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 2024
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 2027
FORMER REFERENCE(S)	SGH-TSH CLIN590 Clinical Business Rule COVID-19 – END OF LIFE SYMPTOM MANAGEMENT
EXECUTIVE SPONSOR	Clinical Stream Director, Palliative Care and End of Life Care
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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.

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

"COVID 19 emergency end of life supportive medications – ADULTS" Power plan on eMED

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

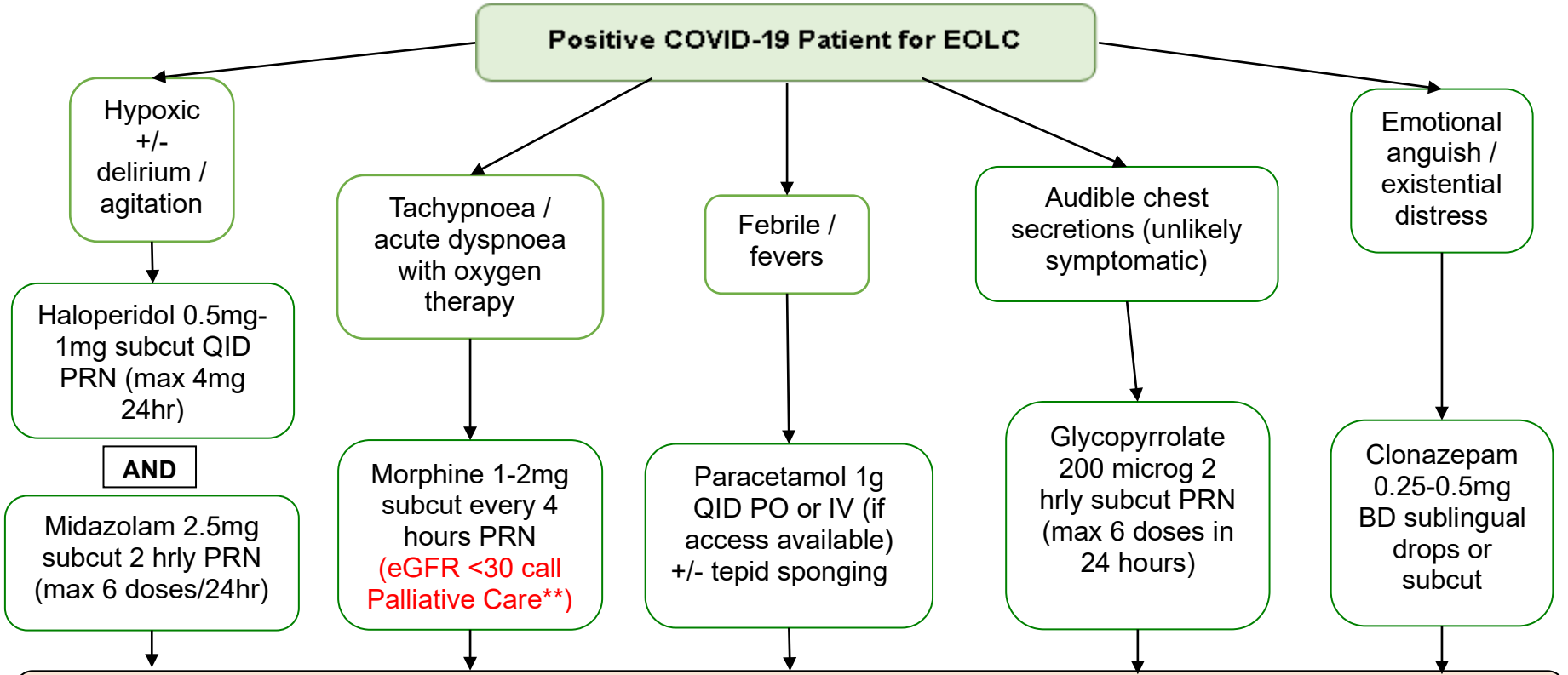
Section 3 – Medication Prescribing and Administration

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.

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 Syringe Driver /Surefuser commenced at above doses:

- 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. Max 30mg in 24 hours
- Glycopyrrolate 200 microg subcut every 2 hours PRN (max 6 doses/24hr) for terminal secretions if not infective

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 Syringe driver /Surefuser to include:

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

Administer over 24 hours via Syringe driver/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 Syringe driver/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 Syringe driver/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 via intranet form) 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.
- **NOTE: Surfuser device NOT used at St George Hospital or The Sutherland Hospital**
  - **Niki T34 Syringe driver**: battery operated syringe driver device used to administer a constant dose/s medication over a prescribed period of time.
  - **BD BodyGaurd™ T:** battery operated syringe driver device used to administer a constant dose/s medication over a prescribed period of time.

4.5 Caveat:

- The above flowchart is in an ideal scenario **BUT if no palliative care on site and patient experiencing significant distress THEN** use the PRN medications as recommended and commence syringe driver ASAP of the following:

Morphine 12mg + Midazolam 20mg combined with water for injection over 24 hours
via Syringe driver/Surefuser

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 ***"COVID 19 emergency end of life supportive medications – ADULTS"*** Power plan on eMED 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 Syringe driver /Surefuser observation form.

References

Australian and New Zealand Society of Palliative Medicine. Essential palliative and end of life care in the COVID-19 pandemic. 2020.

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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

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Version and Approval History

Date	Version	Author and approval notes
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.
13 November 2024	2.1	Minor review: some medication doses reviewed and lowered. Approved at SESLHD Drug and Therapeutics Committee.