Palliative Care Teaching
Tuesday 2nd March 2021

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- Recognising dying and the importance of planning ahead
- Palliative care in Covid-19

The Importance of Planning Ahead

Episode 126

Is my patients dying?

- They appear to be deteriorating
- What has gone before?
- Is there anything reversible? Eg hypercalcaemia, infection, opioid toxicity
- Think-Is there any harm in raising this as a possibility?

Case Discussion 1

- Refereral received for 54 year old woman
- History on MND
- Recent discharge from Salford
- Divorced
- 2 sons age 16 and 21 –splitting time between mum and dad
- Has been to Wythenshawe for assessment re NIV.
- Found to be in Type 2 respiratory failure
- Unable to tolerate NIV even with anxiolytics

Case Discussion 1

- Referral states refusing to discuss DNACPR
- Reluctant to discuss Advance care planning

Case Discussion 1

- What do you need to consider?
- What conversations do you need to have?
- What do you need to do?

Case Discussion 1

- Asked to see urgently 4 days later.
- Fall
- Crawling to sons room in the night to seek help
- DNs concerned as refusing feed
- Son concerned she is ‘Giving up’

Case Discussion 2

- **16th July**
- Referral received 50 year old woman with breast cancer
- 2018 surgery, adjuvant chemo, herceptin
- Fit and well until 10 weeks prior –severe abdominal and back pain
- Scan revealed lung mets, Bone mets T2,T3,T9
- Liver largely replaced by tumour
- Awaiting Palliative Chemo

Case Discussion 2

- **20th July**
- Telephone clinic
- Abdominal pain, back pain,
- Struggling to get out of a chair or walk upstairs
- What might concern you?
- Arranged to see her the following day when she came for bloods on The Churchill Unit

Case Discussion 2

- **21st July**
- Proximal muscle wasting, otherwise neuro OK
- On Dexamethasone 6mg
- Decreased AE right side of chest
- Abdo distended but soft
- Mild jaundice
- Distressed,
- 2 grown up daughters at home, husband outside in car
- Adjusted analgesia, reduced steroids, referred AHP, discussed urgent visit with Community Nurse Specialist following week after chemo

Case Discussion 2

- **27th July**
- Phoned as arranged to make date for visit
- Fatigue, less mobile, muddled, drowsy
- ‘Agonising sore throat’
- Advised call Christie –Christie advised RBH AandE
- Admitted with neutropenic sepsis

Case Discussion 2

- **1st August**
- Patient died in hospital
- What were the challenges?
- What could we have done differently?
- When should we have started advance care planning discussions?

Case Discussion 3

- 62 year old man
- Bowel cancer right hemi-colectomy Oct 18
- Spinal surgery Dec 18. Stabilization L4 then XRT.
- Referred for pain management. Mobilizing with stick
- Palliative chemo
- Not wanting to discuss outlook

Case Discussion 3

- May 2019-mixed response to chemo-explained to patient
- Sept 2019 Daughter upset. Dad says his cancer has gone. Scan explained. No change in liver mets.
- Oct 2019 More back pain. More radiotherapy to L4
- Jan 2020 re-referred to community as unable to mobilize and get to clinic

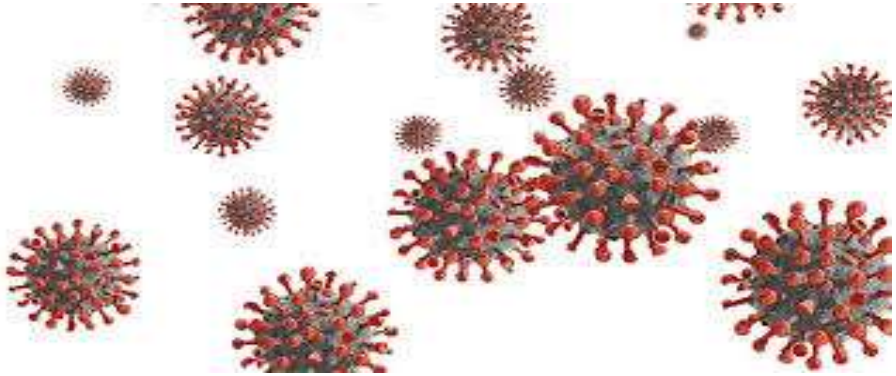
Case Discussion 3

- Jan 2020, largely bed bound, issues with care packages, expecting weekly visits
- AHP discussing emphasis on QoL
- Declined an electronic record
- Always declines hospice
- Defers to daughter re DNACPR
- Feb 2020 oncology discussed unfit for further chemo, April 2020 explained prognosis likely weeks to months

Case Discussion 3

- August 2020
- Admitted to RBH in bowel obstruction
- DNACPR-again deferred to daughter.
- Daughter asking if family have a say. Long conversation regarding DNACPR
- DNACPR in place.
- Discharge home
- Visited – still asking about a trip to India despite being unable to weight-bear, sit comfortably for any length of time, in bowel obstruction

Palliative Care in Covid-19



Lessons Learnt

- APM were quick to release guidance
- Trust ethical framework for difficult decisions re escalation of care-We learnt it is not always ‘Cut and dried’
- Things changed quickly, patients condition changed quickly
- Symptoms did not always respond as quickly with our usual management
- Complicated by visiting restrictions, the need to isolate for loved ones visiting

APM guidance-breathlessness

Non-pharmacological

- positioning
- relaxation techniques
- reduce room temperature
- cooling the face by using a cool flannel or cloth
- portable fans are not recommended for use during outbreaks of infection or when a patient is known or suspected to have an infectious agent

Pharmacological

- opioids may reduce the perception of breathlessness
- morphine modified release 5mg bd (titrate up to maximum 30mg daily)
- morphine 2.5-5mg PO prn (1-2mg SC if unable to swallow)
- midazolam 2.5-5mg SC prn for associated agitation or distress
- anxiolytics for anxiety
- lorazepam 0.5mg SL prn
- **in the last days of life**
- morphine 2.5-5mg SC prn
- midazolam 2.5mg SC prn
- consider morphine 10mg and / or midazolam 10mg over 24 hours via syringe driver, increasing to morphine 30mg / midazolam 60mg step-wise as required

APM guidance delirium Non-pharmacological

- identify and manage the possible underlying cause or combination of causes
- ensure effective communication and reorientation (for example explaining where the person is, who they are, and what your role is) and provide reassurance for people diagnosed with delirium
- consider involving family, friends and carers to help with this
- ensure that people at risk of delirium are cared for by a team of healthcare professionals who are familiar to the person at risk
- avoid moving people within and between wards or rooms unless absolutely necessary
- ensure adequate lighting

APM guidance-Delirium

Pharmacological measures: mild to moderate to severe

- Haloperidol is generally the drug of choice for both hyper- and hypo-active delirium:
- start with 500 microgram / 24h CSCI or PO/SC at bedtime and q2h prn
- if necessary, increase in 0.5–1mg increments
- consider a higher starting dose (1.5-3mg PO/SC) when a patient's distress is severe and / or immediate danger to self or others
- If the patient remains agitated, it may become necessary to add a benzodiazepine, e.g.
- lorazepam 500 micrograms-1mg PO bd and prn or
- midazolam 2.5-5mg SC prn 1-2 hourly

Pharmacological measures: end of life (last days / hours)

- Use a combination of levomepromazine and midazolam in a syringe driver
- Levomepromazine (helpful for delirium)
- start 25mg SC stat and q1h prn (12.5mg in the elderly)
- if necessary, titrate dose according to response
- maintain with 50-200mg / 24h CSCI
- alternatively, smaller doses given as an SC bolus at bedtime, bd and prn
- Midazolam (helpful for anxiety)
- start with 2.5-5mg SC/IV stat and q1h prn
- if necessary, increase progressively to 10mg SC/IV q1h prn
- maintain with 10-60mg / 24h CSCI
- If the above is ineffective, seek specialist palliative care advice

Case Discussion 1

- 98 year old man
- Admitted from a nursing home
- Increasingly breathless. Diagnosed Covid positive
- Not a candidate for escalation to HDU/ITU
- Philosophical ‘I’ve got to die of something-turns out it’s this’
- Treated with oxygen, antibiotics.
- Referred to specialist palliative care
- Stabilised, recovered, returned to nursing home
- Made the papers!!

Case Discussion 2

- 84 year old lady with previous stroke and dementia
- Nursing home resident
- Admitted to Ward R1 for palliative and end of life care
- Son had had ‘Facetime’ contact with her and decided not to visit due to restrictions and personal situation
- Pt unconccious, tachypnoeic, appeared unsettled despite s.c. midazolam PRN and via a syringe pump
- Asked to call son and he asked me if she was on ITU
- Patient died 4 hours later

Case Discussion 3

- 69 year old man IHD, CCF, AF, NIDDM, discharged 6/7 previously
- Admitted with worsening SOB. Likely Covid. Started on ABX
- Covid +ve therefore admitted to respiratory ward
- Focal consolidation on CXR, fluid overload

Case Discussion 3

- Over the next few days
- Desaturating to below 80%, intermittently agitated
- Started CPAP via scuba mask
- 4 days after admission worsening Type 2 respiratory failure, ABGs improved on NIV
- Very agitated and confused, struggling to tolerate mask and poor seal
- Needed PRN midazolam to put bigger mask on

Case Discussion 3

- Felt to be nearing ceiling of care
- Family updated
- Referred to Palliative care Team
- Unconscious but restless
- 12.5mg levomepromazine with little effect
- Repeated-more settled but within 30 minutes unsettled again. Given 50mg levomepromazine

Case Discussion 3

- Discussed with son that NIV might prolong life but would make life more uncomfortable.
- Decided to try to remove mask.
- Breathing immediately changed on removal of mask.
- Died before a syringe pump could be commenced

Summary/Messages

- We have learnt a lot but are still learning

- Patients can deteriorate very quickly-there may not be time to start syringe pumps.
- Agitation is common
- Doses required are often larger
- Decisions around removal of NIV can be difficult and symptom management tricky
- Don’t be afraid to use symptom management alongside active treatment-it might mean that the patient can tolerate their treatment
- Communication with families is difficult, there is guidance on speaking to families over the phone
- Look after yourselves. Access support

- The Adam Buxton Podcast Episode 126
- Apmonline.org