EMERGENCY PALLIATION PROTOCOL FOR NON-VENTILATED COVID-19 PATIENTS – INPATIENT VERSION[1]

Preamble

For patients triaged to supportive end of life care based on either

1. Advanced directive
2. Severe adverse prognostic factors and resource allocation

Underlying principles

1. Patients have a right to relief of suffering at the end of life
2. Application of simple protocols can provide relief in most situations
3. COVID-19 can be a rapidly progressive disease and some patients will need very intensive symptom control urgently
4. Expert consultative back up by palliative care service will be available 24/7
5. Aim to optimise relief and minimise staff exposure
6. Sensitive and effective communication is a core element of care

Essential medicines

1. Transdermal fentanyl (preferred option to minimise staff exposure time)
2. Parenteral morphine
3. Parenteral midazolam
4. Parenteral major tranquilizers (haloperidol, olanzapine or chlorpromazine)

Other important alternatives

1. Transmucosal fentanyl (abstral, fentora, PecFent, instanyl)
2. Intravenous fentanyl
3. Parenteral lorazepam
4. Oral methadone
5. Intravenous diazepam

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Palliation of breathlessness/dyspnoea

If breathless despite oxygen supplementation

- Loading dose IV/SC Morphine 2.5-5 mg
- Start transdermal fentanyl 12 mcg/hr OR morphine CR PO 10-30 mg 12 hrly
- IV/SC morphine 2.5-5 mg as needed, up to every 20 minutes
- Provide IV/SC antiemetic if necessary

If this is inadequate

- Increase dose of transdermal fentanyl to 25 mcg/hr
- Rescue dose of IV/SC morphine 5-10 mg as needed, up to every 20 minutes
- Titrate to effect, dose can be increased every 24 hours

OR

- Start morphine infusion 50 mg/100 cc
- Staring dose 2 cc (1 mg)/hour, titrate to effect
- Rescue dose 5 mg IV push
- Monitor for adequacy of relief, excessive drowsiness
- Titrate to effect, dose can be increased every 12 hours

BE PREPARED TO INCREASE DOSING RAPIDLY IF NEEDED

If agitated

- Use midazolam 2 mg IV/SC push as needed
- If repeated doses are necessary, start midazolam infusion 1 mg/hr
- Titrate midazolam to effect
- Alternatives: diazepam 5 mg IV, chlorpromazine IV 12-25 mg, olanzapine 5-10 mg SC (8-12 hrly)

BE PREPARED TO INCREASE DOSING RAPIDLY IF NEEDED

If still distressed, consider palliative sedation

- Call palliative care consultation 24/7

Monitoring

- ✓ **Adequacy of relief**
- ✓ **Excessive sedation**
- ✓ **Side effects**
- ✓ **Frequent use of rescue doses**

cc=cubic centimetre; CR=controlled release; hr=hour; hrly=hourly; IV=intravenous; mg=milligram; mcg=microgram; PO=orally; SC=subcutaneous

The palliative care clinicians for emergency consultation - List palliative care contact phone numbers

Palliation of agitated delirium

Evaluate for reversible triggers

- Hypoxemia
- Urinary retention/constipation
- Medication reaction
- Uremia, hyponatraemia, hypoglycaemia
- Dehydration
- Urosepsis

If this is inadequate

- Trial of haloperidol SC 0.5 mg 8 hrly or olanzapine 5 mg SC or SL 8 hrly
- Haloperidol can be titrated to maximal dose of 5 mg x3 SC

If agitation persists, or if patient is unconscious and agitated

- Use midazolam 2 mg IV push as needed (up every 5 minutes until relief)
- If repeated doses are necessary, add midazolam infusion 1 mg/hr
  INFUSION RATE CAN BE INCREASED HOURLY
- Some patients will need more than 10 mg/hr

Alternatives

- Diazepam 5 mg IV, chlorpromazine IV/IM 12-25 mg, olanzapine 5-10 mg SC (8-12 hrly)

BE PREPARED TO INCREASE DOSES RAPIDLY IF NEEDED

If still distressed, consider palliative sedation

- Call palliative care consultation

hr=hour; hrly=hourly; IM=intramuscular; IV=intravenous; mg=milligram; SC=subcutaneous; SL=sublingual

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Palliative Sedation for Patients Near Death

When SC infusion device is available

- Start: midazolam 10 mg bolus SC
- <70 years of age 2.5 mg/hour
- >70 years of age 1.5 mg/hour
- Bolus of 5 mg SC as needed 2 hrly
- If repeated bolus doses are needed, dose increment in steps of 50% 4 hrly

BE PREPARED TO INCREASE DOSES RAPIDLY IF NEEDED

SC infusion without pump

- Start: midazolam 10 mg bolus SC
- SC midazolam 5-10 mg 4 hrly; increase in steps of 50% 4 hrly if needed
- Bolus of 5 mg SC as needed 2hrly

BE PREPARED TO INCREASE DOSES RAPIDLY IF NEEDED

Other options

- Rectal diazepam 10 mg every hour till sufficient sedation is reached, in average 40-60 mg/24 hour required

  OR
- Lorazepam tablets or injection fluid sublingual, 2-4 mg 4 hrly

  OR
- Clonazepam sublingual, 1-2.5 mg 6 hrly

hrly=hourly; IV=intravenous; mg=milligram; SC=subcutaneous

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Communication tips

COMMUNICATION WITH PATIENT

Polite introduction	"Good morning Mr/Mrs/Ms ...I am Doctor... (introduce yourself by name)
Reassurance	"…we're doing our best to look after you and take care of you..."
Acknowledge feelings	"I understand that this is an emotional time, anyone would be scared/anxious (repeat the term used by the person) ...it is normal to be worried and scared."
Reassure	We are doing our best to help you and make sure you don't suffer."
Non-abandonment	"I am very sorry that you cannot have your loved ones around you, but as you can see, you are here with us, you are not alone, we will stay with you"
Family	"Even though your family cannot stay in the ward, they are very close" "They call every day to find out how you are, and we make sure we talk to them regularly"

COMMUNICATION WITH FAMILY

Polite introduction	"Good morning Mr/Mrs/Ms ...I am Doctor... (introduce yourself by name) "I'm so sorry that due to this awful situation we cannot meet in person to talk about your father/mother/wife/etc."
Provide information	**Provide information gradually, if possible, using simple language** "We are doing everything in our power for you/your father/mother/brother/sister at this very difficult time…" "...Unfortunately, her/his situation remains fragile and there is a real risk that she/he may deteriorate" "This is a life-threatening situation"
Acknowledge feelings	"I understand that this is an emotional time, anyone would be scared/anxious (repeat the term used by the person) ...it is normal to be worried and scared."
Non-abandonment	"I am very sorry that you cannot be here, but your family member is not alone, we are with her/him"
Reassure	"We are doing our best to make sure that she/he gets the best of care and that she/he doesn't suffer"
Commit to open communication	"We will keep you informed of any further changes" "What is the best number to call you on?"

COMMUNICATION WITH FAMILY WHEN PATIENT IS DYING

Polite introduction	"Good morning Mr/Mrs/Ms ...I am Doctor... (introduce yourself by name) "I'm so sorry that due to this awful situation we cannot meet in person to talk about your father/mother/wife/etc."
Provide information	**Provide information gradually, if possible, using simple language** "We have done everything in our power for you/your father/mother/brother/sister at this very difficult time…" "...Unfortunately, medicine has its limits and now with Mr/Mrs/Ms (name the patient) we have reached that limit." "…his/her condition is deteriorating…"
Sorry statement	"We are sorry"
Explain plan	"At the moment we are doing our best to prevent any suffering..." "…he/she will be settled at the end and won't feel any pain in the final moments of his/her life…"
Commit to open communication	"We will keep you informed of any further changes" "What is the best number to call you on?"