID-19 (PCA March 2020).
- COVID-19 end stage symptom and care management may include (NSW Health, 2020):
    - Acute hypoxia
    - Agitation/delirium
    - Acute dyspnoea and/or tachypnoea
    - Fever
    - Audible chest secretions
    - Emotional Distress
    - Conservative EOL care without respiratory non-invasive support

Section 3 – Medication Prescribing and Administration

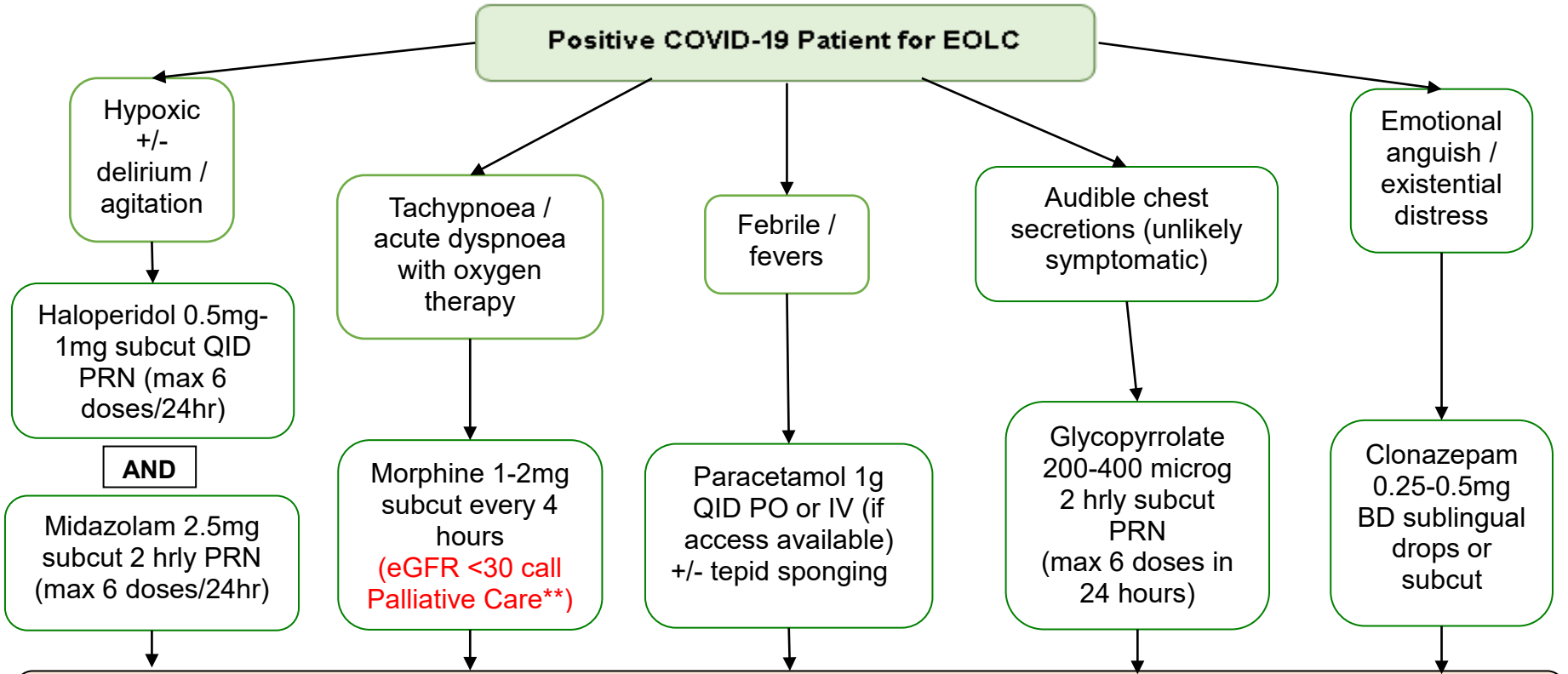
This guideline will support staff to confidently prescribe appropriate doses of opioid and benzodiazepine, proportional to symptom requirements, in patients approaching end of life due to COVID-19.

The Admitting Medical Team should access the *EOLC COVID-19 Powerplan* on eMeds.

The below flowchart is based on a standard or usual clinical scenario. If there are any concerns or specific clinical circumstances requiring specialist palliative care input, the admitting medical team should contact the local palliative care team for further advice.

NOTE: If a Surefuser is not available, the same medications as recommended for a Surefuser can be either;
(1) Administered via Niki T34 syringe driver, OR
(2) Injected into 100mL 0.9% sodium chloride and infused subcutaneously via an IMED pump over 24 hours.

Section 4 - END OF LIFE CARE (EOLC) FOR COVID-19 FLOWCHART



** If Patient has renal impairment with an eGFR < 30 then as per the SESLHDPR/669 - Management of HYDROmorphone in adult patients in SESLHD acute care facilities contact the Palliative Care Team to recommend an appropriate dose of HYDROmorphone (Dilaudid).

4.1 Suggested PRN medications when Surefuser commenced <u>at above doses:</u>

- Morphine 2mg subcutaneous (subcut) every 2 hours as required (PRN) for dyspnoea.
- Midazolam 2.5mg – 5mg subcut every 2 hours PRN for terminal agitation +/- respiratory distress despite appropriate opioid dosing and titration.
- Glycopyrrolate 200-400microg subcut every 2 hours PRN (max 6 doses/24hr) for terminal secretions

4.2 Patient remains symptomatic: If patient remains symptomatic, despite medications via the Surefuser commencing at the doses as per the Flowchart and the use of PRN medications, then consider increasing the medications via the Surefuser to include:

Increase the Morphine based on PRN doses administered
+
Increase Midazolam based on PRN doses administered

Administer over 24 hours via Surefuser

If there are any concerns or questions about symptom management and syringe driver management and titration, the admitting medical team should liaise with the Palliative Care Team for advice.

4.3 Adjusting PRN medications

- Adjust the PRN dosage of opioids and benzodiazepines as the Surefuser doses change. In general terms, PRN doses are calculated using total dose of opioid or benzodiazepine in 24 hour device divided by 6. Using this as a starting point, a dose range may be used according to the clinical context. This dose can be given every 2 hours PRN (max 6 doses/24hr).
    - For example, Morphine 20mg/24hr subcut in Surefuser → divided by 6 → 3mg Morphine every 2 hours PRN (max 6 doses/24hr) [rounded down to nearest whole number]
    - For example, Midazolam 40mg/24hr subcut in Surefuser → divided by 6 → 5mg – 10mg Midazolam every 2 hours PRN (max 6 doses/24hr)
- In addition, in anticipation of potential refractory hypoxic delirium with agitation, chart PRN Levomepromazine 25mg – 50mg subcut TDS (SAS access from pharmacy) as second line to the PRN Midazolam.
- If patient remains agitated, and is requiring PRN Levomepromazine for symptom control of agitation, please contact Palliative Care for advice re commencing/ adding Levomepromazine to the Surefuser.

4.4 Breakthrough medications

- **Breakthrough medication**: medication that is administered between prescribed regular doses for symptom management.
- Continuous Infusion Devices:
    - **Surefuser™:** an elastomeric infusion pump designed to deliver drugs over a specific period of time.

- **Niki T34 Syringe driver**: battery operated syringe driver device used to administer a constant dose/s medication over a prescribed period of time.
- **IMED:** volumetric infusion pump and controller which provides accurate and automatic infusion of intravenous drugs and fluids.

Section 5 – Responsibilities

Line Managers will:

- Ensure staff are aware of and adhere to the guideline as outlined.

Medical Staff will:

- Be familiar with the policies and procedures outlined in this document + the location of the ***EOLC COVID-19 Powerplan*** **on eMeds** for patient with significant respiratory distress.
- Liaise with Palliative Care if they any concerns or questions related to care and comfort of patients approaching end of life due to COVID 19.
- Document all actions and conversations in the patient's eMR progress notes.

Nursing Staff will:

- Be familiar with the policies and procedures outlined in this document prior to providing subcutaneous medications to patients'
- Document all actions and conversations in patient's eMR progress notes.
- Liaise with nursing and medical staff in the medication management of the patient.

Section 6 – Documentation

Prescribing/administration documentation should be as per existing medication CBR/Policy:

- In the inpatient eMR progress notes.
- On MAR in eMR (syringe driver power plan) or in eRIC (ICU) or as per downtime procedures.
- Commence the Surefuser observation form.

Section 7 – References

Australian and New Zealand Society of Palliative Medicine. Essential palliative and end of life care in the COVID-19 pandemic. 2020. <https://www.cebm.net/wp-content/uploads/2020/08/Essential-PEOLC-in-the-COVID-19-pandemic-2.pdf>

Bajwah, S., Et al. 2020. *Managing the Supportive Care Needs of this affected by COVID19.* European Respiratory Journey.

Clinical Excellence Commission, 2017, *Last Days of Life Toolkit*: *Guidance for Prescribing Last Days of Life Medications – Adult* Patients < https://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0007/359269/LDOL-Toolkit-Implementation-Guide-Prescribing-Last-Days-of-Life-Medications.pdf>

Downar, J., & Seccareccia, D. 2009. *Palliating a Pandemic: "All Patients Must Be Cared For".* Journey of Pain and Symptom Management.

Jackson, T., et al. 2020. *End-of-life care in COVID-19: An audit of pharmacological management in hospital inpatients*. Palliative Medicine, Palliative Medicine 2020, Vol. 34(9) p.1235–1240

NSW Health 2020, *COVID-19 and end of life care in hospital - Palliative care,* NSW health < https://www.health.nsw.gov.au/Infectious/covid-19/communities-of-practice/Pages/guide-eolc-hospital-palliative.aspx

Palliative Care Australia, 2020, *Statement on Coronavirus Disease 2019 (COVID -19) March 2020* <https://palliativecare.org.au/wp-content/uploads/dlm_uploads/2020/03/Palliative-Care-Australia-statement-FINALupdated-2603.pdf>

Section 8 – Revision and Approval History

Date	Revision no:	Author and approval
August 2021	DRAFT	Initial draft
September 2021	DRAFT	Approved by Executive Sponsor.
September 2021	1	Amendments made by Quality Use of Medicines Secretariat. Provisionally approved by Quality Use of Medicines Executive and published.
September 2021	2	Listed on Draft for Comments page. Amendments made by Director of Palliative Care and others via SESLHD Draft for Comments page. Approved by Executive Sponsor. To be tabled at Quality Use of Medicines Committee.
October 2021	2	Approved at October QUMC noting 'sub-committee approval endorsed'. To be tabled at Clinical and Quality Council for approval.
November 2021	2	Approved at Clinical and Quality Council.