Palliative Care in the midst of the COVID-19 epidemic (23 March 2020)

These are some suggestions for managing adult patients currently receiving palliative care outside of a hospital context during the COVID-19 epidemic.

a. ***Advance care planning***: Prior to your patient developing symptoms of COVID-19 (acute respiratory illness with sudden onset of at least one of the following: Temp>38˚C, dyspnoea, new cough, sore throat) *discuss what they would prefer to do (remain at home or go to hospital)* if such symptoms develop. Make a note of the decision and the name of their designated health proxy.
b. Encourage compliance with the strategies of hand hygiene & social distancing.
c. If the family has engaged an external carer, they should be asked to report if they develop a fever and a cough. This should be done before coming to work.
d. Discuss what the family should do if they observe symptoms suggestive of COVID-19.
e. Explain that 80% will develop a mild illness, 15% will develop severe disease and 5% become critically ill and may die. The severity of COVID-19 infection increases with age and with the severity of any underlying medical co-morbidity. Symptoms of COVID19 infection can escalate quickly, and decisions regarding escalation of care must be discussed early and are best not made in the midst of an escalating crisis.
f. Assess the patient's condition using the **CRB65 score**[1]. Give 1 point for any of the following:

New confusion	respiratory rate >30/min	BP<90/60	Age>65

Mortality risk: Score 0 = <1% risk; Score 1 or 2 = 1- 9% risk; Score 3 or 4 = 10 – 22% risk. Discuss this result very carefully with the patient and the family.

g. Those with **mild symptoms (CRB65 = 0 or 1):**
    i. Start symptomatic treatment with paracetamol for pain and fever. Encourage appropriate fluid intake.
    ii. Do not use Ibuprofen or NSAIDs as they have been implicated in aggravating the condition of some patients with COVID-19[1].

iii. Explain that your patient should remain in one room until better and have exclusive use of one bathroom, if possible. These rooms should be well ventilated (open windows and an open door). Limit the movement of the patient elsewhere in the house and ensure shared spaces e.g. kitchen and bathroom are well ventilated. Household members to maintain a distance of at least 1m (preferably 2m) from the ill patient. Limit the number of caregivers; ideally caregivers should be in good health with no underlying chronic or immunocompromising conditions. Non-essential visitors should not be allowed.

iv. Encourage hand washing, masks, appropriate disposal of tissues, dedicated crockery and cutlery, cleaning of surfaces with 0.1% hypochlorite or similar cleaning agent. Refer to the WHO guideline "Home care for patients with suspected COVID-19 infection".

v. Patients should be encouraged to wear a medical mask to contain respiratory secretions. If this is not feasible or not tolerated, cover the mouth and nose with disposable paper tissue when coughing or sneezing, and discard immediately after use. If handkerchiefs are used, wash after each use with soap and water.

vi. Arrange for a family member to report progress to you on a daily basis using WhatsApp. Warn of possible sudden deterioration.

h. Those with **worsening symptoms (CRB65 = 2-4):**

i. Refer to hospital if the patient and family request this. Notify the hospital and follow their protocol for triage and admission. Keep up to date with the availability of beds in your local hospital and their admission criteria.

ii. If the patient wishes to remain at home, continue supportive palliative care:

- Low dose (5mg) oral morphine 4 hourly for **dyspnoea** if not already on opioids.
- Consider home oxygen if this is feasible and practical in the home environment.
- Consider an antibiotic if a secondary bacterial infection is suspected but only where this meets the goals of care.

- Sublingual Lorazepam (Ativan, Tranqipam) 1-2mg as required if **restless.** Repeat at 10-minute intervals until peaceful.
- Those patients that are unable to swallow will need to be given medication via a syringe driver or, if that is not available, via intermittent sub-cut injection. Morphine and midazolam should be given in appropriate doses.
  - Suggested starting doses subcut in a syringe driver over 24 hours in opioid naïve: morphine 30mg +midazolam 15mg
  - Alternatively morphine 30mg + midazolam 15mg + "water for injection" filled to 16ml: give 3ml slowly every 4 hours (6 doses in 24 hours) subcut or iv.

  The dosage will vary depending on the patient's current prescription and needs.

iii. Throughout this time provide appropriate information regarding your assessment and the possible future scenarios. We are in a time of great uncertainty and significant risk. Patients and families appreciate doctors who are willing to listen to their fears and provide adequate information and guidance.

iv. Refer for counselling and spiritual guidance if appropriate.

Testing of palliative patients who are bedbound/housebound with possible COVID-19 infection:

In patients with clinical suspicion and contact with a person either confirmed or under investigation for COVID, the NCID PUI form will need to be completed. However many palliative care patients will not be able to visit testing sites. The need for further testing will need to be determined by health authorities.

Protection for health care providers in the community:

Refer to the WHO guideline "Rational use of personal protective equipment for coronavirus disease (COVID-19)". The recommendation differs according to the setting, personnel and type of activity involved.
It is important to note that basic protection and excellent (hand) hygiene is all that is required in day to day interactions with asymptomatic patients. Wear a medical mask if you have respiratory symptoms.

Here are some guiding principles around PPE for healthcare workers when caring for palliative patients in the home with known or suspected COVID-19:

1. Wear gloves, medical mask and perform hand hygiene after disposing the mask.
2. Doctors and patients must stay at least 1m, and preferably 2m apart except during examinations.
3. If tolerated the patient needs to wear a surgical mask.

Note:

N95 masks, face-protectors, goggles and gowns are reserved for procedures where respiratory secretions can be aerosolized such as intubation in known or suspected cases of COVID-19.

Note:

What if you have been in contact with infected person?

- Self-quarantine is advised in Hong Kong when contact was within 2m of a patient for >15mins; in Singapore that would be for >30minutes.
- If exposure <15mins, but within 2m for >2mins: keep working but wear a surgical mask and have temperature checked twice a day.
- If brief incidental contact: monitor yourself.

References:

1. Gavin Barlow, Dilip Nathwani, Peter Davey. The CURB65 pneumonia severity score outperforms generic sepsis and early warning scores in predicting mortality in community-acquired pneumonia. Thorax 2007;**62**: 253–259.
doi: 10.1136/thx.2006.067371
2. Keeping the Corona Virus from infecting heath care workers. Atul Gawande; New Yorker, March 21 2020
https://www.newyorker.com/news/news-desk/keeping-the-coronavirus-from-infecting-health-care-workers

3. World Health Organization. Home care for patients with suspected novel coronavirus (COVID-19) infection presenting with mild symptoms, and management of their contacts. Interim guidance. 04 February 2020.
4. World Health Organization. Rational use of personal protective equipment for coronavirus disease (COVID-19). Interim guidance. 27 February 2020.

Please feel free to contact info@palprac.org should you need to be put in contact with a Palliative Care Clinician in your area.